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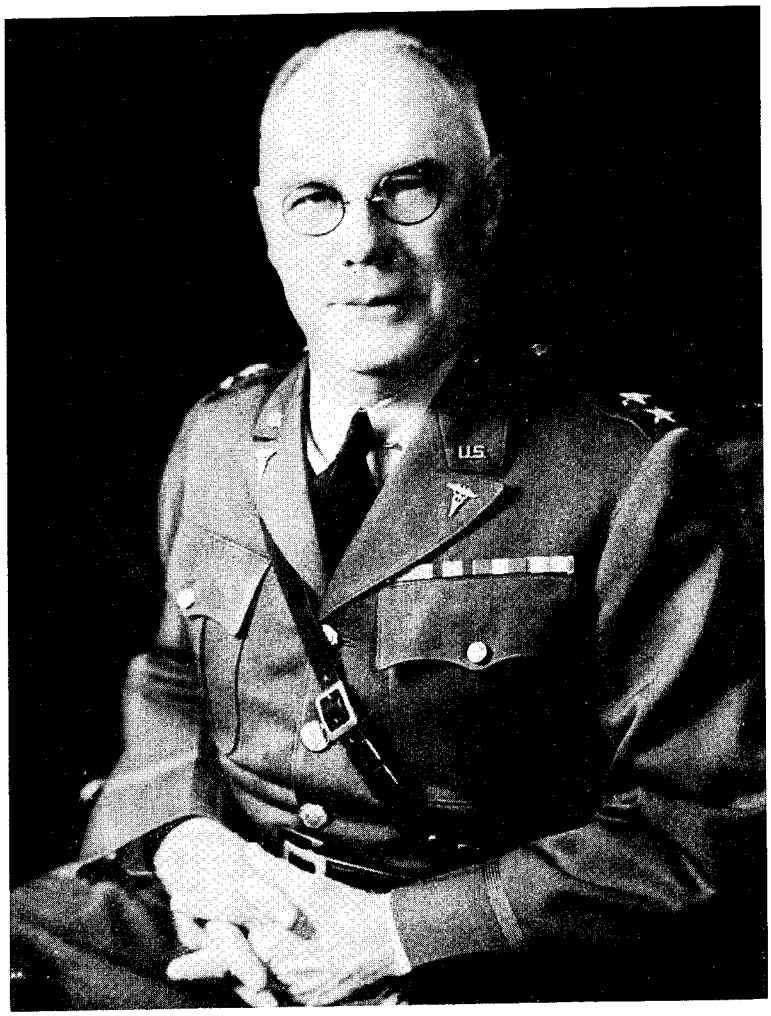
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1939–1943

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ORGANIZATION AND ADMINISTRATION IN WORLD WAR II

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by

BLANCHE B. ARMFIELD, M.A.

ORGANIZATION AND ADMINISTRATION IN WORLD WAR II

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Foreword

In order to meet the challenge of World War II the Medical Department of the United States Army expanded from a service equipped to support a peacetime army of some 200,000 men, based largely in the Zone of Interior, to one that provided the best in medical and surgical care for more than 8,000,000 American soldiers, serving on a war footing on every continent and under the most varied conditions of climate and terrain. The organization by means of which this global wartime mission was carried out, with efficiency and technical skill despite many potential sources of friction, is the theme of this volume in the administrative history of the Medical Department in World War II.

The book begins with an account of the structure and activities of the Office of The Surgeon General in the fall of 1939, when the long-impending outbreak of war in Europe led to the declaration of a national emergency in the United States. Over the next 2 years, leading up to the attack on Pearl Harbor that precipitated American entry into the war, both the Army and the geographical area in which it operated grew rapidly in size. The Selective Service Act, the acquisition of Atlantic bases from Iceland to Trinidad, the inception of the lend-lease program, all compelled expansion of the Army's medical service to keep pace with the demands made upon it. Outstanding authorities in a great variety of the medical and surgical specialties, in the allied sciences, and in the fields of supply and administration were called upon to advise The Surgeon General, while new organizational elements were added to deal with sanitation and other health needs in Army camps across the continent and in island garrisons along the air and sea lanes to Europe and the Middle East.

This rapid expansion of the medical service brought out rival demands from civilian and military interests for the allocation of medical supplies and the control of medically trained personnel, adding measurably to the administrative burden. By early 1942 the 10 prewar divisions of the Surgeon General's Office had increased to 40. Centralized as it was in Washington, the Medical Department had become topheavy, with too many officers reporting to The Surgeon General and the threads of too many functions in his hands.

In March of that year the Medical Department was placed under the Services of Supply—later known as the Army Service Forces—as part of a sweeping reorganization of the War Department. Internal changes in the structure of the Surgeon General's Office resulted in a wider delegation of responsibility and in more efficient administration of the expanding functions of the Medical Department, but these could not outweigh the disadvantages of subordination to an intermediate headquarters. Thereafter, until The Surgeon General was restored to a position on the War Department Special Staff in 1946, medical matters affecting the entire Army reached the Chief of Staff only through the

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Commanding General of the Army Service Forces. Many expedients were devised to minimize the unfortunate effects of the new organization, but as this volume clearly shows, the overall effect of interposing an additional level of authority between The Surgeon General and the Chief of Staff was to make efficient administration of the medical service more difficult.

From Washington the organizational story moves out to the service commands, and finally to the great oversea theaters where the basic mission of the Medical Department was fulfilled. A reorganization at the service command level parallel to that of the War Department downgraded the various service command surgeons from staff to divisional positions and dispersed their medical sections among several offices of the various service command headquarters according to function. This change made it difficult for the medical section at service command headquarters to operate as a unit, or for the service command surgeon to direct its work effectively. The transfer of the general hospitals located within the service commands from command of The Surgeon General to that of the commanding generals of the service commands had the effect of further weakening The Surgeon General's control and supervision over Medical Department installations and activities in the United States.

The Surgeon General's control of the medical service overseas was also less than complete. While Medical Department officers in Washington could communicate directly with theater surgeons overseas, and frequently did so, directives from The Surgeon General could be transmitted only in the name of the Chief of Staff, to whom The Surgeon General had no immediate access. Other factors tending to restrict The Surgeon General's control stemmed from local conditions in the different theaters, such as climate, terrain, the endemic disease pattern, and the degree of contact with civilian populations; and from the extent, frequency, and nature of combat operations.

A broad uniformity in the activities of the medical service in the different theaters was nevertheless achieved. Among the factors tending to bring about this uniformity were the standard tables of organization and equipment for Medical Department units; War Department directives such as those placing responsibility for certain preventive measures upon commanding officers; the use of consultants; a standard organization for malaria control, and another for administering public health measures in occupied areas; special commissions, such as the U.S.A. Typhus Commission, which sent specialists to epidemic areas; and the dispatch of individuals on special missions overseas to emphasize the standards and practices advocated by the Surgeon General's Office. Lastly, but certainly not least in importance, were the knowledgeable medical officers who served overseas in positions of great responsibility. These men were highly intelligent and experienced. Many had served as instructors at the Medical Field Service School at Carlisle Barracks, Pa., and at other service schools in the prewar years. They were familiar with theater medical organization and administration. Some had assisted in the formulation of War Department doctrine covering these matters. Their understanding, loyal co-

operation, and aggressive direction of the medical services in the oversea theaters contributed largely to the successful accomplishment of the medical mission.

The oversea story is told necessarily from the point of view of the major commands, such as the offices of theater and army surgeons, and the medical sections of the more important subordinate elements of both combat and communications zones. Only at this level is it possible to see in perspective the whole organizational pattern of the war, and the place of the Medical Department in the total structure.

Except for the imposition of an Allied command in some theaters, and the quasi-independent status of the Army Air Forces in most, the command structure under which the Medical Department served in an oversea area followed the general outlines laid down in the prewar manuals. The theater command was the highest U.S. Army command in an area; only a surgeon assigned to such a command could exercise overall responsibilities with respect to the health and medical care of all U.S. Army troops in the theater. On the other hand, the medical job at the headquarters of the various communications zones included the operation of the large medical installations in an oversea theater—the fixed hospitals which furnished most of the definitive medical care, and the large medical supply depots. In some cases the same man served as chief surgeon at both the theater and service forces headquarters. In some the entire medical section for the two headquarters was the same, being physically located at one of the two, or, in some cases, split between them. In the case of certain groups with special training sent to the theaters by the Surgeon General's Office to fill specific needs, such as the consultants and the malariologists, the question arose in some theaters as to whether they could be most effectively assigned to theater headquarters or to communications zone headquarters.

Medical Department officers consistently maintained that the chief surgeon of any command should have a position on the commander's staff. Only by being placed at staff level can the surgeon gain the ear of his commander and participate appropriately in the activities and responsibilities in which the surgeon has primary interest. Since the command surgeon is largely an advisor and lacks command authority except in instances in which it is specifically delegated to him, he needs direct access to the commander in order to make known the needs of the medical service. In time of war, guns and ammunition are apt to take priority over medical matters; buildings for warehouses may be constructed in advance of those for hospitals. Yet every commander expects the wounded to be treated, evacuated from the combat zone, and hospitalized with precision and dispatch. *If one single lesson stands out among those learned by the Medical Department in World War II, it is this: That at every important level of command the surgeon, if he is to carry out his mission effectively and well, must be an active and distinct member of*

the commander's staff. His position should not be subordinated nor included within any other staff member's office.

No other volume in the Medical Department series, nor even in the official history of the United States Army in World War II, gives so complete a worldwide picture of Army organization as this volume, which for that reason alone will undoubtedly find wide use outside of the U.S. Army Medical Service as well as internally. It presents clearly and at usable length the wartime organizational framework and the command structure within which the Army Medical Department functioned, and so forms an indispensable introduction to the other volumes of the series, clinical as well as administrative.

LEONARD D. HEATON,
Lieutenant General,
The Surgeon General.

Preface

This volume is one of a series dealing with the administrative history of the Medical Department, United States Army, in World War II. As an account of the organization and administration of the medical service in the United States and major oversea theaters of operations, it necessarily includes not only a description of changes in structure and administrative techniques but the accompanying changes in functions and responsibilities, which are treated here in broad terms.

Attention is focused principally upon the Surgeon General's Office, and upon the offices of the surgeons of the more important commands, both in the Zone of Interior and overseas. Minor theaters such as Alaska, the South Atlantic, and the Middle East, received no separate discussion here since they are treated in adequate detail in other volumes of this series. Problems of organization and administration in these areas did not differ in essentials from those in the larger theaters where the war was fought out. They were problems neither exclusively medical nor purely military, but a fusion of the two.

Other volumes in the administrative series, dealing respectively with hospitalization and evacuation in the Zone of Interior, with personnel, with medical supply, with training, and with all aspects of medical service in the European, the Mediterranean, and the Pacific theaters, necessarily impinge to some extent upon the subject matter of this study, but in a context relating in each case to substantive problems. In this book organization and administration are treated in the context of the whole medical service over the entire span of the defense and war years, thus supplying an essential framework for all segments of the history of the Medical Department in World War II.

Although the author of this volume, Miss Blanche B. Armfield, left The Historical Unit before the final editing of her manuscript, judgments and evaluations, as well as content and language, are basically hers, and full credit for the merits of the book belongs to her. Responsibility for the volume is shared to some extent, by Donald O. Wagner, Ph. D., who supervised the production of the original manuscript; by Col. John Boyd Coates, Jr., MC, USA, who suggested a number of changes in the author's draft; and, more especially by Charles M. Wiltse, Ph. D., Litt. D., who revised and reorganized the text after both Miss Armfield and Dr. Wagner had left The Historical Unit.

Others who influenced the final product are three former members of The Historical Unit, Mrs. Josephine P. Kyle, who served as Chief of the General Reference and Research Branch; and Nora V. Lewis (now Mrs. Thomas H. Major), and William K. Daum, who assisted the author with her research and wrote preliminary drafts of portions of the manuscript; Stetson Conn, Ph. D., Chief Historian of the Office of the Chief of Military History, Department of

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CHARLES M. WILTSE.

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119	Col. George E. Armstrong, MC	523
120	Col. Clyde L. Brothers, MC	526
121	Col. Alexander O. Haff, MC	537
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CHAPTER I

The Medical Department in 1939

In September 1939, when President Roosevelt proclaimed a limited national emergency, the U.S. Army Medical Department was serving an army whose mean annual strength was 191,551 officers and men.[1] The Medical Department functioned as one of six services; the others were the Chemical Warfare Service, the Corps of Engineers, the Ordnance Department, the Quartermaster Corps, and the Signal Corps. Its officer strength, 2,185, was considerably higher than that of any of the other services, being slightly more than twice the number in the Quartermaster Corps, the service next highest in officer strength. Its strength in enlisted men, 9,478, was greater than that of any of the other services except the Quartermaster Corps.

Unlike officer personnel in the other services, those of the Medical Department of the Regular Army were organized into several corps: the Medical, Dental, Veterinary, and Medical Administrative Corps. (Members of the Army Nurse Corps, a fifth component nominally constituting a corps, did not then have officer status.) Considered as a whole, the officer personnel of the Medical Department was more highly specialized than that of the other services, for members of the Medical, Dental, and Veterinary Corps had all obtained degrees in their respective fields before obtaining commissions in the Army, and the technical education which they had received in civilian life was supplemented in the Army by courses in military aspects of their disciplines.

Additional medically trained officers were available to the Army, whenever the need should arise, in the Organized Reserves and the National Guard of the United States. Within the Officers Reserve Corps, part of the Organized Reserves, there existed the following corps, constituting the Medical Department Reserve: Medical Corps Reserve, Dental Corps Reserve, Medical Administrative Corps Reserve, Veterinary Corps Reserve, and Sanitary Corps Reserve. The Sanitary Corps Reserve had no counterpart in the Regular Army, while the Army Nurse Corps had no counterpart in the Reserves. The National Guard of the United States had a Medical Corps, a Dental Corps, a Medical Administrative Corps, and a Veterinary Corps, as well as a complement of enlisted men with Medical Department training.

The Medical Department also had an important asset in its affiliation with a number of agencies and institutions, public and private, prepared to aid it in medical research, in procuring and training qualified personnel, and in various

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

other aspects of its work. In addition to continuous liaison with the Bureau of Medicine and Surgery of the Navy and with the Veterans' Administration, especially with respect to the hospitalization of military personnel, the Medical Department kept in close touch with the American Medical Association, the American Veterinary Medical Association, the American Dental Association, the American College of Surgeons, the American College of Physicians, various civilian nursing groups, and other recognized professional associations. Its relations with the first-named were particularly close, for nearly all doctors in the United States, including Army medical officers, were members of the American Medical Association. The American National Red Cross, chartered by act of Congress in 1905, could be counted on to aid the Army Medical Department with certain medical supplies and auxiliary personnel in the event of war. It maintained a register of medical technologists, and more important, a reserve of nurses for the use of both Army and Navy which compensated in a measure for the lack of a Nurse Corps reserve. Another agency empowered to support the Army Medical Service was the National Research Council, set up in 1916 by the National Academy of Sciences at President Wilson's request. The Council's Division of Medical Sciences was prepared to give the Army Medical Department advice on technical problems. For aid in research the Medical Department could draw upon a number of educational institutions and research foundations.

ORGANIZATION OF THE MEDICAL DEPARTMENT WITHIN THE WAR DEPARTMENT

In September 1939 the Office of The Surgeon General in Washington, D.C., was, as it had been for many years, the office which directed the work of the Army Medical Department. The Surgeon General was appointed by the President of the United States, with the advice and consent of the Senate, for a 4-year term. In the absence of The Surgeon General the chief of the Planning and Training Division usually acted in his stead; this officer was sometimes referred to as the Deputy Surgeon General. Maj. Gen. James C. Magee had become Surgeon General on 1 June 1939, succeeding Maj. Gen. Charles R. Reynolds (fig. 1). He headed an office, located in War Department Annex No. 1 at 401 Twenty-third St. NW. (fig. 2), staffed with about 30 officers and nurses and about 160 civilian employees.[2]

Together with the other services, the Medical Department had been located at staff level in the War Department since 1903, when the General Staff was created. In 1939 it 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 charged with coordinating the development of the separate arms and services in such a way as to insure an efficient military

[2] Annual Report of The Surgeon General, U.S. Army, 1939. Washington: U.S. Government Printing Office, 1940, p. 163.



FIGURE 1.—Maj. Gen. Charles R. Reynolds, MC.

team, but their relations with the chiefs of services, including The Surgeon General, remained about the same as those established in 1903. Measures which the Surgeon General's Office desired to put into effect throughout the Army had to clear through one or more of the five divisions of the General Staff: G–1, Personnel; G–2, Military Intelligence; G–3, Operations and Training; G–4, Supply; and the War Plans Division. Most measures called for the concurrence of G–1 or G–4, or both. The supervision of G–4 over medical service was closer than that exercised by any other of the General Staff elements, for in addition to G–4's general responsibilities for Army supply, it was specifically charged with preparing plans and policies for the evacuation and hospitalization of troops and animals, and for supervising these activities. The War Plans Division had the task of formulating plans for employment of troops in theaters of operations, but in peacetime its supervision over the medical service was limited to the coordination of the medical phases of such plans with other phases.[3]

The Office of The Surgeon General also had close contact with the Office of the Assistant Secretary of War, for the latter was charged by legislation with

[3] (1) 39 Stat. 168. (2) Annual Report of the Secretary of War, 1916. Washington: U.S. Government Printing Office, 1917, pp. 49ff. (3) Army Regulations No. 10–15, 18 Aug. 1936.

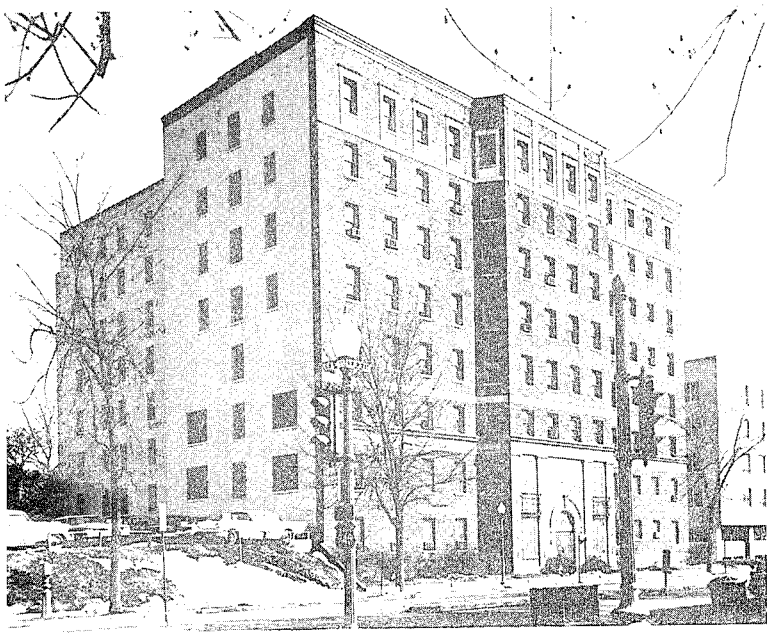


FIGURE 2.—War Department Annex No. 1, 401 Twenty-third St. NW., Washington, D.C., home of the Surgeon General's Office, 1939–41.

supervising the procurement of all military supplies and assuring adequate provision for mobilizing materiel and industrial organizations for wartime needs. The Assistant Secretary's office maintained liaison with manufacturing companies and industrial facilities. The Surgeon General dealt with G–4 on the military aspects of medical supplies and equipment and with the Office of the Assistant Secretary on business or industrial aspects.[4]

Internal Organization and Functions

Divisions of the Surgeon General's Office

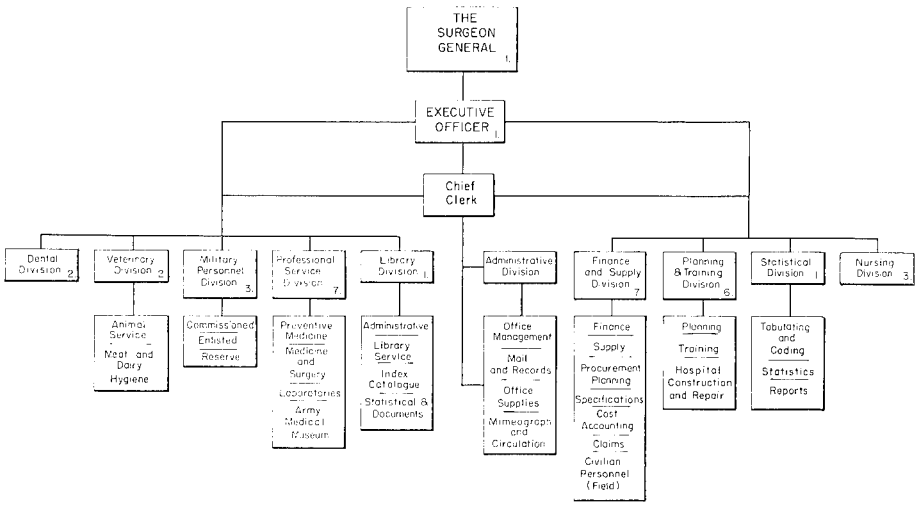
The 10 divisions which made up General Magee's office in 1939 were: Administrative, Finance and Supply, Military Personnel, Planning and Training, Professional Service, Statistical, Library, Dental, Veterinary, and Nursing (chart 1). The organization had existed in substantially this form since 1935.[5]

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[4] (1) 41 Stat. 764. (2) Lecture, Brig. Gen. R. C. Moore, Deputy Chief of Staff, before Army Industrial College, 24 Aug. 1940, subject: The Supply Division, G–4 of the War Department General Staff. (3) Yates, Richard E.: The Procurement and Distribution of Medical Supplies in the Zone of Interior During World War II, pp. 4–13. [Official record.]

[5] (1) Annual Report of The Surgeon General, U.S. Army, 1939. Washington: U.S. Government Printing Office, 1940, pp. 163–250. (2) Annual Report of The Surgeon General, U.S. Army, 1924. Washington: U.S. Government Printing Office, 1925, p. 238.

CHART 1.—*Office of The Surgeon General, October 1939*



Administrative Division.—Major functions of the Administrative Division were the handling of mail and records, the handling of matters relating to the civilian personnel of the office, the administration of certain hospital funds and the admission of patients to the Army and Navy General Hospital, the issuance of office supplies, the management of funds for various publications, and the editing of *The Army Medical Bulletin*, a journal containing articles of medicomilitary interest published by the Medical Department since 1919.

Finance and Supply Division.—Fiscal functions and functions relating to the purchase, storage, and issue of medical supplies and equipment were handled in the Finance and Supply Division. In the procurement of medical supplies and equipment this division worked closely with the Assistant Secretary of War. It prepared budget estimates for The Surgeon General and kept control accounts for appropriations granted the Medical Department. The merging of the supply function with fiscal activities was a natural development, as medical supply and equipment was the major item of expenditure handled by this division. The fact that the division also had general control of civilian employees in field installations indicates that the management of civilian employees was then considered largely a routine fiscal matter. The procurement and induction of civilian employees for extensive use in the Surgeon General's Office and field installations of the Department was not yet, as it later became, a pressing problem.

Military Personnel Division.—The Military Personnel Division selected, classified, and assigned commissioned medical personnel of the Regular Army

and the Reserve Corps. It also maintained records on enlisted medical personnel.

Planning and Training Division.—The Planning and Training Division, made up of the subdivisions of Planning and of Training, developed major policies in those two fields. Although Medical Department planning had to deal with supply, personnel, and so forth, as well as training, the last-named had been closely associated with planning since 1923, when the two functions of planning and training were assigned to a single division. This division prepared tables of organization (numbers, ranks, and duties of personnel and their unit equipment) for new medical units and detachments and revised those for current ones. It also planned the development of medical field equipment. Its work in training included making plans for the technical training of enlisted men, the tactical training of medical units, and the training of National Guard and reserve officers at Army professional schools, summer camps, and certain medical civilian centers. The division also developed plans for hospital construction and repair in conjunction with the Office of the Quartermaster General. In 1939 it was still concerned also with developing medical policies for the Civilian Conservation Corps.

Professional Service Division.—Policies on physical standards for the Regular Army and the Reserve Corps were prepared in the Professional Service Division. This division reviewed papers concerned with the physical examinations of officers and nurses. It also reviewed the examinations of applicants for commissions, the medical records of candidates for service schools, and complaints and claims involving personnel of the Civilian Conservation Corps and trainees of the Citizens Military Training Camps and Reserve Officers' Training Corps. It drafted Army-wide regulations relating to health, sanitation, and preventive medicine and the Medical Department forms to be used for reporting the health of Army troops, as well as the regular circular letters which the Department distributed to field installations. These were designed to standardize professional policies and maintain uniform professional standards in hospitals. It supervised the work of the Army Medical Museum, which classified and displayed medical specimens, equipment, and photographs, particularly of a pathological nature.

Dental, Veterinary, and Nursing Divisions.—The Dental, Veterinary, and Nursing Divisions handled administrative and professional matters relative to the Dental, Veterinary, and Army Nurse Corps respectively. In the fields of personnel and training for their respective corps they were practically autonomous.

Statistical Division.—The Statistical Division tabulated and analyzed reports on disease and mortality in the Army and the Civilian Conservation Corps. Data on individual soldiers played an important role in decisions on pension and disability claims. Statistical summaries kept the Medical Department informed of the major threats to the Army's physical well-being,

thus aiding in the determination of policies as to treatment, and contributed valuable data to medical history.

Library Division.—The functions of the Library Division were the formulation of policies for, and the administration of, the Army Medical Library.

Boards and committees

In addition to the divisional setup in the Surgeon General's Office, a few boards and committees handled certain special problems of an administrative nature. Among the functions handled by boards were, for example, the determination and review of ratings of Medical Department officers and the approval of efficiency ratings of civilian employees.

Liaison With Other War Department Units

Army Air Corps.—Certain units of the War Department other than the Surgeon General's Office had medical functions which they carried out under the aegis of, or in liaison with, the Surgeon General's Office. The major group of this type was the Medical Division of the Air Corps. Since World War I the War Department had recognized that in providing medical service for the Air Corps, it was important to give special consideration to the physical qualifications required of fliers, and to certain diseases and injuries peculiar to, or relatively more common among, fliers. The recognition of the necessity for examination and care of fliers by medical officers specially trained in this work had taken the form of the assignment of a group of Medical Department officers to the Air Corps. Most of these officers were trained as "flight surgeons," a term coined in 1918.

The series of circular letters, training manuals, and other technical documents in which the Surgeon General's Office formulated professional standards for medical, dental, and veterinary service went to Air Corps headquarters and installations as well as to the remainder of the Army. Air Corps medical officers had to keep the same statistical records and fill out the same reports to the Surgeon General's Office as medical officers assigned to other parts of the Army. These served to insure Army-wide uniformity of professional standards. However, medical officers assigned to the Air Corps had to acquaint aviators with the physical and psychological hazards of flying—the physical strain imposed by rapid shifts of altitude and temperature and the mental tension caused by the dangers of flight. Special training was required for either of the two chief assignments in Air Corps medical work—the aviation medical examiner, who tested candidates for their ability to withstand the hazards of flight, and the flight surgeon, who treated fliers and had to be versed in the maladies common among them. Since spotting the source of infection is difficult in the case of such a highly mobile force, the standard environmental sanitary measures of the Army were of limited value for air

troops; the Medical Division of the Air Corps had to issue special instructions and set up special procedures for disease control.

In late 1939 the group of medical officers assigned to the Office of the Chief of the Air Corps constituted a division and was a major unit of that office. Although personnel, physical examinations, aviation medicine, and research and statistics were recognized as major fields of work of the division, no true functional breakdown on the basis of personnel assignment existed. Only two Medical Corps officers, with three or four civilian assistants, were then on duty, and the division was primarily concerned with the review of physical examinations for fliers. Other activities were the pursuit of certain research projects, especially investigations of the effects of variation in air pressure upon the efficiency of fliers, the development of oxygen equipment, and the training of medical officers in the principles of aviation medicine to qualify them as aviation medical examiners or flight surgeons.

During the periods between World Wars I and II, Air Corps theory favoring an air force separate from the Army was reflected in the relations between the Office of The Surgeon General and the Medical Corps officers assigned to the Air Corps. The latter sporadically exhibited some tendency to pull away from the jurisdiction of The Surgeon General, insisting from time to time on the special characteristics of Air Corps medical service. During this period, however, the doctrine of separatism among medical officers assigned to the Air Corps was not emphatically voiced; many apparently felt a greater long-range loyalty to the Medical Corps to which they belonged than to the Air Corps. The fact that medical officers with the Air Corps, had been given their assignments by The Surgeon General, or by those previously so assigned by him, helped maintain the chain of loyalty that bound them to The Surgeon General. The need for flight surgeons was not yet fully recognized by Air Corps officers. As late as October 1939 the Chief of the Air Corps, Maj. Gen. (later General of the Army) Henry H. Arnold, irritated by a personal experience, directed the appointment of a board of officers to justify the existence of flight surgeons.[6]

Medical officers of the Surgeon General's Office were not in complete agreement as to where the group directing medical service for the Air Corps should be located. They frequently stated that they recognized the special problems of medical service for aviators but pointed out that the distinctive features of aviation medicine made it at most a medical specialty rather than a separate science. The "peculiarities" of aviation medicine did not warrant, in their opinion, the assignment of it to a group of officers responsible to the Air Corps. They recognized, however, as a practical consideration in any attempt to transfer medical functions of the Air Corps to the Office of The Surgeon General (and its medical installations to the control of The Surgeon

[6] 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, pp. 26–27.



FIGURE 3.—Lt. Col. C. L. Beaven, MC.

General) the greater drawing power of the Air Corps in obtaining appropriations from Congress. Public and congressional interest in aviation was so strong that whereas a request for additional appropriations to the Medical Department to take care of medical service for the Air Corps might be turned down, any Air Corps request for an appropriation for the same purpose would be accepted in the general appropriation for the development of Army aviation. At the same time they felt that the degree of autonomy already established by the medical group in the Air Corps violated the principle that each supply service of the Army should have a single head.

In early 1939 General Reynolds embarked upon an effort, renewed by General Magee in the fall, to have the medical group of the Air Corps transferred to his office and the School of Aviation Medicine at Randolph Field, Tex., removed to his jurisdiction. This move began a struggle on the part of the Surgeon General's Office for coordination of the entire Army medical service under it and on the part of the medical group in the Air Corps for autonomy, one phase of the general struggle for autonomy of the Army's air forces which continued through the war. Lt. Col. (later Col.) C. L. Beaven, MC (fig. 3), then Chief of the Medical Division of the Air Corps, agreed with The Surgeon General's desires in the matter, while Lt. Col. (later Maj. Gen.) David N. W.

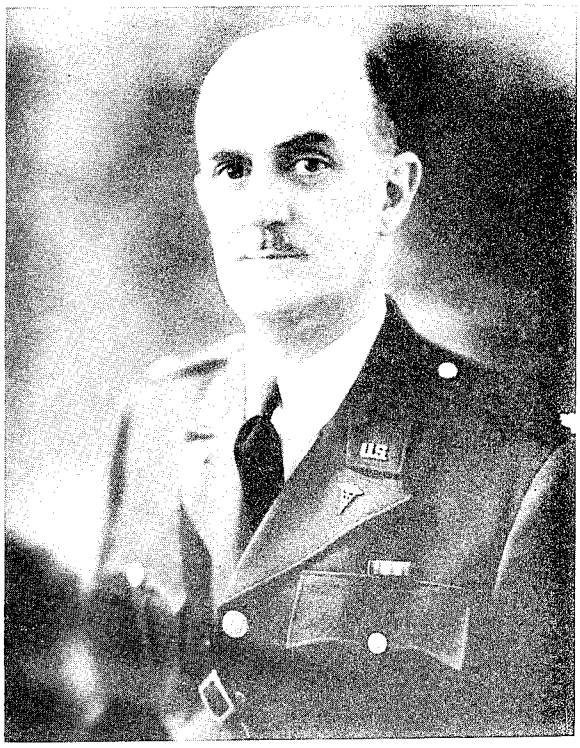


FIGURE 4.—Lt. Col. David N. W. Grant, MC.

Grant, MC (fig. 4), his assistant who soon succeeded him, favored retention of the Medical Division and the School of Aviation Medicine by the Air Corps. During the early months of his tour of duty, however, Colonel Grant went along with Colonel Beaven's policies, for the latter was still nominally in charge.[7]

National Guard Bureau.—The Medical Department also had an officer assigned as medical adviser to the National Guard Bureau, the unit of the War Department which handled National Guard Affairs. In 1939 this post in the office of the chief of the bureau was held by Col. (later Maj. Gen.) Howard McC. Snyder, IGD (fig. 5). His duties were primarily the provision of medical care in training camps for the National Guard, direction of the training of medical units, and issue of the necessary medical supplies and equipment.[8]

[7] (1) Coleman, Hubert A.: Organization and Administration, Army Air Forces Medical Service in the Zone of Interior, pp. 33–36, 132–135. [Official record.] (2) Annual Report of The Surgeon General, U.S. Army, 1939. Washington: U.S. Government Printing Office, 1940, p. 259. (3) Armstrong, Harry G.: Principles and Practice of Aviation Medicine. Baltimore: Williams & Wilkins, 1943, pp. 20–27. (4) Letter, Maj. Gen. David N. W. Grant, MC, USAF (Ret.), to Col. John Boyd Coates, Jr., MC, Director, The Historical Unit, U.S. Army Medical Service, 11 Aug. 1955, subject: Comments on preliminary draft of this volume.

[8] (1) Annual Report of the Chief, National Guard Bureau, 1939. Washington: U.S. Government Printing Office, 1940, p. 1. (2) Interview by the author with staff members, National Guard Bureau, 28 June 1948.

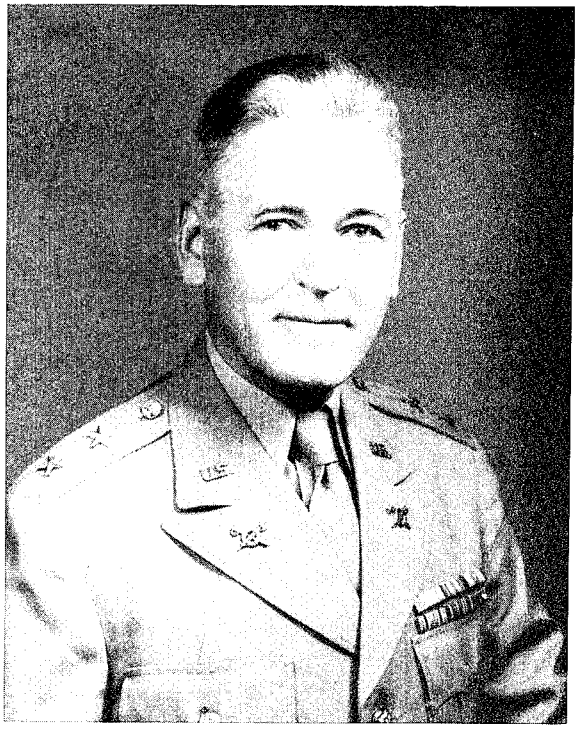


FIGURE 5.—Maj. Gen. Howard McC. Snyder, IGD.

MEDICAL FIELD OFFICES AND INSTALLATIONS

The Surgeon General's Office directed the medical work of the Army throughout the United States and the oversea possessions where elements of the Army were stationed. Nearly 75 percent of Army troops were stationed in the United States; most of the remainder were in Hawaii, Panama, the Philippines, and Puerto Rico.[9] At major Army headquarters there existed a network of medical administrative offices which carried out the policies established by the Washington office. Policies and procedures established by the office with respect to hospitalization, medical supply, and equipment, as well as the technical instructions which the office drew up for the prevention and treatment of disease, were embodied in the series of circular letters, issued and revised regularly since 1918. These were distributed to corps areas and departments, general hospitals, and the surgeons of stations and tactical installations.

Medical Research Division, Edgewood Arsenal

At the chief field installation maintained by the Chemical Warfare Service, Edgewood Arsenal, Md., certain Medical Department officers constituting a

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

Medical Research Division, were engaged in research on preventive and curative measures to counteract chemical warfare agents. Research in this field dated from the widespread use of gases in World War I. During the pre-World War II period, research in chemical warfare medicine had not progressed rapidly. Various factors had made it difficult to procure and retain highly qualified civilian personnel, including poor pay, the semi-isolation of the arsenal, and the fact that the nature of the work prevented publication of much of the research. Appropriations had been meager, and frequent rotation of officers had handicapped the continuity of the research.

In 1935 the Medical Department had recognized that progress to date was unsatisfactory, and The Surgeon General had endorsed proposals to the Chief of the Medical Research Division at Edgewood Arsenal for more thorough research into methods of definitive treatment of gas casualty cases; the latter had pointed out recent developments in chemistry which enlarged the possibilities of effective treatment. The Surgeon General had increased funds allotted to the work, and research in chemical warfare medicine had then entered upon a period of more direct guidance by the Medical Department. This was the setup in 1939, which prevailed throughout most of General Magee's administration. In 1939 and preceding years two or three Medical Department officers received training annually in the Chemical Warfare School at Edgewood Arsenal.[10]

Corps Areas and Territorial Departments

In 1939 the United States was divided into nine corps areas, each in charge of a corps area commander. On the commander's special staff was a corps area surgeon. Three territorial departments (four before the close of the year) were the corresponding units for certain of the U.S. possessions overseas: the Hawaiian, Philippine, and Panama Canal Departments. The corps area or department surgeon was responsible for the training of Medical Department personnel in his area; for recommendations as to the construction and repair of Medical Department buildings, particularly hospitals; for coordinating inspections to determine sanitary conditions, the efficiency of medical personnel, and the adequacy of medical supplies throughout the corps area; and for making recommendations as to the transfer of medical personnel from station to station within the corps area or department; and for transfer of patients from station hospitals to the general hospitals which gave more advanced or definitive treatment. He prepared regular reports for The Surgeon General on the efficiency of medical officers serving directly under him and

[10] (1) Cochrane, Rexmond C.: Medical Research in Chemical Warfare, Chemical Warfare Service, 1947. [Official record.] (2) Army Regulations No. 50–5, 31 May 1939. (3) Report on Training of Medical Department Officers, 1 July 1939–30 June 1944, p. 19. [Official record.] *See also* Brophy, Leo P., Miles, Wyndham D., and Cochrane, Rexmond C.: United States Army in World War II, The Chemical Warfare Service: From Laboratory to Field. Washington: U.S. Government Printing Office, 1959.

annual reports to The Surgeon General on the health of troops stationed within the area.

In the effort to lay some responsibility upon line officers for health conditions within their commands, Army regulations held commanding officers of all grades responsible for the enforcement of measures to control and prevent disease, including regulations on sanitation and hygiene and the control of venereal disease. The cooperation of commanders of troop elements within the corps area in the enforcement of these measures was important to the corps area surgeon.

The corps area surgeon's office

The corps area surgeon's office was small and did not require a divisional breakdown. Usually three or four medical officers, with perhaps an additional Medical Administrative Corps officer, and about the same number of civilian clerical personnel were assigned to the office. The corps area surgeon, or a representative from his office, customarily visited each medical installation in the corps area in the course of a year. Complaint of shortage of personnel, particularly dental, throughout the corps area was fairly common. In the maintenance of medical service for the Civilian Conservation Corps—an additional responsibility to which corps area surgeons attributed in part their personnel shortages—medical, dental, and veterinary Reserve officers were sometimes employed on a civilian status, along with civilian dentists and nurses.[11]

The Surgeon General's relationship with corps area surgeons and medical installations in the corps areas involved both technical and command control. The Surgeon General had technical control over all Medical Department officers and offices, including those of the Air Corps; technical instructions issued by his office were applied throughout the Army. The channels of technical control extended downward from The Surgeon General to corps area surgeons, and from them to station and unit surgeons. In theory this technical control could be nullified by the commanding general of a corps area, who exercised command authority over all medical personnel within his jurisdiction, but in practice The Surgeon General's orders were rarely questioned. The corps area surgeon had direct access to his commander by virtue of his staff position, and in peacetime, at least, enjoyed a considerable degree of autonomy.[12]

The prevailing practice was that the corps area commander should have command of installations within the geographical boundaries of his corps area. Hospitals or dispensaries located at posts or stations within corps areas

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[11] (1) Army Regulations No. 170–10, 18 Aug. 1936 and 10 Oct. 1939. (2) Annual Reports of the Corps Area Surgeons, 1938, 1939. 319.1–2 (CAS) AA. (3) Army Regulations No. 40–5, 15 Jan. 1926, with change 1, 9 June 1938; Army Regulations No. 40–205, 15 Dec. 1924; Army Regulations No. 40–210, 21 Apr. 1923; Army Regulations No. 40–235, 11 Oct. 1939; Army Regulations No. 40–270, 21 Apr. 1923.

[12] History, Office of the Surgeon, II Corps Area and Second Service Command, 9 September 1940–2 September 1945. [Official record.]

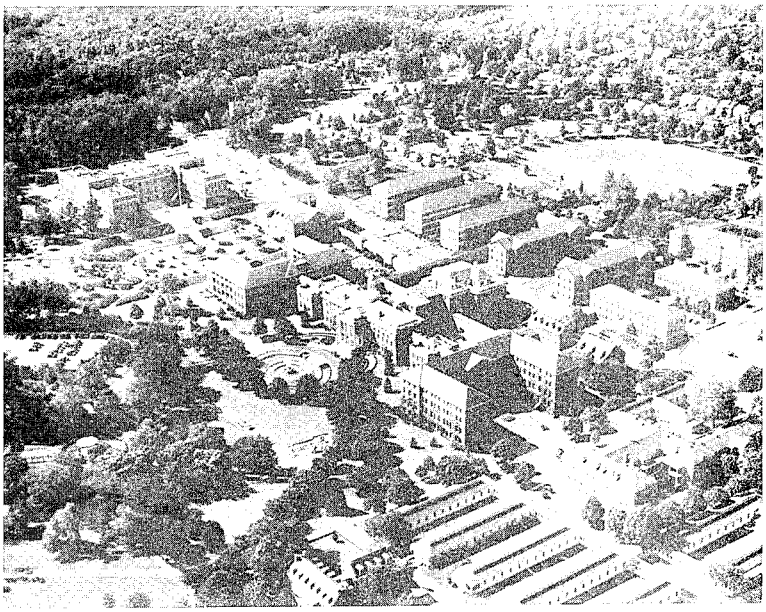


FIGURE 6.—Army Medical Center, Walter Reed Army Hospital, Washington, D.C., about 1939.

were therefore within the corps area chain of command, with certain exceptions. However, a tendency existed to give the chief of a service, or a combat arm, command control over stations concerned exclusively (or perhaps primarily) with the work of that service or arm. Thus an ordnance arsenal was under command of the Chief of Ordnance; thence the station hospital at the arsenal was within the Ordnance Department's chain of command. A station hospital might be within the command channel of one of the arms or services or of the corps area commander.

Major medical installations

Other than station hospitals, major medical installations in the United States in 1939 were of the four following main types: General hospitals, which received patients needing advanced or definitive treatment without regard to the corps area in which the patient has been stationed; the service schools of the Medical Department; the medical supply depots; and medical laboratories. Over most of these The Surgeon General had command control.[13] In the course of the war the extent of his command over some of these installations underwent considerable change.

The principal Medical Department installation commanded by The Surgeon General was the Army Medical Center (fig. 6), in Washington, D.C.; it

[13] See Army Regulations No. 170–10, 10 Oct. 1939, for detailed list of stations and installations commanded by The Surgeon General.

was made up of three of the types mentioned above—a general hospital (Walter Reed); the Medical, Dental, and Veterinary Schools; and the Medical, Dental and Veterinary Laboratories.[14] Two other installations located in Washington were the Army Medical Library and the Army Medical Museum. Both of these, as well as the Army Medical Center, remained under The Surgeon General's command throughout the war.

General hospitals.—General hospitals then in existence in the United States (in addition to Walter Reed) were: Army and Navy in Hot Springs, Ark.; Fitzsimons in Denver, Colo.; Letterman in San Francisco, Calif.; and William Beaumont in El Paso, Tex. These installations were under the command control of The Surgeon General, because they received patients from various corps areas. It was desirable that the Surgeon General's Office exercise central control over the transfer of a patient from a station hospital to the general hospital, located in whatever corps area, which could best give him the definitive treatment which he needed. On the other hand, the two general hospitals in the departments—Tripler in Hawaii and Sternberg in the Philippines—were under the command of the department commander. The remoteness of the Pacific island territories made command by the local department commander more feasible than command from Washington. Any general hospital that might function in a theater of operations would similarly come under the command of the tactical commander within whose jurisdiction it was located.[15]

Service schools.—Schools under command control of The Surgeon General were the three professional schools at the Army Medical Center and the Medical Field Service School at Carlisle Barracks, Pa. At the professional schools in Washington, Medical Department officers and enlisted technicians received training in medical specialties and in the military aspects of the medical, dental, and veterinary services. The school at Carlisle Barracks trained medical, dental, veterinary, and Medical Administrative Corps officers, as well as enlisted men in the fieldwork of the Medical Department, emphasizing such matters as administration, training, military art, and sanitation. The School of Aviation Medicine, which dated from World War I, had been located at Randolph Field, Tex., since 1931. In name and function a medical school, it was under command control of the Air Corps, specifically the Air Corps Training Center, although it was planned to transfer it to The Surgeon General's jurisdiction in the event of mobilization.[16]

Medical supply depots.—In 1939 the only depot handling medical supplies exclusively was the St. Louis Medical Depot. It was under the command

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[14] Army Regulations No. 40–600, 31 Dec. 1934.

[15] See footnote 14.

[16] (1) Report on the Training of Medical Department Officers, 1 July 1939–30 June 1944, pp. 3–5. [Official record.] (2) Coleman, Hubert A.: Organization and Administration, Army Air Forces Medical Service in the Zone of Interior, pp. 243–244. [Official record.] (3) Annual Report of The Surgeon General, U.S. Army, 1939. Washington: U.S. Government Printing Office, 1940, pp. 180–182. (4) Armstrong, Harry G.: Principles and Practice of Aviation Medicine. Baltimore: Williams & Wilkins, 1943, p. 12.

control of The Surgeon General. Three of the general depots, under the command control of the Quartermaster General, had medical sections along with sections for the other supply services: the New York, San Francisco, and San Antonio General Depots. The Medical Section, New York General Depot, which was larger than the St. Louis Medical Depot as well as larger than the medical sections of either of the other two general depots, bought the great bulk of medical supplies and equipment, as most of the medical supply firms were concentrated in northeastern United States. It stored and issued medical supplies as well. The St. Louis Medical Depot and the medical sections of the San Antonio and San Francisco General Depots acted primarily as storage and issue depots.[17]

Medical Department laboratories.—The Medical Department's laboratory system was made up of units concerned with problems of general medicine, veterinary medicine, dentistry, or aviation medicine. The Army Medical Center in Washington had laboratories of the first three types. During 1938 the Dental Division, Surgeon General's Office, had been engaged in establishing five central dental laboratories, including the dental laboratory at the Army Medical Center, to give prosthetic service to troops in specified corps areas. By the middle of 1939 these were in operation. Except for the laboratory at the Center, they were under the command control of the commanding officer of the Army station where they were located. In addition to its research, its diagnostic work with animal diseases, and the preparation of veterinary biological products, the veterinary laboratory at the Army Medical Center made examinations of samples of meat, meat food, and dairy products supplied to the Army. In the fall of 1939 the Veterinary Division, Surgeon General's Office, undertook the establishment of a new laboratory, the Veterinary Research Laboratory, to work on problems of animal disease, especially equine influenza and periodic ophthalmia, at the Quartermaster Depot (Remount) at Front Royal, Va. This, too, was under the command control of the commanding officer of the installation.[18]

Research installations.—In the fall of 1939 the single separate installation of the Medical Department which had been designed exclusively for research, the Army Medical Research Board in Panama, was discontinued for lack of money. For several years it had undertaken studies in malaria, the dysenteries, and various animal diseases. Research on problems of aviation medicine was carried on at two Air Corps installations, the School of Aviation Medicine mentioned above, and the Aero-Medical Research Unit, later called

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[17] (1) See footnote 4(3), p. 4. (2) Memorandum, Director, Storage and Maintenance Division, Office of The Surgeon General, for Historical Division (later Historical Unit), 16 Nov. 1944, subject: Supply Depot Historical Highlights.

[18] (1) Medical Department, United States Army. Dental Service in World War II. Washington: U.S. Government Printing Office, 1955, p. 217. (2) Annual Report of The Surgeon General, U.S. Army, 1939. Washington: U.S. Government Printing Office, 1940, pp. 200, 205. Annual Report of The Surgeon General, U.S. Army, 1940. Washington: U.S. Government Printing Office, 1941, p. 211. (3) Medical Department, United States Army. Veterinary Service in World War II. Washington: U.S. Government Printing Office, 1962, pp. 429–431.

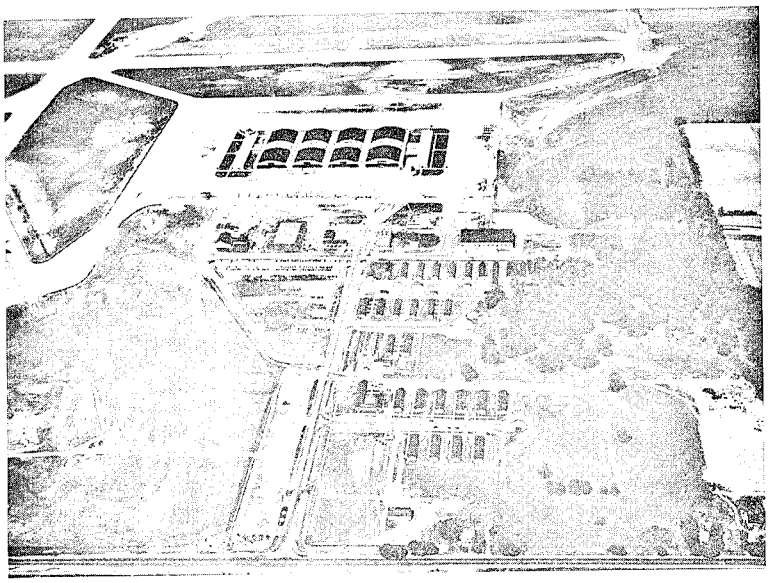


FIGURE 7.—Aero-Medical Research Laboratory, Wright Field, Dayton, Ohio, about 1939.

the Aero-Medical Research Laboratory (fig. 7), at Wright Field, Ohio. The latter, under the Materiel Division of the Air Corps, had as commandant Capt. (later Maj. Gen.) Harry G. Armstrong, MC (fig. 8), who became Surgeon General of the Air Force in the postwar period. The research projects of the School of Aviation Medicine and the Aero-Medical Research Unit overlapped somewhat. The theory expressed at intervals was that the School of Aviation Medicine should be concerned with the psychological and physiological effects of flying, whereas the Aero-Medical Research Unit, under the jurisdiction of a command concerned largely with supply and maintenance, should deal with problems of adaptation of planes and equipment to the human organism. However, it was difficult to divorce the two fields, and the question continued to come up for discussion.[19]

The oversea departments

The organization of medical service in the oversea departments corresponded generally to that in the corps areas, and the headquarters organization was similarly small and uncomplicated. Medical officers in the department surgeon's office were usually termed simply "assistants," one being assistant in charge of supply, another of personnel, and so forth. The medical work of

[19] (1) Folder, Aero-Medical Laboratory, Wright Field, Ohio, HU : TAS. (2) Armstrong, Harry G. : The Principles and Practice of Aviation Medicine. Baltimore : Williams & Wilkins, 1943, p. 16. (3) Annual Report of The Surgeon General, U.S. Army, 1934. Washington : U.S. Government Printing Office, 1935, p. 154. Annual Report of The Surgeon General, U.S. Army, 1938. Washington : U.S. Government Printing Office, 1939. p. 178. Annual Report of The Surgeon General, U.S. Army, 1940. Washington : U.S. Government Printing Office, 1941, p. 195.



FIGURE 8.—Maj. Gen. Harry G. Armstrong, MC, USAF.

the department surgeon's office corresponded to that of the office of the corps area surgeon except for certain programs made necessary by local conditions in the departments. The department surgeon's office directed the usual dental and veterinary, as well as medical, services and reported to the Surgeon General's Office on disease rates and the general health of the command. Malaria and venereal disease control demanded special effort in the Panama Canal and Philippine Departments. The office of the department surgeon directed certain field training programs, although the number of officers and enlisted personnel was not usually large enough to permit extensive field medical training for Regular Army personnel. In the Philippines, the 12th Medical Regiment of Philippine Scouts, which later rendered effective service at Bataan and Corregidor, was undergoing training, and in the Hawaiian Department, the largest of the departments in troop strength, a few reserve officers were trained on active duty status.[20]

[20] (1) Whitehill, Buell: Administrative History of Medical Activities in the Middle Pacific (1946). [Official record.] (2) History of Medical Department Activities in the Caribbean Defense Command in World War II, vol. I. [Official record.] (3) Annual Report of the Department Surgeon, Panama Canal Department, 1939. (4) Annual Report of the Department Surgeon, Philippine Department, 1939. (5) Annual Report of the Department Surgeon, Hawaiian Department, 1939. (6) Cooper, Wibb E.: Medical Department Activities in the Philippines from 1941 to 6 May 1942, and Including Medical Activities in Japanese Prisoner of War Camps. [Official record.]



FIGURE 9.—Maj. Gen. Morrison C. Stayer, MC.

In each department the Medical Department maintained a number of installations of the same types as those in the corps areas. In the Philippine Department, for instance, were Sternberg General Hospital, five station hospitals, and a medical supply depot at Manila. At each of three station hospitals, as well as at Sternberg, was a dental clinic. Sternberg also had a laboratory (including a veterinary section) and a general and station dispensary service. These installations provided medical service for approximately 30,000 personnel, of whom about two-thirds were civilians.

Panama Canal Department.—In the Panama Canal Department, where troop strength averaged between 14,000 and 15,000 in 1939, a unique medical organization existed, a result of the control of the administration of the Canal Zone by the War Department. The Governor of the Canal Zone was customarily a retired Engineer officer, appointed by the President of the United States and responsible to the Secretary of War. At the head of the Health Department of the Canal Zone and reporting directly to the governor was the chief health officer, who was a Medical Department officer designated for the position by The Surgeon General. In 1939 Col. (later Maj. Gen.) Morrison C. Stayer, MC (fig. 9), was chief health officer.

The Chief Health Officer was responsible for environmental sanitation, the prevention and control of transmissible diseases, and the enforcement of quarantine regulations in the Canal Zone and the terminal cities of Panama and Colon. It was important that the orderly passage of ships through the canal should proceed unhampered by adverse health conditions. In general the work of the Panama Canal Health Department resembled that of a large city health

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department. It was also responsible for such tasks as garbage collection and street cleaning for which a department of sanitation was usually responsible in cities in the United States. In addition it ran several hospitals, including the well-known Gorgas Hospital, and a number of dispensaries to care for U.S. Government employees and their dependents in the Canal Zone.

The Surgeon, Panama Canal Department, whose office was at Quarry Heights, was responsible for the health of U.S. Army troops in the Canal Zone and controlled the usual Army Medical Department installations there. He reported to the department commander. Some disagreement existed between the chief health officer on the one hand and The Surgeon General and department surgeon on the other as to the respective responsibilities of the chief health officer and the department surgeon. The Surgeon General apparently took the position that the department surgeon, his representative, should rule on all medicomilitary policies in the Canal Zone. Colonel Stayer contended that his position as adviser to the Governor and his many civilian contacts put him in a better position than the department surgeon to be chief adviser to the Army commander in the area; that is, to advise on military as well as civil health problems. In spite of this disagreement as to proper jurisdiction, effective coordination of the work of the two officers prevailed in specific fields. Cooperation was particularly close in the fieldwork undertaken by the Division of Sanitation of the Health Department and the Field Sanitary Force of the department surgeon's office to eliminate the breeding grounds of mosquitoes, a major health project of the Zone.[21]

Puerto Rican Department.—On 1 July 1939 a fourth oversea department came into being when the Puerto Rican Department was established, including both Puerto Rico and the Virgin Islands, with headquarters at San Juan, P.R. Before that date the two military installations in Puerto Rico, the Post of San Juan and Henry Barracks, both staffed with Puerto Rican troops, had been attached to the Second Corps Area, but the surgeon at San Juan had been even then in effect a department surgeon. The station hospital at the Post of San Juan provided hospitalization for the department.[22]

Field Tactical Units

The only tactical units of the Medical Department in existence in June 1939 were four medical regiments and a medical squadron organized at peacetime strength. The 11th Medical Regiment and the 12th, the latter made up of Philippine Scouts, were stationed in Hawaii and the Philippines, respectively.

[21] (1) Letters, Maj. Gen. Morrison C. Stayer, MC, USA (Ret.), to Col. Roger G. Prentiss, Jr., MC, Director, Historical Division (later The Historical Unit), Office of The Surgeon General, 17 Jan. 1950 and 1 Feb. 1950. (2) History of Medical Department Activities in the Caribbean Defense Command in World War II, vol. I, p. 127. [Official record.]

[22] (1) Memorandum, The Adjutant General, for the Commanding General, Second Corps Area, 1 May 1939, subject: Establishment of the Island of Puerto Rico, Including the Virgin Islands, as a Territorial Department. (2) Army Regulations No. 170–10, 10 Oct. 1939. (3) Annual Report of the Department Surgeon, Puerto Rican Department, 1939. (4) History of Medical Department Activities in the Caribbean Defense Command in World War II, vol. I, pp. 105ff. [Official record.]

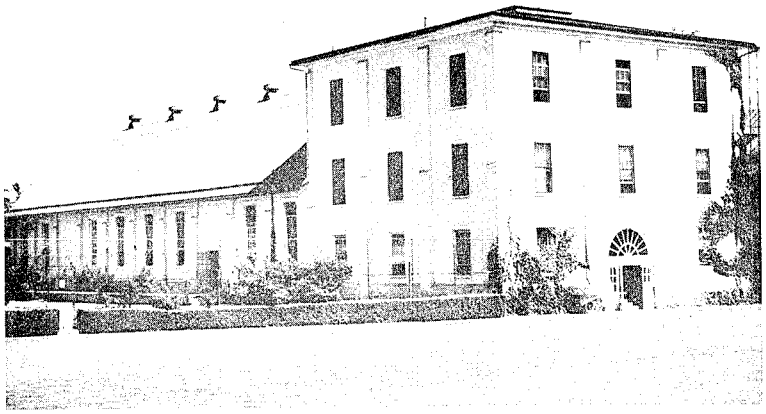


FIGURE 10.—Carlisle Barracks, Pa., home of the Medical Field Service School, about 1939.

The 1st Medical Regiment was in training at Carlisle Barracks (fig. 10), where it was used as a demonstration unit for the Medical Field Service School and for the training camps for the Organized Reserves and the Reserve Officers' Training Corps units conducted at Carlisle Barracks. The 2d Medical Regiment, stationed at Fort Sam Houston, Tex., was taking part in extensive exercises and maneuvers with the streamlined infantry division then undergoing test as a new combat unit. In addition to the medical regiments the 1st Medical Squadron (cavalry) at Fort Bliss, Tex., was partially organized. By the date the President declared the limited emergency a few additional medical regiments, squadrons, and smaller units had been activated.[23]

DEVELOPMENTS OF LATE 1939: PLANNING

The work of the Planning and Training Division in 1939 reflected the prospects of war and the War Department's plans for defense. As the additions to the Panama garrison and the expanding Air Corps made increased demands on the medical service, the division began planning the construction of additional hospitals. It renewed efforts of previous years to increase to 7 percent the quota of enlisted men in the Medical Department, limited since 1920 to 5 percent of the Army's enlisted strength.[24] In 1939 the division was

[23] (1) Annual Report of The Surgeon General, U.S. Army, 1939. Washington: U.S. Government Printing Office, 1940, p. 172. Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1942, p. 153. (2) Annual Report of the Station Hospital, Schofield Barracks, Territory of Hawaii, 1941.

[24] (1) Memorandum, Col. Albert G. Love, MC, for the Committee on Medical Care, 15 Oct. 1942, subject: Review of Oral Testimony on Work of the Planning and Training Division, 1 Apr. 1938–31 July 1939, Before the Committee to Study the Medical Department. (2) Annual Report of The Surgeon General, U.S. Army, 1939. Washington: U.S. Government Printing Office, 1940, pp. 176–190.

also busy preparing medical plans called for by the revised War Department Protective Mobilization Plan of that year. It estimated the number and types of medical units and personnel necessary to support the War Department plan and established policies for their training. As a means of providing the hospitals which the plan called for, the division undertook to revive certain reserve hospital units formerly established in civilian medical schools and hospitals and staffed with their personnel. Similar so-called "affiliated units" had acquitted themselves creditably in World War I, but during the thirties when the War Department had shifted to a policy of decentralizing the administration of Reserve Corps affairs to the control of corps area commanders, the Office of The Surgeon General had lost touch with the affiliated units. In August 1939 the War Department gave approval to their revival, and the Medical Department set about this task.[25]

The Protective Mobilization Plan

The Surgeon General's Protective Mobilization Plan for 1939, which appeared in final form in December, included plans for expanding medical facilities in the United States as well as plans for increase in personnel for hospitals, supply, and other matters. It contemplated only limited expansion in the Surgeon General's Office in the event of mobilization. Two major functions of the existing Professional Service Division would be raised to divisional status and become the Preventive Medicine Division and the Museum Division. The Professional Service Division itself would become the Hospital and Professional Service Division.

Recognition of the coming significance of preventive medicine and of hospital administration was prophetic; these functions soon became the basis for principal organizational segments of the Surgeon General's Office. Plans of several years earlier, in fact, had recognized the wartime importance of not only preventive medicine but also hospital construction, as well as hospital administration, and of certain professional specialties such as internal medicine, surgery, and neuropsychiatry. Planning documents of earlier years had also recommended setting up an inspection division in the Surgeon General's Office, which would be charged with inspecting all administration and technical activities of the Medical Department at large. The question of the role of this division vis-a-vis that of the Inspector General's Department and, indeed, vis-a-vis possible inspection of field activities by divisions currently

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[25] (1) Memorandum, The Surgeon General (Reynolds), for The Adjutant General, 17 Mar. 1939, subject: Affiliation of Medical Department Units With Civil Institutions and Appointment and Promotion in the Medical Corps Reserve. (2) Memorandum, The Adjutant General, for The Surgeon General, 3 Aug. 1939, subject: Affiliation of Medical Department Units With Civil Institutions and Appointment and Promotion in the Medical Corps Reserve. (3) Annual Report of The Surgeon General, U.S. Army, 1939. Washington: U.S. Government Printing Office, 1940, p. 179. (4) Memorandum, The Adjutant General, for The Surgeon General, 26 Jan. 1940, subject: Officers of Affiliated Medical Units—Appointment, Reappointment, Promotion, and Separation. (5) See footnote 24(1), p. 21.

responsible for them, was not fully clarified.[26] The concept apparently constituted recognition that a more thoroughgoing system than the existing one for examining the quality of medical service in field installations would become necessary as installations multiplied rapidly during an emergency period.

Role of the U.S. Public Health Service.—In 1939 the question came up as to the type of aid which the Medical Department should request of the U.S. Public Health Service in the event of war. By legislation of 1902 the President had been authorized to use this Federal agency in time of actual or threatened war in such a way as, in his opinion, best promoted the public interest. Accordingly, President Wilson had issued an Executive order in April 1917 ordering that in time of actual or threatened war the U.S. Public Health Service should constitute part of the military forces of the United States. Various moves had been made towards amalgamating civilian and military agencies handling public health programs. However, Secretary of the Treasury William G. McAdoo had opposed a bill to transfer functions relating to sanitary measures in areas near military establishments, then being exercised by the U.S. Public Health Service under his jurisdiction, from the Treasury Department to the War Department. Moreover, legal interpretation had held that the U.S. Public Health Service could not be considered a part of the Army or Navy and had prevented the granting of Army pensions to U.S. Public Health Service officers detailed to the Army. During World War I the U.S. Public Health Service had continued to provide extracantonment sanitation in cooperation with the Army and State and local health authorities. The Medical Department concluded that it would be wise to follow the same general plan in the current emergency.[27]

A foreshadowing of the inevitable expansion of activities in the field of preventive medicine and of concomitant liaison with the U.S. Public Health Service appeared on the horizon concurrently with The Surgeon General's Protective Mobilization Plan. After discussion with the General Staff in October 1939, The Surgeon General recommended making use of the facilities of the Public Health Service in preserving good health conditions in areas adjacent to Army camps. His detailed plan to this effect (December 1939) called for control of extracantonment sanitation by the U.S. Public Health Service, in cooperation with local and State health authorities, and for the use of the services of that agency in inter-State quarantine measures, prevention of pollution of streams, and control of venereal disease. A report by the American Social Hygiene Association, a civilian organization which had

[26] Lecture, Maj. Gen. Charles R. Reynolds, The Surgeon General, at Army War College, 30 Nov. 1936, subject: The Medical Service of the Army and the Development of the Medical Resources of this Country in War.

[27] (1) Memorandum, Col. Albert G. Love, MC, for The Surgeon General (Reynolds), 9 Jan. 1939, subject: Utilization of the U.S. Public Health Service. (2) Memorandum, Col. Albert G. Love, MC, for The Surgeon General (Magee), 31 July 1939, subject: Utilization of the U.S. Public Health Service. (3) Memorandum, Lt. Col. Charles B. Spruit, MC, for Col. Albert G. Love, MC, 18 Dec. 1939, subject: Utilization of the U.S. Public Health Service in Cooperation With the Army in Connection With the Present Increase in the Regular Army, and attachments.

cooperated with the Medical Department in the control of venereal disease during World War I, that serious vice conditions prevailed in areas near several Army camps added weight to the argument for the aid of the U.S. Public Health Service. In February 1940 the Secretary of War made arrangements with Federal Security Administrator Paul V. McNutt, who had jurisdiction over the U.S. Public Health Service, for the cooperation of that agency in safeguarding the health of soldiers through extramilitary area sanitation.[28]

Role of the American Red Cross.—The Surgeon General's Protective Mobilization Plan contained the nucleus of a plan for aid by the American National Red Cross in the event of mobilization. In March 1938 the Military Relief Committee of that organization had asked, in a preliminary report to the War Department, that some definite task relative to emergency aid to the Army be assigned it. The Protective Mobilization Plan of 1939 stipulated that the Red Cross should provide at every Army hospital of 250-bed capacity or higher a recreational building, that it should continue its present system of enrolling and classifying nurses for the Army and undertake the same work with respect to medical technicians and dietitians, and that it should furnish occupational therapy equipment and the necessary personnel for its use, as well as certain nonstandard medical equipment.[29] Thus was laid in 1939 a firm groundwork for still closer cooperation in time of war with certain public and private agencies engaged in medical work with which The Surgeon General's Office had kept in contact in peacetime.

Medical Supplies and Equipment

A growing awareness of coming difficulties in procuring medical supplies for the Army was in evidence after the declaration of the limited emergency. The Surgeons General of the Army and the Navy decided to enlist the aid of manufacturers of medical supplies and set up several industry advisory committees in certain major fields of medical supply. These committees consisted of representatives from medical supply houses, together with medical officers of the War and Navy Departments. The following committees were constituted: Drugs Resources Advisory Committee, Dental Supplies Advisory Committee, and Medical and Surgical Instruments Advisory Committee. The major function of these, and of similar committees established later in other fields of medical supply, was to keep the Army and Navy informed as to the productive capacity of the industries which they represented.

At the beginning of the emergency the immediate assets of the Medical

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[28] (1) See footnote 24(1), p. 21. (2) Memorandum, The Adjutant General, for The Surgeon General, 21 Oct. 1939, and indorsements, subject: Utilization of the U.S. Public Health Service During the Emergency. (3) Letter, American Social Hygiene Association to Col. J. E. Baylis, MC, 8 Jan. 1940, and indorsement, The Surgeon General to The Adjutant General, 16 Jan. 1940. (4) Memorandum, The Surgeon General to The Adjutant General, 16 Jan. 1940, subject: Utilization of the U.S. Public Health Service. (5) Letter, Federal Security Administrator to Secretary of War, 12 Feb. 1940.

[29] (1) See footnote 24(1), p. 21. (2) The Surgeon General's Protective Mobilization Plan, 1939.

Department in trained personnel and reserves of medical supplies and equipment were adequate for the peacetime Army. The Surgeon General's Office was organized on an adequate peacetime basis. It maintained close affiliation with other governmental agencies and with private institutions capable of supporting it with medical research and additional personnel and supplies. Very little theory existed as to how the Surgeon General's Office should be set up in wartime, although certain immediate steps which mobilization would call for were envisioned. After Septemer 1939 the Medical Department faced an emergency expansion in almost every phase of its work, and the Surgeon General's Office took steps late in the year to enlist the aid of other agencies.

CHAPTER II

The Emergency Period: 1940–41

During 1940 and 1941, before the United States entered the war, the Medical Department's responsibilities increased enormously. Three developments of those years added to its task—a rapid increase in the size of the Army, the advent of large-scale economic and military aid to foreign countries, and the acquisition of new Atlantic bases.

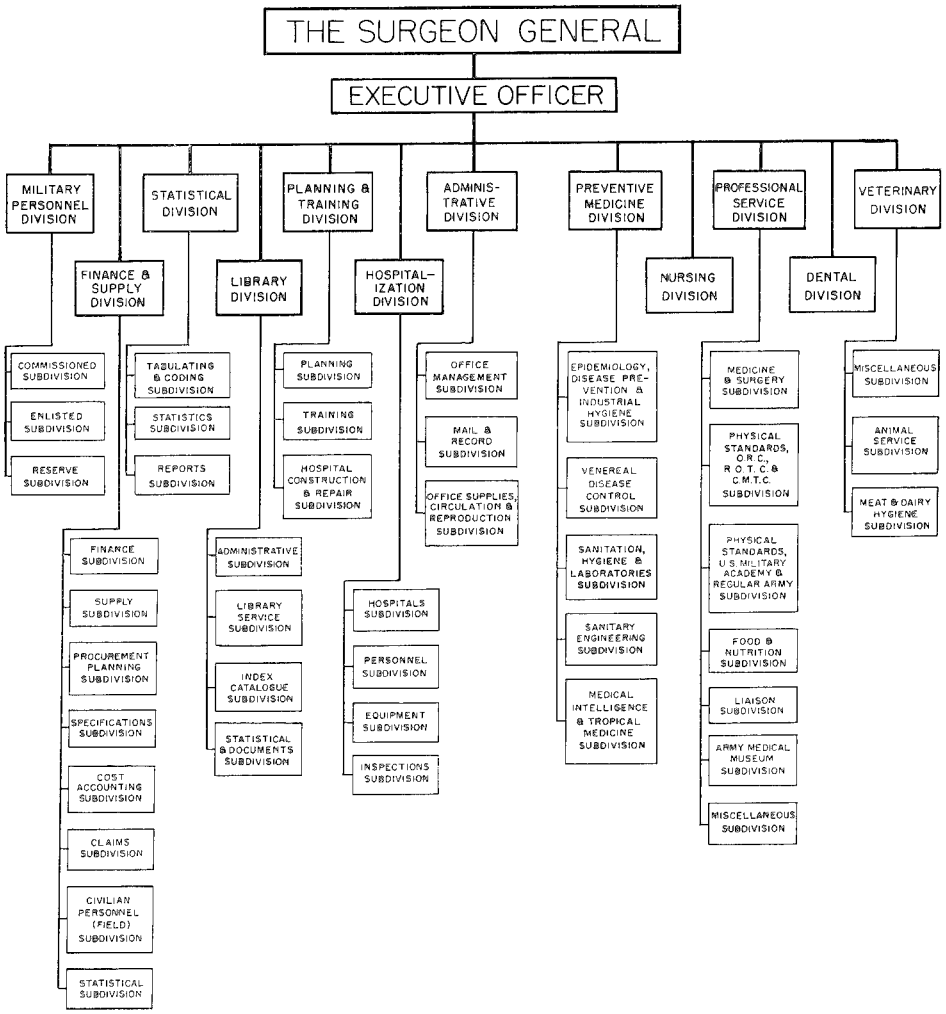
The congressional resolution of 27 August 1940 calling up the National Guard, many of the Reserves, and some retired Army personnel, and the general draft in September brought about large increases in Army troop strength. In May 1940 the War Department had obtained from Congress an increase in the authorized strength of enlisted medical personnel after repeated requests by the Surgeon General's Office. The new legislation had permitted Medical Department personnel to increase to 7 percent instead of 5 percent of the strength of the Army, with additional limited increases possible at the discretion of the President in the event of hostilities. The first new Atlantic bases were occupied pursuant to the agreement between the United States and Great Britain in September 1940, and the formal lend-lease program, by which the United States undertook to send supplies (including medical supplies) abroad to aid the enemies of Nazi Germany and Fascist Italy, was initiated in March 1941. All these measures added to the responsibilities of the Medical Department and led to changes in its organization, as well as increased liaison between the Surgeon General's Office and other governmental and private agencies. They also complicated problems of administration in various fields, such as medical supply, hospitalization, training, and the acquisition and use of personnel.

THE SURGEON GENERAL'S OFFICE

During 1940 and 1941 the Surgeon General's Office underwent considerable expansion in personnel. By the end of June 1940 personnel had not increased greatly over the figure for 1939, but between 30 June 1940 and 30 June 1941 it more than doubled. At the end of June 1940 there were 43 officers and nurses and 201 civilians in the office; a year later the numbers had increased to 102 officers and nurses and 717 civilian employees. In January 1941 the expanding office moved from its former location into a portion of the Social Security Building at 4th and C Streets, S.W., Washington, D.C. In December it moved to 1818 H Street, N.W., Washington, D.C., where it remained till the end of the war.

During 1940–41 only two new divisions developed in the Surgeon General's Office, although many new subdivisions, some of which were later to attain divi-

CHART 2.—*Organization of the Office of The Surgeon General, 15 May 1941*



sion rank, sprang up as the office was given added duties (chart 2). These were the Hospitalization Division and the Preventive Medicine Division, formerly a subordinate element of the Professional Service Division. The expansion of the professional services and the carving up of the Professional Service Division into a number of subdivisions, with the emergence of preventive medicine in particular strength, were the chief developments of the emergency period.

The Professional Services

In 1940 The Surgeon General, foreseeing expanding problems in sanitation and control of disease, particularly of malaria and venereal disease, in



FIGURE 11.—Brig. Gen. Charles C. Hillman, MC.

Army camps and adjacent areas, established close liaison with the U.S. Public Health Service, the Bureau of Medicine and Surgery of the Navy, the Rockefeller Foundation, the National Research Council, and other Government and private agencies. Growing problems in preventive medicine received formal recognition when a Preventive Medicine Subdivision was set up in the Professional Service Division in May. Five other subdivisions formally set up at that time in the same division, then headed by Col. (later Brig. Gen.) Charles C. Hillman, MC (fig. 11), were: Medicine and Surgery; Physical Standards, U.S. Military Academy and Regular Army; Physical Standards, Officers' Reserve Corps, and National Guard; Army Medical Museum; and Miscellaneous.

Medicine and Surgery Subdivision

The Medicine and Surgery Subdivision developed medical and surgical policies, including new methods of treatment, rendered professional opinions, and, in liaison with the Military Personnel Division, selected personnel for key professional positions in Army medical installations. The two Physical Standards Subdivisions formulated physical standards for the military elements indicated in their titles and took action on reports of physical examinations of applicants for admission to the schools or to the various military elements

and applicants for commissions in the Regular Army. The administration of the Army Medical Museum was handled by the subdivision of that name. The functions of the Miscellaneous Subdivision are worth noting: "Office action on line of duty boards pertaining to Regular Army personnel; correspondence pertaining to enlisted personnel, CCC enrollees, and veterans; miscellaneous correspondence on professional subjects; office action on medical aspects of claims against the government; liaison between the Offices of The Surgeon General and The Adjutant General." [1] The variety of duties assigned to this subdivision shows that thinking as to the organization of those activities regarded as professional as opposed to those of administrative character had still not crystallized by the middle of 1940. It illustrates the great difficulty encountered in a medicomilitary organization in divorcing the two types of activity.

Preventive Medicine Subdivision

Lt. Col. (later Brig. Gen.) James S. Simmons, MC (fig. 12), Chief of the Preventive Medicine Subdivision, had been brought into the Office early in 1940 by The Surgeon General to head the work in preventive medicine [2] and remained in that capacity throughout the war. The principal activities of his subdivision were at that date envisioned as advisory supervision over military sanitation and the control of communicable disease; maintenance of liaison with the Quartermaster Department in matters relating to food and water supplies, waste disposal, insect control, choice of housing sites, use of sanitary appliances, and maintenance of sanitary conditions in bathing pools; advisory supervision over Medical Department laboratories; and maintenance of liaison with the U.S. Public Health Service and other health agencies. The activities of the Preventive Medicine Subdivision in the field of sanitation were greatly stimulated by the Selective Training and Service Act of September 1940, which stipulated that adequate sanitary facilities should be established at Army camps in advance of the arrival of inductees.

Health and sanitation under military government.—Before mid-1940 the Preventive Medicine Subdivision had embarked on a project which led to two programs of future importance, later made the responsibility of two organizational elements of the Surgeon General's Office. Three Sanitary Corps officers were brought into the Preventive Medicine Subdivision by Colonel Simmons in May to prepare a section on health and sanitation in a manual of military government being drafted by the Office of the Chief of Staff. Issued as Field Manual 27–5, 30 July 1940, the document was designed as a guide both for planning and for administering military government in territory occupied by U.S. Army troops. The plan for medical organization within military government devised by the Sanitary Corps officers pointed to the need for advance information on health and sanitary conditions in countries

[1] Office Order No. 51, Office of The Surgeon General, 7 May 1940.

[2] (1) Office Order No. 20, Office of The Surgeon General, 26 Feb. 1940. (2) Testimony, Committee to Study the Medical Department, 1942, p. 244. IIU :321.6.

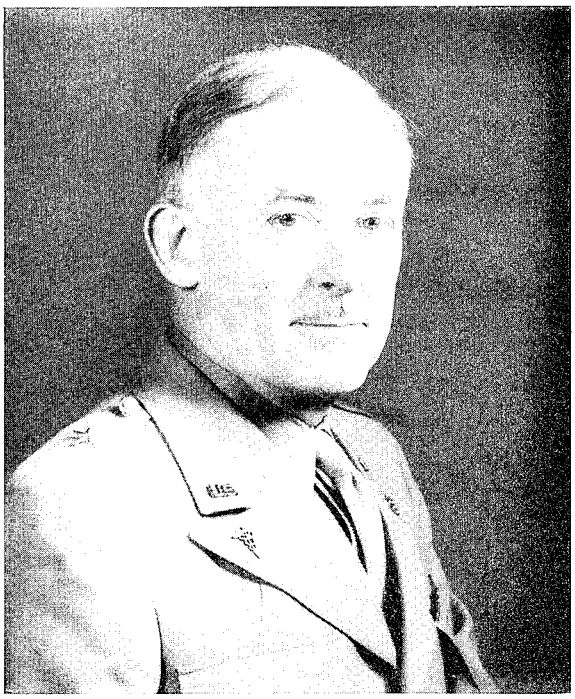


FIGURE 12.—Brig. Gen. James S. Simmons, MC.

where troops might be stationed. Firsthand surveys were made of Newfoundland and Bermuda, where the British had granted bases, and of some Caribbean and South American areas. These paved the way for the extensive system of similar surveys of areas throughout the world which developed in 1941 and 1942; that is, the work which came to be known as "medical intelligence." The plan for health organization for civilians in areas of troop location overseas was the beginning of a comprehensive "medical civil affairs" program for which The Surgeon General was eventually given direct responsibility. The program was ultimately to embrace, after the Army's advances into enemy-held territory, wide-range activities in the prevention and treatment of disease among the civil populations in the liberated countries, designed both to preserve civilian health and to protect U.S. Army troops. The surveys also constituted a forward step in planning in still a third field, sanitary engineering, which embraces engineering activities in connection with water purification, garbage disposal, sewage treatment, and control of insect and rodent carriers of disease.[3]

Laboratory service.—In July 1940 the need of the expanded Army for

[3] (1) Memorandum, Capt. Tom Whayne, MC, for Chief, Preventive Medicine Division, 2 Sept. 1941, subject: General Outline for Activities of Subdivision of Medical Intelligence, Preventive Medicine Division, Including Studies Completed for August 1941. (2) Committee to Study the Medical Department, Exhibits 45, 41, and 19.

an enlarged medical laboratory service was recognized when the Preventive Medicine Subdivision recommended the activation of corps area and department laboratories in the nine corps areas and the Panama Canal and Puerto Rican Departments. After War Department approval they were established in 1941. This system of laboratories, planned since 1925 but not needed in peacetime, was designed to provide a central laboratory in each corps area or department to deal with epidemiological and sanitary matters relating to the health of all troops in the area, in contradistinction to the laboratories of station and general hospitals; the latter handled, for the most part, diagnostic work required in the care of individual patients. War broke out while similar laboratories were being considered for the Hawaiian and Philippine Departments.[4]

Industrial health hazards.—The Surgeon General became concerned over potential hazards to the health of employees in Army-owned munitions plants. Congressional legislation of July 1940 authorized the Secretary of War to provide plans for manufacturing and storing military equipment and supplies. Although the War Department was not charged by legislation with providing medical service for civilian employees at the plants, the Medical Department soon assumed some responsibility, for the legislation had made the Secretary of War responsible for efficient operation of the plants. In 1938 the Chief of Ordnance had asked the Medical Department to make periodic physical examinations of civilian employees engaged in dangerous work; for example, the handling of TNT, at ordnance plants. Civilian contract surgeons had been hired by the Medical Department for the purpose, but at some plants their service had been limited to the giving of first aid treatment. The program had not developed along the broader plan of attempting to forestall occupational injuries and diseases.

Realizing that the program needed establishment upon a sounder and more comprehensive basis, The Surgeon General proposed in December 1940 to assign Medical Department personnel to serve Air Corps and Quartermaster Corps depots as well as Ordnance plants, and to ask the U.S. Public Health Service to make surveys to determine existing industrial hygiene hazards. The surveys got underway about May 1941. This move initiated what was to become an extensive health program with a coverage of about 1 million civilians.[5] It eventually grew administratively complex as a result of several factors: the widening of coverage as lend-lease commitments, and, later, the Pearl Harbor attack spurred on expansion of the Army's industrial facilities;

[4] (1) Committee to Study the Medical Department, Exhibit 42. (2) Memorandum, The Surgeon General, for The Adjutant General, 12 Dec. 1940, subject: Personnel for Corps Area and Department Laboratories. (3) Memorandum, Executive Officer, Office of The Surgeon General, for Surgeon, Panama Canal Department, 27 Dec. 1940, subject: Establishment of Corps Area and Department Laboratories. (4) Report of Conference, The Surgeon General and the Corps Area surgeons, 14–16 Oct. 1940.

[5] (1) 54 Stat. 712. (2) Annual Report, Subdivision of Epidemiology, Disease Prevention, and Industrial Hygiene, Office of The Surgeon General, 1940, 1941. (3) Cook, W. L., Jr.: Preventive Medicine, Occupational Health Division, 1 July 1946. [Official record.]

addition of new types of care; local variation in degree and types of service rendered, depending upon the closeness of the relations of the Army with the groups involved and the adjacency of the area to good civilian medical facilities; and variations in the allocation of cost between the Army and the civilian patients served.

Statistical studies.—Analysis and interpretation of data on the incidence of various diseases also developed during 1940. The Statistical Division supplied information on incidence of disease among Army personnel, and the U.S. Public Health Service furnished similar information as to the civilian population in the United States. Toward the end of the year the surveys of foreign areas mentioned above began to provide this information for foreign areas.

Army Epidemiological Board.—In late 1940 the Medical Department embarked on an effort to enlist the aid of civilian specialists in the control of epidemic disease. Upon the recommendation of The Surgeon General, the Secretary of War set up the Board for the Investigation and Control of Influenza and Other Epidemic Diseases, usually referred to as the "Army Epidemiological Board," in January 1941. On the various subsidiary commissions of the Board the civilian medical profession, represented by more than 100 members, collaborated with the Preventive Medicine Subdivision throughout the war in the investigation of potential epidemics in the Army. As a rule the War Department entered into a research contract with the civilian institution at which the director of the particular commission resided.[6]

Immunization program.—The initiation of a large-scale program for immunizing Army personnel against specific epidemic diseases got underway in 1940. After conference with specialists in preventive medicine of the Navy, the U.S. Public Health Service, the National Research Council, and the International Health Division of the Rockefeller Foundation, the Preventive Medicine Subdivision worked out a coordinated program for immunization. Specifically, the immunization of all Army personnel against tetanus was recommended to the General Staff in May 1940, and triple typhoid vaccine, previously used, was readopted in July. The same agencies made various recommendations on the use of yellow fever vaccine in the Army and took steps toward production of a supply of the vaccine. They began a series of conferences late in 1941 to plan an extensive program for immunizing troops against yellow fever, typhus, cholera, and plague.[7]

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[6] (1) Long, Arthur P.: The Epidemiology Division, 1 July 1946. [Official record.] (2) Committee to Study the Medical Department, Exhibit 19. (3) Report of the Army Epidemiological Board for 1943.

[7] (1) Simmons, J. S.: Immunization Against Infectious Diseases in the United States Army. So. Med. Jour. vol. 34. (2) Simmons, J. S.: The Army's New Frontiers in Tropical Medicine. Ann. Int. Med. vol. 17, December 1942. (3) Memorandum, Col. J. S. Simmons, MC, for Dr. Lewis A. Weed, chairman, Division of Medical Sciences, National Research Council, 5 Aug. 1942, subject: Conference on Materials and Procedures for Immunization Against Typhus, Cholera, and Plague. (4) Committee to Study the Medical Department, Exhibit 47.

Expansion of Professional Service

Early in 1941 Colonel Simmons called the attention of General Magee to the new responsibilities devolving upon his subdivision since its establishment in May 1940. He requested the assignment of additional medical officers and the reorganization of the subdivision on a functional basis.[8] The Professional Service Division, of which Colonel Simmons' preventive medicine subdivision was only a part, faced also the task of expanding the system of general and station hospitals to serve the growing Army. Accordingly in April 1941 it was split into three divisions: the Professional Service, the Preventive Medicine, and the Hospitalization Divisions.[9] Several subdivisions existed within each (chart 2).

Food and Nutrition Subdivisions.—The only part of the Professional Service Division, as reorganized, which marked any innovation since 1939 was the Food and Nutrition Subdivision. Late in 1940 The Surgeon General, citing the establishment of a Division of Food and Nutrition in the Surgeon General's Office in the First World War, had requested authorization for a Subdivision of Food and Nutrition in his Professional Service Division, to be headed by a Reserve officer. This subdivision was established early in 1941. It had advisory supervision over those aspects of selection and preparation of Army food which were related to the health of the soldier. It remained in the Professional Service Division when the latter was reorganized in April.

Hospitalization Division.—The duties of the new Hospitalization Division were not clearly defined but appear to have been conceived of largely in terms of policy development and liaison with other areas of the Surgeon General's Office. The division was to work with the Planning and Training Division in preparing total requirements for hospital beds and training specially qualified persons for hospital work, with the Finance and Supply Division on matters of hospital equipment, and with the Professional Service Division on professional care at military stations.[10] Little was done during the following year to clarify the organizational concepts in this field. The four subdivisions contemplated for the Hospitalization Division—Personnel, Equipment and Supply, Hospitals, and Inspections—apparently remained largely paper units. The meager personnel (four officers and four clerks), assigned to the division in June 1942, a year after its establishment, gives further proof that hospitalization was not considered a primary function per se but was thought of as a matter of coordination of the work of other divisions. Its failure to attain greater size and to receive a more pointed delineation of its functions

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[8] Memorandum, Lt. Col. J. S. Simmons, MC, for The Surgeon General, 25 Feb. 1941, subject: The Subdivision of Preventive Medicine.

[9] (1) Office Order No. 32, Office of The Surgeon General, 17 Feb. 1941. (2) Office Order No. 87, Office of The Surgeon General, 18 Apr. 1941.

[10] See footnote 9 (2).



FIGURE 13.—Col. Harry D. Offutt, MC.

was noted when its operations were made a subject of attack by the Services of Supply in 1942.[11]

A major problem facing the new Hospitalization Division was that of regulating the transfer of patients from station to general hospitals for definitive care. The so-called "bed-credit system," whereby the station hospital was allotted a certain number of beds in the nearest general hospital to which it could transfer its patients, was adopted in June 1941. The division thus acted as a central station to make the most efficient use of the available hospital beds during a period of rapid change. In attempting to conserve hospital beds it also undertook to effect, through revision of Army Regulations, more expeditious disposition of hospital cases.[12] Col. Harry D. Offutt, MC (fig. 13), who had undertaken revision of the equipment lists for Medical Department tactical units, including hospitals for oversea use, while stationed at the Army

[11] (1) Annual Report, Operations Service, Office of The Surgeon General, 1942. (2) Memorandum, Director, Control Division, Office of The Surgeon General, for The Surgeon General, 13 Jan. 1944, subject: Proposal for Overall Plan for Modifications in Present Organization.

[12] (1) Letter, Brig. Gen. Harry D. Offutt, to Col. H. W. Doan, MC, 10 June 1948, and inclosure 1. (2) Memorandum, Col. Harry D. Offutt, MC, for Chief, Operations Service, Surgeon General's Office, 8 July 1943, subject: List of Personnel Hospitalization Division. (3) Annual Report, Operations Service, Office of The Surgeon General, 1942.

Medical Center, was made Chief of the new Hospitalization Division and retained that office throughout General Magee's administration.

Medical Supply

Throughout 1940 and 1941 functions relating to medical supplies and equipment continued to be concentrated mainly in the Finance and Supply Division of the Surgeon General's Office. The measures to increase the size of the Army and the acquisition of Caribbean bases from Great Britain in the latter half of 1940 stimulated the demand for medical supplies and equipment. Additional supplies were needed for the rapidly increasing number of station hospitals in the United States and for use in the training of new tactical medical units to go overseas. Appropriations for buying medical supplies and equipment for the fiscal year 1941 increased over those for the fiscal year 1940 more than 16 times.[13]

The appointment of the Advisory Commission to the Council of National Defense with its Commissioner of Industrial Materials, in the middle of 1940, the creation by the Reconstruction Finance Corporation in August of the Defense Plant Corporation to deal in strategic and critical materials, and the establishment of the original priorities system by the Army-Navy Munitions Board initiated a network of agencies which affected the procurement of medical supplies. With these and their successors medical supply officers in the Finance and Supply Division dealt in their efforts to obtain strategic materials, high priority ratings, and other concessions for manufacturers of medical supplies.[14]

Certain legal problems arose in buying medical supplies. On those involving policy the Judge Advocate General of the Army, the Comptroller General, or the Attorney General of the United States (as the case demanded) customarily rendered decisions. However, an increasing volume of work requiring legal knowledge was developing in connection with contracts for medical supplies and certain claims arising against the department. A Medical Administrative Corps officer with legal training was assigned to the Finance and Supply Division in August 1940, to prepare contracts with medical supply houses and research agencies, and to examine and adjudicate claims by various civilian and government agencies for medical services rendered to Army personnel, Civilian Conservation Corps enrollees, and other groups for

[13] (1) Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1941, pp. 129ff. (2) Robinson, Lt. Col. Paul I.: Major Changes in Organizational Structure, Finance and Supply Division, 30 June 1940 to 7 Dec. 1941 (18 Nov. 1942) [Official record.] (3) Hearings Before a Special Committee Investigating the National Defense Program, United States Senate. 77th Cong., 1st Sess., on Senate Resolution 71, 15 July 1941. Washington: U.S. Government Printing Office, 1941.

[14] (1) Yates, Richard E.: The Procurement and Distribution of Supplies in the Zone of Interior During World War II, pp. 77–81. [Official record.] (2) U.S. Government Manual. Washington: U.S. Government Printing Office, 1940, pp. 52–53. (3) U.S. Government Manual. Washington: U.S. Government Printing Office, 1941, pp. 155, 444–45.

whose care the Medical Department was ultimately responsible.[15] Other officers with legal training were subsequently assigned to legal work, but the group did not reach the stature of a division until 2 years later.

Research and development.—Other activities which were concentrated in the Finance and Supply Division in 1940 were those pertaining to research and to the development of special Medical Department equipment. This program had expanded to include about 36 projects at 4 main scenes of Medical Department research and developmental work—the Army Medical Center, Washington, D.C., the Medical Department Equipment Laboratory at Carlisle Barracks, Pa., the Quartermaster Remount Depot at Front Royal, Va., and Edgewood Arsenal, Md. As these entailed some work on the part of five divisions of the Surgeon General's Office, a central place to record research data and advise The Surgeon General of the progress of research projects was necessary. Since the Finance and Supply Division had been handling the fiscal affairs of all these programs, the Research and Development Section was set up in that division to work out a coordinated research program.[16]

Shortages.—Supply problems developed thick and fast in 1941. The loss of certain continental European sources, particularly Germany, for surgical instruments, a possibility foreseen for many years, had its effect. Export of surgical instruments to France and England during 1940 and 1941 constituted a drain on domestic production. In 1941 the Finance and Supply Division surveyed medical supply firms in the attempt to expand their manufacturing facilities and to convert factories making other products to the manufacture of medical supplies and equipment. It computed requirements for strategic and critical raw materials and submitted these to the Office of the Under Secretary of War, to which were transferred in April 1941 the supply functions formerly exercised by the Assistant Secretary. Marked shortages had developed in aluminum needed for litters and for operating room lamps, and in corrosion-resistant steel for surgical and dental instruments. In an attempt to aid manufacturers of medical supplies and equipment to obtain scarce materials, the Finance and Supply Division maintained liaison with the Army-Navy Munitions Board, which set up the original priorities system and which had taken over in late 1940 the industry advisory committees created the previous year by the Medical Department. In 1941 the division maintained liaison with the Office of Production Management, which (preceding the War Production Board) administered the priorities system throughout 1941. In late 1941, the work of the Army-Navy Munitions Board in reviewing preference ratings granted to Army contractors grew too heavy and was decentralized to the services. At the order of the Office of the Under Secretary, a Priorities Com-

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[15] (1) Hilsher, Maj. John M.: Summary of Legal Activities (Covers period 1924 through 1941). [Official record.] (2) Office Order No. 126, Office of The Surgeon General, 27 Aug. 1940.

[16] (1) Memorandum, Lt. Col. Francis C. Tyng, MC, for The Surgeon General, 30 Oct. 1940, subject: Research and Development Section. (2) Office Order No. 205, Office of The Surgeon General, 3 Dec. 1940.

pliance Section was set up in the Surgeon General's Office to review the preference ratings granted to subcontractors of medical supplies and equipment.[17]

Effect of lend-lease.—The passage of the Lend-Lease Act in March 1941 and the swelling list of countries declared eligible for lend-lease aid accounted in part for the Medical Department's later difficulties with medical supply for the Army. At the outset neither the Medical Department nor the War Department appear to have been aware of the potential effects of the lend-lease program on procurement of medical supplies for the Army. Promptly after passage of the Lend-Lease Act the Secretary of War authorized the establishment of a Defense Aid Division in the Office of the Under Secretary to coordinate the lend-lease programs of the supply services. Defense Aid Requirements Committees were established for several services at the same time, but none for the Surgeon General's Office until near the end of the summer, when a Defense Aid Medical Requirements Subcommittee was set up. The Surgeon General's Office had already established a Defense Aid Subsection in its Finance and Supply Division.

Even before the passage of the Lend-Lease Act some demands for aid to potential Allies had been made on the Medical Department. These included litters for Yugoslavia and $1,200,000 worth of medical supplies requested by the Chinese for use by the U.S. Public Health Service in the medical care of workers on the Yunnan-Burma Railway, which was to become a supply line for lend-lease itself. The work of the Medical Department in filling these early requisitions involved the following steps: Receipt of the requisition from the Defense Aid Medical Requirements Subcommittee; identification of the requested items in Medical Department or American commercial terms; computation of cost; the forwarding of purchase requisition to the procurement depot, after receipt of allotment of funds from the War Department Budget Officer; and finally the forwarding of shipping instructions from the foreign government to the appropriate defense-aid depot for action after the Secretary of War (through the Defense Aid Division) had authorized the transfer. This was a complicated procedure. Authorities of the War Department involved were: The Defense Aid Subsection of the Surgeon General's Office and the medical procurement districts and medical supply depots; the Defense Aid Medical Requirements Subcommittee; and the Defense Aid Division in the Office of the Under Secretary. Outside the War Department were the Division of Defense Aid Reports of the Office for Emergency Management, superseded by the Office of Lend-Lease Administration in October, and the Washington office, whether embassy or supply mission, of the country making the requisition. By December 1941, after the submission of the First Russian Protocol outlining

[17] (1) Yates, Richard E.: The Procurement and Distribution of Supplies in the Zone of Interior During World War II, pp. 33-36. [Official record.] (2) See footnote 13 (1) and (3), p. 36. (3) Memorandum, Director, Production Branch, Office of the Under Secretary of War, for The Surgeon General, 13 Oct. 1941, subject: Establishment of a Priority Compliance Section in the Offices of the Chiefs of Supply Arms and Services. (4) Memorandum, Lt. Col. C. G. Gruber, MC, for Lt. Col. F. C. Tyng, MC, 22 Oct. 1941, subject: Compliance Section of Procurement Planning Subdivision.

Russian lend-lease requirements, Medical Department supply officers had become more cognizant of the impact which the lend-lease program would have upon the procurement of medical supply. One of them noted that the "astronomical" figures of the Russians were already materially affecting the procurement program.[18]

RELATIONS OF THE SURGEON GENERAL'S OFFICE WITH OTHER AGENCIES CONCERNED WITH MEDICAL SERVICE

Under pressure of the national emergency, relations of the Surgeon General's Office with established Government and private agencies engaged in medical programs became closer. A number of new Government agencies, usually termed "defense" agencies, were created. Some were assigned functions relating to medicine or public health which supplemented—or in some cases conflicted with—the Army's medical program. While these agencies, and the U.S. Public Health Service, for the most part worked harmoniously with the Army Medical Department, occasional disagreements developed over matters of policy or in areas of conflicting interests.

U.S. Public Health Service

Increasing health hazards to Army troops, particularly the venereal diseases, were the subject of continued discussion between the Surgeon General's Office and other agencies. During 1940 the U.S. Public Health Service put into effect measures designed to control venereal disease and maintain sanitary conditions in the vicinity of Army camps.[19] It made special arrangements for aid to the Army during maneuvers to be held in the southeast that spring and summer. While mutual efforts of the Army Medical Department and the U.S. Public Health Service in sanitation and malaria control worked smoothly, some conflict developed over ways and means of controlling venereal disease. An informal conference of representatives of the Medical Department and of the U.S. Public Health Service in March 1940 to lay plans for control of venereal disease during the maneuvers revealed a tendency by both agencies to disclaim

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[18] (1) Yates, Richard E.: The Procurement and Distribution of Supplies in the Zone of Interior During World War II, pp. 212–214. [Official record.] (2) See footnote 13(2), p. 36. (3) History of Lend-Lease, pt. I, ch. IV, pp. 162ff. [Official record in National Archives.] (4) Historical Report of Lend-Lease Activities of The Surgeon General's Office. [Incomplete official record in THU.] (5) Memorandum, Under Secretary of War, for Secretary of War, 19 Sept. 1941, subject: Lend-Lease Procedure. (6) History of Medical Department Lend-Lease Activities. [Official record.] (7) Memorandum, Lt. Col. C. F. Shook, MC, Office of The Surgeon General, for Under Secretary of War, 4 Dec. 1941, subject: Data on Foreign Countries.

[19] (1) Memorandum, Col. Albert G. Love, MC, for the Committee on Medical Care, 15 Oct. 1942, subject: Review of Oral Testimony on Work of the Planning and Training Division, 1 Apr. 1938–31 July 1939, Before the Committee to Study the Medical Department. (2) Committee to Study the Medical Department, Exhibit 22. (3) Testimony, Committee to Study the Medical Department, 1942, pp. 351–352. (4) Report, Conference of The Surgeon General with Corps Area Surgeons, 14–16 Oct. 1940. (5) Report, Ad Hoc Subcommittee of Committee on Medicine, National Research Council, to Survey Venereal Disease Control Program, February 1942.

responsibility for undertaking any measures to suppress prostitution, although they appeared to agree that such measures were desirable. Representatives of the Medical Department pointed out that the Army had no police power outside military reservations.

In May 1940 a conference of State and territorial health officers reached a formal agreement as to services which State and local health agencies and police authorities should provide as their share of the venereal disease control program. State authorities agreed to cooperate with military authorities in educating the civilian and military population in the dangers of venereal disease and in exchanging information as to sources of infection. The agreement recognized the direct responsibility of civilian authorities for isolating and treating infected civilians and the primary responsibility of local police authorities for repressing prostitution.[20] The War Department gave its official sanction to this program in June, and in September informed commanding generals of corps areas and departments of their responsibility for supporting it in their respective jurisdictions. The U.S. Public Health Service agreed to assign a liaison officer to each corps area to work with the corps area surgeon on mutual health problems; late in 1940 it put this plan into effect in each corps area and in the Puerto Rican Department.

Nevertheless, the Army was subjected to a good deal of criticism, beginning as early as the fall of 1940 and continuing throughout 1941, when reports of high venereal disease rates among soldiers became widespread. A barrage of attacks emanated from U.S. Public Health Service liaison officers stationed in the corps areas, and from State health department officials, the American Social Hygiene Association, and the public. They criticized the tendency of some Army line officers, according to reports from scattered areas throughout the country, to tolerate segregated red-light districts. In addition, examination of inmates of houses of prostitution as a protective measure by a few medical officers—a practice which was not consonant with previous agreements that the repression of prostitution and rehabilitation of prostitutes was primarily the responsibility of local authorities—gave rise to reports that the Army condoned commercialized prostitution. Although the Medical Department maintained firmly its policy for repressing prostitution, the record shows a good deal of divergence of opinion, on the part of the public and a few health authorities as well as on the part of some Army line officers, as to the necessity for tolerating a certain degree of condoned prostitution.

The Surgeon General's Office recalled to corps area surgeons in January 1941 its previous instructions for carrying out the agreement. In February medical officers of the Army and Navy held a joint conference with a few leading civilian authorities, including the Chairman of the Subcommittee on Venereal Diseases of the National Research Council. The conference renewed

[20] Agreement by War and Navy Departments, Federal Security Agency, and State Health Departments on Measures for Control of Venereal Disease in Areas where Armed Forces or National Defense Employees are Concentrated, adopted by conferences of State and Territorial health officers, 7–13 May 1940.

the established policy of the Medical Department and so informed commanding officers. Gen. George C. Marshall, the Chief of Staff, emphasized the Army's policy in a personal letter to corps area and Army commanders.

In July, at the instance of the American Social Hygiene Association, the May Act, making prostitution a Federal offense in the areas in which it was invoked, was passed by Congress. It was supported by the Surgeons General of the Army, Navy, and U.S. Public Health Service. The War Department shortly afterward issued instructions to commanders of corps areas as to the procedure for invoking the act, and a Division of Social Protection was set up in the Office of Defense Health and Welfare Services in the fall to aid in the repression of commercialized prostitution by working through State and local authorities. The Army was unwilling to invoke the act, however, except as a last resort in areas where local authorities had unquestionably failed to cooperate in its program. It was sensitive to the reaction of local communities, some of which insisted that they wanted to take repressive measures themselves and wanted only the Army's moral backing. Although Charles P. Taft, Assistant Director of the Office of Defense Health and Welfare Services (like the U.S. Public Health Service, under the jurisdiction of the Federal Security Administrator), apparently agreed with the Army's position, in the latter part of 1941 Drs. Thomas Parran and R. A. Vonderlehr, Surgeon General and Assistant Surgeon General of the U.S. Public Health Service, criticized the Army in a jointly written book, "Plain Words About Venereal Disease," for its failure to invoke the May Act.

Medical Department officers resented these attacks and similar ones in the public press. The Truman Committee inquired into the Army's policy during its December hearings on the National Defense Program. In a War Department circular General Marshall reemphasized the responsibility of the unit commander for the enforcement of control measures. The Surgeon General asked the National Research Council to set up a commission to survey and report on the situation as to venereal disease in the Army. In general the commission's report (February 1942) supported both the soundness and the consistency of the Medical Department's policy. Meanwhile The Surgeon General provided for reinforcement of the program by arranging for the assignment of a venereal disease control officer as an assistant to the surgeon of the following commands: Each division, army, communications zone headquarters, general headquarters, corps area, department, and each station complement serving 20,000 or more troops.[21]

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[21] (1) Memorandum, Executive Officer, Office of The Surgeon General, for surgeons of all corps areas and departments and independent stations, 13 Jan. 1941, subject: Cooperation With the U.S. Public Health Service in the Control of Venereal Disease. (2) Hearings Before a Special Committee Investigating the National Defense Program, United States Senate, 77th Cong., 1st Sess., on Senate Resolution 71, 5 Dec. 1941. Washington: U.S. Government Printing Office, 1942, pt. 10, p. 3768. (3) Diary, Historical Division, Surgeon General's Office, entry by Col. Albert G. Love, MC, 15 Nov. 1941. (4) Annual Report, Surgeon, Fourth Corps Area, 1941. (5) Annual Report, Surgeon, Eighth Corps Area, 1941. (6) Sternberg, Lt. Col. Thomas H., and Howard, Maj. Ernest B.: History of Venereal Disease Control and Treatment in Zone of Interior. [Official record.]

National Research Council

Another agency with which the Army Medical Department established close liaison during the emergency period was the National Research Council. In May 1940 The Surgeon General asked the Division of Medical Sciences of the Council to establish committees to advise the Medical Department on technical problems.[22] This request initiated the appointment of a number of civilian physicians and medical officers from the Army, Navy, and U.S. Public Health Service. These rendered significant service to the Medical Department in giving technical advice on advanced methods of prevention and treatment of various diseases. The Surgeon General's Office based a number of its most technical circular letters on advice given by the committees and subcommittees of the Council.

American Medical Association

In June 1940 at the annual meeting of the American Medical Association, the major professional organization of physicians with which the Medical Department maintained close contact, The Surgeon General's representatives solicited the aid of the association in procuring medical officers for the Army. They asked the association to survey doctors in the United States and their qualifications and to determine which doctors could be considered available for military service and which should remain in civilian life because they were essential to the health of the community.[23] The American Medical Association unanimously agreed to give the aid requested and created a Preparedness Committee of civilian doctors representing each corps area. During the remainder of 1940 and the following year, the committee conducted a survey of the medical profession and began to give information to the Surgeon General's Office on the availability of certain doctors for military service. However, the machinery created at this date for procurement of medically trained personnel for the Army was soon superseded by Federal machinery created for the purpose.

Schools and Hospitals

The aid of civilian schools and hospitals was also enlisted through the revival of the affiliated units under the plan developed the previous year. The details of the plan as approved by the War Department were published in January 1940. The Surgeon General's Office began efforts to interest selected civilian institutions, explaining to each affiliating institution the procedure for affiliation, policies as to appointment in the Reserve Corps, the positions to be filled, training required, mobilization, and issue of equipment. By

[22] Report, Committee to Study the Medical Department, November 1942, Tab: Relations With Others.

[23] See footnote 19(1), p. 39.

mid-1941, 41 general hospitals, 11 evacuation hospitals, and 4 surgical hospitals had been organized at universities and hospitals.[24]

Defense Agencies

The year 1940 also witnessed the inception of several Federal defense agencies which were designed to promote civilian health as an essential aspect of the defense effort and to handle special civilian health problems arising therefrom.

In some fields civilian and military claims to supplies, labor, and facilities had already begun to clash with each other. The field of medicine was no exception, and the Medical Department of the Army on occasion locked horns with agencies devoted primarily to civilian interests. These agencies sprang up rapidly during the emergency period and underwent various changes of jurisdiction. Responsibility for most of the health and medical aspects of national defense was eventually vested in the Federal Security Administrator, Paul V. McNutt.

Office of Defense Health and Welfare Services.—By the fall of 1941 Mr. McNutt had been made Director of the Office of Defense Health and Welfare Services. A major committee in this office was the Health and Medical Committee, on which General Magee served, along with the Surgeons General of the Navy and U.S. Public Health Service. The Surgeon General's Office worked closely with the Health and Medical Committee and its subcommittees, as well as with certain other elements of the Office of Defense Health and Welfare which cooperated with State and local agencies in a broad attack on the problem of venereal disease. The office of the Federal Security Administrator provided a point of contact for military and civilian authorities in areas, particularly those near defense industrial establishments, in which military and civilian health impinged upon each other. The U.S. Public Health Service was under the jurisdiction of the Federal Security Administrator, as was, at a later date, the chief Federal civilian agency concerned with problems of medical manpower, the War Manpower Commission. The latter, through its Procurement and Assignment Service, attempted to solve the problem of allocating sufficient medical personnel to government agencies, including the military forces, while retaining adequate numbers in civilian practice—the task for which the Medical Department had previously enlisted the aid of the American Medical Association.[25]

[24] (1) Memorandum, The Adjutant General for The Surgeon General, 26 Jan. 1940, subject: Officers of Affiliated Medical Units—Appointment, Reappointment, Promotion, and Separation. (2) Memorandum, Executive Officer, Office of The Surgeon General for each Affiliating Institution, 16 May 1940, subject: Affiliated Units, Medical Department, U.S. Army. (3) Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1941, pp. 101–114. See also Medical Department, United States Army, Personnel in World War II, ch. V. [In press.]

[25] For full discussion, see Medical Department, United States Army, Personnel in World War II, ch. VI. [In press.]

Office of Civilian Defense.—The Office of Civilian Defense, which made plans for community health programs and medical care of civilians in the event of military attack upon the United States, was created by the President in May 1941. Although it was not put under jurisdiction of the Federal Security Administrator, it belongs with the series of agencies just named in that it, too, claimed a quota of the available medical personnel, supplies, and facilities. It was particularly interested in the Army's development of protective measures, should the enemy resort to gas warfare against the civilian population, and in certain medical supplies which the Army might make available for civilian defense. In the latter part of 1941 the liaison officers of the U.S. Public Health Service on duty with corps area surgeons were assigned to serve as medical consultants with the local district offices (serving areas conterminous with Army corps areas) of the Office of Civilian Defense.[26]

Office of Scientific Research and Development.—In June 1941 the President set up the Office of Scientific Research and Development which was authorized, among other duties, to "initiate and support scientific research on medical problems affecting the national defense." Its Committee on Medical Research, with Col. James S. Simmons, MC, as Army representative, was to advise the Director of the Office of Scientific Research and Development as to the need for, and character of, medical research contracts which the Office should make with hospitals and universities. This agency and the National Research Council were the two agencies which contributed most heavily to the alleviation of the Army's heavy needs for medical research during the war. Both these agencies worked in collaboration with the U.S. Department of Agriculture laboratory at Orlando, Fla., in developing DDT for widespread Army use in the control of insect-borne diseases. Both also had responsibilities in connection with the research program, then largely civilian controlled, into methods of treatment of gas casualties.[27]

Research to counter biological warfare.—The antibiological warfare program also led to the creation of new agencies. Biological warfare has both offensive and defensive aspects, and defense against potential biological warfare on the part of the enemy is a civilian as well as a military problem. Consequently, research into the potentialities of biological warfare and programs to counteract the effects of any such warfare in which the enemy might engage were undertaken at a number of levels of Government organization, both within and without the War Department. A major problem, so far as the

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[26] (1) U.S. Government Manual. Washington: U.S. Government Printing Office, September 1941, pp. 69–72. (2) Report of Committee to Study the Medical Department, 1942, Tab: Relations With Others.

[27] (1) Millett, John D.: United States Army in World War II. The Organization and Role of the Army Service Forces. Washington: U.S. Government Printing Office, 1954, pp. 236ff. (2) Report of Committee to Study the Medical Department, 1942, Tab: Research Program. (3) Medical Department, United States Army. Preventive Medicine in World War II. Volume II. Environmental Hygiene. Washington: U.S. Government Printing Office, 1955, pp. 251–269. (4) Brophy, Leo P., Miles, Wyndham D., and Cochrane, Rexmond C.: U.S. Army in World War II. The Chemical Warfare Service: From Laboratory to Field. Washington: U.S. Government Printing Office, 1959, pp. 75–100.



FIGURE 14.—Brig. Gen. Raymond A. Kelser, VC.

Medical Department was concerned, was to confine its responsibility, as in the case of chemical warfare to the defensive aspects. Bacteriological warfare methods had been studied jointly by the Chemical Warfare Service and the Medical Department for many years.

When the Secretary of War became alarmed over the potentialities of biological warfare in 1941, he informally placed some responsibilities for research in this field upon the Chemical Warfare Service and asked the National Academy of Sciences in Washington, D.C., to study the problem. In November 1941 the Academy appointed the WBC Committee to undertake the study.[28] Col. (later Brig. Gen.) Raymond A. Kelser, VC (fig. 14), Chief of the Veterinary Division, Office of The Surgeon General, was a member, for the introduction of disease among cattle in the United States was recognized as a serious threat to the nation's food supply. The committee's reports in 1942 delineated various means of biological warfare which threatened human beings, plants, and animals, stressing the danger of the spread of rinderpest among cattle.

[28] According to Brophy, Miles, and Cochrane, on p. 103 of the volume cited in footnote 27(4), p. 44, the initials stood for "War Bureau of Consultants." However, it is the recollection of Brig. Gen. Stanhope Bayne-Jones, MC, USA (Ret.), then Deputy Chief of the Preventive Medicine Division, Office of The Surgeon General, and one of The Surgeon General's representatives in the group, that the initials stood for "Biological Warfare Committee," deliberately scrambled for security reasons. Statement of General Bayne-Jones to the editor, 12 Oct. 1961.

Secretary Stimson indicated to the President the two main considerations which he deemed of importance in setting up a body to take action on the committee's report: selection of the right men and entrustment of the program to a civilian agency. The latter measure, he stated, "would help in preventing the public from being unduly exercised over any ideas that the War Department might be contemplating the use of this weapon offensively." He noted that a knowledge of offensive possibilities was indispensable to the preparation of an adequate defense, comparing biological warfare in this respect to chemical warfare, for which research into both offensive and defensive possibilities had been found necessary.[29]

To avoid alarming the public, a civilian-controlled War Research Service in the Federal Security Agency was authorized in May 1942, superseding the WBC Committee. Through the Surgeon General's Office the War Research Service developed antibiological warfare programs in the Hawaiian Department Civilian Defense Command, the military districts of the United States, and the oversea theaters of operations. General Kelser was made a liaison member of a new advisory group—arbitrarily called the ABC Committee—set up in October by the National Research Council and the National Academy of Sciences to give technical and professional aid to the War Research Service. He also became co-chairman of a joint United States-Canadian commission (appointed by the Secretary of War and the Canadian Minister of National Defense) to plan measures for protecting North American cattle against the introduction of rinderpest. The Medical Department's participation in the antibiological warfare program was thus largely limited in the early war years to the use of some of its personnel by, or in liaison with, other agencies to which direct responsibility for the program was assigned.[30]

MEDICAL OFFICES IN OTHER BRANCHES OF THE ARMY

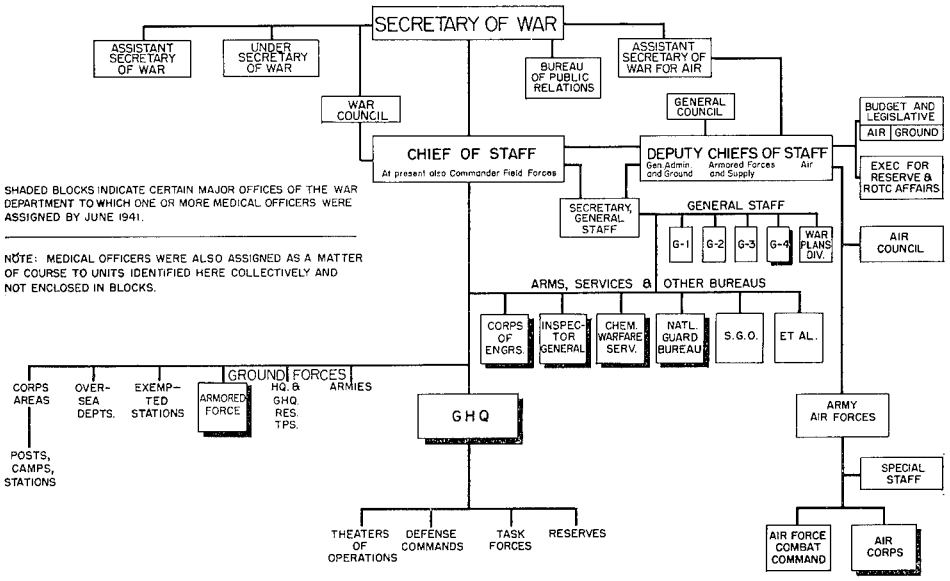
At the beginning of 1940, medical officers held positions in three major branches of the War Department other than the Surgeon General's Office—the National Guard Bureau, the Office of the Chief of the Air Corps, and the Chemical Warfare Service. During that year medical officers were assigned to four other branches—the Office of the Inspector General; the G–4 section of the General Staff; General Headquarters (a new creation of this period); and the Corps of Engineers—and in mid-1941, to the Armored Force (chart 3). Some of these assignments reflected the Army's expanding medical activities;

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[29] Letter, Secretary of War, to the President, 29 Apr. 1942.

[30] (1) Medical Department, United States Army. Veterinary Service in World War II. Washington: U.S. Government Printing Office, 1962, p. 433. (2) Brophy, Leo P., Miles, Wyndham D., and Cochrane, Rexmond C.: U.S. Army in World War II. The Chemical Warfare Service: From Laboratory to Field. Washington: U.S. Government Printing Office, 1959, pp. 101–122. (3) Letter, Brig. Gen. R. A. Kelser, VC, USA (Ret.), to Director, Historical Division, Office of The Surgeon General, 10 July 1951, with attachment, commenting on preliminary draft of this chapter.

CHART 3.—*Organization of the Army, showing assignment of medical officers to major offices, June 1941*



ADAPTED FROM OFFICIAL CHART OF JUNE 1941, WITH ADDITION OF CERTAIN DETAIL.

others the increased staff work calling for technical advice by Medical Department officers or the General Staff's growing awareness of medical problems.

Army Air Forces Medical Division

The Medical Division of the Air Corps grew in size and stature during the emergency period in consonance with the rapid expansion of the air forces. The running argument in 1939 and 1940 over General Magee's effort to transfer the Medical Division to his jurisdiction had died down largely because the Air Corps had claimed that if the establishment of the Army Air Forces, already contemplated, took place, the new organization must have complete jurisdiction over its medical personnel. When the Army Air Forces was set up as the highest Air Force Command in mid-1941 and given control of its stations and all assigned personnel, The Surgeon General recommended that the Medical Division of the Air Corps be moved to the higher headquarters. In October Col. David N. W. Grant, MC, was transferred from the Medical Division, Office of the Chief of the Air Corps, to Headquarters, Army Air Forces (with an additional reassignment to the Chief of the Air Corps). At the same time he was designated "the Air Surgeon." By February 1942 he had succeeded in having the Medical Division, Office of the Chief of the Air Corps, transferred to his office. His office remained the major medical office within the Army Air

Forces throughout the war.[31] By mid-1941, some 8 months before the transfer took place, this office, which in the preemergency period had possessed only two medical officers, had acquired enough military and civilian personnel to staff a functional organization of several sections. At that time slightly more than 1,000 Medical Department officers (including Reserve officers), the majority qualified as aviation medical examiners or flight surgeons, were on duty with the various elements of the expanding Air Corps. As the year 1941 wore on it became obvious that the medical service of the Army Air Forces was becoming independent of The Surgeon General except for the latter's technical supervision in professional matters and his control over the procurement of medical personnel and supplies.[32]

Office of the Inspector General

The appointment of a medical officer to the staff of the Inspector General was an outgrowth of the Chief of Staff's dissatisfaction with the information he was receiving concerning needs for Army hospitals. In the spring of 1940 General Magee had prefaced a survey of the current status of hospital facilities with the words: "There devolves upon me, as Surgeon General of the Army, the inescapable duty of bringing to the attention of higher authority the unpreparedness of the Medical Department for war."[33] He resubmitted a previous request for authorization for 17,500 beds in station and general hospitals—less than half the number called for by the Protective Mobilization Plan.

The General Staff, particularly G–4, tended to minimize somewhat The Surgeon General's estimate of requirements for hospital beds and equipment. Among other considerations which made the staff hesitate to give them high priority was the possibility of using civilian hotels for Army hospitals. The General Staff also believed that General Magee was not giving due weight to the increased productive capacity, since the First World War, of the manufacturing facilities which produced medical supplies and equipment.

The draft removed this problem, under consideration throughout the summer of 1940, from the ranks of academic questions, for the need for increases in all types of Army supplies and facilities was now apparent. However, the Chief of Staff, Gen. George C. Marshall, still puzzled over the conflicting statements as to requirements. Accordingly he asked the Inspector General for confidential information on the medical problems which would result from large troop concentrations. He was skeptical of requirements

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[31] (1) Coleman, Hubert A.: Organization and Administration, Army Air Forces Medical Service in the Zone of Interior, pp. 36, 69–77. [Official record.] (2) Army Regulations No. 95–5, 20 June 1941.

[32] (1) Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1941, pp. 256–257. (2) Craven, Wesley F., and Cate, James L., Eds.: Army Air Forces in World War II. Volume VI, Men and Planes. Chicago: University of Chicago Press, 1955, pp. 362–397.

[33] Memorandum, The Surgeon General, for The Adjutant General, 10 May 1940, subject: Status of Medical Department for War.

estimates by technical services, and expressed doubt as to whether the Surgeon General's Office really needed all it had asked for. He remarked on the tendency of the War Department supply services to ask for more than they expected to get, thus clearing their skirts in advance of a possible investigation. He was under the impression that both G–4 and the Surgeon General's Office were giving him a "desk reaction" instead of a reaction based on direct observation of conditions in the Army at large.[34]

The request made of the Inspector General was an effort to get advice from an impartial unit of the War Department. In October General Marshall appointed a medical officer, Brig. Gen. Howard McC. Snyder, then medical adviser to the National Guard Bureau, as Assistant to The Inspector General. Before this date nearly all inspections of Medical Department installations by the Office of the Inspector General had been made by nonmedical officers. The Chief of Staff impressed upon General Snyder his own concern that all should go well with the medical service for the new inductees. General Snyder remained at his post throughout the war and, with the aid of his assistants in the Medical Division of the Office of the Inspector General, conducted inspections of various aspects of the medical service, both in the Zone of Interior and overseas, including hospitalization and evacuation, personnel, training, and other activities. He was instrumental in finding ways of making the most efficient use of hospital facilities and medical personnel.[35]

G–4 Medical Liaison

Shortly after General Snyder's appointment, Lt. Col. (later Brig. Gen.) Frederick A. Blesse, MC (fig. 15), one of several officers recommended by The Surgeon General, was assigned to G–4. Colonel Blesse's appointment enabled G–4 to get more direct professional advice on matters of medical supply and hospitalization and evacuation than formerly. He was a firm believer in effective staff work and attributed some of the difficulties which the Surgeon General's Office experienced in getting acceptance of its proposed policies to the lack of training and experience of some members of the Office in staff work. In G–4 a strong interest in plans for hospitalization and evacuation and various problems related to medical supplies for troops developed after Colonel Blesse was succeeded by Maj. (later Col.) William L. Wilson, MC (fig. 16), as The Surgeon General's representative on G–4 in 1941. Late in the year

[34] (1) Memorandum, The Surgeon General, for The Adjutant General, 6 Apr. 1940, subject: Status of Medical Department for War. (2) See footnote 33, p. 48. (3) Memorandum, Acting Assistant Chief of Staff, for The Surgeon General, 10 Aug. 1940, and indorsements, subject: Increase in Number of General Hospitals. (4) Memorandum, Chief of Staff, for the Inspector General, 14 Sep. 1940, subject: General Hospitals. (5) Memorandum, Chief of Staff, for Deputy Chief of Staff, 13 Nov. 1940, subject: General Hospitals.

[35] (1) Interview, Maj. Gen. Howard McC. Snyder, 25 May 1948. (2) Memorandum, Assistant Inspector General, for the Inspector General, 10 Nov. 1942, subject: Survey of Hospital Facilities and Their Utilization. (3) Inspector General's Report, 13 Jan. 1944, subject: Utilization of Medical Corps Officers in the Zone of Interior.



FIGURE 15.—Col. Frederick A. Blesse, MC.

and early in 1942, additional Medical Department officers were assigned to G–4 in a liaison capacity.[36]

Assignments of medical officers to G–4 of the General Staff and to the Office of the Inspector General were intended to establish more immediate sources of information on medical matters than the Surgeon General's Office afforded within the prevailing organization of the War Department. They also furnished a means by which the General Staff might appraise, without approach to the Surgeon General's Office, the efficiency of Army medical service. The placing of certain functions relative to the medical service in Army elements other than the Office of The Surgeon General, however, created the potential difficulty of disagreement on policy between the Surgeon General's Office and medical representatives at other levels of Army organization.

While no serious difficulties ever grew out of the relations of the Surgeon General's Office with the Office of the Inspector General, strained relationships between G–4 and the Surgeon General's Office developed by late 1941.

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[36] (1) Memorandum, The Surgeon General, for Acting Assistant Chief of Staff, G–4, 20 Sept. 1940, subject: Detail of a Medical Officer for Duty in G–4. (2) Letters, Brig. Gen. Frederick A. Blesse, MC, USA (Ret.), to Director, Historical Division, Office of The Surgeon General, 5 Dec. 1950 and 6 Sept. 1951, commenting on preliminary draft of this volume.



FIGURE 16.—Col. William L. Wilson, MC.

Controversy originally arose over policy on the issuance of unit medical equipment to units in training in the United States. About May 1941 when Major Wilson entered on duty in G–4, G–4 began pressing The Surgeon General to issue equipment to "numbered" or tactical units, largely hospitals, being trained for oversea duty. The Surgeon General opposed issuance of the equipment for several reasons: the stations where units were assigned lacked space to store the equipment, the equipment might deteriorate or be damaged when handled by inexperienced troops, motor transport for moving it was lacking, and the units had adequate equipment for training purposes. His policy on the issuance of medical equipment was not in line with G–4's current policy for the issuance of all authorized equipment to units being trained for oversea duty. Although not emphasized at this time, a major reason for withholding hospital equipment was the fact that it was in short supply.

At a conference early in 1942 between The Surgeon General and Maj. Gen. (later Gen.) Brehon B. Somervell, then Assistant Chief of Staff, G–4, a compromise was effected. It was decided that units in training would receive soldiers' individual equipment, equipment necessary for field training, and motor transport. The full assemblage would be stored and would be issued only at the time the unit was specifically assigned by the War Department to a mission involving the care of the sick and wounded. Meanwhile General Somervell authorized Major Wilson to proceed on a tour of the United States

extensive enough to permit a study of units being trained for hospitalization and evacuation and of their equipment. Major Wilson's findings with respect to the need for issuing equipment to units and his impressions as to lack of plans in the corps areas for hospitalization and evacuation in the event the United States was bombed led to conflict between him and members of the Surgeon General's staff in 1942.[37]

General Headquarters Medical Liaison

Medical representation was also established at General Headquarters set up in July 1940 to supervise the training of the field forces in continental United States—the four armies then being built up. In November a Medical Corps officer was assigned to the special staff of Maj. Gen. (later Lt. Gen.) Lesley J. McNair at the Army War College in Washington, D.C. The work of General Headquarters expanded in mid-1941 to include the planning and command of military operations. Medical Department officers assigned to its staff were charged with preparing the medical phases of operating plans for the base commands accompanying task forces sent overseas and for whatever expeditionary forces the course of events might require. A medical section was organized in July 1941, and Lt. Col. Frederick A. Blesse, MC (previously with G–4), became its head with the title of Surgeon, General Headquarters. His medical section, to which several Medical Corps officers were assigned in late 1941, prepared the medical plan for the Iceland Task Force and similar plans for other task and expeditionary forces. In planning the medical personnel and supplies to accompany a particular force, his office was aided by the appropriate division of the Surgeon General's Office or of the Air Surgeon's Office. This medical section had increased planning responsibilities throughout 1941. In the course of that year, the Bermuda, Newfoundland, and Greenland Base Commands were put under General Headquarters, as well as the Caribbean Defense Command, and soon after the Japanese assault on Pearl Harbor the Northeastern and Western Defense Commands, transformed into the Eastern and Western Theaters of Operations, also came under its control. Early in 1942 it had brief command of the forces in the British Isles, and Colonel Blesse's office prepared the medical plan for V Corps.[38]

Armored Force Medical Section.—In mid-1941 a small medical section was also established at the Fort Knox headquarters of the Armored Force, created as a subcommand of General Headquarters. It consisted originally

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[37] 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, pp. 141–142, 151–152.

[38] (1) Greenfield, Kent R., and Palmer, Robert R.: Origins of the Army Ground Forces, General Headquarters, U.S. Army, 1940–1942. Study No. 1, Historical Section, Army Ground Forces, 1946. [Official record.] (2) Interview, Brig. Gen. Charles B. Spruit, MC, USA (Ret.), 31 Oct. 1947. (3) Annual Report, Medical Section, General Headquarters, U.S. Army, 1941.

of two Medical Corps officers, who had previously served at headquarters of I Armored Corps, and four enlisted men. Since German successes with tanks in the invasion of France during the summer of 1940 had made it appear likely that the Armored Force would achieve the status of a combatant arm separate from the infantry, the Army began building up armored divisions in greater proportion to infantry divisions. As General Magee pointed out, in protesting the tendency of Air Forces medical officers to emphasize the peculiar psychology of the airman and his special medical needs, the men in tanks also faced dangerous environmental conditions and special combat hazards. "Moreover," he stated, "in his steel-enclosed quarters, from which escape is difficult, with the firing of artillery in immediate proximity, with the presence of noxious gases from rapidly firing guns and the operation of motors, with the possibility of being blown to bits by landmines or being incinerated from the ignition of ammunition or gasoline, one would be slow to decide that the support of his morale or the furtherance of his physical recuperation is less in need of attention than that of the airman." Although they faced medical problems of a specialized character, the staff medical section at Armored Force headquarters apparently never developed any doctrine of separatism from the medical service of the rest of the Army.[39]

Corps of Engineers, Eastern Division.—Late in 1940 Lt. Col. (later Brig. Gen.) Leon A. Fox, MC (fig. 17), was assigned as chief health officer for the newly created Eastern Division of the Corps of Engineers. This assignment differed from the other assignments noted above in that Colonel Fox had concrete responsibilities for the furnishing of medical service whereas the others were mainly concerned with planning and with liaison. The task of the Health Division (within the Eastern Division) headed by Colonel Fox was to provide medical care for civilian employees of private business firms which had contracted with the Corps of Engineers for the construction of airbases at the sites (in Newfoundland, Bermuda, the Bahamas, Jamaica, Antigua, St. Lucia, Trinidad, and British Guiana) acquired by the destroyer-base agreement of September 1940 with the British.[40] Colonel Fox's assignment and that of other medical officers to this work resulted in the development of a medical organization responsible to the Chief of Engineers rather than to The Surgeon General. It pioneered in establishing Army health service in foreign areas outside continental United States and the Army overseas departments. Colonel Fox's headquarters was originally with the Eastern Division

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[39] (1) The Armored Force Command and Center. Study No. 27, Historical Section, Army Ground Forces, 1946. [Official record.] (2) Memorandum, Surgeon, Headquarters, Armored Force, for The Surgeon General, 22 Jan. 1943, subject: Record of Activities of the Armored Force Surgeon's Office From Date of Activation to 31 Dec. 1942. (3) Memorandum, The Surgeon General, for Commanding General, Services of Supply, 13 Oct. 1942, subject: Specialized Hospitals and Recuperative Facilities for Army Air Forces Personnel.

[40] For more detailed and documented treatment, see Wiltse, Charles M.: The Medical Department: Medical Service in the Mediterranean and Minor Theaters. United States Army in World War II. The Technical Services. [In preparation.]



FIGURE 17.—Brig. Gen. Leon A. Fox, MC.

headquarters in Washington, but he and certain assistants spent the first half of 1941 making sanitary surveys of the territories concerned, preparatory to selecting sites for the bases. The survey typically contained information on existing health facilities and specific disease hazards of the region. In the late summer of 1941, when the Caribbean Division and the Atlantic Division, both with headquarters in New York, superseded the Eastern Division, Colonel Fox was put in charge of the medical service for both. From late 1940 his office sent Medical Corps officers to the Engineer districts which served as the agencies for carrying out construction and other activities of the Corps of Engineers in the Caribbean area, Bermuda, and Newfoundland, and later in 1941 to the districts in Iceland and Greenland. By the end of 1941 one or more Medical Corps officers (11 at Trinidad) had been sent to each of the bases, and in several a Dental Corps officer was present. For a brief period the Engineer medical service, which included some small hospitals, existed side by side with the medical service developing for troops at the bases, but was withdrawn or merged with the latter as ground and Air Force units replaced engineer troops. Medical Department personnel assigned to the base setup were in a chain of command which led back to the General Staff through

General Headquarters (through the Caribbean Defense Command as an additional echelon in the case of bases in the Caribbean).

RELATIONS WITH THE GENERAL STAFF

During 1940 and 1941 the War Department General Staff gave increasingly close supervision to the administration of Army medical service. Changes in requirements for medical supplies and accompanying storage space, increased hospital bed requirements to accord with increases in the authorized strength of the Army, and the adoption of standard plans for hospital construction led to closer contact between the Surgeon General's Office and G–4, as did the question of the issuance of unit assemblages to troops.[41] Personnel guides proposed by the Surgeon General's Office for manning additional station and general hospitals in the United States, the office's calculations of the increased requirements for doctors, dentists, veterinarians, and nurses, and its plans for procuring, classifying, and assigning Medical Department officers and enlisted men required the approval of G–1. The dispatch of troops to oversea bases called for recommendations by the Surgeon General's Office as to the immunizations to be given them and other preventive measures to be taken for their protection; these had to be cleared with the War Plans Division of the General Staff as well as with G–4 and G–1.

Officers in the Surgeon General's Office stressed the importance of adopting certain preventive measures which they believed would maintain high standards of health in the growing Army. Acutely mindful of the heavy toll of the influenza epidemics of World War I, preventive medicine officers attempted, beginning late in 1939, to maintain adequate standards of air space, floor space, and ventilation in new hospitals under construction, as well as in barracks. In this effort they came into conflict with G–3 which was anxious to get as many soldiers into training as possible and hence wanted to house more men in the available barrack space than preventive medicine officers of the Surgeon General's Office thought desirable.[42] The Chief of Staff and the General Staff hesitated to adopt in full some of the recommendations of the Surgeon General's Office for immunizations for troops. In the case of recommendations for certain task forces slated to go overseas, for instance, the uncertainty as to their destination and the time of their departure led to delay in staff approval. Although relations of the Surgeon General's Office with the General Staff remained formally the same as they had been in the prewar period, the staff became of necessity more involved than formerly with the details of operations of the medical service.

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[41] (1) Memorandum, Acting Assistant Chief of Staff, G–4, for Assistant Chief of Staff, G–1, 25 Nov. 1940, subject: Detail of Medical Officer to G–4. (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, ch. II–IV.

[42] Committee to Study the Medical Department, 1942, Exhibit 41.

LOCAL AGENCIES AND FIELD UNITS PROVIDING MEDICAL SERVICE

During 1940 and 1941, field installations engaged in Medical Department work increased markedly in number and size. The surgeon's offices of the corps areas and departments underwent similar expansion, while medical offices were created for the new defense commands and field armies, the rapidly growing air commands, and the new Atlantic bases. A few medical officers accompanied the military missions sent overseas to keep in touch with the war situation in various friendly countries. When the United States entered the war these officers became the nuclei of the medical sections of theater commands. Several became chiefs of service in their respective theaters of operations.

Field Installations

During 1940 and 1941 the field installations under command control of The Surgeon General increased in number and were augmented by one new type—the medical replacement training center. The Surgeon General still had command of the Army Medical Center with its Professional Service Schools and Walter Reed General Hospital, of the other "named" general hospitals in the United States (13 by October 1941), of the Medical Field Service School at Carlisle Barracks, and of the medical depots. During 1941 the floor space allotted to the medical depot system expanded almost fivefold. By the end of the year there were three medical depots, a depot having been established at Savannah and one at Toledo in addition to the St. Louis Medical Depot, and medical sections in nine general depots at the following locations: Chicago, Columbus (Ohio), New Cumberland (Pa.), New Orleans, New York, Ogden (Utah), San Antonio, San Francisco, and Schenectady.[43]

Early in 1941 two Medical Department replacement training centers were set up, one at Camp Lee, Va., in the Third Corps Area and the other at Camp Grant, Ill., in the Sixth Corps Area. These, designed to train enlisted men for Medical Department units, were originally placed, along with most replacement training centers, under direct control of the corps area commander. The Surgeon General, through the Plans and Training Division, exercised jurisdiction over such technical matters as the content of courses, the tables of organization for the various units, and so forth. Late in the year another medical replacement training center was established at Camp Barkeley, Tex., and soon afterward the three replacement training centers were placed under the direct jurisdiction of The Surgeon General. With a capacity of several thousand men each, they gave basic military training and certain specialized training for the position of medical and surgical technician, clerk, cook, chauffeur, and auto mechanic.[44]

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[43] Yates, Richard E.: The Procurement and Distribution of Supplies in the Zone of Interior During World War II, pp. 43, 157. [Official record.]

[44] Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1941, pp. 159–161.

Corps Areas, Departments, and Bases

Corps area medical service.—During the emergency period the organization of the corps area surgeon's office underwent a general expansion in numbers of personnel.[45] Four field armies were being built up, and until late in 1940 the headquarters of several corps areas served also as the headquarters for a field army. The Medical Department annexes to the Corps Area Protective Mobilization Plans formulated by corps area surgeons' offices in 1939 had anticipated expansion in the event of mobilization. They had varied widely as to the number of officers, enlisted men, and civilians which they calculated a corps area surgeon's office would need in the event of mobilization, and as to the organization of his office. The plan for the Seventh Corps Area contemplated setting up 12 divisions, 11 of which tallied with the 12 contemplated for the Surgeon General's Office in its plan of 1939. A separate museum division for each corps area was unnecessary, of course. The twelfth was to be an Inspection Division. The plan for the same corps area for 1940, however, exhibited a tendency toward greater concentration of functions, listing only eight divisions. It contemplated a single Inspection, Preventive Medicine, and Vital Statistics Division instead of a full division for each of these functions, and it omitted the previously listed Nursing and Library Divisions.

In general the plans exhibited a lack of uniformity in unit designation, in numbers of personnel contemplated, and in organizational pattern. Nor did most of them specify the extent to which Medical Administrative Corps personnel would be substituted for professionally trained officers and the extent to which enlisted men and civilian personnel would be used in clerical positions. Wide divergencies thus render rather fruitless any attempt to indicate the degree to which the actual setup of the corps area surgeons' offices in 1940 and 1941 followed the medical annexes to the Corps Area Protective Mobilization Plans. The expansion which took place in the relatively large surgeon's office in the Second Corps Area seems typical enough to give an idea of general trends in expansion. In September 1940 this office consisted simply of four officers, six civilian clerical employees (three of whom were paid from Civilian Conservation Corps funds), one civil-service physician acting as Assistant Surgeon for the Civilian Conservation Corps, and six enlisted men. The corps area surgeon, who was, of course, on the special staff of the corps area commander, also served as surgeon of the First U.S. Army. The other three medical officers were a colonel of the Medical Corps, a captain of the Medical Administrative Corps, and a captain of the Medical Corps Reserve. The following month the assignment of the Reserve officers to the handling of professional administrative matters and training constituted the initial step toward the organization of the office on a functional basis as contemplated in the plan for the corps area.

[45] This discussion of corps area medical services is based on: (1) Protective Mobilization Plans, First, Second, Fifth, Sixth, Seventh, and Eighth Corps Areas, 1939. (2) Annual Reports, all corps area surgeons, 1940 and 1941. (3) History, Office of The Surgeon, Second Corps Area and Second Service Command, From 9 September 1940 to 2 September 1945. [Official record.]



FIGURE 18.—Brig. Gen. Charles M. Walson, MC.

By the end of the year the Headquarters of the First U.S. Army had been separated from that of the Second Corps Area. The corps area surgeon, Col. (later Brig. Gen.) Charles M. Walson, MC (fig. 18), had 10 officers assigned to him, as well as a chief nurse, an assistant surgeon for the Civilian Conservation Corps, and a liaison officer of the U.S. Public Health Service. During 1941, four officers were added. There were then in the Second Corps Area surgeon's office 26 civilian employees and 17 enlisted men of the Medical Department, who with the 15 officers and the chief nurse made an aggregate of 59 in the office, exclusive of the assistant surgeon for the Civilian Conservation Corps and the liaison officer from the U.S. Public Health Service.

So long as the offices of the corps area surgeons remained small, the lack of clear-cut organizational lines presumably caused little trouble. Apparently the theory prevailed that a flexible organization with personal control exercised by the corps area surgeon, who might make frequent changes in assignment according to his needs, produced better results than a fixed organization with demarcation of duties. The corps area surgeon was able to keep in touch with all his staff. With continuous expansion of the corps area surgeon's office, however, this personal type of organization ceased to be feasible. The difficulty of making efficient assignment and classification of civilian personnel, especially of newcomers, under an organization with no fixed pattern was pointed out in a classification survey made of the civilian positions in the surgeon's office of the

Eighth Corps Area in July 1941. With the rapid growth of corps area surgeon's offices in both military and civilian personnel, more detailed organizational charts and clearer delineation of function became necessary for efficient administration.

By the end of 1941 the surgeon's office of the Eighth Corps Area, as well as that of one or two other corps areas, showed a more definite organizational pattern. The surgeon, his executive officer, the office administrator, and a chief clerk constituted the executive staff of the Eighth Corps Area surgeon's office. The following divisions existed: Professional, Finance and Supply, Dental, Civilian Conservation Corps, Veterinary, and Personnel. The Civilian Conservation Corps Division handled the corps area surgeon's responsibilities for providing medical service to Civilian Conservation Corps camps in the Eighth Corps Area; this work was an important task of corps area surgeons until the Civilian Conservation Corps was abolished in 1942. The surgeon's office of most corps areas had not attained the degree of organizational development reached by that of the Eighth Corps Area, but specific divisions and sections were emerging in all of them, including sections concerned with civilian personnel. These latter were a result of the rapid increase in use of civilians in hospitals in the corps areas.[46]

Two innovations in corps area medical service before the United States entered the war have already been recounted: the assignment of U.S. Public Health Service officers to corps area surgeons' offices, and the establishment of corps area laboratories. The assignment of a dental surgeon to each corps area headquarters in October 1940 was also a uniform development in the expansion of corps area medical organization.[47] About the same date it was decided at a conference of corps area surgeons that a nurse in the grade of assistant superintendent would be assigned to each corps area surgeon's office to supervise the expanding nursing service throughout the corps area.[48]

Another development in corps area medical service, authorized in 1940 but not put into effect until 1941, was the establishment of the position of camp surgeon separate from that of hospital commander. It had been customary for camp or station surgeons to act also as hospital commanders, as the work involved in the two functions could be headed by a single medical officer. With the tremendous expansion of many Army camps after the draft, however, new duties developed which were distinct from the administration of the hospital proper, such as medical aspects of the processing of new recruits throughout the corps area, preparation of an increasing number of medical reports, and work on multiplying sanitary problems. At the same time the work of directing the expanding hospitals became a full-time activity.

[46] Memorandum, Col. Achilles Tynes, MC, for Corps Area Surgeons and Department Surgeons, 12 Sept. 1940, subject: The Use of Civilian Personnel in Army Hospitals. 231.1 (Hawaiian Department) AA.

[47] Medical Department, United States Army, Dental Service in World War II. Washington: U.S. Government Printing Office, 1955, p. 31.

[48] Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1941, p. 245.

The obvious solution was to divorce the two jobs of hospital commander and camp surgeon in the larger installations and to assign additional personnel to the office of the new camp surgeon to carry out the general duties noted above.

Departments and bases.—The establishment of the Caribbean Defense Command in the spring of 1941 was intended to coordinate the military activities of the Panama and Puerto Rican Departments with those of the Caribbean bases acquired from Great Britain under the agreement of September 1940. The command headquarters was located at Quarry Heights, C.Z., and the commanding general served in the additional capacity of commanding general of the Panama Canal Department. Three "sectors," the Panama, Trinidad, and Puerto Rican Sectors, were set up. The area was neither geographically nor politically cohesive. The Puerto Rican Sector included the Virgin Islands, Jamaica, Cuba, and Antigua; and the Trinidad Sector eventually included Dutch, British, and French Guiana, as well as St. Lucia, Aruba, and Curaçao. Moreover, the Commanding General, Caribbean Defense Command, apparently preferred to keep his special staff small in order to preserve the mobility of his headquarters in the event of enemy attack. The creation of a staff medical section was postponed, and the surgeons of the departments and of the multiplying base commands in this area continued to report directly to the War Department. The medical service maintained by the Corps of Engineers for civilians employed on Army construction in the bases existed side by side with the usual Army medical service for ground and air troops and further complicated the structure of Army medical organization within the bases. The Caribbean Air Force, which was established in May 1941, absorbing the previous Panama Canal Department Air Force, had its own surgeon and medical organization. Thus Army medical service in the Caribbean Defense Command was directed by, and reported through, three command channels during early war years. Although the regions around the Caribbean presented a homogeneity of medical problems, no unification of Army medical service under a surgeon at Caribbean Defense Command headquarters took place until October 1943.[49]

Except for a general expansion to furnish medical care for increasing forces, few significant changes took place in the organization of medical service in the Hawaiian and Philippine Departments until the Pearl Harbor attack. No surgeon was appointed for the new tactical command, the U.S. Army Forces in the Far East, organized in the Philippines in July 1941. The departmental surgeon continued as head of the medical service in that area.

Armies and Continental Defense Commands

Field army surgeons.—The offices of field army surgeons were revived when the headquarters of the four field armies were established separately from

[49] (1) History of Medical Department Activities in the Caribbean Defense Command in World War II, vol. I, pp. 105ff and 155ff. [Official record.] (2) Annual Reports, Surgeon, Puerto Rican Department, 1940, 1941. (3) Annual Reports, Surgeon, Panama Canal Department, 1940, 1941. (4) Annual Reports, Surgeon, Hawaiian Department, 1940, 1941. (5) Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1941, pp. 40–41.

the headquarters of four corps areas with which they had previously been integrated. The offices of army surgeons did not differ greatly from the offices of corps area surgeons; during the initial stages of their development, they rather resembled the corps area surgeons' offices of 1939 in smallness and simplicity.

When separate headquarters were established, the Army surgeon's office consisted of the surgeon and one or two officers and enlisted men. The War Department at that time authorized one Reserve medical officer in addition to the Regular Army surgeon, with a provision for later increase to three Reserve officers. The Surgeon General and the army surgeons recommended that all four officers be of the Regular Army; other than the surgeon, a plans and training officer, who would act as executive assistant to the surgeon; the army dental surgeon; and the army veterinary surgeon. Believing that Reserve officers had not had sufficient experience to qualify them for training duties, The Surgeon General stressed the importance of having a Regular Army officer fill the position of plans and training officer, who would be the normal alternate for the surgeon. In December the four Regular Army officers were authorized. In April 1941 the number of officers was increased to six and in September to eight. The number of enlisted men allotted to the Army surgeon's office increased proportionately.

In 1941 medical officers were not available in the numbers needed to fill all the positions for which they were authorized, and the number assigned to the army surgeon's office was not usually equal to that allotted. Although the army surgeons' offices were theoretically set up on a functional basis by this date, it was thus not always possible to establish all of the organizational subdivisions called for. Some units of an army surgeon's office originally thought necessary were found to be necessary only during maneuvers. Except in one or two instances permanent assignments of dental and veterinary surgeons were found unnecessary during the emergency period as the corps area medical organization provided the requisite service. The fact that during maneuvers an army's units might be dispersed among several corps areas seemed to argue against a settled functional pattern for the office of an army surgeon, subject as it was to periodic unsettlement.[50]

The supervision of training was an important function of both the corps area surgeon and the army surgeon, but neither was responsible for all the training of medical troops within his jurisdiction. In general the tactical medical units of armies received technical training in hospitals under the jurisdiction of corps areas, while personnel assigned to the medical installations of corps areas were given tactical training with the armies. Sanitation was

[50] (1) Bronk, William W.: History of the Eastern Defense Command, 1945. [Official record.] (2) History of the Western Defense Command, 17 March 1941–30 September 1945. [Official record.] (3) Annual Report, Surgeon, Headquarters, Eastern Theater of Operations, and First U.S. Army, 1941. (4) Annual Report, Surgeon, Eastern Defense Command and First U.S. Army, 1942. (5) Annual Report, Surgeon, Second U.S. Army, 1941. (6) Annual Reports, Surgeon, Third U.S. Army, 1941 and 1942. (7) Annual Report, Surgeon, Fourth U.S. Army, 1941.

primarily a responsibility of corps area command, but the army surgeon was responsible for sanitary precautions in the field. While the army remained at its home base the corps area command furnished it hospitalization and medical supplies. On maneuvers hospitalization became a concern of the army surgeon, but responsibility beyond the stage of the evacuation hospital rested with the station and general hospitals of the corps area within which particular army units were stationed. As for dental treatment and training in dentistry, the regimental dispensaries and aid stations of armies confined themselves to making dental surveys and to providing emergency treatment and training in the handling of emergency cases. Cases requiring definitive treatment or specialized dental equipment were handled in the camp dental clinics and hospital dental clinics of corps areas, and the clinics gave instruction in the care of such cases.

Defense command surgeons.—In March 1941 the continental United States was divided into four defense commands, the Northeastern, Central, Southern, and Western. The Northeastern Defense Command was redesignated the Eastern Theater of Operations in December 1941, which in turn was renamed the Eastern Defense Command 3 months later. The Eastern and Western Defense Commands exceeded the others in importance, as they comprised most of the eastern and western coastal areas. The commanding generals of the armies located in them took over the administration of these defense commands. Hence in 1942 the surgeon of the First U.S. Army, Col. (later Brig. Gen.) Frank W. Weed, MC (fig. 19), was also surgeon of the Eastern Defense Command, which eventually included (though it did not supersede) not only the First, Second, Third, Fifth, and Sixth Corps Areas, and that portion of the Fourth Corps Area that comprised the Carolinas, Georgia, and Florida, but also the base commands in Iceland, Greenland, Newfoundland, and Bermuda. The surgeon's office was at the joint headquarters of the First U.S. Army and the Eastern Defense Command on Governors Island, N.Y. Col. (later Brig. Gen.) Condon C. McCornack, MC (fig. 20), surgeon of the Fourth U.S. Army, became similarly surgeon at the joint headquarters of Fourth U.S. Army and Western Defense Command at the Presidio of San Francisco. The Alaska garrison which had grown rapidly during 1940, being then attached to the Ninth Corps Area, had become the Alaska Defense Command early in 1941 and was now assigned to the Western Defense Command.

Medical installations within the boundaries of the defense commands were for the most part under corps area jurisdiction, but a few station hospitals in the Atlantic bases and in Alaska—immediately under the base commands—were within the defense command chain of control.[51]

During the southern maneuvers of 1941, certain problems of medical administration, already prophesied by army surgeons, developed. The army

[51] (1) See footnote 50(1) and (2), p. 61. (2) McNeil, Gordon H.: History of the Medical Department in Alaska in World War II (1946). [Official record.]



FIGURE 19.—Brig. Gen. Frank W. Weed, MC.

surgeons' offices had to split up, a portion going forward with troops, and the rest remaining at headquarters. Certain officers, especially dental and veterinary, and a medical inspector, had to be added temporarily during maneuvers. This situation strengthened, if it did not clinch, the argument for sufficient medical personnel in the army surgeon's office to allow for such divided operation during maneuvers. A similar need for additional personnel later developed in oversea theaters whenever large headquarters split into forward and rear echelons. During the maneuvers many units of the army for whose health the army surgeon was responsible were stationed in, or moving about, territory outside their home corps area. The corps area surgeon was interested in reports on the sick and wounded, and on sanitary conditions, from stations within the geographic limits of the corps area. The army surgeon was interested in getting the same statistics from the units of the army command. Aside from the intrinsic value of the reports for information as to the health of the command, it was desirable to train the medical officers in units to prepare the reports which they would have to make if their units were moved overseas. It became a special problem for the army surgeon to obtain the necessary reports whenever units of the army were stationed in some corps

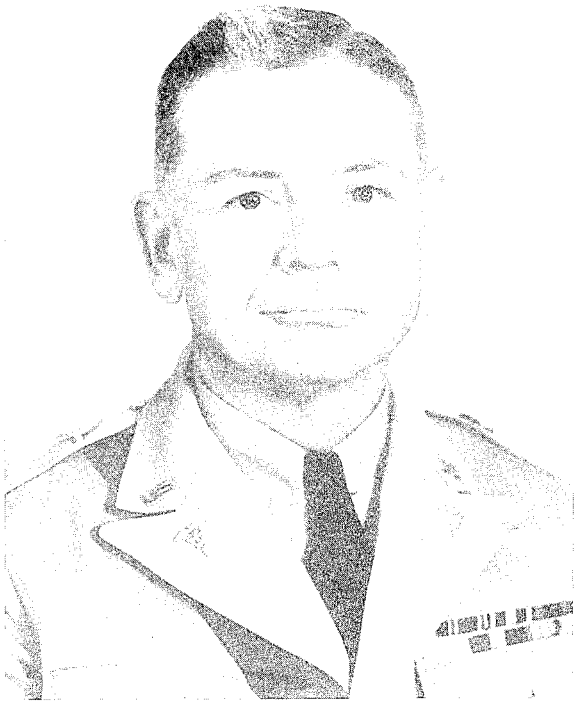


FIGURE 20.—Col. Condon C. McCornack, MC.

area other than the army's home territory. The problem was finally solved by negotiation between army surgeons and corps area surgeons and by clarifying regulations issued by the War Department.[52]

Medical Units for Oversea Service

Field units.—While the army surgeon's offices were building up, the medical elements of subordinate commands of the field army—that is, the tactical medical units—were being activated. The Plans and Training Division of the Surgeon General's Office was engaged throughout the emergency period in reorganizing these units and revising their tables of equipment. The reduction in strength of the standard field army, army corps, and division which was underway at this date, and the concomitant transformation of the division from a unit composed of four regiments (the "square division") into one composed of three regiments (the "triangular division"), made necessary much revision of standard medical units. The medical regiment, which had served the corps and the square division, was replaced by the medical battalion as the largest unit. However, the field forces were not at once completely reorganized, and

[52] See footnote 50(3), p. 61.

some medical regiments continued to exist until after the entry of the United States into the war. The structure of the medical detachments "organic" to combat regiments and of the evacuation and surgical hospitals normally attached to field armies also underwent revision.

Communications Zone units.—The planning of the emergency period further included the medical units which were to operate in the communications zone of an oversea theater, such as the station and general hospitals, the medical laboratories, and the medical supply depots. These were distinct from their counterparts in the Zone of Interior in having a standard structure or "table of organization." The Planning and Training Division also developed new types of medical units to serve with such new types of Army units as the armored division, airborne division, and mountain division.

Subordinate Air Commands

Throughout the emergency period and the war, surgeons' offices sprang up in the shifting commands and forces under the Air Corps and, after June 1941, the Army Air Forces. These commands had a surgeon on the special staff of the commanding officer, although few had any appreciable number of medical personnel at headquarters until late in 1941.

A few air commands undertook medical work peculiar to the air forces. These were chiefly of two types: the training commands, concerned with the training of aircrews (usually referred to as "flying training") and with the training of technicians for ground crews (called "technical training"), and the service or maintenance commands, concerned with supply and maintenance. The major departure from the standard Army pattern of medical service developed in the training commands, which were engaged in selecting a body of men for flight training and combat training on the basis of special physical and psychological attributes.

Air training commands.—Besides the general administration of medical service resembling the work of the surgeon's office of any command, the air training commands administered a series of elaborate tests, which went considerably beyond the usual physical and mental tests, to candidates for pilot training. Until July 1940 the Air Corps Training Center at Randolph Field, San Antonio, Tex., was responsible for the training of all fliers. At that date it was split into three centers, located at Randolph Field, at Moffett Field, Calif., and at Maxwell Field, Ala. The staffs of these centers eventually included a surgeon who headed a small office. Among the early duties of the training center surgeons was the task of passing upon the healthfulness of potential sites for Army flying schools and that of sites of civilian flying schools under consideration for contract by the Air Corps. When schools were established or selected, the surgeons had the responsibility of making arrangements for

medical service for trainees at each school, either through the assignment of medical personnel to the school or through contract with civilian doctors.[53]

In the fall of 1941 and in early 1942 three Air Corps replacement training centers were set up, one under the jurisdiction of each of the training centers, at the following locations: Maxwell Field; Kelly Field, Tex.; and Santa Ana, Calif. At these were established "psychological research units" to put into effect the results of a psychological research project begun about mid-1941 in the Medical Division, Office of the Chief of the Air Corps. The latter had been working not only on physical and mental tests but also on psychomotor tests to measure the muscular coordination, equilibrium, and so forth, of pilot candidates. The new psychological research units, staffed with officers trained in psychology, were to apply the tests, experimentally at first, to candidates at the replacement training centers and carry on research in this field.

Until March 1941 the training for ground crews in mechanics, photography, radio, and so forth, was conducted by the Air Corps Technical School at Chanute Field, Ill. Out of the staff surgeon's office developed the office of the surgeon for the Air Corps Technical Training Command (with headquarters first at Chanute Field, later at Tulsa, Okla.), which was established in March 1941 with responsibility for technical training for the Air Corps throughout the United States. For this training, as well as for flying training, contracts were made with civilian schools, in some cases the same schools as those used for flying training. As in the case of the flying trainees, medical service was insured for technical trainees either by providing in the contract for the services of school physicians, by making special contracts with civilian doctors, or by assigning Army medical officers to the work whenever the number of trainees so warranted.

Supply and maintenance commands.—The second type of air command, that dealing with supply and maintenance, also existed in two separate commands in the latter part of the emergency period: The Materiel Division (later termed the Materiel Command), and a succession of commands which finally became in October 1941 the Air Service Command. The principal function of the Materiel Division was that of procuring supplies for the Army Air Forces. Its one function in the special field of aviation medicine was the administration of the Aero-Medical Research Unit at Wright Field. The work of the Aero-Medical Research Unit was hampered by lack of technically trained personnel until a group of specialists sponsored by the National Research Council began to arrive in early 1941. Not until early 1942 was the name of the unit changed to Aero-Medical Research Laboratory and con-

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[53] (1) Coleman, Hubert A.: Organization and Administration, Army Air Forces Medical Service in the Zone of Interior, pp. 157–183. [Official record.] (2) History of the Army Air Forces Flying Training Command and Its Predecessors, 1 January 1939–7 July 1943 (1 March 1945), vols. I, II. [Official record.] (3) History of the Army Air Forces Technical Training Command and Its Predecessors, 1 January 1939–7 July 1943 (1 March 1945), vol. I. [Official record.] (4) History of The Army Air Forces Training Command, 1 January 1939–V–J Day (15 June 1946), vol. II. [Official record.] (5) Annual Report, Office of The Air Surgeon, 1942.

struction of a main building to house the laboratory undertaken at Wright Field. The Air Service Command determined requirements and handled distribution of supplies for the Army Air Forces. Neither it nor its predecessors had any functions peculiar to the field of aviation medicine, but as the command employed thousands of civilians, its headquarters surgeon supervised a large program of industrial medicine. The functions of his office were closely related to those of the Occupational Hygiene Branch (later Division) of the Surgeon General's Office and in some respects duplicated them.[54]

Numbered air forces.—Soon after the four Army defense commands were announced in March 1941 and their administration combined with that of the four armies, four similarly numbered air forces were set up to operate under Headquarters, Army Air Forces. The office of the air force surgeon, or flight surgeon, who was on the special staff of the air force commander, consisted originally only of the surgeon and one or two enlisted men. The medical section advised the commanding general on the health and sanitation of the air force under his command, the training of all personnel in sanitation and first aid, and on hospitalization and evacuation; supervised the operation of medical service in subordinate units and the training and inspection of Medical Department troops; handled the procurement, storage, and distribution of medical, dental, and veterinary equipment through the usual channels; and prepared records and reports. The four numbered air forces, under command of the Air Corps, were charged with air defense of the United States and with giving intensive training to aircrews and attached ground personnel. Although the areas assigned to them did not coincide entirely with the boundaries of the defense commands, they were coordinated with the defense commands as follows: First Air Force, Eastern Defense Command; Second Air Force, Central Defense Command; Third Air Force, Southern Defense Command; and Fourth Air Force, Western Defense Command. Like the First and Fourth U.S. Armies, identified with the Eastern and Western Defense Commands, respectively, the First and Fourth Air Forces were those concerned primarily with defense of the coastal areas. The operations of the Second and Third Air Forces were eventually confined largely to training.[55]

Like the combat arm it served, the medical organization of the air forces was building up all through 1941. In addition to operational activities, the air force surgeon's office set up the necessary medical reporting system, and aided in surveying sites for new air bases. Additional medical personnel came in with units sent to the new bases, and air base surgeons were assigned. In

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[54] (1) Medical History, Air Technical Service Command, 1 January 1945. [Official record.] (2) Mitchell, T. W., Walker, Imogene B., and Smith, Duane D.: History of the Army Air Forces Service Command, 1921–1944 (1945). [Official record.] (3) History of the Army Air Forces Materiel Command, 1926–1941, vols. I, II. [Official record.] (4) History of the Aero-Medical Laboratory, 1935–1943. [Official record.]

[55] (1) Coleman, Hubert A.: Organization and Administration, Army Air Forces Medical Service in the Zone of Interior, pp. 185–219. [Official record.] (2) History of The First Air Force. Vol. I, Organization Development. [Official record.] (3) History of Headquarters, Second Air Force, vol. I. [Official record.]

February 1941, while trying to straighten out the matter of source of payment to civilian employees requested for the surgeons' offices, the Surgeon General's Office referred to them as "new organizations with which this office has had no previous experience, and on which information available to The Surgeon General is relatively meager." These offices were small and expanded only slightly during 1941. Among the personnel added at intervals were an assistant flight surgeon and a veterinary officer (added to the staff of each air force surgeon about the middle of 1941). The surgeons' offices of air forces did not find it necessary to adopt a fully functional pattern of organization until about the end of 1942.

CHAPTER III

The Medical Department Under the Services of Supply, March–September 1942

In the months following the attack on Pearl Harbor, the chief development affecting the administration of the Surgeon General's Office was the reorganization of the War Department in March 1942. This resulted in a change in the position of The Surgeon General and his office within the War Department, as well as a number of changes in the internal organization of the office.

CHANGES IN THE SURGEON GENERAL'S OFFICE DECEMBER 1941 TO MARCH 1942

After the entry of the United States into war in December 1941, the Surgeon General's Office, in common with many Federal agencies in Washington, "mushroomed," new divisions and branches being created to handle increased responsibilities.

Training and Hospital Construction

Among the immediate problems were those of increasing the number of Medical Department units and intensifying their training. In January the Secretary of War approved plans for an expansion of the Army to 3,600,000 enlisted men by the end of the year, with special emphasis on expansion of training in the schools and replacement training centers. More hospitals would be necessary for the expanding Army. Thus two activities, training and hospital construction, emerged, with the advent of war, from the realm of planning and became fields of immediate operations. In February 1942 the Training Subdivision achieved the status of a division, with Planning left as a separate division. The former Hospital Construction and Repair Subdivision of the Planning and Training Division was reorganized into the Hospital Construction Division. As the Protective Mobilization Plan of 1939 had contemplated, the administration of the Army Medical Museum, formerly a function of the Professional Service Division, was raised in the same month to the level of a division, for increased work in pathology had also resulted from the expanded medical work of the Army. Early in 1942, therefore, the office was made up

of 15 divisions, with personnel of approximately 150 officers and 1,000 civilians by March (chart 4).[1]

Expanding Activities

The office subdivisions most significant for future development were those of the Preventive Medicine Division, especially Occupational and Military Hygiene which became for the first time a separate subdivision; those of the Finance and Supply Division; those handling medical specialties, such as neuropsychiatry, medicine and surgery, in the Professional Service Division; and, finally, two new subdivisions added to the Administrative Division, the Public Relations and Intelligence Subdivision and the Historical Subdivision. Most of these rose to divisional status during 1942.

The historical program.—The month of August 1941 had witnessed the genesis of the Medical Department's historical program. The Surgeon General, "feeling that some steps should be taken for the organization of the historical work of the Medical Department," had recalled Col. Albert G. Love, MC, Chief of the Plans and Training Division from April 1938 to his retirement in mid-1941, to active duty to head this work. His action anticipated by some months the inception of the general War Department historical program, which developed under the impetus of President Roosevelt's expressed interest. In 1941 the only other organizational unit of the War Department engaged in historical work was the Historical Division of the Army War College, in existence since World War I. The Medical Department, which had maintained a historical unit in the years 1917–29 and had produced during those years a comprehensive account of its activities in World War I,[2] was more "history-conscious" than most offices of the War Department.

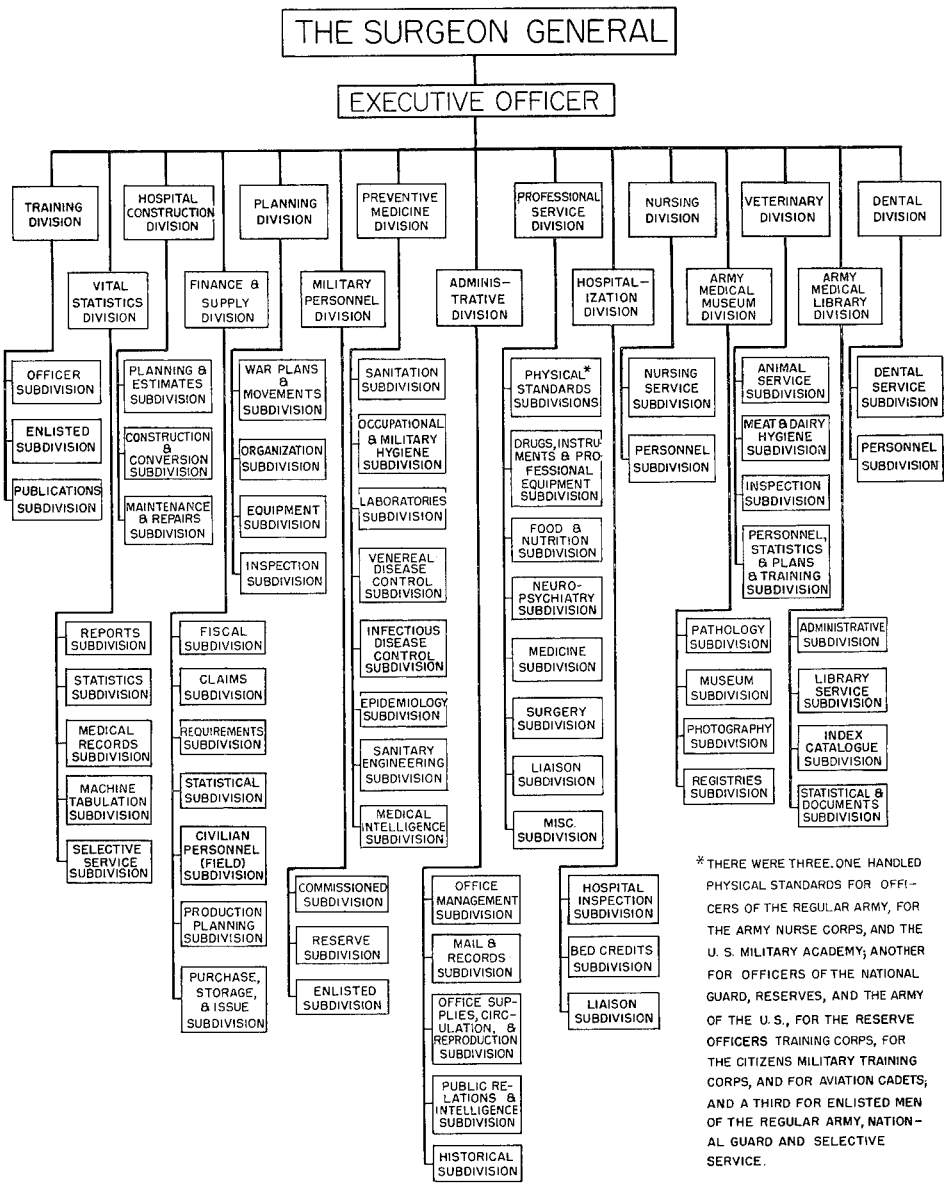
However, the scope of the historical work then contemplated was quite limited, since the United States was not at war and the Medical Department had undergone only the expansion of the emergency period. Moreover, the Division of Medical Sciences of the National Research Council then planned to sponsor a history of medical activities, both military and civilian, during the emergency period. The Chief of the Historical Subdivision, mindful of difficulties encountered by the editor of the history of the First World War (Col. Frank W. Weed) and convinced that the Council was in a better position than the Medical Department to obtain qualified personnel, cooperated with the plans of that body. He limited his own plans to the production of some volumes on the administrative and tactical phases of the Medical Department's work not

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[1] (1) Morgan, Edward J., and Wagner, Donald O.: Organization of the Medical Department in the Zone of Interior (1946), p. 9. [Official record.] (2) Annual Report, Operations Service, Office of The Surgeon General, 1942. (3) Annual Report of The Surgeon General, U.S. Army, 1941. Washington: U.S. Government Printing Office, 1942, p. 172. (4) Letter, The Adjutant General, to Commanding Generals, Army Air Forces, Army Ground Forces, and Services of Supply, 7 Apr. 1942, and inclosure: Mobilization and Training Plan (15 Jan. 1942).

[2] The Medical Department of the United States Army in the World War. Washington: U.S. Government Printing Office, 1923–29, vols. I–XIII.

CHART 4.—*Organization of the Office of The Surgeon General, 21 February 1942*



*THERE WERE THREE. ONE HANDLED PHYSICAL STANDARDS FOR OFFICERS OF THE REGULAR ARMY, FOR THE ARMY NURSE CORPS, AND THE U. S. MILITARY ACADEMY; ANOTHER FOR OFFICERS OF THE NATIONAL GUARD, RESERVES, AND THE ARMY OF THE U. S., FOR THE RESERVE OFFICERS TRAINING CORPS, FOR THE CITIZENS MILITARY TRAINING CORPS, AND FOR AVIATION CADETS; AND A THIRD FOR ENLISTED MEN OF THE REGULAR ARMY, NATIONAL GUARD AND SELECTIVE SERVICE.

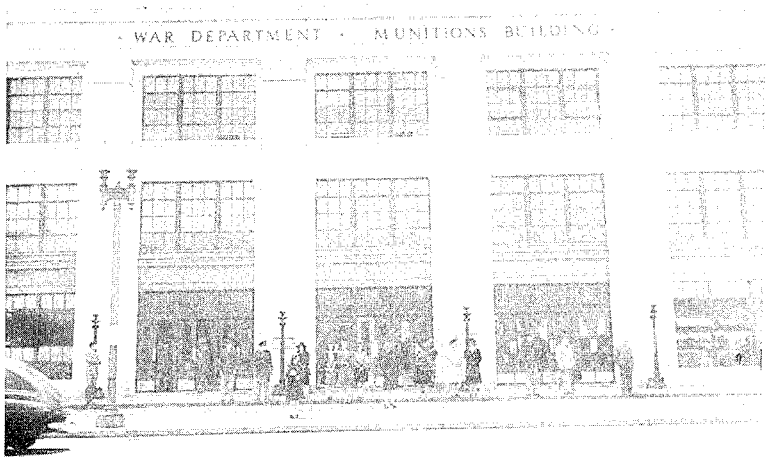


FIGURE 21.—The Munitions Building where Services of Supply Headquarters was located at the time of the March 1942 reorganization.

included in the Council's program.[3] Later in the war the scope of the Medical Department's official history was greatly broadened.

WAR DEPARTMENT REORGANIZATION OF MARCH 1942

In a general War Department reorganization of March 1942, the Medical Department was placed under the Services of Supply or the Army Service Forces as the command was later called. This reorganization had a good deal to do with determining the structure of the Medical Department throughout the war. Some changes in organization of the medical service at various levels in the Army resulted from a natural coordination of the subordinate service with the new superstructure, others from direct orders and recommendations of Services of Supply headquarters (figs. 21, 22).

Effect Upon the Medical Department's Position in the War Department

The Surgeon General and the Medical Department, along with the Corps of Engineers, the Quartermaster Corps, and the rest of the supply services (later termed "technical services"), were placed in March under the direct com-

[3] (1) Office Order No. 237, Office of The Surgeon General, 22 Aug. 1941. (2) Love, Albert G.: The Historical Division, 1 Aug. 1941–28 July 1945. [Official record.]

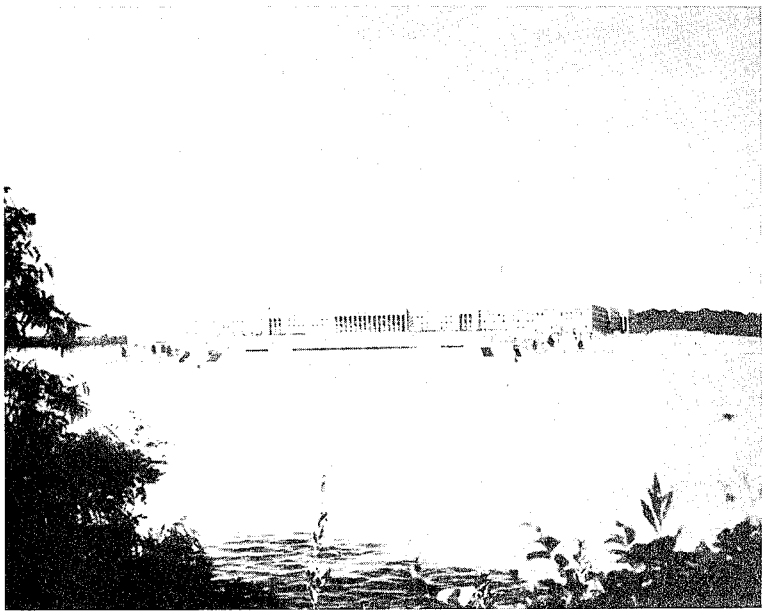
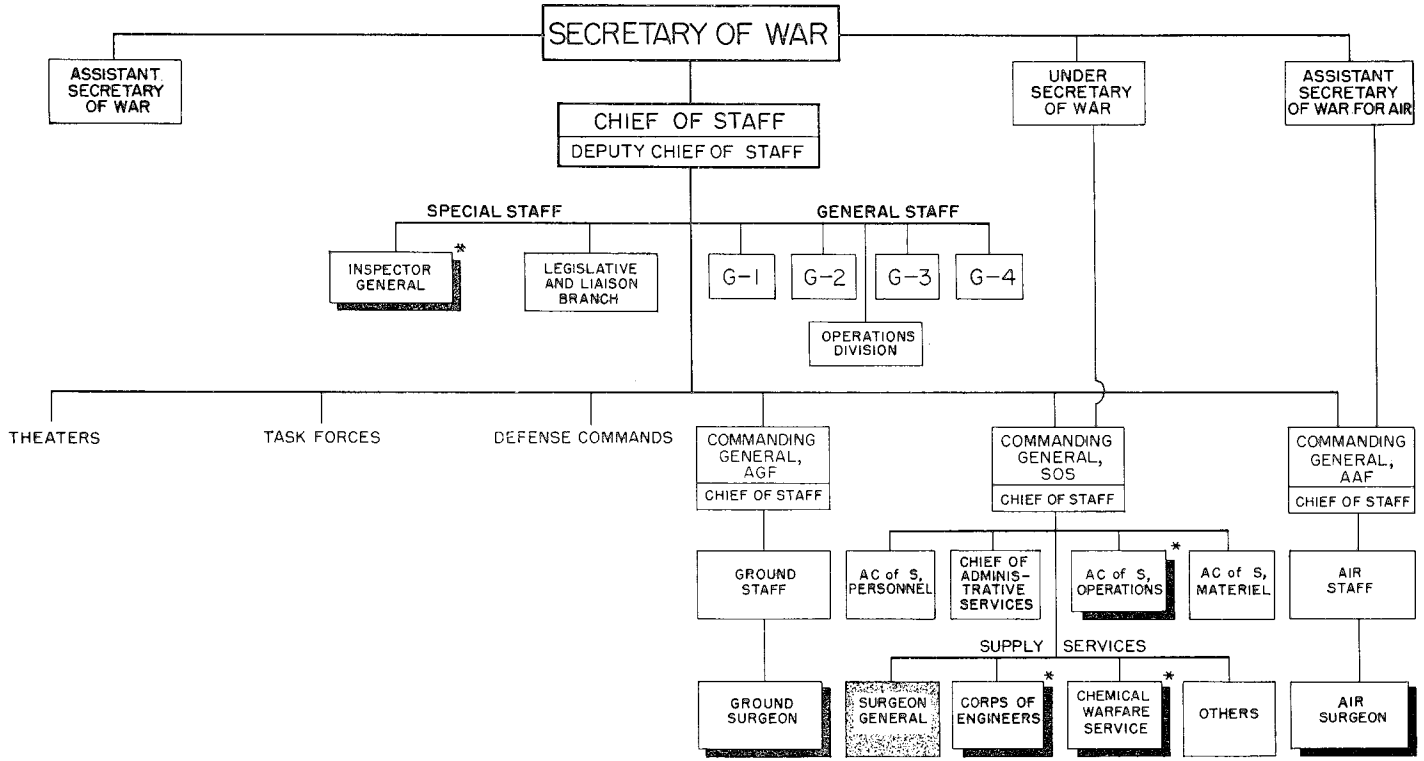


FIGURE 22.—The Pentagon, home of Services of Supply-Army Service Forces Headquarters after 1942.

mand of Maj. Gen. (later Lt. Gen.) Brehon B. Somervell, Commanding General of the Services of Supply. The Army Ground Forces (replacing General Headquarters as a Training Command) and the Army Air Forces, established as major commands along with the Services of Supply, were to be provided by the latter with "services and supplies to meet military requirements," except "those peculiar to the Army Air Forces" (chart 5).

With the reorganization, the operating functions of the Office of the Under Secretary of War and of G–1 and G–4 of the War Department General Staff were transferred to the Services of Supply. Thus the reorganization led to the interposition of the Commanding General, Services of Supply, between The Surgeon General and the Secretary of War and between The Surgeon General and the Chief of Staff. Under the original setup General Somervell had a Chief of Staff, a Chief of Procurement and Distribution, and a "functional staff" consisting of an officer in charge of each of certain functions, such as operations, control, training, personnel requirements, and defense aid. With all of these, or, at later dates, with their successors, the Medical Department had close relations. The divisions of the Surgeon General's Office which handled functions relating to civilian and military personnel and to training, for example, dealt with their obvious counterparts in the Services of Supply. Relations of the Surgeon General's Office with G–1, G–3, and G–4 of the War Department General Staff continued also, although it was intended that the reorganization should make close relations with the General Staff unnecessary.

CHART 5.—*The Medical Department within the War Department structure, August 1942*



* A MEDICAL OFFICER WAS ASSIGNED AS CHIEF OF A BRANCH OF THIS OFFICE.

ADAPTED FROM VARIOUS WAR DEPARTMENT OFFICIAL CHARTS.

The Services of Supply Operations Division

The reorganization led to a shift of some of the medical offices and medical responsibilities assigned to elements of the War Department other than the Surgeon General's Office to new positions in War Department and Army structure. By August 1942 medical offices were located in other elements of the War Department than the Surgeon General's Office (chart 5). The functions in the field of planning for medical supply handled by Maj. (later Col.) William L. Wilson in G–4 of the War Department General Staff were transferred under the March reorganization to the Operations Division, headed by Brig. Gen. (later Lt. Gen.) LeRoy Lutes, of the Services of Supply. Major Wilson was stationed in General Lutes' office until the middle of 1943. Under the original setup, General Lutes' office was given responsibility for preparing plans and instructions on projected and current operations in order to coordinate the work of the supply services and that of the corps areas in troop movements and the movements of supplies and equipment. In this work it was to maintain close liaison with divisions of the War Department General Staff and those of the Army Ground Forces and the Army Air Forces. In April 1942 the functions of General Lutes' Operations Division, the only division in the upper structure of the Services of Supply which contained a medical officer for purposes of liaison, were redefined and extended to include the planning of requirements as to equipment and supply for troops overseas. To the extent that medical matters fell within the scope of these activities, Major Wilson—promoted at that time to lieutenant colonel, and to full colonel in October—was responsible for liaison with the Surgeon General's Office.[4]

Colonel Wilson carried on his liaison work while assigned to the Miscellaneous Branch of the Planning Subdivision of General Lutes' Operations Division. He emphasized the constant staff work which he had to undertake and informed General Lutes of his belief that a medical section, to be headed by a medical officer of the rank of colonel, should be established in the Miscellaneous Branch. When General Lutes' title was changed in July from Director of the Operations Division, Services of Supply, to Assistant Chief of Staff for Operations, Services of Supply, and the scope of his activities was broadened, a Hospitalization and Evacuation Branch, headed by Colonel Wilson, was created within the Plans Division of General Lutes' office. The duties of the Hospitalization and Evacuation Branch, Services of Supply, which included several other Medical Department officers late in the year, embraced liaison with surgeons of the Western Task Force in planning the handling of medical

[4] (1) Memorandum, Commanding General, Services of Supply, for Chiefs of all Supply Arms and Services, Corps Area Commanders, etc., 9 Mar. 1942, subject: Initial Directive for the Organization of Services of Supply. (2) History of Planning Division, Army Service Forces, ch. XIX. [Official record.] (3) Services of Supply Circular No. 7, 25 April 1942. (4) Leighton, Richard M.: History of Control Division, Army Service Forces, 1942–45 (April 1946). [Official record.] (5) General Orders No. 4, Services of Supply, 9 April 1942; and No. 24, 20 July 1942. (6) See also Millet, John D.: The Organization and Role of the Army Service Forces. U.S. Army in World War II. Washington: U.S. Government Printing Office, 1954.

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supplies for the landing in French Morocco and the evacuation of the wounded back to the United States. As the responsibilities of this medical office broadened, disagreement arose over its responsibilities vis-a-vis those of the Surgeon General's Office in the preparation of plans for hospitalization and evacuation and other phases of medical administration.

Medical functions at other levels

In addition to this shift of Medical Department representation from G–4 of the General Staff to Operations, Services of Supply, the reorganization brought about changes in the relations of the Surgeon General's Office with some of the other War Department and Army offices where medical officers were stationed. (Medical representation on the National Guard Bureau had disappeared in late 1941, for the Bureau's activities declined as the National Guard was absorbed into the Army, and no medical officer was stationed there again until after the war.) Relations with the Medical Division of the Chemical Warfare Service were scarcely affected by the reorganization, as the Office of the Chief of Chemical Warfare Service was shifted, like the Surgeon General's Office, to the jurisdiction of the Services of Supply and remained on the same level with the Surgeon General's Office.

Under the reorganization the Headquarters, Army Ground Forces, succeeded General Headquarters as the chief command for training ground troops, and the group of medical officers constituting the Medical Section, General Headquarters, were transferred to Army Ground Force headquarters at the Army War College, Washington, D.C., with Col. Frederick A. Blesse as surgeon and head of the staff medical section.[5]

Although the new organization placed the Army Ground Forces on the same level with the Services of Supply (chart 5) and hence the Ground Surgeon on the same level as The Surgeon General, only minor difficulties developed in the course of the war in the relations of the two offices. The story of the relations between the Surgeon General's Office and the Medical Division of the Army Air Forces, however, is quite otherwise. In spite of the role of the Army Service Forces as the supply agency for the War Department and Army, the Medical Division of the Army Air Forces used the fact that it was now operating under a jurisdiction on the same organizational level as the Services of Supply as leverage for developing a medical service independent of the Surgeon General's Office. It took the position that The Surgeon General had been reduced by the March reorganization to the status of surgeon for elements of the Services of Supply alone. The Ground Surgeon, who might also have taken this position, apparently never did so.

The Chief of the Medical Division of the Inspector General's Office, Brig. Gen. Howard McC. Snyder, was actually at a higher level under the new organization than was The Surgeon General, for the Inspector General remained on

[5] Annual Report, Personnel Service, Office of The Surgeon General, 1942.

the War Department Special Staff. Inspections of medical installations made by General Snyder's office were those directed by the Secretary of War, the Chief of Staff, or those requested by the commanding generals of Army Ground Forces, Army Air Forces, and the Services of Supply. Despite General Snyder's responsibility, under the direction of higher authority, for making critical appraisal of the work done at various Medical Department installations, including those overseas, no serious friction developed between his office and the Surgeon General's Office.

Attempts to clarify the Medical Department's new relationships

In the early months after the reorganization, much effort was devoted to clarifying the Medical Department's new relationships with other segments of the War Department. At the outset General Magee called to General Somervell's attention certain problems that his office had encountered in the administration of the Army medical service under the previous organization by reason of having to deal with several sections of the War Department General Staff and other War Department agencies. He stressed the difficulty of obtaining decisions on Medical Department proposals from a single War Department element with final authority. In the case of some proposals, he reported, a good many months had elapsed before he could get any action. He noted conflicting decisions or instructions received by his office from various segments of the General Staff and from General Headquarters. The failure of higher authority to furnish his office promptly with full information as to type, size, and destination of task forces had made it difficult to plan properly for hospitals, tactical medical units, and supplies to accompany forces overseas. A third problem lay in the issuance, upon some occasions, of Army regulations, or other official documents affecting Medical Department operations, without prior submission of drafts to the Surgeon General's Office: resultant errors had made revisions necessary. In certain War Department planning The Surgeon General's responsibility for directing the medical service of the Air Corps had not been taken into consideration. Finally, many tactical medical units, such as hospitals, medical supply depots, and laboratories, had passed from the control of The Surgeon General to that of the field armies. They had later been emasculated by the removal of key personnel to other units. Tactical medical units, Magee maintained, should remain under his jurisdiction until assigned to a task force. He made three major recommendations: that definite uniform staff channels be followed, that prompt information on task forces be furnished the Surgeon General's Office, and that official directives affecting the Medical Department be submitted to it prior to issuance.[6]

General Lutes, Director of the Operations Division, replied for General Somervell, advising a use of the "judicious shortcuts" advocated in the circular reorganizing the War Department as a method of obviating difficulties in get-

[6] Memorandum, The Surgeon General, for Commanding General, Services of Supply, 16 Mar. 1942.

ting prompt and final decision. He also listed for the information of The Surgeon General and his staff the staff elements of the Services of Supply with which they should deal in handling specific matters. These included various subdivisions of his own Operations Division, which were to be consulted on current war planning, on the activation, organization, and tables of organization of units, on the movements of troops and supplies, and on coordination of supply. The Miscellaneous Subdivision (to which Maj. William L. Wilson, MC, was assigned) was to be consulted on hospitalization and evacuation and miscellaneous matters not coming within the jurisdiction of other Services of Supply divisions. All medical matters involving the Army Ground Forces or the Army Air Forces were to be submitted for approval to General Somervell. With regard to the complaint as to lack of information on task forces, General Lutes stated that the War Plans Division (soon to be renamed Operations Division) of the General Staff was making every effort to allow more time in the planning of units and supplies for task forces.[7]

Information on task forces.—Some of these difficulties of the Surgeon General's Office, particularly the problems of relations with the Army Air Forces medical organization and the lack of information on task forces, persisted. This last problem was not peculiar to the Medical Department, for the interests of secrecy information on troop movements was limited to as few officers as possible. A number of other War Department offices, including Headquarters, Services of Supply, voiced the same compaint at intervals. Within the Surgeon General's Office, officers of the Preventive Medicine Division in particular stressed the necessity of their being kept informed of the destination and composition of task forces and the general military situation at the location, as well as the types of medical installations planned. They needed the information in order to provide troops with advance detailed information on methods of controlling communicable diseases in specific areas and to select such specialized personnel as malariologists, sanitary engineers, and laboratory staff members to accompany forces overseas.

On the other hand, members of the Surgeon General's Office who dealt directly with higher War Department officials engaged in setting up task forces were somewhat unsympathetic with the point of view of the specialists in preventive medicine. They appear to have accepted the necessity for confining information on the destination of task forces to four or five officers in the War Department, pointing out that even the commander of a task force sent to Australia, for example, would not be informed of its ultimate destination in the Pacific. They minimized the need for advance information on the size of the task force and its mission, stating that malaria would be a problem in Gambia, whatever the size and the mission of the task force. Apparently they were implying that preventive measures could be taken against malaria upon

[7] (1) Memorandum, The Surgeon General, for Commanding General, Services of Supply, 16 Mar. 1942, first indorsement thereto, Brig. Gen. LeRoy Lutes, 23 Mar. 1942. (2) Memorandum, Brig. Gen. Larry B. McAfee, for Training Division, Services of Supply, 31 Mar. 1942.

arrival of the force and were ignoring the thesis of the preventive medicine experts that specialists in preventive medicine should be assigned to a task force in numbers proportionate to its size. Arrangements for keeping military plans secret, especially those concerning troop movements, continued to put some hindrance in the way of medical planning.[8]

Relations with Army Air Forces.—Toward the end of March, General Magee attempted to obtain an official statement which would clarify the Medical Department's responsibilities under the new regime. Apparently he did not at the outset grasp the full scope of difficulties he would encounter in operating the medical service under it. He had reason to think that General Somervell would give the Medical Department some backing in its efforts to regain control of the medical service of the Army Air Forces. In the interests of greater coordination of the supply services and of thoroughgoing control by his own headquarters, General Somervell could hardly favor the growth of a medical hierarchy in the Army Air Forces or the Army Ground Forces. However, War Department Circular No. 59, which had outlined the new War Department organization in March, had assigned to the Army Air Forces "command and control of all Army Air Force stations and bases not assigned to defense commands or theater commanders and all personnel, units, and installations thereon." Although General Magee noted that the passage quoted prevented "parallel procedure in rendering medical service to the Ground Forces and the Air Forces," in his opinion the new organization did not "alter in any respect the duties of the Medical Department of the Army or the responsibilities of The Surgeon General." Nevertheless, he attempted to obtain a clear statement of policy in writing, and the fact that he confined his attention to the Air Forces indicates that he considered the Ground Forces less likely to cause difficulties. On 25 March he proposed to General Somervell certain major policies to govern relations between the Medical Department and the Army Air Forces, designed primarily to maintain existing administrative procedures.[9]

Clarification of medical activities.—These proposals initiated a series of memoranda and conferences among representatives of the Surgeon General's Office, the Operations Division and the Training Division, SOS, G–3 of the War Department General Staff, the Army Air Forces, and the Army Ground Forces. Colonel Wilson, then in the Operations Division, Services of Supply, attempted to amalgamate all of General Magee's proposals into a document,

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[8] (1) Memorandum, Chief, Preventive Medicine Division, for Chiefs, Plans and Training and Military Personnel Divisions, 28 Mar. 1942, subject: Planning for the Control of Communicable Diseases in Theaters of Operation. (2) Memorandum, Col. H. T. Wickert, for Brig. Gen. Larry B. McAfee, 7 Apr. 1942. (3) Memorandum, Executive Officer, Office of The Surgeon General, for Lt. Louis S. Gimbel, Jr., Chief, Intelligence Section, Ferrying Command, 12 May 1942, subject: Dissemination of Medical Information.

[9] (1) Memorandum, The Surgeon General, for Commanding General, Services of Supply, 5 Mar. 1942. (2) Memorandum, The Surgeon General, for Commanding General, Services of Supply, 25 Mar. 1942, subject: Medical Service of the Army. (3) War Department Circular No. 59, 2 Mar. 1942, sections 6, 7. (4) Coleman, Hubert S.: Organization and Administration, Army Air Forces Medical Service in the Zone of Interior, pp. 90 ff. [Official record.]

acceptable to all parties concerned, to clarify the relations of the Medical Department under the Services of Supply with the Army Ground Forces and the Army Air Forces. Many changes in wording were proposed by all these offices. The wording of the final statement of policy was substantially agreed on by April 1942. As issued, with amendments in June, to all corps area commanders and other authorities concerned, it was broader in scope than the proposals of General Magee, although it embodied most of them.[10] The substance of this document appears below (with some omission of insignificant phraseology); a few sections of it were to be cited at intervals by interested parties in support of their effort to gain added control, to deny increased control to other claimants, or to maintain the status quo:

1. Supplementary to War Department Circular No. 59, 1942 the following general policies will govern medical activities within your command:

a. [Reference to pertinent sections of Circular No. 59.]

b. Sanitation in the continental United States other than that provided by units under tactical control will be administered by the Medical Department under command of the Commanding General, Services of Supply.

c. Hospitalization and evacuation for the Army Ground Forces in the continental United States, other than that provided by field medical units operating under tactical control, will be furnished by the Medical Department under command of the Commanding General, Services of Supply.

d. The routine conduct of Medical Department activities with the Army Air Forces shall be a responsibility of each local surgeon acting under the Air Surgeon, who is responsible to The Surgeon General for the efficient operation of Medical Department technical activities with the Air Forces. In accomplishing his mission the Air Surgeon will operate in advisory and administrative capacities—advisory in his relation as a staff officer and administrative in his conduct of Medical Department technical service under control of the Commanding General, Army Air Forces.

In order to determine the status of these Medical Department activities the Commanding General, Services of Supply, may direct necessary technical inspections of Army Air Forces stations and commands with deficiencies to be reported to the Commanding General, Army Air Forces, for corrective action.

e. The activation, organization, and training of field medical units listed in the Mobilization and Training Plan, 1942, is a responsibility of the Army Ground Forces, except as provided in paragraph 1 f, below.

f. In view of the fact that the Services of Supply controls the majority of installations suitable for certain unit training of field medical units, the Services of Supply will organize and train numbered station and general hospitals and such other medical units as may be requested by the Commanding Generals, Army Air Forces or Army Ground Forces.

g. Due to responsibilities for operations placed upon commanders concerned (corps area, air, etc.), training operations will be administered by them in such manner as to permit adaptation of training to concurrent operations.

h. Insofar as practicable, medical equipment and supplies will be provided to the Army Air Forces and the Army Ground Forces by the Services of Supply. Requirements in excess of those authorized by tables of allowances [equipment authorized for

[10] Letter, Commanding General, Services of Supply, to all Corps Area Commanders and The Surgeon General, 26 May 1942, subject: Medical Activities Under War Department Circular No. 59, 1942, and Amendment of 4 June.

posts, camps, and stations] and tables of basic allowances [equipment authorized for units and individuals] plus normal maintenance will be estimated by Army Air Forces and Army Ground Forces and reported to the Services of Supply.

i. In the discharge of his duties, the Air Surgeon will utilize the services available in the Services of Supply to the maximum degree consistent with the proper control of the Medical Department within the Army Air Forces. No activity of the Office of The Surgeon General will be duplicated, with the exception of those procedures necessary for the proper control of Medical Department personnel while under the jurisdiction of the Army Air Forces and of Medical Department activities under the jurisdiction of the Army Air Forces.

j. Basic reports required by The Surgeon General and estimates for all funds shall be submitted by station surgeons through corps area surgeons with separate consolidation of estimates for Medical Department activities of the Army Air Forces by the corps area surgeon to be forwarded to The Surgeon General.

k. The medical supply policy for the Army Air Forces shall be as follows:

(1) The Surgeon General shall establish medical sections in Air Forces depots. They shall be stocked with initial and maintenance stocks for the supply of tactical medical units attached to the Air Forces.

(2) Supply for fixed medical installations of the Air Forces, Zone of Interior, to continue under present War Department policy, or under changes as announced.

2. With reference to paragraph 1 b preceding, corps area commanders were to procure and allocate funds for, and effect inspections and general supervision over, necessary sanitary procedures in all posts, camps, or stations in their respective corps areas.

3. With reference to paragraph 1 d each corps area commander was to act as a direct representative of The Surgeon General, directing technical inspections necessary to determine the efficiency of operation of Medical Department activities. In addition to disposition of reports as directed in paragraph 1 d, a copy of each report of deficiencies noted should be forwarded to The Surgeon General, who will report to the Commanding General, Services of Supply, those matters the correction of which are beyond his control.

4. With reference to paragraphs 1 e, f, and g attention is invited to letter (SPRTU 353 (5-20-42)) this headquarters, subject: "Unit Training of Field Medical Units by the Services of Supply," which will govern the training of numbered station and general hospitals, and of such other field medical units as may be requested by the Commanding Generals, Army Air Forces and Army Ground Forces.

5. [Reference to an attached table outlining the proper channels for routing of all station hospital reports.]

This document was not limited to defining the powers and functions of the Commanding General, Army Air Forces (and his surgeon) vis-a-vis those of The Surgeon General, as The Surgeon General had proposed. It attempted to specify the powers and duties of the three new War Department commands—the Army Ground Forces, the Army Air Forces, and the Army Service Forces—with respect to provision of hospitalization, training of Medical Department units, medical supply inspections, and submission of reports. With two exceptions the policies defined were essentially those which had prevailed before the March reorganization. One exception lay in paragraph f above; it marked the beginning of the shift in responsibility for the organization and training of Medical Department units (as well as those of the other services) intended for use in the communications zone of a theater of operations from

the field armies to the Services of Supply. The other significant change was embodied in paragraph i; it gave the Army Air Forces a claim to greater autonomy in its handling of Medical Department matters. The Army Air Forces had insisted upon excepting from the stipulation as to nonduplication of the Surgeon General's Office's activities not only activities as to Medical Department personnel under control of the Army Air Forces but also any Medical Department activities under control of the Army Air Forces. As noted above, Circular No. 59 had already given the Army Air Forces control of its stations and bases (not assigned to defense commands or theater commanders) and all personnel, units, and installations thereon, including station complement personnel and activities. The policies in the supplementary document specified for the Army Air Forces these broad powers with respect to the Medical Department in particular. The addition of the word "activities" provided an additional weapon to the already well-stocked arsenal of the Air Surgeon's battle for autonomy, which paralleled the similar struggle of the Air Forces themselves.[11]

Effect on Medical Department administration

The total effect of the War Department reorganization upon Medical Department administration appeared only in the course of the war. Certain problems arose from the fact that The Surgeon General, whose responsibility for medical policies and services was Army-wide, was put under a command which, in spite of its own responsibilities for furnishing supplies and services to the Army Ground Forces, Army Air Forces, and their subordinate elements on an Army-wide basis, was only coordinate in the command structure with these other two major Army commands in the United States. These, equally with the Services of Supply, were subordinate to the General Staff (chart 5). The Surgeon General's technical instructions on the prevention and treatment of diseases and injuries, issued in the form of circular letters, went, of course, to all Army Commands. However, efforts of the Surgeon General's Office to have certain measures requiring a command decision (which the Office considered essential to good medical service) adopted throughout the Army were hindered at times by the necessity for obtaining the concurrence of the staff elements of a number of commands. Under the previous organization of the War Department the Surgeon General's Office could have issued, after obtaining concurrence from the appropriate divisions of the War Department General Staff, command directives which went to all the subordinate commands of the Army. An entire level of command was now inserted between The Surgeon General and the General Staff, and in order to bring about issuance of a directive by the Chief of Staff, the Surgeon General's Office had to obtain

[11] Craven, Wesley F., and Cate, James L., editors: The Army Air Forces in World War II. Volume VI, Men and Planes. Chicago: University of Chicago Press, 1955, pp. 374ff.

the concurrence of the appropriate staff elements of the Services of Supply as well as subsequent concurrence by elements of the General Staff.

During the ensuing months the allocation of major responsibilities and functions among the three major commands was established. Medical Department personnel, installations, and Medical Department tactical units were split among the Services of Supply, the Army Ground Forces, and the Army Air Forces. Hence, although the Services of Supply was designed, under the theory back of the reorganization, to furnish the other two commands, primarily made up of tactical forces, with the necessary services, including medical service, in practice the assignment of the so-called "medical means" of the Army and certain medical functions to the two other commands led to many breaches of this principle. Some questions of jurisdiction, particularly as between the Services of Supply and the Army Air Forces, led to conflict. Many, on the other hand, were solved amicably, and rapid decisions attained through extensive liaison and conferences among the staff surgeons concerned, frequently with representatives of the general staffs of these commands in attendance.

In addition to its effect upon the administration of the Medical Department at home, the placement of the Surgeon General's Office at the Services of Supply level also made communication with the surgeons of oversea theaters more circuitous. Like the offices of the chiefs of other services, the Surgeon General's Office often noted the difficulty of communication through the channels above it with the offices of surgeons at theater headquarters overseas. Like the chiefs of some of the other services, The Surgeon General, and some of his staff as well, made use of personal correspondence, which did not have to go through channels, as a means of speeding communication with Medical Department officers overseas. By mid-1943, the Surgeon General's Office developed a system of periodic reports from the oversea theaters; these were the so-called ETMD's (Essential Technical Medical Data) which for the first time gave the Office adequate information on the medical situation overseas.

The Surgeon General and his staff also ran into the reverse difficulty, that of getting their plans for oversea medical service—the use of new types of Medical Department units, for example—accepted and put into effect by oversea commanders. The dispatch of Medical Department officers of the Surgeon General's Office on special missions often proved effective in this respect. The chief consultants in medicine and surgery of the Surgeon General's Office visited the theater on inspection trips, and experts on tropical medicine investigated the problem of control of malaria in a number of trouble spots. Medical supply missions went to the Pacific, European, and China-Burma-India theaters. These emissaries, like the personal correspondence between The Surgeon General and oversea surgeons, served to bridge the great distances and bring about an adjustment between the plans made by the Surgeon General's Office and the requirements drawn up by oversea staff medical officers.

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EFFECTS OF THE WAR DEPARTMENT REORGANIZATION UPON THE INTERNAL STRUCTURE OF THE SURGEON GENERAL'S OFFICE

The organizational pattern of the Surgeon General's Office throughout 1942 reflects the influence of the theories on sound organization and administration which prevailed among administrators at Services of Supply headquarters. Certain of General Somervell's ideas especially left their mark. A few other changes stemmed from higher authority than the Services of Supply.

Internal Reorganization

One important tenet held by General Somervell was that the number of individuals or units reporting directly to a superior should be limited to the number with which the latter could feasibly keep in close touch.[12] In the face of this doctrine the prevailing organization of the Surgeon General's Office (chart 4), whereby 15 chiefs of divisions reported to The Surgeon General, was impracticable. Accordingly, shortly after the Surgeon General's Office was placed under the new jurisdiction it was reorganized in terms of the new principle (chart 6). Under the new organization, divisions were logically grouped under nine "Services"—an arrangement that continued throughout the war. Theoretically this change cut down the number of officers reporting directly to General Magee to 10 (including the chief of the Control Division, discussed below, which was placed at staff level).

Nevertheless, "mushrooming" received a fresh impetus under the new organization, for most of the new "services" were expanded divisions wherein many of those entities labeled subdivisions in the previous organization were raised to the status of divisions. The new organization had more than 40 divisions in lieu of the 15 in existence the month before. Out of the previous subdivisions of the Preventive Medicine Division, now a "service," were created six new divisions, and out of those in the former Professional Service Division, now simply Professional Service, were created seven. Thus, in spite of the consolidation at the top, the reorganization laid the groundwork for further expansion. Insofar as organizational units, such as divisions and subdivisions, call for certain numbers of military personnel of specific rank and civilians of specific civil-service grade, the larger number of divisions warranted promotions and increases in numbers of personnel. More colonels, for example, would be necessary to head the greater number of divisions now in existence. However, a freeze placed on the recruitment of civilian personnel throughout the War Department during the summer of 1942 hampered the acquisition of additional civilian employees about the time that the Surgeon General's Office was becoming aware of its need for substantial numbers of civilians.

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[12] (1) Services of Supply Organization Manual, 10 Aug. 1942. (2) See footnote 4(4), p. 75.

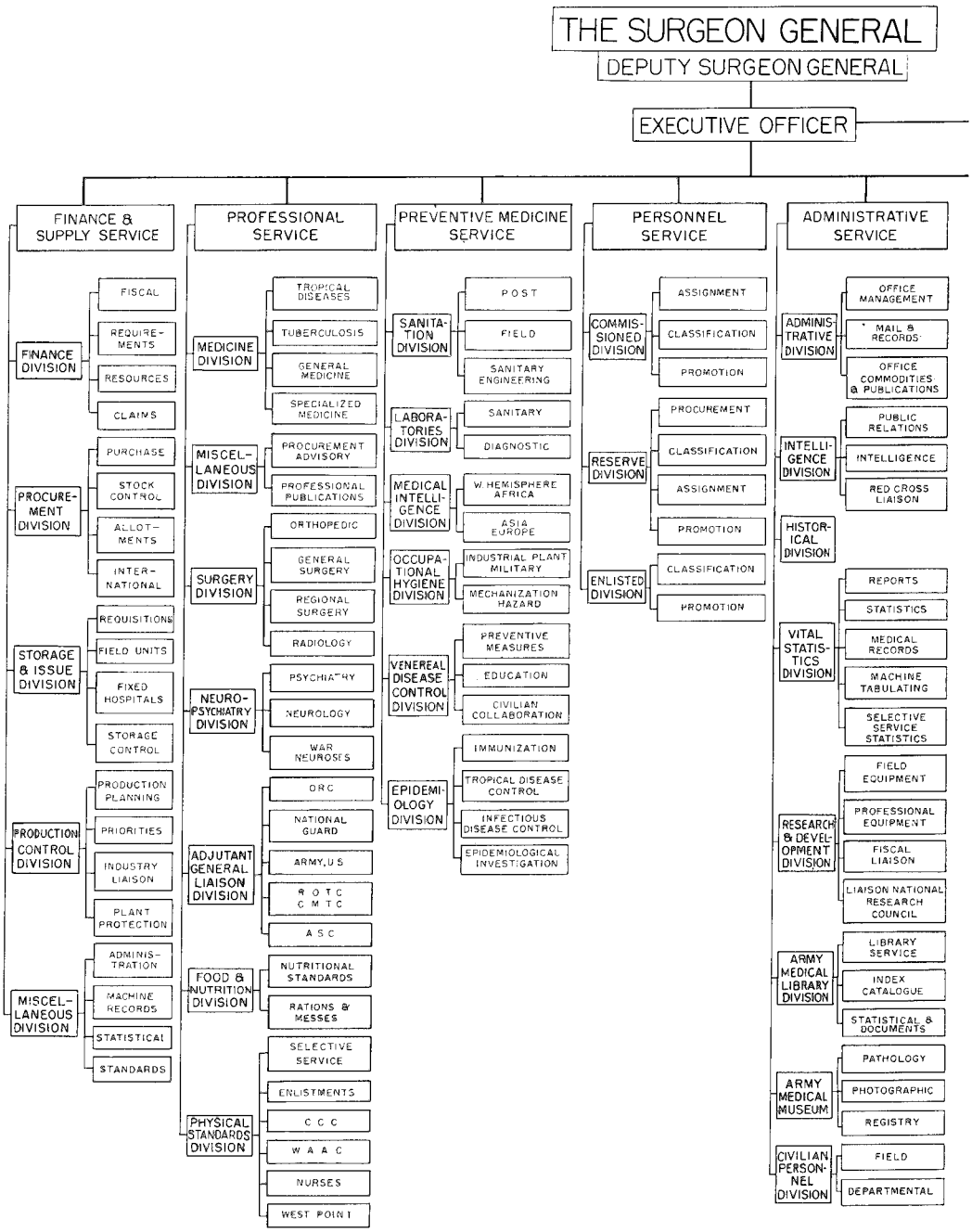
Nor did the reorganization limit the men reporting directly to The Surgeon General to those officers who held the positions of chiefs of services. Several of the chiefs of divisions who had had personal access to General Magee and had addressed memoranda directly to him under the previous setup continued to do so, although after the March reorganization they should theoretically have dealt with the chiefs of their respective services. This tendency to perpetuate the status quo was perhaps inevitable. The top personnel had been placed in their positions by the existing Surgeon General and it was unlikely that long-established relationships would be suddenly changed by an organization chart.

Control Division.—Another idea of General Somervell's which the reorganization fostered was the establishment of a Control Division in the Surgeon General's Office. This device had its origin in General Somervell's administrative experience with the Quartermaster Corps and with G–4 before and during the emergency period. General Somervell established a Control Division, headed by Col. (later Maj. Gen.) Clinton F. Robinson, MC, at Services of Supply headquarters to make surveys and studies of existing organizational units and procedures, appraise their effectiveness, and recommend ways of simplifying operations and increasing efficiency. The placing of the entire statistical service of the Services of Supply under the Control Division in July reflected belief in the value of statistics as a tool of management and the importance which General Somervell attached to the principle of control; that is, to the accurate forecasting of production and the measurement of production accomplished. The program of management control long existent in most large business enterprises gave the Services of Supply its cue. It recommended a counterpart of the Control Division in each of the supply services to perform similar functions for its parent organization.

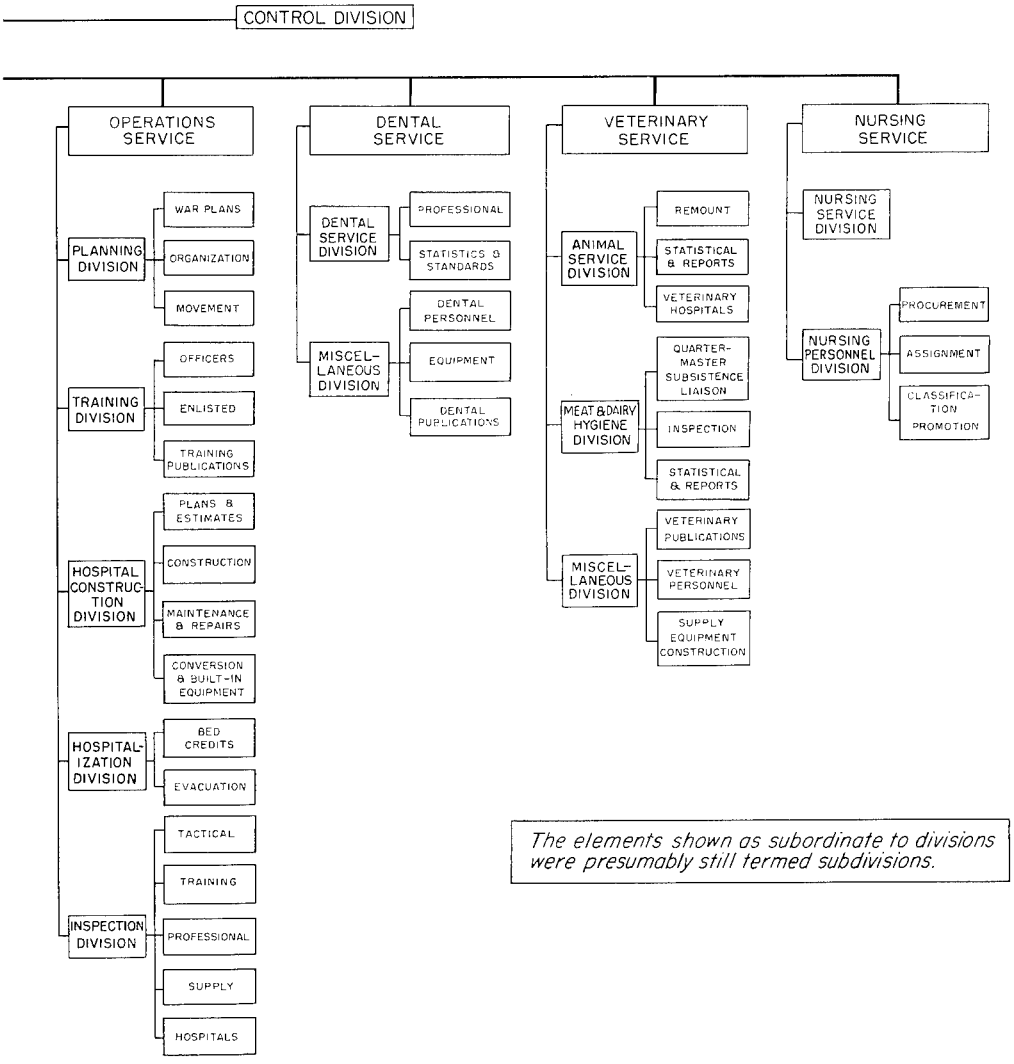
The Control Division of the Surgeon General's Office was set up as a staff division in April but did not receive the necessary civilian personnel for key positions until July. Acting under suggestions for studies thought advisable by the Control Division, Services of Supply, or on its own initiative, the Control Division, Surgeon General's Office, studied procedural practices in the various office divisions in order to ascertain their efficiency. It inquired into the use of space assigned the division, the complexity and number of forms in use, the effectiveness of filing systems, the adequacy of training given employees, and so forth. In recommending changes, members of the Control Division emphasized the necessity of cutting down the number and length of forms, reducing the number of steps in processing forms, simplifying filing systems by the removal of inactive or relatively unused files, and the training of employees to be alert to discover new means of attaining efficiency. The Control Division attempted to make more efficient use of facilities and civilian personnel in the face of growing shortages.

Statements in reports turned out by the Control Division, Surgeon General's Office, that a certain operation involved many unnecessary steps were,

CHART 6.—*Organization of the Office*



of The Surgeon General, 26 March 1942



The elements shown as subordinate to divisions were presumably still termed subdivisions.

of course, critical of past performance or of the ability of certain people in administrative positions. Many employees of long service were unwilling to change established methods. The fact that higher elements of the War Department, as well as most other Government agencies, were also applying continued pressure to simplify work and increase efficiency in this crucial period did not make the two Control Divisions any the more popular. Personnel of various divisions of the Surgeon General's Office charged that constant demands by the Control Divisions for information on present procedures and for suggestions for improvement hampered their regular work. Changes in procedures usually created additional work in the period during which they were being put into effect. Moreover, recommendations made in the many reports on surveys by the Control Division called for further reports. Consequently it appeared for a time that the control program was actually leading to an increase in paperwork.

Thus the members of the Control Division, Surgeon General's Office, like the members of the parent Control Division, Services of Supply, acquired the reputation of "snoopers" and were nicknamed "the commissars." At the same time the Control Division, Services of Supply, criticized its offispring for its slowness in grasping the concept of "control." In September 1942 members of the former division stated that effective measures for "control" had developed too slowly during the first 6 months of the life of the Control Division, Surgeon General's Office. It is not clear whether the dissatisfaction within the Surgeon General's Office with the control program was the fault of the Control Division, Surgeon General's Office, of the concept which lay back of it, or of the prejudice within the office against it. But General Somervell's control program did not meet with any warmer welcome in the Surgeon General's Office than his theory of limiting the number of personnel reporting directly to a superior.[13]

Between March and the fall of 1942, a number of changes took place in internal elements of the Surgeon General's Office which were traceable, directly or indirectly, to the War Department reorganization of March. In its attempts to coordinate the work of the supply services General Somervell's new organization naturally tried to establish uniformity in structure and names of organizational units and in procedures. Uniformity was desirable, in some cases necessary, if the divisions of Services of Supply were to deal effectively with their counterparts in the services. The pressure for uniformity was brought to bear most directly upon those fields of work which

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[13] (1) Office Order No. 105, Office of The Surgeon General, 20 Apr. 1942. (2) See footnote 4(4), p. 75. (3) Report on Administrative Developments in the Surgeon General's Office, 1 Dec. 1942. [Official record.] (4) Memorandum, Commanding General, Services of Supply, for The Surgeon General, 9 Sept. 1942. (5) Gottschalk, O. A.: Report on the Control Division of the Surgeon General's Office, 24 Sept. 1942. [Official record.] (6) Russell, John C.: Survey of Non-Technical Segments of the Surgeon General's Office, 24 Sept.–10 Oct. 1942. [Official record.] (7) Gendebien, Albert: Administrative Survey of Selected Portions of the Surgeon General's Office, September 1942. [Official record.] (8) Interviews, Albert Gendebien, June and July 1947. (9) Committee to Study the Medical Department, 1942, Testimony, pp. 1625–1666.

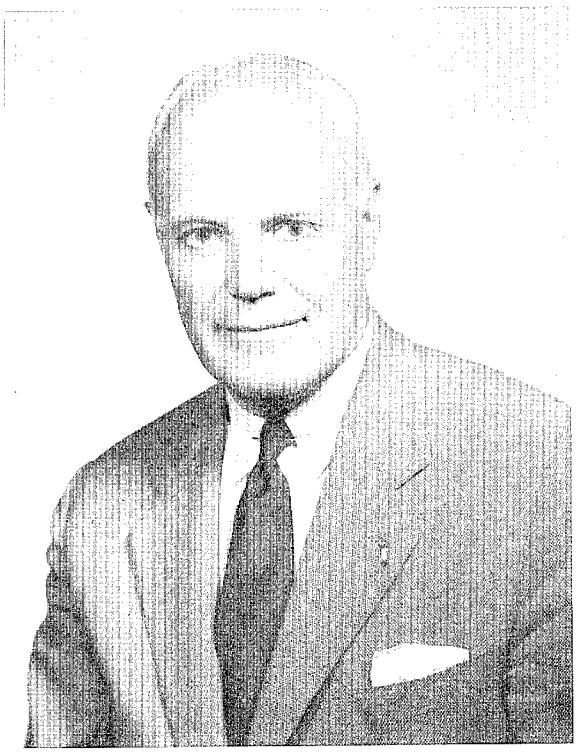


FIGURE 23.—Col. Tracy S. Voorhees, JAGD.

the services had in common, where nevertheless a good deal of diversity had developed—legal and fiscal work, for example. In order to coordinate the steps in handling Army supply, it was necessary that the chiefs of service develop supply divisions of similar structure in their offices and employ uniform or similar reports and procedures. The training divisions in the offices of the chiefs of service were also patterned after the Training Division, Services of Supply. The Preventive Medicine Service, the Professional Service, and various other technical fields of work in the Surgeon General's Office were, on the other hand, little affected by the theories of General Somervell's administrators.

Legal Division.—The assignment of an officer to wartime legal work dated from the fall of 1940. Early in 1942 the Office of the Under Secretary of War undertook the creation of a legal entity in each service to handle legal matters peculiar to the service. When the Services of Supply authorized a legal officer for each service in March, Tracy S. Voorhees (fig. 23), a New York lawyer brought into the War Department by Under Secretary of War Patterson, was chosen to head the legal work in the Surgeon General's Office. Mr. Voorhees, commissioned as a colonel and assigned to the Judge Advocate General's Department in November 1942, had a prominent part in

molding the organization of the Surgeon General's Office during the war years and after the war became an Assistant Secretary of the Army.

His first task was a study, made about mid-1942, of the operations of the Procurement Office of the New York Medical Depot. The legal work of the Medical Department was then largely concerned with drawing up contracts for medical supplies and equipment. Colonel Voorhees was impressed at the outset by the "enormous business responsibility of purchasing all medical supplies for the Army and for Lend-Lease," the large number of contracts necessary, and the tremendous dollar volume involved. The preparation of standardized contracts in legally enforceable language, the checking of contracts drawn up by the procurement officers, the writing of procurement regulations, and the selection of legal personnel for the procurement districts were to be the duties of the new legal group assigned to the Supply Service of the Surgeon General's Office in the summer of 1942. This group of civilian lawyers, drawn mainly from large city firms and headed by Colonel Voorhees, remained under the Supply Service until November. After that date they continued their work under a newly formed Legal Division.[34]

Fiscal Division.—The organization of the fiscal work of the Surgeon General's Office was also affected by the Services of Supply's efforts to establish uniformity throughout the services. Since the fiscal work at the latter's headquarters was handled by a single division, the fiscal functions of the Surgeon General's Office were similarly concentrated as of the beginning of the fiscal year 1943—that is, on 1 July 1942. A study made by the Fiscal Division, Services of Supply, of the handling of funds in the War Department had indicated the need for a single fiscal division in each supply service, a standard accounting system which would reduce the number of authorities allocating funds, and a simplified system of reporting allocations and expenditures. Concentration of all fiscal activities of the Surgeon General's Office in one spot was brought about by transferring the functions of the Fiscal and Claims Subdivisions of the old Finance Division, Finance and Supply Service, to the new Fiscal Division. Fiscal functions with respect to civilian personnel, which had been handled by the Civilian Personnel Division of the Administrative Service, were also turned over to the new division. The Fiscal Division was made directly responsible to The Surgeon General, and its procedures were adjusted to conform with those of the Fiscal Division, Services of Supply. In line with the principle of decentralization advocated by the Services of Supply the new division established branch fiscal offices in the fall of 1942 at distribution depots and at the New York and St. Louis Medical Department Procurement Districts.

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[34] (1) Administrative Memorandum No. 2, Services of Supply, 20 Mar. 1942. (2) Administrative Memorandum No. 11, Services of Supply, 11 May 1942. (3) Annual Report, Legal Division, Office of The Surgeon General, 1943. (4) Memorandum, Director, Administrative Division, Services of Supply, for Chief of Staff Divisions, 15 May 1942, subject: Coordination of Legal Work Within the Offices of the Commanding General, the Staff Divisions, and the Supply Services. (5) Interview, Tracy S. Voorhees, 22 Sept. 1950. (6) Office Order No. 496, Office of The Surgeon General, 30 Nov. 1942.

The branch offices received allotments of funds from the Fiscal Division and made suballotments to several hundred Army stations, thus doing away with the necessity for direct allotment from Washington. Authorization for local purchases of medical supplies and the auditing of certain accounts, such as those for hospital laundry, were also decentralized to the branch offices.[15]

Programs Established by Higher Authority

Contract renegotiation.—The establishment of certain programs in the Surgeon General's Office was directed by higher authority than that of the Services of Supply. The renegotiation of medical supply contracts in cases where costs or profits of contractors were excessive, for instance, grew out of the program for continuous readjustment of war contracts pursuant to shifts in costs to the contractor which was promulgated by an Executive order of the President. The War Department established a Price Adjustment Board in the spring of 1942, assigned it to the Services of Supply, and then directed the latter to create in the supply services two types of units: price adjustment sections to renegotiate contracts with contracting companies, and cost analysis sections to obtain information upon which renegotiation could be based. Accordingly, a Cost Analysis Section was set up in the Fiscal Division of the Surgeon General's Office and a Price Adjustment Section in the Supply Service. Colonel Voorhees and his Deputy Director of the Legal Division selected legal personnel for the new price adjustment work and made contacts with major medical supply houses in New York preliminary to renegotiation.

Military history.—The backing given by the President and the Bureau of the Budget to the preparation of an official military history of World War II brought the already established historical program of the Surgeon General's Office within the orbit of the general program. A Historical Section of the Control Division, Services of Supply, coordinated the historical work of the various supply services, beginning about July.[16]

Public relations.—Higher authority in the War Department built up a pyramidal organization to handle public relations, a field in which a number of overlapping agencies at different levels had grown up. The maintenance of good public relations was centered in the War Department Bureau of Public Relations. Various segments of the War Department provided technical information, and the Bureau of Public Relations cleared it for release. Accordingly an Office of Technical Information was set up in the Services of Supply. The Public Relations Division of the Surgeon General's Office, which by Au-

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[15] (1) Executive Order No. 9127, 10 Apr. 1942. (2) Memorandum, Col. Paul I. Robinson, MC, for Col. Albert G. Love, MC, 31 Oct. 1942, subject: Report on Administrative Developments in the Fiscal Division of the Surgeon General's Office. (3) See footnote 14(3), p. 90. (4) Memorandum, Chief, Supply Service, for Mr. Guido Pantaleoni, Member, Price Adjustment Board, 25 Aug. 1942, subject: Report of Price Adjustment Division, Supply Service, Office of The Surgeon General.

[16] Memorandum, Executive Officer, Office of The Surgeon General, for chiefs of all services, 31 July 1942, subject: Outline of Historical Work of Services of Supply.

gust had developed as a staff division (out of the old Intelligence Division of the Administrative Service), was transformed into the Office of Technical Information. Placed at staff level in the Surgeon General's Office, it provided medical data on the Army for release through higher channels.[17]

Reorganization of the Surgeon General's Office, August 1942

The process of reorganizing the Surgeon General's Office, which began with the general reorganization of March 1942 and continued with certain piecemeal changes in subsequent months, proceeded still further with a general reorganization in August. It resulted from a survey of the entire office in July by the Control Division of the Surgeon General's Office, followed in August by a communication from Headquarters, Services of Supply, directing The Surgeon General to submit a plan for reorganization. This reorganization reduced the number of services from nine to five (chart 7). Divisions were reduced from 41 to 23, largely by the reduction of many to branch status.

The reorganization also established a more systematic nomenclature for units of the office. These were termed in descending order: service, division, branch, and section; in practice the branch became the lowest recognized level. Services were headed by "chiefs," divisions by "directors," and branches by "chiefs." [18]

Four divisions remained outside the five services. Two of these, the Public Relations Division (later called the Office of Technical Information) and the Control Division, were termed staff divisions. The other two were operating divisions. One of these was the Fiscal Division, separated in July from the Finance and Supply Service. The other was the Training Division, now removed from the Operations Service and reorganized into branches at the request of the Director of Training, Services of Supply.[19] Since these divisions reported directly to The Surgeon General, the reduction in number of services did not produce a corresponding reduction in the number of officers reporting directly to him.

The Supply Service remained largely as it had developed since early July. A major change in the Administrative Service at this date was the removal of the Civilian Personnel Division to the Personnel Service. The latter, formed in March, had heretofore been exclusively concerned with military personnel. This move constituted recognition that the handling of problems relating to civilian employees was a function of growing importance. A Civilian Person-

[17] (1) Services of Supply Circular No. 54, 29 Aug. 1942. (2) Office Order No. 396, Office of The Surgeon General, 13 Oct. 1942.

[18] (1) Morgan, Edward J., and Wagner, Donald O.: Organization of the Medical Department in the Zone of Interior (1946) pp. 15–20. [Official record.] (2) Office Order No. 340, Office of The Surgeon General, 1 Sept. 1942. (3) Annual Report, Control Division, Office of The Surgeon General, 1943. (4) See footnote 13(3), p. 88.

[19] (1) Memorandum, Director of Training, Services of Supply, for The Surgeon General, 13 Aug. 1942, subject: Organization of a Training Division, with 1st indorsement, Executive Officer, Office of The Surgeon General, to Chief, Control Division, Services of Supply (through Director of Training, Services of Supply), 21 Aug. 1942. (2) See footnote 13(3), p. 88.

nel Policy Committee of the Services of Supply, which had a Medical Department representative, had been engaged for some time in planning the organization of civilian personnel divisions for the various supply services. The need for large numbers of civilians to fill jobs in the Supply Service, the Administrative Service, and other elements of the Surgeon General's Office, increased the work in the procurement, classification, placement, and training of civilian employees.[20] However, the Civilian Personnel Division did not become an integral part of the Personnel Service at this date because of the emphasis on recruitment of military personnel.

The reduction in number of services was achieved by making divisions out of five former services concerned with professional work and placing them under a newly constituted Professional Service. These were the old Professional Service, renamed the Medical Practice Division; the Preventive Medicine Division; the Dental Division; the Nursing Division; and the Veterinary Division. This rearrangement, which interposed the Chief of Professional Service between the Director of the Dental Division and The Surgeon General, was frequently criticized by dental officers. Many had long been wont to resent the subjection of dental service to medical service, and this move seemed to them a further reduction in status.[21]

OTHER CHANGES IN THE SURGEON GENERAL'S OFFICE

During the process of War Department reorganization from March 1942 to August of that year, some significant developments took place in the organization of the Surgeon General's Office which resulted from the rapidly expanding functions of the office and were not closely related to the changes occurring in the higher ranges of the War Department. They occurred at intervals between the general reorganizations of the Surgeon General's Office in March and August 1942.

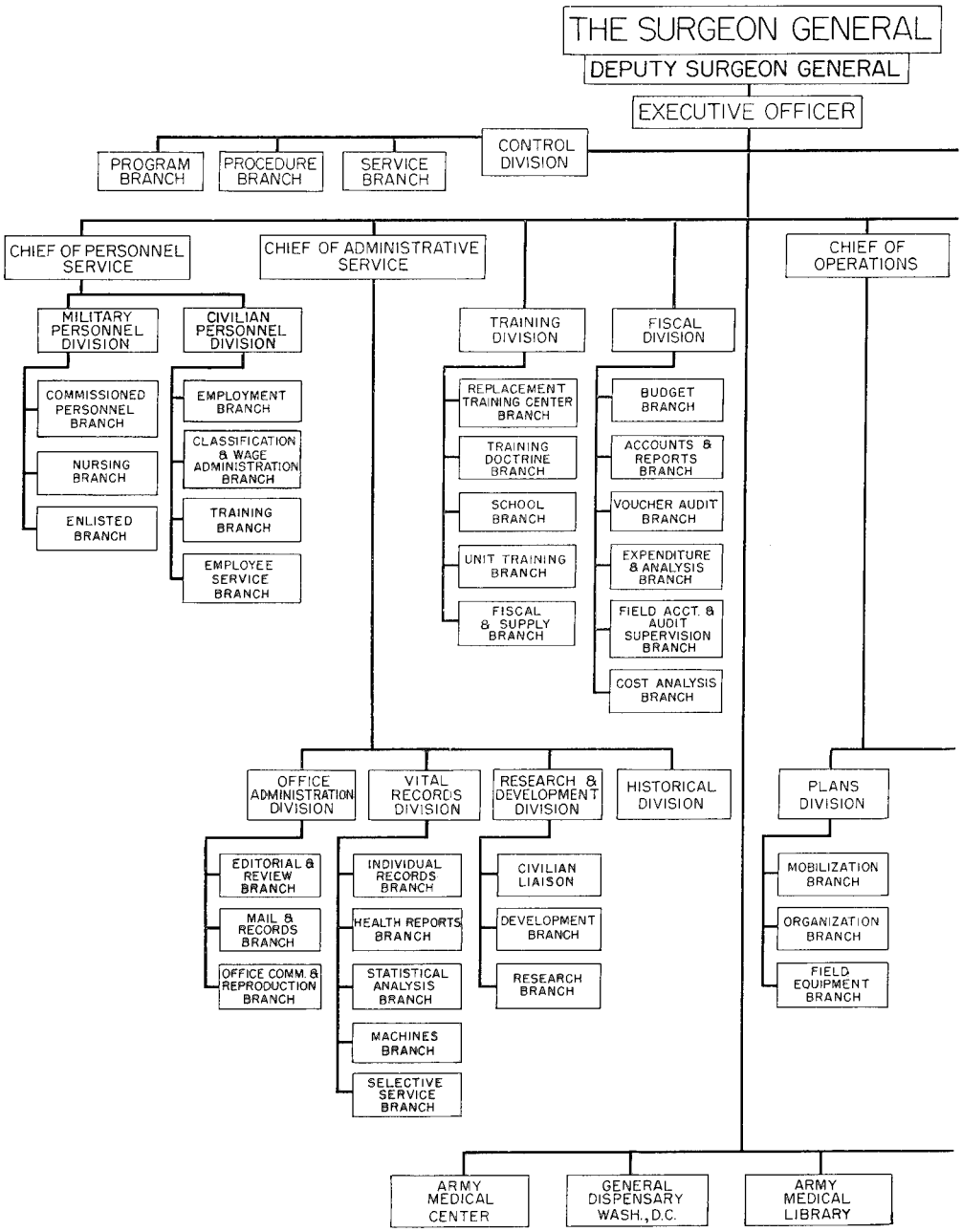
The Administrative Service

Research and Development Division.—The major development of this period in the Administrative Service was the addition of a Research and Development Division. As previously pointed out, the Surgeon General's Office had customarily relied upon certain Army installations, as well as certain civilian facilities, for the actual performance of medical research. Hence the research function assigned to the Surgeon General's Office was chiefly that of supervising and coordinating the research projects farmed out to a number of facilities. A Research and Development Section had been established in the Finance and Supply Division in late 1940, but its duties had been essen-

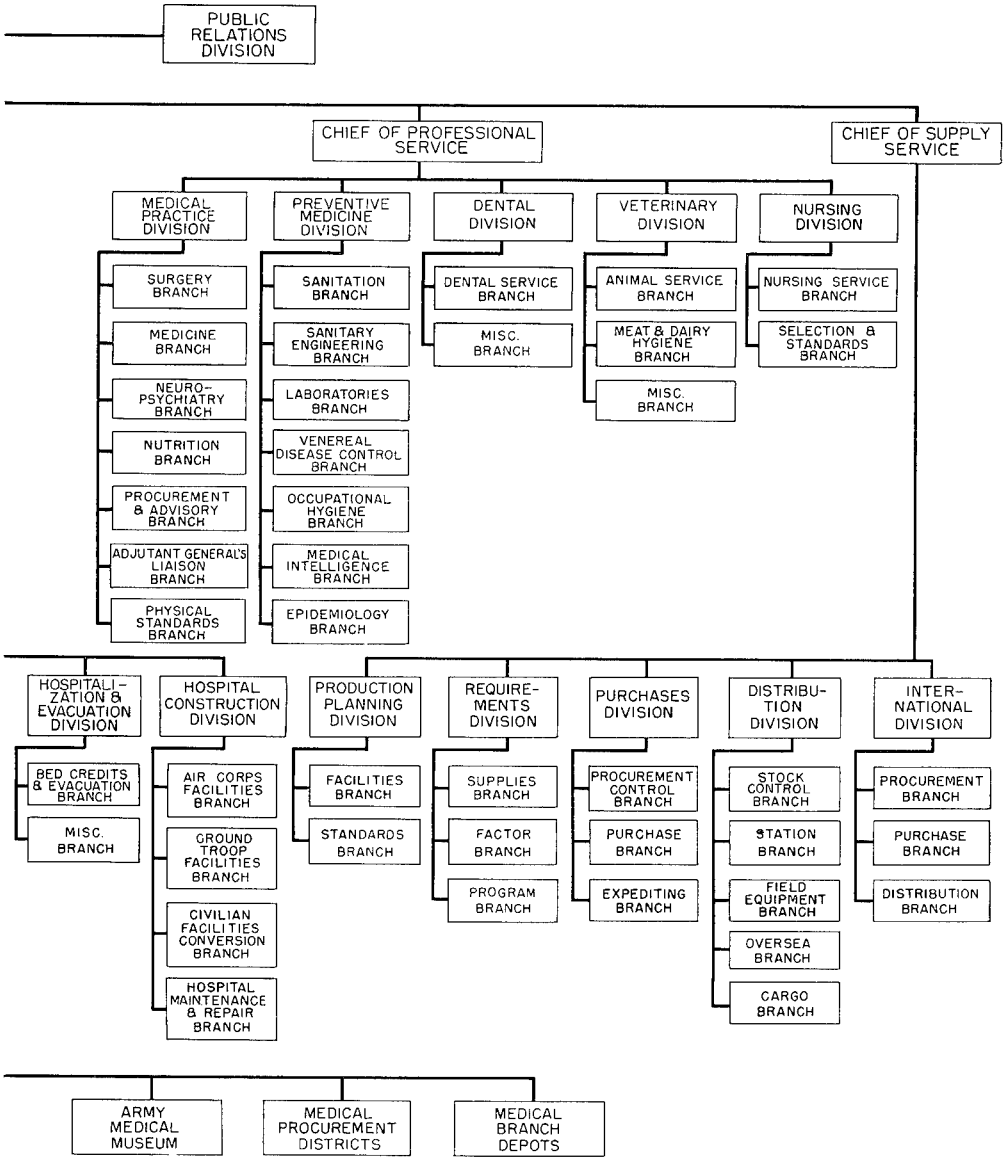
[20] (1) Memorandum, H. M. Watts, Medical Department Representative, Civilian Personnel Policy Committee, for Director of Personnel, Services of Supply, 24 July 1942. (2) Office Order No. 288, Office of The Surgeon General, 4 Aug. 1942.

[21] Medical Department, United States Army. Dental Service in World War II. Washington: U.S. Government Printing Office, 1955, p. 7ff.

CHART 7.—*Organization of the Office of the Surgeon General and*



medical installations under command control, 24 August 1942



tially restricted to the maintenance of records on expenditure of funds. A Medical Research Coordinating Board, functioning under the Professional Service Division, had had the task of coordinating research activities supported by Medical Department funds. In the spring of 1942, the Surgeon General's Office undertook for the first time thoroughgoing coordination of all research activities, both projects assigned to War Department facilities and those entrusted to outside agencies by establishing a Research and Development Division in the Administrative Service. The Chief of the new division worked closely with the Division of Medical Sciences of the National Research Council, with the Health and Medical Committee of the Office of Defense Health and Welfare Services, and with the National Inventors' Council. A proposal for a certain research project might come to the Research and Development Division from one of various sources in the Surgeon General's Office or the War Department, or from another Government agency. The division referred the project to whatever segment of the Surgeon General's Office had the strongest interest in it. If the appropriate unit considered it worthwhile, the Research and Development Division obtained the approval of the Development Branch, Headquarters, Services of Supply, and notified the laboratory best equipped to do the research, outlining its purpose, the funds to be spent, and so forth. The interested division of the Surgeon General's Office supervised the progress of the research, while the Research and Development Division coordinated the work with that of other research projects.[22]

Library and Museum.—The Army Medical Library and the Army Medical Museum were placed on field status at this date; hence divisions to conduct their administration were no longer included in the Surgeon General's Office. However, these two installations remained under the direct control of The Surgeon General, and their relations with the Office remained largely as before.[23]

The Preventive Medicine Service

With the accelerated shift of troops overseas during 1942, the sphere of activities of the Preventive Medicine Service continued to widen. The Sanitation Division's work, except for the areas assigned to the Laboratories Division and to the Venereal Disease Control Division, included most of the preventive medicine activities of the Army in the years of peace; the activities of the Medical Intelligence, Occupational Hygiene, and Epidemiology Divisions, on the other hand, were largely the result of added wartime responsibilities. The Sanitation Division supervised the Medical Department's con-

[22] (1) Research and Development Program, Fiscal Year 1942, 20 Aug. 1941; and Medical Department Project Program, Fiscal Year 1941. [Official record.] (2) Memorandum, Lt. Col. J. F. Lieberman, MC, Executive Officer, Professional Service, for Lt. Col. Francis C. Tyng, MC, 1 May 1942, subject: Professional Service Activities. (3) Office Order No. 123, Office of the Surgeon General, 1 May 1942. (4) Committee to Study the Medical Department, 1942, Testimony, p. 655ff.

[23] (1) Office Order No. 237, Office of The Surgeon General, 1 July 1942. (2) See footnotes 13(3), p. 88, and 18(3), p. 92.

tinuous work in preserving sanitary conditions in and around Army installations, especially in the preparation of food, and in maintaining systems of garbage and sewage disposal, as well as pure water supply systems, for troops.

Sanitation Division.—In a period of rapid expansion the division's task of maintaining desirable standards was greatly increased. Some outbreaks of food poisoning occurred in 1942, and sanitary reports showed that commanding officers of some posts and camps were not satisfactorily meeting their responsibilities for maintaining sanitary conditions. The struggle of the Surgeon General's Office with higher War Department authority over standards for kitchen and mess sanitation and the maintenance of sufficient airspace in barracks and hospitals, begun in the pre-Services of Supply period, continued. The Services of Supply, rather than the General Staff, now applied the immediate pressure upon the Medical Department to lower standards in order to take into account shortages of materials, labor, or facilities and to cope at the same time with the pressing demands of the expanding Army.[24]

The Sanitation Division and especially its Sanitary Engineering Branch, through liaison with the Quartermaster Corps and the Corps of Engineers, shared in some of the responsibilities for making repairs, maintaining utilities, and furnishing certain supplies at Army posts and camps. The procurement and distribution of insect repellants and insecticides was a case in point, being variously assigned at different periods. In June 1943 an amusing experience was recorded by a captain of the Medical Corps at Robins Field, Ga., who had been unable to get a supply of carbon disulfide for ant control. His medical supply officer had stated that he was unable to issue it, and the local quartermaster had informed him that he could issue the item only if the ants to be exterminated were inside a building. If they were outside, the responsibility was that of the Engineers. In commenting on his frustration, the captain noted the disinterest of meandering ants in adhering to established Army channels.

Sanitary engineering was assigned in early 1942 to a subdivision of that name within the Sanitation Division as one phase of the general work in sanitation. Engineering problems connected with purifying water and treating sewage and those connected with the operation of swimming pools and the control of insect and rodent carriers of disease were handled in that period, along with the general functions discussed above, by the Sanitation Division, and after August by the Sanitary Engineering Branch, made coordinate with the Sanitation Branch (chart 7). In efforts to control malaria, Sanitary Corps officers attempted to recommend nonmalarious sites for constructing new Army installations.

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[24] (1) Committee to Study the Medical Department, 1942, exhibits 19, 41, and 45. (2) Memorandum, Lt. Col. Charles L. Kirkpatrick, MC, Acting Executive Officer, Office of The Surgeon General, for Commanding General, Services of Supply, 8 July 1942, subject: Sanitation. (3) Copy of 1st wrapper indorsement (no letter file reference), Capt. Frank C. Owens, Medical Inspector, Station Hospital, Robins Field, Ga., to Medical Supply Officer, Station Hospital, Robins Field, 12 June 1943.

Some major projects by the Sanitation Division in 1942 were surveys of water and sewage installations, especially of installations in hotels taken over by the Army Air Forces to house personnel, and preparation of a directive for protection of Army water supplies. In collaboration with the U.S. Fish and Wildlife Service, the U.S. Public Health Service, departments of public health of the various States, and universities, the Sanitation Division undertook a program of rodent control in order to reduce or eliminate endemic typhus fever, and possibly plague in some areas. Specialists in rodent control, commissioned in the Sanitary Corps, were assigned to the Fourth, Eighth, and Ninth Service Commands.

Medical Intelligence Division.—The medical surveys of foreign areas by the Medical Intelligence Division became, with American entry into war, a part of formal War Department planning. The division prepared them for foreign areas upon request by the General Staff, as medical sections of the War Department Strategic Surveys. They contained information on health conditions and the medical resources of specified areas. In this work the officers of the Medical Intelligence Division maintained liaison with Military Intelligence Service, G–2, which prepared other sections of the Strategic Surveys. The medical surveys were also used as the subject matter of lectures given to officers being trained at the School of Military Government at Charlottesville, Va. In addition to the lengthier summaries, the division prepared brief résumés of medical data for surgeons of task forces going overseas.[25]

Laboratories Division.—By the end of 1941, the Laboratories Division of the Preventive Medicine Service had completed the establishment of the system of corps area laboratories. Each corps area had acquired a laboratory, with the exception of the Third which was served by the laboratories of the Army Medical Center in Washington, and the Ninth Corps Area which had two laboratories. Each laboratory had a veterinary component, consisting of one or more Veterinary Corps officers and enlisted and civilian technicians who performed tests or conducted special investigations in connection with animal disease and foods of animal origin. The Laboratories Division now had the task of planning a system of laboratories for use overseas. It outlined the functions of the diagnostic laboratories of several types of hospitals—surgical, evacuation, station, general, and convalescent—and specified the types and number of personnel needed in each. As an oversea counterpart of the corps area laboratory, it planned the Medical Laboratory, Army or Communications Zone, to serve the field army or the communications zone in an oversea theater. Another type, the Medical Laboratory, General, was designed as a central laboratory to serve an entire theater of operations. In addition to its routine functions as an epidemiological and general laboratory for a large area, it was to train any additional laboratory personnel who might be needed within the theater, furnish standardized laboratory techniques and supplies for the theater,

[25] (1) Committee to Study the Medical Department, 1942, exhibits 30–35. (2) Interview, Col. Tom Whayne, MC, 29 Sept. 1949.

and produce diagnostic sera, standard chemical solutions, and so forth, if necessary. The scope of laboratory work of this theater unit was to be comparable to that of the Army Medical Center in Washington.[26]

A major problem of the Laboratories Division of the Preventive Medicine Service was the procurement of enough medical officers to man the Medical Department's network of laboratories in the United States and overseas. The division aided the Personnel Service in procuring pathologists and other specialists and arranged for special training of additional officers at a few universities. Other responsibilities included the devising of laboratory procedures for such programs of Army-wide scope as the determination of the blood group of all Army personnel, continual review of the supply items for laboratories listed in the Army Medical Supply Catalog, and the review and revision of Army regulations pertaining to medical laboratories.

Occupational Hygiene Division.—Until late in 1941 the Medical Department's concern with problems of industrial hygiene in industrial plants operated by the Army had undergone a gradual evolution, and The Surgeon General had obtained authorization for bit-by-bit expansion of the program. Civilian doctors under contract, or medical officers, and nurses were then unevenly assigned to Ordnance arsenals, Quartermaster depots, and Air Corps depots, the Ordnance plants being favored. Surveys of Army plants by the U.S. Public Health Service had revealed occupational hazards, such as lead poisoning, existing in specific plants, the likelihood of new ones with the growth of the Army's industrial work, and the inadequacy of medical service in the plants. The Surgeon General believed that the Medical Department should assume full responsibility for emergency medical treatment and supervision of industrial hygiene among civilian employees in the plants. In September 1941, he had requested a statement of policy on this matter. Although the Medical Department had assumed some responsibility during the emergency period, the program had lagged, for the War Department had not given The Surgeon General authorization for a general program and hence had not recognized the large personnel needs involved.[27]

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[26] (1) Committee to Study the Medical Department, 1942, exhibits 42 and 44. (2) Memorandum, Col. James S. Simmons, MC, for Operations Service, 23 Mar. 1944, subject: Medical General Laboratories. (3) Medical Department, United States Army, Veterinary Service in World War II. Washington: U.S. Government Printing Office, 1962, pp. 429–431. (4) Interview, Maj. Everett B. Miller, VC, 7 Oct. 1949.

[27] (1) Memorandum, Executive Officer, Office of The Surgeon General, for Secretary of the General Staff, 17 Sept. 1941, subject: Policy on Medical Service to Civilian Employees in Army-Operated Industrial Plants and Depots. (2) Memorandum, Assistant Chief of Staff, for The Adjutant General, 1 Jan. 1942, subject: Policy. (3) Committee to Study the Medical Department, 1942, exhibit 53. (4) Memorandum, Executive Officer, Office of The Surgeon General, for Commanding General, Services of Supply, 4 Apr. 1942, subject: Status of Contract-Operated Industrial Plants. (5) Annual Report of The Surgeon General, U.S. Army, 1942. [Official record.] (6) See footnote 18(3), p. 92. (7) Memorandum, Executive Officer, Civilian Personnel Division, Services of Supply, for Corps Area Surgeons, 18 June 1942, subject: Responsibility for Industrial Hygiene and Environmental Sanitation in Government-Owned, Privately Operated Munitions Plants. (8) Memorandum, Executive Officer, Office of The Surgeon General, for Chief of Ordnance, 30 June 1942, subject: Industrial Hygiene Survey for Government-Owned, Contractor-Operated Munitions Plants. (9) War Department Circular No. 59, 24 Feb. 1943.

Early in January 1942, The Surgeon General received full responsibility for industrial hygiene in plants operated by the Army and the authority to establish dispensaries in them. By April the Occupational Hygiene Division was tackling the total program in conjunction with corps area surgeons and was making plans for an industrial hygiene laboratory at the Army Medical Center. Since it was difficult to find sufficient personnel in Washington, the laboratory was established at the School of Hygiene and Public Health at The Johns Hopkins University in Baltimore, Md. It remained there for the duration of the war. Personnel of the Army Industrial Hygiene Laboratory made surveys of industrial health hazards, studying such factors as the presence of dust and gases and conditions of ventilation and lighting, and analyzed samples and specimens sent in from the plants.

About this time the question came up as to the Army's responsibility for maintaining an industrial hygiene program in plants—chiefly for ordnance production—which it owned but which were operated by private contractors. Under the contracts the provisions of the Workmen's Compensation Act as to the safety of employees applied, the contractor being responsible for industrial safety and hygiene. Since the grounds on which these plants were located were considered Federal reservations, State and local public health authorities had no jurisdiction and lacked authority to inquire into conditions at the plants. Surveys by the Public Health Service had revealed unsatisfactory supervision of health and safety programs in some of them.

Accordingly, The Surgeon General asked for an additional statement of policy as to this group of plants. In June 1942, the Judge Advocate General declared that contractor-operated ordnance plants, as well as Government-operated ones, were military reservations, subject to the authority of the corps area commander, and The Surgeon General became responsible for maintaining satisfactory sanitary conditions at the plants operated by contractors. At his request the Division of Industrial Hygiene of the National Institutes of Health of the U.S. Public Health Service sent out men to inspect conditions at each contractor-operated plant.

In August, the Services of Supply charged the Provost Marshal General with responsibility for preparing policies and instructions on methods of preventing accidents at plants and facilities. Because of the close relationship of problems of accident prevention with those of industrial medicine, the Occupational Hygiene Division of the Surgeon General's Office—redesignated a branch in the general downgrading of units under the August reorganization—became a part of the War Department machinery for accident control. The chief of the branch served on the War Department Safety Council, which met from December 1942 to the end of the war, along with representatives of the office of the Provost Marshal General, of the other technical services, and of other offices of the War Department, Army Air Forces, and Navy.

During the year the Army's industrial hygiene program grew quite large in certain highly industrialized areas. In the Second Corps Area, for



FIGURE 24.—Col. Paul F. Russell, MC.

example, a medical officer specializing in industrial medicine was assigned to the corps area surgeon's office, and 40 medical officers and civilian doctors were assigned to 28 plants in that area. Eventually the surgeon's office of every corps area except the First had an officer assigned to industrial hygiene.

By September 1942, the Occupational Hygiene Branch was supervising emergency medical service for more than half a million employees of more than 150 Army-operated plants of the Ordnance Department, Chemical Warfare Service, Quartermaster Corps, Signal Corps, and Army Air Forces, as well as supervising the contractors' programs in about 250 contractor-operated plants. It had aided in organizing the Armored Force Medical Research Laboratory established at Fort Knox, Ky., in the fall of 1942 and was assisting the latter's efforts to determine the hazards of mechanized warfare, including experiments with tanks. It had assigned an industrial hygiene officer to the Surgeon, Air Service Command, and it maintained liaison with the research laboratories of the Air Forces at Wright Field and Randolph Field engaged in work on aviation hazards. The program had become a large field enterprise with continually increasing civilian coverage.

Epidemiology Division.—With the reorganization of the Surgeon General's Office in March 1942, the Epidemiology Division had the four subdivisions shown on chart 6 (p. 86). The Subdivision of Epidemiological Investigation administered the Army Epidemiological Board (formally termed Board for Investigation and Control of Influenza and Other Epidemic Diseases in the Army) as a civilian adjunct to the Epidemiology Division. The Tropical Disease Control Subdivision was established in May, when Dr. (later Col.) Paul F. Russell (fig. 24), a specialist in malariology with the Rockefeller Foundation, was brought into the office.

Courses in tropical medicine had been inaugurated at the Army Medical Center late in 1941. The following February, the Commission on Tropical Diseases of the Army Epidemiological Board had been organized with Dr. Wilbur A. Sawyer, Director of the International Health Division, Rockefeller Foundation, as Director. The Chief of the Preventive Medicine Division, Col. James S. Simmons, MC, had noted in April 1942 that from the beginning of the emergency, The Surgeon General had been concerned with the fact that few doctors newly entering the Army had received adequate training in tropical medicine. He pointed out that the Army had neither the facilities nor the time "to remedy so great an educational deficiency" and urged civilian medical schools to offer short intensive courses in tropical medicine.[28] In August 1942, the Tennessee Valley Authority agreed to give intensive courses in fieldwork in malariology at Wilson Dam, Ala.

By the date of Colonel Russell's appointment, the low malaria rates among troops in the United States were still further declining, as a result of the joint antimalaria efforts of the Army and the U.S. Public Health Service, termed by Colonel Simmons "the most gigantic mosquito-control campaign carried out in the history of the world." The admission rate for troops in the United States dropped in the course of the war from 1.8 per 1,000 in 1941 to 0.13 for the first half of 1945. But rates among troops in some areas outside continental United States, Panama and Puerto Rico, for example, were rising. High rates in combat areas would seriously interfere with military operations. Accordingly, The Surgeon General sent Colonel Russell and a member of the Tropical Medicine Commission of the Army Epidemiological Board to the Caribbean Defense Command in the fall of 1942. They were to determine whether the spraying of insecticides to destroy anopheline mosquitoes in civilan areas adjacent to Army installations, then more commonly practiced by the British in the Near and Middle East than by the U.S. Army, would be effective in the Caribbean Defense Command. By that date high malaria rates had occurred among troops on the islands of the South Pacific Area and in New Guinea.

The Infectious Disease Control Subdivision made epidemiological investigations, analyzed data on epidemics, and initiated measures to control various infectious diseases. It pointed out, for example, the danger of conducting large-scale troop maneuvers in San Joaquin Valley, Calif., because of the occurrence of coccidioidomycosis, or "valley fever." The Immunization Subdivision investigated various problems connected with immunizing troops and the use of prophylactic biologicals. It maintained close liaison with the Supply Service, which bought biologicals, and with the Subcommittee on Tropical Disease of the National Research Council, which advised the Medical Department on the desirability of using specific vaccines. An important step taken

[28] Simmons, J. S.: The Army's New Frontiers in Tropical Medicine. Ann. Int. Med. 17: 979–988, December 1942.

by the Immunization Subdivision in 1942 was the institution of a system of authenticated immunization registers, acceptable to foreign governments, for American military personnel on oversea missions. Previously the personnel of American missions had been denied entry into certain foreign areas, or detained, because they lacked proof of having been immunized against certain diseases or because foreign governments were unwilling to accept the available proof. Through the U.S. State Department, agreements were reached with a number of the governments of African and Asiatic areas and of British-controlled islands of the Pacific as to the type of documentation which each government would accept as proof that U.S. military personnel had been immunized against specific diseases.

Other than malaria, the most serious problem to plague the Epidemiology Division during the months between March and August 1942 was the widespread occurrence of jaundice among American soldiers throughout the world. The yellow fever vaccine then being supplied the Army by the International Health Division of the Rockefeller Foundation was shortly suspected as the cause. The Surgeon General ordered the abandonment of this vaccine and the adoption of vaccine supplied by the U.S. Public Health Service. An investigation in the ensuing months traced the disease to specific lots of faulty vaccine.[29]

Venereal Disease Control Division.—In 1942, the Venereal Disease Control Division was engaged in the study of prophylactic agents and various methods of venereal disease control, the preparation of forms for reports, the analysis of statistical data on venereal disease, and the handling of syphilis registers maintained for individual cases of syphilis among Army personnel. It aided the Personnel Service in obtaining men qualified in venereal disease control and in giving them supplementary training. It prepared material designed to school the individual soldier in avoiding venereal disease infection. (At this date the development of specific methods of treatment for the venereal diseases was a responsibility of the Medicine Division of the Professional Service.)

During the year the division continued its extensive liaison with the U.S. Public Health Service, Navy, American Social Hygiene Association, and other

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[29] (1) Long, Arthur P.: Preventive Medicine, The Epidemiology Division (1946). [Official record.] (2) Committee to Study the Medical Department, 1942, exhibit 47. (3) Memorandum, Lt. Col. S. Bayne-Jones, MC, for Chief, Preventive Medicine Division, 29 Mar. 1942, subject: Report of Subdivision on Epidemiology for 1 Jan.–29 Mar. 1942. (4) Simmons, J. S.: Progress in the Army's Fight Against Malaria. J.A.M.A. 120: 30–34, 5 Sept. 1942. (5) See footnote 28, p. 102. (6) Memorandum, The Surgeon General, for the Secretary of War, 3 June 1942, subject: Outbreak of Jaundice in the Army. (7) Circular Letter No. 95, Surgeon General's Office, 31 Aug. 1942, subject: Outbreak of Jaundice in the Army.

For discussion of cases of jaundice associated with yellow fever vaccine, see Medical Department, United States Army. Preventive Medicine in World War II. Volume III. Personal Health Measures and Immunization. Washington: U.S. Government Printing Office, 1955, pp. 307–313; and Volume V. Communicable Diseases Transmitted Through Contact or by Unknown Means. Washington: U.S. Government Printing Office, 1960, pp. 419–431.

agencies, through a new medium, the Inter-Departmental Committee on Venereal Disease. After the rift caused by the book "Plain Words About Venereal Disease" (by Drs. Parran and Vonderlehr) between the Surgeon General's Office and the U.S. Public Health Service, the Federal Security Administrator had undertaken the task of reconciliation. Pursuant to President Roosevelt's request for an investigation, Mr. McNutt had stated his confidence in the Army's awareness of the seriousness of the problem and had conferred with the Secretaries of War and Navy. As in other cases of conflict between Government agencies, the attack on Pearl Harbor had probably aided in the closing of this internal breach in Government relations. Mr. McNutt suggested an interdepartmental committee of six, to be composed of two representatives from the Army, Navy, and U.S. Public Health Service. Later representation included the American Social Hygiene Association and the Federal Bureau of Investigation; the latter would be concerned in case of invocation of the May Act which made prostitution a Federal offense in an area in which it was invoked. The Chief of the Venereal Disease Control Division of the Surgeon General's Office acted as one of the Army representatives. In 1942 the Inter-Departmental Committee was largely concerned with problems of control in the United States and the Caribbean Defense Command. It observed closely the operation of the May Act in the two areas in which it was invoked—at Camp Forrest, Tenn., in May and at Fort Bragg, N.C., in July. Both the committee and the Venereal Disease Control Division were aided by utterances of highly placed leaders of the military effort. In March, the Secretary of War sent a letter to all State Governors warning them of the menace of prostitution and venereal disease. In May, President Roosevelt sent the Federal Security Administrator a letter commending the work of the Inter-Departmental Committee, which Mr. McNutt forwarded to more than 8,000 executives of plants engaged in war production. The low rates of venereal disease incidence among soldiers stationed in the United States during World War II compared with the rates of World War I testify to the effectiveness of administrative measures adopted to control the venereal diseases, as well as to the advances in treatment achieved since the First World War.[30]

The Professional Service

Addition of civilian specialists.—The Professional Service, which had remained relatively unchanged during the emergency period as compared with the rapid growth of the Preventive Medicine Service, now entered upon its period of intensive expansion. Less than a month after the United States entered the war, General Magee took steps to obtain for the Professional Service some of the outstanding civilian specialists in major fields of medicine.

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[30] (1) See footnote 27(5), p. 99. (2) Sternberg, T. H., and Howard, Ernest B.: History of Venereal Disease Control and Treatment in the Zone of Interior (1946). [Official record.]

This group of men were known as consultants.[31] Under that title, specialists in the three major fields of internal medicine, surgery, and neuropsychiatry were assigned to the Surgeon General's Office. Their chief functions were the establishment of Army-wide policies on diagnosis and treatment of injuries and diseases in their special fields, and the appraisal of the qualifications and performance of fellow specialists, particularly in the hospitals. In retrospect the latter function, the "constant assessment and reassessment" of the assignment of key professional individuals, stood out as a major contribution in the opinion of the Chief Surgical Consultant in the Surgeon General's Office.[32]

Early in 1942, General Magee appointed Dr. Hugh J. Morgan (fig. 25), then Professor of Medicine at Vanderbilt University School of Medicine, as Chief Consultant in Medicine and Dr. Fred W. Rankin (fig. 26), Clinical Professor of Surgery at the University of Louisville, as Chief Consultant in Surgery. These two fields, which had been lumped together in one subdivision of Professional Service during the emergency period, were now to be handled by separate subdivisions; with the March reorganization, they became full divisions. The Neuropsychiatry Subdivision, which also became a division in March, was headed as of August by Col. Roy D. Halloran, MC (fig. 27), formerly superintendent of the Metropolitan State Hospital at Waltham, Mass., and Professor of Clinical Psychiatry at Tufts College Medical School in Boston. Drs. Morgan and Rankin were later given the rank of brigadier general, and headed their respective programs to the end of the war.

These three fields—internal medicine, surgery, and neuropsychiatry—each headed by a chief consultant charged with the coordination of matters pertaining to his special field throughout the Army, were the fields recognized in 1942 by the Surgeon General's Office as of primary importance. A number of subspecialties were later recognized with similar appointments, and staffs of the three mentioned above increased gradually.

From the inception of their offices, the consultants assisted The Surgeon General in the preparation of written instructions as to methods of treatment

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[31] This discussion is concerned only with the network of commissioned consultants brought into the Surgeon General's Office and later introduced into the corps areas and oversea theaters for purposes here described. Many other specialists, frequently remaining in civilian status and used mostly in an advisory capacity, were referred to as "consultants" during World War II. Specialists in tropical medicine assigned to the Army Medical Center in 1941 to inaugurate courses in tropical medicine were known as "consultants," while members of the Army Epidemiology Board were termed "consultants to the Secretary of War."

[32] (1) Rankin, Fred W.: Mission Accomplished: The Task Ahead. Ann. Surg. 130: 289–309, September 1949. (2) Medical Department, United States Army. Internal Medicine in World War II. Volume I. Activities of Medical Consultants. Washington: U.S. Government Printing Office, 1961, pp. 1–141. (3) Memorandum, The Surgeon General, for Commanding General, Services of Supply, 28 May 1942, subject: Coordination of Medical Service in Corps Area Installations. (4) Memorandum, The Surgeon General, for Commanding General, Services of Supply, 23 June 1942, subject: Coordination and Supervision of Medical Service in Station Hospitals. (5) Beck, Claude S.: Surgical History, Fifth Service Command. [Official record.] (6) Office Order No. 337, Office of The Surgeon General, 31 Aug. 1942. (7) Annual Report, Eighth Service Command Medical Branch, 1942. (8) Annual Report of the Surgeon General, U.S. Army, 1943. [Official record.] (9) Medical Department, United States Army. Neuropsychiatry in World War II. Volume II. Oversea Theaters, ch. V. [In preparation.]

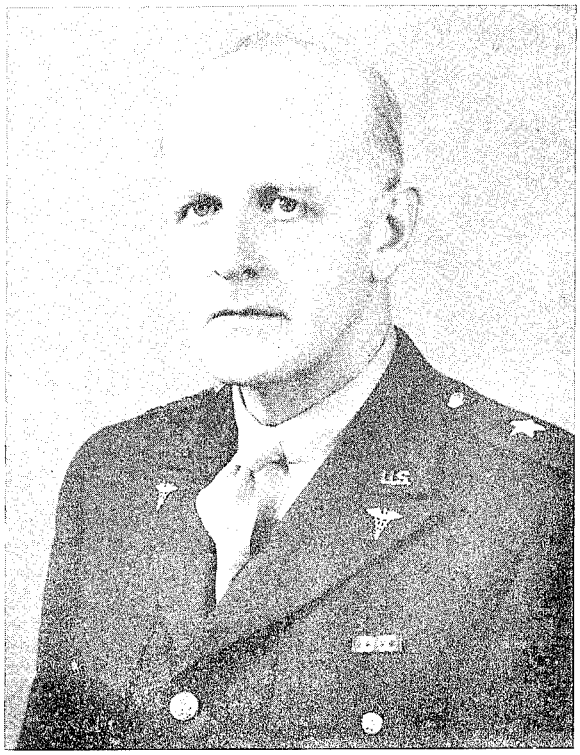


FIGURE 25.—Brig. Gen. Hugh J. Morgan, MC

for Army-wide use, supplementing and to some extent superseding the technical role of advisory committees of the National Research Council. As more and more civilian doctors entered the Army, with great diversity of training and experience, and as troops were sent in increasing numbers to oversea regions with various patterns of endemic disease, the Professional Service needed a staff of specialists directly assigned to the task. The new group of specialists from civilian life was to further the use of advanced methods of diagnosis and treatment by continued scrutiny of techniques in current use and by suggestions for new methods or modifications of old ones. Among the advantages of having an advisory group on technical matters integrated into the Surgeon General's Office and commissioned in the Army was the fact that specialists within the Office would become better acquainted with the conditions imposed by military organization and tactical situations in oversea areas than could specialists outside the Army. Moreover, as officers, they could be held responsible for their decisions.

Extension of the consultant system to corps areas.—Brig. Gen. Charles C. Hillman, Chief of the Professional Service, and his chief consultants agreed that this system should be decentralized by placing a consultant in each of the major specialties, internal medicine, surgery, and neuropsychiatry, in the office

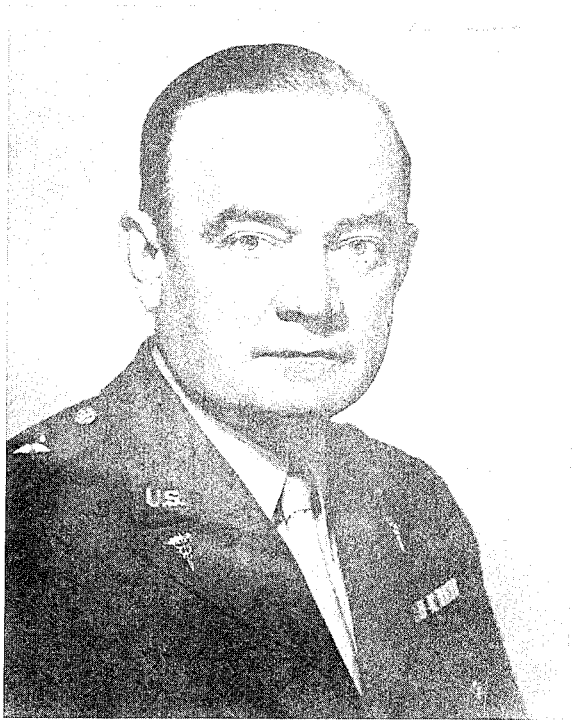


FIGURE 26.—Brig. Gen. Fred W. Rankin, MC.

of each corps area surgeon to supervise methods of treatment in their special fields employed in hospitals throughout the corps areas. Consultants in the Surgeon General's Office could supervise in the general hospitals, then under direct control of The Surgeon General, but specialists were also needed to observe and assess performance in the station hospitals. The latter, controlled by various jurisdictions, including the Army Air Forces, were rapidly increasing in number, and were acquiring more and more specialists from civilian practice with varied training and experience. A consultant assigned to the corps area surgeon could, by frequent visits to the station hospitals, supervise technical practices in his specialty throughout the corps area. The assignment of consultants to corps areas would provide specialists where they were needed, and at the same time would conserve scarce medical personnel.

The War Department authorized the appointment of consultants to the corps areas in July. By fall a number had been assigned to four corps areas where troops, and hence station hospitals, were heavily concentrated: the Fourth, Seventh, Eighth, and Ninth. They acted as consultants to hospital staffs; evaluated new therapeutic techniques, drugs, and other therapeutic agents; coordinated professional practices among the various hospital staffs; and evaluated the professional qualifications of medical personnel. Installations which they served included, in addition to the hospitals for Army and Air

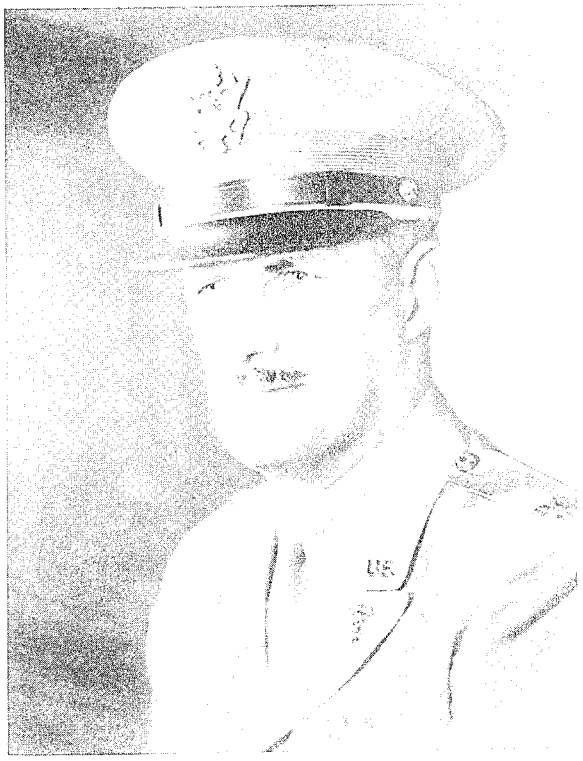


FIGURE 27.—Col. Roy D. Halloran, MC.

Forces troops, induction stations, internment camps, and Army-operated industrial facilities. Consultants in the three major specialties were later appointed to the remaining corps areas, to the medical staffs of field armies both in the United States and overseas, and at various levels of command in the oversea theaters of operations.

The Surgeon General's Office came in for some criticism, beginning as early as 1942, because of internal disagreements among its specialists. The always touchy question of venereal disease, for example, was one on which experts sharply disagreed. In November 1942, the sole responsibility for issuing instructions on methods of treatment, as well as for policies on control and prevention, was established in the Venereal Disease Control Branch of the Preventive Medicine Division. That branch cooperated closely with the Medical Practice Division, as well as with the consultants in medicine assigned to the service commands, in working out policies for both control and treatment. Nevertheless, some of the specialists in internal medicine found this arrangement unconventional and organizationally unsound. Although the Chief Consultant in Medicine admitted that it worked, he considered the assignment of venereal disease control to men with public health training and little clinical

experience "a glaring example of inconsistency and improvisation in Medical Department organization." [33]

The Operations Service

The Operations Service as originally established in March consisted of four divisions: Training, Planning, Hospital Construction, and Hospitalization.[34] It remained the coordinating agency of the Surgeon General's Office until the end of the war.

Training Division.—The Training Division had the job of establishing all training policies for the various Medical Department schools and for the Medical Department training centers established in 1941 and early 1942, as well as for the medical training courses given to officers and men in general War Department schools. It developed training manuals and training films, allocated quotas of personnel to medical units and installations, prepared estimates for construction and maintenance of schools and replacement training centers, and inspected these installations. In the course of 1942, the Training Division received responsibility for planning the training of the Medical Department nondivisional units commonly used in the communications zone of an oversea theater, such as the general, station, and field hospitals and various types of laboratories and medical supply units, which were turned over to the Services of Supply for activation and training. In August the Services of Supply directed a reorganization of the Division to conform to the organization of the corresponding division at the Services of Supply level. It was to include a Unit Training Branch to take care of the additional responsibilities with respect to units. At this time the Training Division, Surgeon General's Office, was removed from the Operations Service and made a staff division.[35]

Planning Division.—The work of the Planning Division was to recommend and prepare tables of organization (numbers of officers and enlisted men by specialty and rank) and tables of basic allowances (of equipment) for Medical Department units and medical detachments. It recommended medical units for inclusion in the troop basis, as well as the types and numbers for medical service in oversea theaters, and prepared on request the medical sec-

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[33] See footnote 30 (2), p. 104.

[34] An Inspection Division indicated on charts in 1942 was never created.

[35] (1) Memorandum, Chief, Administrative Branch, Services of Supply, for Directors and Chiefs of Staff Divisions, Services of Supply, 9 May 1942, subject: Clarification of Responsibilities of Chief of Supply Services in Relation to Army Ground Forces and Army Air Forces. (2) Memorandum, Chief, Training Division, Office of The Surgeon General, for Chief, Control Division, Office of The Surgeon General, 29 Oct. 1942, subject: Report on Administrative Developments. (3) Memorandum, Director, Training Division, Services of Supply, for The Surgeon General, 13 Aug. 1942, subject: Organization of a Training Division, with 1st indorsement, Executive Officer, Office of The Surgeon General, to Chief, Control Division, Services of Supply, 21 Aug. 1942. (4) Annual Report, Training Division, Office of The Surgeon General, 1942–43. (5) Medical Department, United States Army. Training in World War II. [In preparation.]

tions of War Department plans. It also supervised the development and testing of medical field equipment.

Hospital Construction Division.—The Hospital Construction Division was charged with preparing plans for the construction and repair of hospitals and all construction activities in which The Surgeon General was interested, including hospital ships and quarters for patients on Army transports. It worked closely with the Office of the Chief of Engineers, which had been responsible since December 1941 for constructing Army hospitals—previously a function of the Office of the Quartermaster General.[36]

Hospitalization Division.—The Hospitalization Division (renamed Hospitalization and Evacuation Division in the August reorganization) was primarily concerned with developing policies on hospitalization and treatment, with administrative supervision of the named general hospitals in the United States and advisory supervision over the administration of other hospitals, with allotment to station hospitals of bed credits in the named general hospitals, and with assignment to the latter of patients transferred from overseas.

The activities and policies of this division were largely responsible for the steadily worsening relations between the Medical Department and the Services of Supply between March and September 1942. The friction went back to February, when Lt. Col. William L. Wilson, then assigned to G–4, had followed up a tour of the corps areas with charges that the Medical Department had no adequate plans for evacuating and hospitalizing civilian or military wounded should the United States be bombed. Brig. Gen. LeRoy Lutes, who came to the Services of Supply Operations Division from command of an antiaircraft brigade in the Los Angeles, Calif., area, had become concerned over the lack of a plan for hospitalization if the city were bombed and had asked Colonel Wilson to inquire as to what the situation was throughout the United States. Colonel Wilson and General Lutes believed that the Surgeon General's Office had not anticipated a possible declaration of martial law and the Medical Department's responsibilities for civilians, as well as military, in the event of bombing. Colonel Wilson found corps area surgeons concerned over possible confusion as to lines of authority if it should become necessary to evacuate wounded civilians and soldiers from one corps area to another. He and General Lutes considered a plan by each corps area surgeon and a master plan by the Surgeon General's Office essential.[37]

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[36] (1) Annual Report, Hospital Construction Division, Office of The Surgeon General, 1942. (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, pp. 61–63.

[37] (1) Working papers for report by Lt. Col. William L. Wilson, MC, on his survey of corps areas. HU: Wilson files. (2) Memorandum, Brig. Gen. LeRoy Lutes, for Lt. Gen. Brehon B. Somervell, 19 Apr. 1942, subject: Coordination of Medical Activities, Air and Ground Forces, and Services of Supply. (3) Letter, Lt. Gen. LeRoy Lutes, to Director, Historical Division, Office of The Surgeon General, 8 Nov. 1950. (4) 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, pp. 55–56.

In March, General Lutes directed The Surgeon General to submit a basic Army-wide plan for hospitalization and evacuation. In May, he informed General Somervell that The Surgeon General had failed to publish an Army-wide hospitalization and evacuation plan and that the one he had finally submitted at the direction of General Lutes' office was unsuitable. General Lutes' office (that is, Colonel Wilson) had had to prepare such a plan and submit it through G–4. General Lutes coupled this charge with an implication that administration of the Medical Department had been deficient by stating that The Surgeon General had only five officers with "basic military training" in "key positions" in his office and that two of the four Army surgeons had not had such training. He recommended to General Somervell that The Surgeon General be required to study and report upon the status of medical personnel in his office and make recommendations for correction of deficiencies.[38]

In reply, General Magee pointed out the lack of a definition of "key positions" and of "basic military training." He assumed that by the latter term General Lutes intended reference to training in the Command and General Staff School and/or the Army War College. He stated that 54 of his medical officers had graduated from either or both of those schools and that he had exercised great care in the appointment of officers to key positions. Of the four Army surgeons—Col. Raymond W. Bliss, MC, First U.S. Army (fig. 28); Col. Frank H. Dixon, MC, Second U.S. Army (fig. 29); Col. John H. Dibble, MC, Third U.S. Army (fig. 30); and Col. Condon C. McCornack, MC, Fourth U.S. Army—all except Colonel Bliss were graduates of one or both of these schools, and Colonel Bliss (later Major General and The Surgeon General), he emphasized, was a man "of high intelligence, wide experience, and great industry."[39] The controversy was finally halted, if not resolved, with the issuance of a jointly developed hospitalization and evacuation directive in November 1942.

The Critical Services: Personnel and Supply

In 1942 the Personnel Service and the Supply Service were the elements of the Surgeon General's Office in which the two major problems confronting the Medical Department appeared. The Chief Surgeon, European Theater of Operations, informed the Chief of Staff, Services of Supply, in September, that the medical service in the European Theater of Operations had "suffered badly from shortage of personnel and somewhat less from shortage of

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[38] Memorandum, Brig. Gen. LeRoy Lutes, for Lt. Gen. Brehon B. Somervell, 8 May 1942, subject: Activities of The Surgeon General. For detailed account of the dispute, see 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, pp. 63–67.

[39] Memorandum, Lt. Gen. Brehon B. Somervell, for Maj. Gen. James C. Magee, 8 May 1942, with 1st indorsement by General Magee, 12 May 1942.



FIGURE 28.—Maj. Gen. Raymond W. Bliss, MC.

supplies." [40] The term "shortage" is relative, of course, and in this case applies to a particular time and situation. Whether or not there were ever actual widespread shortages, a strong fear of future shortages of medical personnel and supplies permeated the Surgeon General's Office in 1942 and was reflected in the oversea theaters. It appeared doubtful that the established requirements could be met.

Personnel Service.—The prospective shortage of medical personnel was the more serious, for it posed graver problems and would be the harder to overcome. The Army, as well as the rest of the military forces, was in competition with civilians for available medical personnel. The transfer to the Army of a goodly number of doctors who were considered necessary to the well-being of their communities would have a deteriorating effect on civilian morale. The time required to train additional doctors precluded any appreciable increase in the number of those available at an early date. Higher officials of the War Department, including the Chief of Staff and the Secretary of War, as well as officers at Services of Supply headquarters, exhibited growing

[40] Memorandum, Chief Surgeon, Services of Supply, European Theater of Operations, for Chief of Staff, Services of Supply, 10 Sept. 1942.



FIGURE 29.—Col. Frank H. Dixon, MC.

concern over this situation. Procurement was the major job of the Personnel Service throughout 1942.[41]

The chief difficulty in getting doctors into the Army was that in effect they were not subject to the draft and that as late as several months after Pearl Harbor they were not volunteering in the numbers hoped for by the Medical Department. In late 1941 the President had approved the establishment in the Office of Defense Health and Welfare of an agency termed the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians. Originally proposed by the American Medical Association, this agency had the support of the Surgeons General of the Army, Navy, and Public Health Service. Its purpose was to coordinate "the various demands made on the medical, dental and veterinary personnel of the Nation" and to promote "the most efficient use of medically trained personnel." [42]

After April 1942 the Procurement and Assignment Service functioned under the War Manpower Commission, headed by Paul V. McNutt. One of the Commission's tasks was the allocation of personnel between military and civilian interests. By that date it had become abundantly clear that the United States was threatened with a shortage of doctors. A clash of civilian and military interests now ensued over the allocation of medical personnel—only one

[41] For detailed discussion, see Medical Department, United States Army. Personnel in World War II, ch. VI. [In press.]

[42] Letter, Paul V. McNutt, Federal Security Administrator, to the President, 30 Oct. 1941.

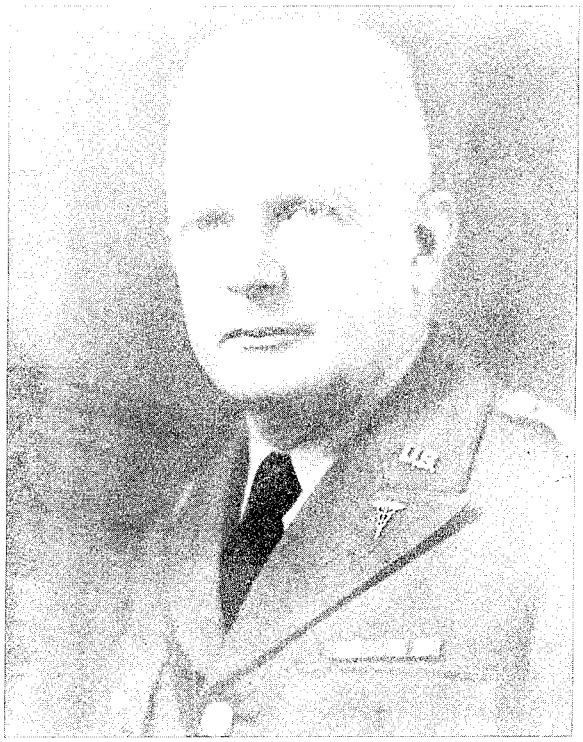


FIGURE 30.—Col. John H. Dibble, MC.

phase of the struggle over allocation of the general labor supply throughout the United States. Whereas the Procurement and Assignment Service became increasingly concerned in the latter half of 1942 over the difficulty of retaining in civilian life sufficient doctors, strategically located, to protect civilian health, the Medical Department was chiefly interested in getting into the Army the numbers which it considered essential to maintain the health of troops. The shortage of physicians led to pressure from the General Staff and from the Services of Supply upon the Medical Department to reduce, after conducting practical tests, the number of doctors in the tables of organization of certain medical installations and tactical units. They also urged wider use of Medical Administrative Corps officers or other officers in administrative jobs which did not require professional medical training.[43]

A Medical Officer Recruiting Board was set up in each State by early May after the Director of the Military Personnel Division, Services of Supply, ordered procurement decentralized to the States. These boards had authority to commission applicants in the lower ranks directly, without recourse to the

[43] (1) Memorandum, Director of Military Personnel, Services of Supply, for The Surgeon General, 12 May 1942, subject: Availability of Physicians. (2) Memorandum, Col. John M. Welch, for Chief, Control Branch, Services of Supply, 13 June 1942.

traditional method of commissioning by The Adjacent General's Office. As a result of their drive for faster commissioning, the number of doctors procured for the Medical Department skyrocketed in the summer and fall of 1942.[44]

In June 1942 the Control Division, Services of Supply, made a report on the procurement of medical officers pursuant to a suggestion from Mr. Goldthwaite Dorr, Special Assistant to the Secretary of War, after Mr. McNutt had raised certain medical personnel problems at a Cabinet meeting. The report recommended that a thorough survey of the procurement of Medical Corps officers be made by a committee to be appointed by the Commanding General, Services of Supply. General Somervell disapproved of the study recommended. He criticized the office of his Director of Military Personnel (then containing 68 officers) severely for lack of imagination and for dealing in reams of studies and platitudes. He did, however, approve a recommendation for fresh study of the whole organization of the Medical Department for the purpose of determining the number of medical officers that could be released to full-time medical duties by substituting officers of the Medical Administrative Corps, the Sanitary, and other corps. A committee which the Secretary of War appointed in September to study Medical Department administration tackled this matter along with many other problems.[45]

By fall the Medical Officer Recruiting Boards had been withdrawn from all but five States at the request of members of the Procurement and Assignment Service who believed that too many doctors were being withdrawn from civilian life. In October problems in allocating medical personnel between civilian and military interests came up before a subcommittee of the U.S. Senate Committee on Education and Labor. At the hearings of the subcommittee, Medical Department officers defended the Surgeon General's Office's statement of its requirements. Dr. Frank H. Lahey, Chairman of the Directing Board of the Procurement and Assignment Service, noted the difficulty of getting definite information on Army Medical Department requirements for personnel because of The Surgeon General's position under the Services of Supply. In his opinion The Surgeon General of the Army worked at a great disadvantage compared with the Surgeon General of the Navy; the latter had direct control over the assignments of Navy medical officers. About the same time General Magee himself pointed out his limited control over the assignment of Army doctors.

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[44] (1) Memorandum, Lt. Col. Durward Hall, MC, for Director, Military Personnel Division, Army Service Forces, 22 July 1943, subject: Procurement of Physicians and Dentists. (2) See footnote 13(6), p. 88. (3) Committee to Study Medical Departments, 1942, exhibit 15-B. (4) Memorandum, Director, Military Personnel Division, Services of Supply, for The Surgeon General, 12 Apr. 1942. (5) Memorandum, Col. George F. Lull, MC, for The Adjutant General, 16 Apr. 1942.

[45] (1) Memorandum, Chief, Control Division, Services of Supply, for Commanding General, Services of Supply, 16 June 1942. (2) Memorandum, Chief of Staff, Services of Supply, for Director, Military Personnel Division, Services of Supply, 20 June 1942, and reply of 23 June. (3) Memorandum, Director of Military Personnel, Services of Supply, for The Surgeon General, 23 June 1942. (4) Memorandum, Director of Military Personnel, Services of Supply, for The Adjutant General, 10 July 1942, subject: Relief of Medical Corps Officers From Duties Which Do Not Require Professional Medical Training.

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Protesting to the Chief of Staff against a reduction in the numbers of medical officers on the grounds that it would tend to lower the standards of medical service, he stated: "I wish to point out that I have a very limited supervision and control of the medical service of the Air Forces." In his opinion, many duplications existed in the medical services controlled by his office and those under control of the Air Surgeon. A similar, though lesser, duplication existed with respect to medical services directed by the Ground Surgeon. The Surgeon General believed that more direct control of allotments and assignments of medical officers by his own office would eliminate duplications and free medical personnel for use in other positions.[46]

Supply Service.—Whereas the shortage of medically trained personnel in 1942 attracted the attention of highly-placed officials of the legislative and executive branches of the Government, the potential shortage of medical supplies was dealt with largely within the War Department. Both in the Surgeon General's Office and in Services of Supply headquarters grave doubts arose as to whether the Medical Department would be able to meet increasing demands for medical supplies for the Army and for our allies. Lend-lease requisitions included medical items for the use of civilians as well as of military forces, in the beneficiary country. The feeling of being swamped by lend-lease demands for medical supplies and equipment was well expressed by one medical officer: "It seemed for a time that we are running sort of an international WPA."[47]

It is not clear to what extent the extreme concern over the status of medical supplies was justified; rather few general shortages seem to have existed. Spot shortages apparently developed as a result of hoarding by various commands and installations, maldistribution of stocks, or inadequate transportation. Some of the uncertainty undoubtedly derived from inadequate stock records.

In the course of efforts by Services of Supply headquarters and the Surgeon General's Office to speed the procurement of medical supplies and equipment, sharp differences in the outlook of the two agencies showed up. The Services of Supply concentrated from the outset on achieving efficient procurement of the items used by the various supply services. It aimed at eliminating the competition among them for scarce raw materials, skilled labor, and manufacturing facilities. Headed by men of Engineer, Quartermaster, and G–4 experience and staffed by many men from industry, it established statistical methods for planning goals for procurement, for forecasting procurement, and

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[46] (1) Hearings Before a Subcommittee of the Committee on Education and Labor, United States Senate, 77th Cong., 2d Sess., on Senate Resolution 291, Investigation of Manpower Resources, Part I, October 15–November 20, 1942, and Part II, December 14–16, 1942. Washington: U.S. Government Printing Office, 1942, 1943. (2) Memorandum, The Surgeon General, for the Chief of Staff, 23 Oct. 1942.

[47] (1) Lecture, Lt. Col. Carl R. Darnall, before Fiscal Officers Training Class, 6 Oct.–14 Nov. 1942. (2) Medical History, 1 Troop Carrier Command, 30 Apr. 1942 to 31 Dec. 1944. [Official record.] (3) Medical Department, United States Army. Medical Supply in World War II. [In preparation.] (4) Medical Department, United States Army. Dental Service in World War II. Washington: U.S. Government Printing Office, 1955. pp. 165ff.

for periodical reporting of quantities bought. Tending to stress the similarities of supply problems among the services, it attempted to standardize procedures for the procurement of Army supplies and to eliminate managerial weaknesses in methods of procurement used by the services. Administrators of the Services of Supply conceived all supply activities of the Army as a single immense operation, in which the major steps were determination of requirements, procurement, storage, distribution, etc. This way of thinking, if carried to an ultimate consistency, would have largely eliminated the Medical Department as the procurement agency for items used by it—an arrangement that had already been tried without success after World War I.[48]

The Surgeon General's Office, on the other hand, emphasized the technical problems encountered in selecting and buying medical supplies and equipment, and maintained that the job of procurement could be satisfactorily handled only by medically trained men, for only the medically trained could properly assess the quality, as well as use, of these technical tools. For these reasons it consistently attempted to exercise considerable autonomy in handling the medical supply program and to oppose the hiring of civilians with experience in industrial management—a measure consistently advocated by the Services of Supply.

In other respects, the divergence in point of view of the Surgeon General's Office and that of the Services of Supply was primarily one of emphasis. The Surgeon General's Office did not actually deny the importance of formulating statistical goals and making statistical forecasts, but laid considerably less emphasis than did the Services of Supply upon their value. From time to time, it opposed changes in the medical supply system which Services of Supply headquarters advocated in the name of economy or efficiency on the ground that the Medical Department's experience indicated that the proposed changes were actually less efficient or would tend to lower the quality of the medical supplies and equipment used by Army doctors.[49]

The Supply Service of the Surgeon General's Office received direction from two large organizational elements of Headquarters, Services of Supply. These were the Offices of the Assistant Chief of Staff for Materiel (Brig. Gen. Lucius D. Clay) and the Assistant Chief of Staff for Operations (General Lutes). The Supply Service dealt with the former largely with respect to problems of requirements for medical supply, including those for lend-lease purposes, and problems of procurement. From the outset the Office of the Assistant Chief of Staff for Operations exercised supervision over the storage and warehousing activities of all the supply services, but its added respon-

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[48] (1) Annual Report of The Surgeon General, U.S. Army, 1919. Washington: U.S. Government Printing Office, 1919, p. 1190. (2) Annual Report of The Surgeon General, U.S. Army, 1920. Washington: U.S. Government Printing Office, 1920, pp. 357–358. (3) Annual Report of The Surgeon General, U.S. Army, 1921. Washington: U.S. Government Printing Office, 1921, pp. 161–162.

[49] (1) Memorandum, Commanding General, Services of Supply, for The Surgeon General (and others), 27 Apr. 1942, subject: Management Service. (2) Millett, J. D.: The Direction of Supply Activities in Our War Department. Ann. Pol. Sci. Rev. 38: 249, 475, April, June 1944.

sibility for logistical planning for troops moving overseas soon enlarged the supply functions of General Lutes' office considerably beyond the province of storage and distribution. Hence in the summer of 1942 the Hospitalization and Evacuation Branch (headed by Colonel Wilson) in the Planning Division of General Lutes' office became concerned with the status of Medical Department supply and estimates of future production in relation to meeting the needs of troops going overseas. Throughout 1942, the Offices of the Assistant Chiefs of Staff for Materiel and for Operations brought pressure on the Supply Service of the Surgeon General's Office to adopt certain measures which they believed would lead to more rapid procurement and more efficient handling of medical supply.[50]

A barrage of criticisms of the Supply Service of the Surgeon General's Office and proposals for reform emanated from Services of Supply headquarters. The major difficulties, noted chiefly by officials of the Office of the Assistant Chief of Staff for Materiel, may be summarized as follows: Lack of personnel trained in large problems of management, such as purchasing procedures, inventory control, and warehouse methods; too high a degree of centralization of work in Washington; and unsatisfactory records on current and future production, on stocks, and on shortages in the Washington office, the procurement office, and the depots. The critics recognized as contributory causes certain factors largely outside the control of the Medical Department: Shortages of critical raw materials, lack of office space, insufficient allotment of personnel, and small allocations to the Department for supply purchasing prior to the fiscal year 1940. Small appropriations, an old military ghost, had served to nullify in part the well-planned program for training of medical officers in the handling of medical supply in the 1930's. Only two officers had been given this training per year, and they had not received the experience with large-scale purchasing which officers engaged in procurement now sorely needed.[51]

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[50] (1) General Order No. 4, Services of Supply, 9 Apr. 1942. (2) General Order No. 22, Services of Supply, 11 July 1942. (3) General Order No. 24, Services of Supply, 20 July 1942. (4) See footnote 4(4), p. 75. (5) Memorandum, Assistant Chief of Staff for Operations, Services of Supply, for Chiefs of Services, 22 Aug. 1942, subject: Supply Planning Personnel.

[51] (1) Wilson, Clara B.: History of Medical Supplies in World War II, Distribution and Accomplishments, Zone of Interior Depots (1949). [Official record.] (2) Memorandum, Priority Representative, Office of The Surgeon General, for Priorities Division, Army-Navy Munitions Board, 1 May 1942. (3) Memorandum, Priority Representative, Office of The Surgeon General, for Technical Advisor, Office of the Under Secretary of War, 10 June 1942. (4) Memorandum, C. Tyler Wood, Office of Director of Procurement, Services of Supply; Lt. Col. Fred C. Foy, Purchases Division, Services of Supply; and Maj. Philip W. Smith, Ordnance Department Purchases Division, Services of Supply, for Director of Procurement, Services of Supply, 27 July 1942, subject: Summary of Findings at New York and St. Louis Medical Procurement Offices, 24 and 25 July 1942. (5) Memorandum, Lt. Col. Fred C. Foy and C. Tyler Wood, for Director of Procurement, Services of Supply, 11 Aug. 1942, subject: Summary of Report on Decentralization of Operations of Supply Division, inclosure to memorandum, Director of Procurement, for The Surgeon General, 12 Aug. 1942. (6) Memorandum, Lt. Col. William L. Wilson, for Assistant Chief of Staff for Operations, 23 Aug. 1942, subject: Status of Procurement of Medical Supplies. (7) Memorandum, Director, Purchases Division, for Assistant Chief of Staff for Operations, 26 Aug. 1942, subject: Procurement of Medical Equipment and Supplies.

Two important measures which the Services of Supply undertook in the effort to improve the efficiency of the medical supply system were the separation from the supply organization of all functions which were only indirectly related to supply and the decentralization of all supply functions that could conveniently be moved out of Washington to various field offices. Both efforts began about mid-1942, but the major moves out of Washington did not take place until after the fall of 1943.

A survey of the Finance and Supply Service of the Surgeon General's Office and the medical supply depots, including the procurement offices of the New York and St. Louis depots, by the Control Division, Services of Supply, in June 1942 showed a number of weaknesses in the medical supply system. Medical Corps officers were being used for work in depots where technical skill was unessential. Depot procedures varied, and the territories within which the New York and St. Louis procurement offices bought medical supplies and equipment overlapped. A report made by the Control Division, Services of Supply, recommended the following measures: Substitution of nonmedical officers and civilians, especially women, for Medical Corps officers in depot operations (except distributing depots, where technical knowledge was needed); standardization of depot procedures and of depot reports for comparative purposes; and procurement of nonmedical items by services other than the Medical Department. It also proposed to transfer to St. Louis, where it was easier to obtain civilian personnel, various components of the Supply Service in Washington, especially those handling purchase, storage, and issue functions, as well as the procurement functions of the New York Medical Depot. Finally, the report recommended the divorce of fiscal functions of the Surgeon General's Office from supply functions.

This last recommendation was promptly carried out, and a new Supply Service headed by Col. Francis C. Tyng, MC (fig. 31), was established. Promulgation of most of the others was begun, but the recommended move of the Purchasing and Contracting Office of the New York Medical Depot to St. Louis aroused a good deal of opposition in the Surgeon General's Office, as well as in the New York office. A resurvey of the situation by representatives of the Office of the Assistant Chief of Staff for Materiel of the Services of Supply pointed out the heavy concentration of medical supply manufacturers in the New York area and the importance of close contact between procurement officers and manufacturers. The move was accordingly canceled, but not until the morale of New York office employees had been damaged and the flow of procurement hampered by the unstable situation. Pursuant to the recommendations of the resurvey, the Surgeon General's Office established in August the New York and St. Louis Medical Procurement Offices separate from their respective depots. The New York and St. Louis offices purchased nearly all the medical supplies bought by the Army in continental United States during the war. The heaviest year of procurement by far was 1943, during which the



FIGURE 31.—Col. Francis C. Tyng, MC.

estimated dollar value of Medical Department items delivered was $305,064,000, more than twice the amount delivered in any other year.[52]

The separation of procurement functions from the depots in New York and St. Louis had a parallel development in the separation of similar functions in the Supply Service, Surgeon General's Office. A Purchases Division and a Distribution Division were established in the new Supply Service. The Purchases Division supervised the preparation of contracts for medical supplies and equipment, handled matters relating to prices and their adjustment, prepared statements of policy for procurement officers in the field, and maintained statistics on current production and procurement as a check on the status of

[52] (1) Memorandum, Lt. Col. Kilbourne Johnson, W. C. Nunnecke, Col. M. E. Griffith, and Col. Silas B. Hays, for Commanding General, Services of Supply, and The Surgeon General, 20 June 1942, subject: Survey of Supply Functions of The Surgeon General's Office. (2) Memorandum, Julius H. Amberg, Special Assistant to the Secretary of War, for Col. C. F. Robinson, 29 July 1942, subject: Senate Investigation. (3) Committee to Study the Medical Department, 1942, testimony, p. 103ff. (4) Yates, Richard E.: Procurement and Distribution of Medical Supplies in the Zone of Interior During World War II, p. 60ff. [Official record.] (5) See footnote 51(4), p. 118. (6) Memorandum, The Surgeon General, for the Commanding General, Services of Supply, 14 Aug. 1942, subject: Medical Department Procurement Districts. (7) See footnote 51(5), p. 118. (8) Memorandum, Director, Purchases Division, Services of Supply, for Committee to Study the Medical Department, 5 Nov. 1942, subject: Surgeon General's Supply Service. (9) Crawford, Richard H., and Cook, Lindsley F.: Statistics; Procurement, 9 Apr. 1942. [Official record, subject to revision.]

individual items. The Distribution Division was responsible for maintaining adequate storage space and stocks in depots and good standards of warehousing, and for issuing field equipment and supplies to troops at home and abroad.

Most other major changes in the Supply Service of the Surgeon General's Office accompanied, or followed close upon, the reorganization of the Services of Supply in July and the divorce of fiscal and supply functions of the Surgeon General's Office (chart 7, p. 94). The Requirements Division and the International Division were newly added. The computation of requirements of raw materials and finished items had formerly been a function of the Finance Branch of the old Finance and Supply Division, while the International Division grew out of the old Defense Aid Branch. The functions of the old Production Control Division which were related to current production were assigned to the Purchases Division, and the new Production Planning Division came into existence.[53]

SERVICE COMMAND MEDICAL ORGANIZATION

In addition to the organizational changes which the Services of Supply advocated for the Washington offices of the supply services, it undertook in July 1942 and subsequent months a thoroughgoing decentralization of many functions to the corps areas, now renamed service commands. The intent was to make each service command a field agency for administering the supply services and fixed installations within its boundaries and to achieve uniformity in the organization of the nine service command headquarters. Up to this time the chiefs of the various services in Washington, including The Surgeon General, had controlled within the service commands a number of activities, including fiscal operations and the recruitment of civilian personnel, and certain installations pertaining to their particular services. The Services of Supply wished to eliminate duplication of effort in these fields.

In the effort to reduce the number of staff officers reporting to the commanding general of the service command (as it had attempted to decrease the number of officers reporting directly to the chiefs of services in Washington), Services of Supply Headquarters directed that service command headquarters be reorganized along functional lines—that is, into divisions handling training, personnel, supply, and so forth—so as to include the functions of all the supply services in each of these fields. In the new setup the office of the service command surgeon was placed, along with the offices of the chiefs of other services, under the supply division of the service command. His office was usually termed the "medical branch," and he was given the title of "chief of the medical branch." Thus the service command surgeon was now responsible to a director of supply and through him to the commanding general of the service command. In a word, he had lost his staff position. Moreover, he

[53] Yates, Richard E.: The Procurement and Distribution of Medical Supplies in the Zone of Interior During World War II, pp. 56–58. [Official record.]

had no direct official channel of communication to The Surgeon General. The latter had to issue instructions on matters of policy in the name of the commanding general, Services of Supply, to the commanding general of the service command for the attention of the surgeon.

Besides this change in the position of the service command surgeon, a major change in medical organization took place with the removal to service command control of certain medical installations and units. Of the 15 general hospitals in operation in August 1942, all except Walter Reed were transferred from the direct control of The Surgeon General to that of the commanding generals of the service commands. The Surgeon General succeeded in retaining the important function of allocating the beds at general hospitals reserved for patients transferred from station hospitals; he also continued to control allotments of medical officers to the staffs of general hospitals until April 1943, when this power, too, was transferred to the service commands. In addition to the general hospitals, the following installations and units were placed under control of the service commands: Medical and dental laboratories, except for those at the Army Medical Center in Washington; the general dispensaries (established in the larger cities to care for troops absent from station), except the General Dispensary, Washington, D.C.; and the Medical Officer Recruiting Boards operating in the various States. Medical Department schools and replacement training centers also passed to the control of the service command, but as in the case of the general hospitals The Surgeon General succeeded in keeping control of certain activities in these centers. Such matters as the issuance of training doctrine, the scheduling of programs, supervision of training, and the selection and assignment of faculty personnel remained under control of The Surgeon General acting through Headquarters, Services of Supply. The service commands were also given control of prisoner-of-war camps, formerly assigned to the Provost Marshal General. This change was of greater significance to the Medical Department for the future than the present, as hospitals for these installations were only just getting under way.[54]

Other than the Army Medical Center (including Walter Reed General Hospital and the professional schools and laboratories), the General Dispensary, the Army Medical Library, and the Army Medical Museum—all in Washington, D.C.—the installations still under command of The Surgeon General were the New York and St. Louis Medical Department Procurement Districts (separated about this date from the respective depots) and the eight medical

[54] (1) See footnote 4(4), p. 75. (2) Staff Conference, Reorganization of Service Commands, Headquarters, Services of Supply, 4 Aug. 1942. [Official record.] (3) Millett, John D.: Organization and Role of the Army Service Forces. United States Army in World War II. Washington: U.S. Government Printing Office, 1954, ch. XXI. (4) Lecture, Lt. R. H. Fuchs, Services of Supply, before Fiscal Officers Training Class, 6 Oct.–Nov. 1942. (5) Memorandum, Executive Officer, Office of The Surgeon General, for Director, Control Division, Services of Supply, 1 Aug. 1942. (6) Report, Conference of Commanding Generals, Services of Supply, 30 July–1 Aug. 1942. (7) Memorandum, Chief of Staff, Services of Supply, for all Chiefs of Supply Services, 22 July 1942, subject: Relationships Between Service Commands and Headquarters, Services of Supply and the Administrative and Supply Services of the Services of Supply. (8) Army Regulations No. 170–10, 10 Aug. 1942, and change 2, 14 Aug. 1943.

depots then in operation at Binghamton (N.Y.), Savannah, Toledo, St. Louis, Kansas City, Denver, Los Angeles, and San Francisco (chart 7). Thus installations handling medical supplies were the major type remaining under his direct control. In addition to the medical depots the Medical Department then maintained medical sections within eight Quartermaster depots at the following locations: Schenectady, New Cumberland (Pa.), Atlanta, Columbus (Ohio), Chicago, San Antonio, Ogden (Utah), and Seattle. These depots were under control of the Quartermaster General.[55]

Jurisdiction over station hospitals under this reorganization remained unchanged for the most part. Medical officers commanding hospitals at posts housing ground force troops were under a post commander responsible to the commanding general of the service command. Hospitals at airfields were under the control of the Army Air Forces.

The difficulty immediately foreseen by General Magee in the new service command organization was that under the new setup the service commander might make undesirable transfers of medical personnel—as, for example, the transfer of specialized personnel from a hospital staff to his own office. In the opinion of General Somervell and some Services of Supply officers, the presence of the right kind of service command surgeon would obviate this difficulty. General Somervell also stated that The Surgeon General could communicate with the service commander by telephone in such cases in order to make his position known. Services of Supply personnel frequently stressed the possibility of bypassing, by telephone communication, the circuitous lines of communication established by the reorganization of July. Over the long run the Medical Department found this pattern of internal organization of service command headquarters (which prevailed until the end of 1943) unsatisfactory, as did the other technical services.

In addition to these direct and specific changes in organizational structure, Services of Supply headquarters instituted a continuing pressure, on the Medical Department as on the other services, for decentralization of various functions to service command control. It asked the commanding generals of service commands to submit lists of activities, including medical ones, which they thought should be decentralized to service command jurisdiction. It requested The Surgeon General to review certain powers of decision reserved to him by existing Army regulations and to point out those which might feasibly be transferred to the service commands. All were of relatively minor importance. The Surgeon General readily agreed to transfer control of some of these powers, such as authorizing certain types of hospital admissions and procuring various items locally, to the commanding generals of service commands; others

[55] (1) Memorandum, Col. Joseph F. Battley, Control Division, Services of Supply, for Control Division, Office of The Surgeon General, 24 Aug. 1942, subject: Field Installations. (2) See footnote 13(3), p. 88. (3) Millett, John D.: Organization and Role of the Army Service Forces. United States Army in World War II. Washington: U.S. Government Printing Office, 1954, pp. 300–302. (4) Memorandum, Chief, Machine Records Branch, Adjutant General's Office, for The Surgeon General, 11 Sept. 1942, subject: Strength Returns.

he desired to retain. Jurisdiction over specific detailed functions, as between service command and the Surgeon General's Office, continued under discussion by the Headquarters, Services of Supply, and the Surgeon General's Office in 1942 and early 1943.[56]

[56] (1) Memorandum, Chief of Staff, Services of Supply, for The Surgeon General, 27 Aug. 1942, subject: Decentralization of Actions to Service Commands. (2) Memorandum, Chief of Staff, Services of Supply, for The Surgeon General, 5 Feb. 1943, subject: Decentralization of Function. (3) See footnote 18(3), p. 92.

CHAPTER IV

Troop Medical Care Under Other Commands

Although The Surgeon General, under the Services of Supply, was responsible for all Army medical care, there were three areas in which a medical service developed more or less independently of the Surgeon General's Office. From March 1942 to the end of the war, a surgeon and a staff medical section existed at the headquarters of the Army Ground Forces and of the Army Air Forces. Within the Army Service Forces the Office of the Chief of Transportation was the only functional element, other than the Surgeon General's Office itself, which administered any extensive system of medical care for troops in the United States.[1] In the early years of the war it had no medical officers assigned to it, but it controlled medical care afforded by hospitals at ports of embarkation, and on rail and water carriers.

MEDICAL RESPONSIBILITIES OUTSIDE THE SURGEON GENERAL'S OFFICE

The Army Ground Forces was created in March 1942, assuming the training functions of General Headquarters but without responsibility for oversea theaters or bases. Medical Department officers assigned to General Headquarters were reassigned to the new headquarters at the Army War College, where they formed a special staff medical section, originally headed by Col. (later Brig. Gen.) Frederick A. Blesse, MC. To the end of the war this medical office had top responsibility for the training, tactical as well as medical, of Medical Department units assigned to the Army Ground Forces.

The following commands were placed under Army Ground Forces at the outset: the field armies; the Antiaircraft Command, with headquarters originally at Richmond, Va., and later at Fort Bliss, Tex.; the Armored Command, with headquarters at Fort Knox, Ky.; the Replacement and School Command; and the Tank Destroyer Command. These and other subcommands, or training centers, of the Army Ground Forces created in the course of 1942 developed, trained, and equipped specialized fighting units or trained regular units for fighting in certain climatic conditions. Among the chief subcommands added to the Army Ground Forces in the course of the war were: The Airborne Command created in March 1942 with headquarters at Fort Bragg, N.C.; the Desert Training Center, which trained troops for desert fighting in a simulated theater of operations in southern California and Arizona; the Mountain Training Center in Colorado, which trained men to operate over steep terrain at high

[1] The Office of the Chief of Engineers operated its own station hospitals in the earlier part of the war, but at bases outside continental United States.

altitudes; and the Amphibious Training Center, originally located at Camp Edwards, Mass., and later at Carrabelle, Fla. These subcommands developed and trained specialized types of tactical units—airborne, armored, and mountain divisions and their subordinate elements, and the antiaircraft battalions; the Amphibious Training Center trained several divisions in amphibious operations.

Hence the work of the Ground Medical Section at the Army War College in Washington, D.C., and of the small medical sections at the headquarters of its subordinate commands was chiefly that of developing the Medical Department detachments and mobile units which should render service overseas to the tactical elements mentioned above. These staff medical sections had the functions commonly entrusted to the headquarters medical section of any command in the United States: assigning Medical Department officers and enlisted men to subordinate elements, maintaining channels for distributing medical supplies and equipment throughout their respective commands, and taking the usual measures that fall into the category of preventive medicine. Their direct medical care of ground troops, however, was generally limited to that furnished by dispensaries at ground force installations. For most ground troops, hospitalization was supplied by station or general hospitals under control of the Services of Supply. Only for troops being trained in a simulated theater of operations did the Army Ground Forces operate fixed hospitals of a communications zone type.

After the reorganization of March 1942, responsibilities for training Medical Department units for use in an oversea theater of operations were divided among the Services of Supply, the Army Ground Forces, and the Army Air Forces. Previously, Medical Department units designed for use in oversea theaters of operations had been assigned to the field armies, and then to General Headquarters (predecessor of Army Ground Forces) for training. After the reorganization, those service units (Ordnance, Engineers, and so forth, as well as Medical Department) designed to support troops within the combat zone of a theater of operations were assigned to the Army Ground Forces for activation and training, while those intended to give support within the advance, intermediate, and base sections of the communications zone became the responsibility of the Services of Supply. The third major command of the War Department, the Army Air Forces, was made responsible for certain service units which supported it. In October 1942 the War Department broadened the responsibilities of the Army Ground Forces for the buildup of tactical units by authorizing that command to prepare the tables of organization, tables of equipment, and tables of basic allowances for (as well as to activate and train) the units that served ground elements.[2]

[2] (1) Memorandum, Commanding General, Army Ground Forces, for Commanding General, Services of Supply, 2 June 1942, subject: General and Station Hospitals. (2) Memorandum for Record, Deputy Chief of Staff, Army Ground Forces, 16 Oct. 1942, subject: Journal of Actions Taken. (3) Memorandum, Brig. Gen. Larry B. McAfee, Assistant to The Surgeon General, for Commanding General, Services of Supply, 28 Oct. 1942, subject: Recommendations in Regard to Activation, Control, and Training of Medical Units. (4) Interview, Col. William E. Shambora, MC, formerly Surgeon, Army Ground Forces, 22 Apr. 1949.

By January 1943, responsibility for developing tables of organization, equipment, and basic allowances for the following medical units and for training them had devolved upon the Army Ground Forces: 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. Medical Department units for whose training the Services of Supply was then responsible consisted of general, station, and convalescent hospitals (including veterinary types); 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 the museum and medical arts service; and medical sections for the headquarters of a communications zone.[3]

This division of responsibilities that prevailed early in 1943 was by no means final. Many of these units were altered in name, size, or organization; some types were abolished or superseded by others; some new types were developed to meet special oversea needs. A few units, such as the field hospital, were to be used in both the combat and the communications zone, and a few others, such as those used for evacuation of patients by sea from the theater of operations to the United States, did not serve in either zone. Hence many readjustments took place in the list above. Nevertheless, the allocation of responsibilities between the two commands for developing, activating, and training Medical Department units continued to rest, until the end of the war, upon the basis of the zone of the oversea theater within which they were to be employed. The Army Air Forces trained less than half a dozen types of medical units designed to fit the special needs of air troops—chiefly a medical supply, an evacuation, and a dispensary unit.

MEDICAL WORK OF THE ARMY GROUND FORCES

The position of the Ground Medical Section, the office which guided medical activities within the Army Ground Forces and its subordinate commands, within its own headquarters was similar to that which the Surgeon General's Office had had in the War Department before the March reorganization, for Army Ground Forces headquarters had a general staff similar to that of the War Department. The Ground Medical Section had to obtain

[3] Tabulation, Responsibility for Tables of Organization of Service Units, 8 Jan. 1943, and amendments, 27 Jan. 1943, Headquarters, Army Ground Forces.

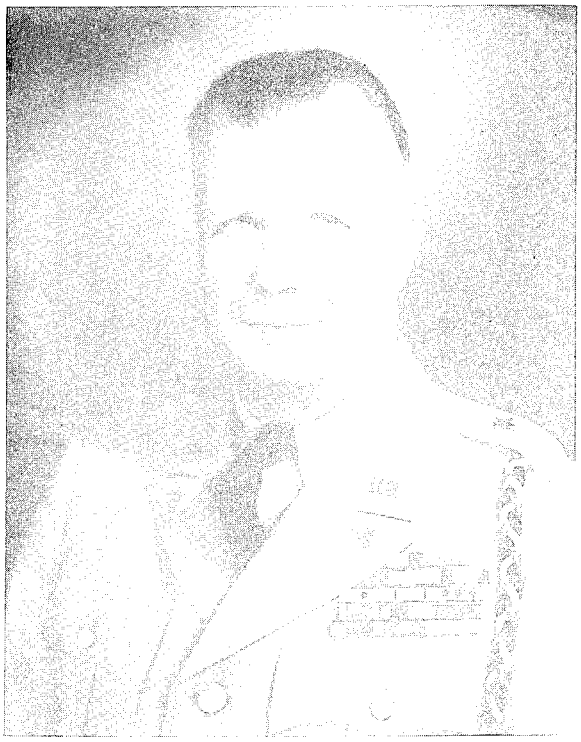


FIGURE 32.—Brig. Gen. William E. Shambora, MC.

concurrence from the elements of this general staff, especially from G–3, which had responsibility for operations and training, and G–4, charged with matters of supply, evacuation, transportation, and construction. Colonel Blesse continued as head of the medical section until December 1942, when he was promoted to brigadier general and sent to North Africa. From the close of 1942 to May 1944, Col. William E. Shambora, MC (fig. 32), served as Ground Surgeon, and from mid-1944 to the close of the war, General Blesse once more. This medical section remained small throughout the war, containing only about a half dozen officers, assigned chiefly to plans and operations, supply, personnel, and preventive medicine. Army Ground Forces headquarters imposed strict limits on the size of its staff sections, and it was therefore necessary for the Ground Surgeon to get along with a minimum number of officers. Technical information was supplied in the circular letters coming out of the Surgeon General's Office, and specialist personnel were available in the Services of Supply hospitals which served ground troops.[4]

[4] (1) General Order No. 22, Army Ground Forces, 13 July 1942. (2) Ground Medical Section, Chronological file, 1944. (3) Greenfield, Kent Roberts, Palmer, Robert R., and Wiley, Bell I.: Organization of Ground Combat Troops. United States Army in World War II. Washington: U.S. Government Printing Office, 1947, p. 359.

The Ground Surgeon's Office

However, over the long run the Ground Surgeon, as well as the Surgeon General's Office, noted that a representative of each of the major fields of medical work handled in the Surgeon General's Office was needed in the Ground Medical Section. Many matters—for example, the question of whether a neuropsychiatrist should be added to the staff of the division—called for coordination and conferences between the Surgeon General's Office and the Ground Medical Section. In such cases, General Blesse's office needed an officer with training in the special field concerned to discuss the matter with the Surgeon General's Office. By March 1945, General Blesse (who had returned to Army Ground Forces in May 1944 after a tour of duty as Chief Surgeon of the North African Theater) was pressing for the assignment of additional Medical Department officers to his medical section—particularly to fill the posts of chief of professional services, dental officer, and veterinary officer. Pointing out that the commanding general of each of the three major commands was responsible for the medical service of his component, he noted that the Surgeon General's Office then had 336 officers, the office of the Air Surgeon 63, while the Ground Medical Section contained only 6. However, the office underwent no appreciable increase to the end of the war.[5]

The Ground Force surgeon's staff traveled throughout the United States inspecting hundreds of medical units activated by Army Ground Forces, as well as health conditions among tactical ground units being readied for oversea duty at maneuver areas and camps of the Army Ground Forces and at the ports of embarkation controlled by the Services of Supply. A good many of their problems, as well as those of the staff surgeons of subordinate commands, had to do with establishing measures for protecting the health of, and keeping up standards of physical fitness for, men undergoing rigorous training on maneuvers. The fitness of men being trained for mountain duty, for example, aroused concern among commanding officers at the Mountain Training Center in Colorado, and in 1943 a board of medical officers determined that it would be desirable to establish special physical standards for mountain troops. The Mountain Training Center approved the board's recommendations for special standards, but Army Ground Forces and the Surgeon General's Office were alike averse to the establishment of special qualifications for particular types of duties, maintaining that the two broad categories of general and limited service were adequate. The discussion of physical standards for mountain troops continued until mid-1943, when the commanding general of the Mountain Training Center was given permission to administer

[5] (1) Annual Report, Personnel Service, Office of The Surgeon General, 1942. (2) Memorandum, Brig. Gen. Frederick S. Blesse for Brig. Gen. William L. Mitchell, 16 Mar. 1945. (3) Letter, Brig. Gen. Frederick A Blesse to Chief, Historical Division, Office of The Surgeon General, 6 Sept. 1951. (4) Army Ground Forces Memorandum No. 14, 19 May 1945, subject: Allotment of Officers. (5) Medical Department, United States Army. Dental Service in World War II. Washington: U.S. Government Printing Office, 1955, p. 33.

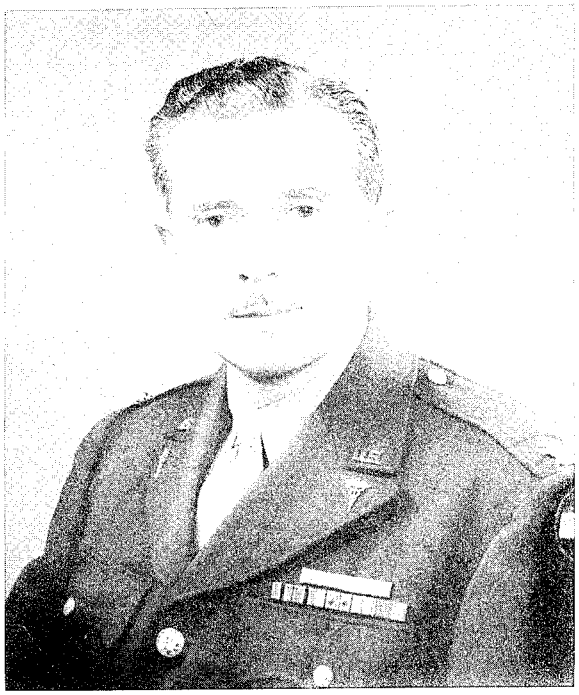


FIGURE 33.—Col. Robert B. Skinner, MC.

special tests to units of the center and to have those physically unfit for mountain duty reassigned by Army Ground Forces headquarters.[6]

Through the assignment of some members of the Ground Medical Section to oversea service during periods of combat, the Ground Surgeon and his staff were able to keep in touch with the workings of the field medical service. The experience gained in the early months of 1944 by the Deputy Ground Surgeon, Col. Robert B. Skinner, MC (fig. 33), as surgeon of several task forces in the Southwest Pacific Area and as a member of the Army Ground Forces Board in New Guinea, for example, furnished a basis for the changes which he succeeded in bringing about in the tables of organization and equipment of portable surgical and evacuation hospitals, as well as ideas for incorporation in a training bulletin for the treatment of malaria through suppressive drugs. General Blesse had extensive experience as theater surgeon in the Mediterranean theater of operations before returning to the post of Ground Surgeon in 1944. Oversea experience of these men and of others who returned to serve with the Ground Medical Section enabled them to determine what changes were needed in the tables of organization to be issued by the War Department for Army-wide use. Theater surgeons frequently proposed that sporadic changes and provisional units which they found effective under

[6] Study No. 24, Historical Section, Army Ground Forces, 1948, History of the Mountain Training Center. [Official record.]

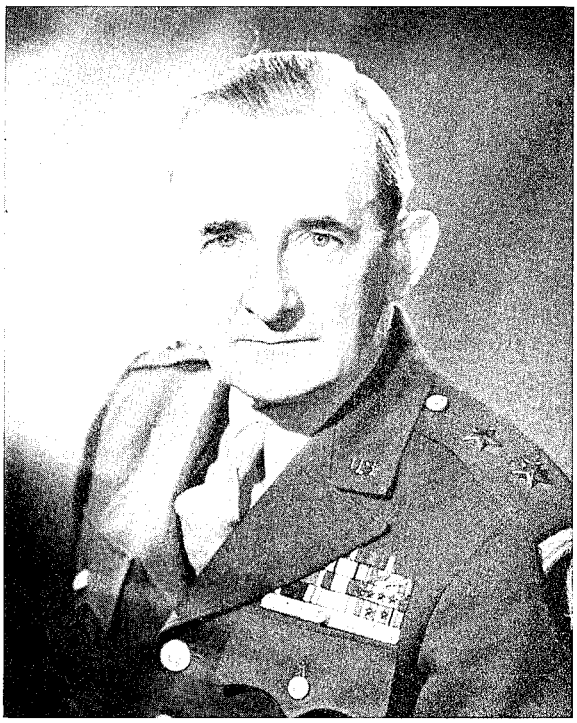


FIGURE 34.—Maj. Gen. Albert W. Kenner, MC.

combat or environmental conditions in their theaters be incorporated in tables of organization. It was the Ground Medical Section's task to sift the experience with Medical Department units operating in various areas and under a variety of conditions in order to determine what proposed changes were worthy of incorporation in tables of organization.[7]

The Armored Force

Of the subcommands concerned with the training of troops for specialized types of combat, the Armored Force, under the command of Maj. Gen. (later Gen.) Jacob L. Devers, was the most nearly independent. From its inception in May 1941 through 1942, the year of its greatest expansion, it trained at Fort Knox many armored units for assignment to corps or armies. Its original headquarters medical section, created in May 1941, consisted of only two officers, both of whom had previously been in charge of medical work in the I Armored Corps. During 1942 the office of the Armored Force surgeon, Col. Albert W. Kenner, MC (fig. 34) (made brigadier general in December, after he had served as Western Task Force surgeon in the North African invasion), had as its chief task the development of tables of organization and equipment

[7] See footnote 4(2), p. 128.

for the medical detachments organic to the armored division and the specialized armored medical battalions equipped with surgical trucks and ambulances—units soon to be tested in the North African campaign. It also prepared instructions for training these units. The office increased during 1942 to 6 officers, 1 warrant officer, and 17 enlisted men, the numbers allotted the medical section by the table of organization for Armored Force headquarters.

During 1942, Colonel Kenner undertook the development of a special laboratory, which the headquarters medical section had proposed in the summer of 1941. War Department sanction for this Armored Medical Research Laboratory was obtained in February 1942; it opened when the building to house it was completed in September. Its staff worked in close cooperation with the Surgeon General's Office and with the Office of Scientific Research and Development in Washington. Their task was to do research and experimentation on special industrial and combat hazards to armored force troops. They produced studies on acclimatization of the human body to heat, problems of night vision, the effects of toxic gases, and so forth. The work of the laboratory broadened into an examination of the mental and physical capacities of Armored Force combat troops, together with the planning of their assignments, and the adjustment of the design of tanks and their equipment to accord with these capacities. The Medical Corps officer who commanded the laboratory under the direction of the Armored Force surgeon was an ex officio member of the Armored Force Board which conducted tests to determine the combat efficiency of Armored Force vehicles and equipment.[8]

THE ARMY AIR FORCES AND SUBORDINATE COMMANDS

The medical organization of the Army Air Forces expanded rapidly in 1942, the four continental air forces continuing a rapid buildup in the United States. Large air commands, such as the Flying Training Command and the Air Service Command, each with its own geographic districts or areas for administrative purposes, were set up in 1941 and early 1942. These had direct control of hospitals at their installations. The Office of the Air Surgeon and the medical offices of the continental air commands grew with the general expansion.

Office of the Air Surgeon

The increased powers over its medical service granted to the Army Air Forces by War Department Circular No. 59 of March 1942 and the interpretive memorandum of May have been pointed out. After March the Air Surgeon, Col. David N. W. Grant, MC, made brigadier general in June, reported directly to the Chief of Staff, Army Air Forces. By June his office contained, in addi-

[8] (1) Study No. 27, Historical Section, Army Ground Forces, The Armored Force Command and Center, 1946. [Official record.] (2) Historical Report, Armored Medical Research Laboratory, 10 Jan. 1946. [Official record.]

tion to an Administrative Section, the following six divisions: Personnel, Plans and Training, Professional Service, Psychological, Research, and Statistical. The first named, the Personnel Division, expanded primarily as the result of the enlarged command control by the Army Air Forces over all personnel assigned to it and the permission which the Air Surgeon obtained in June 1942 to recruit Medical Corps officers directly for the air forces.

Plans and Training Division.—The Plans and Training Division determined requirements for medical personnel, supplies, and facilities and developed training policies for the Army Air Forces. In 1942 its work in the following fields grew rapidly: The development and revision of tables of organization and basic allowances and of equipment lists for the few special medical units of the Army Air Forces; the calculation of hospital beds, types and amounts of hospital construction, and medical supplies needed at posts of the Army Air Forces in the United States; decision as to numbers and specialties of trained Medical Department men needed by the command; the designing of training courses in medical matters peculiar to the Air Forces.

Professional Service Division.—The Professional Service Division in early 1942 had six sections, as follows: Professional Care, Aviation Medicine, Aviation Cadet, Dental, Venereal Disease Control, and Preventive Medicine. The last three of these duplicated certain units within the Office of the Surgeon General, but apparently the Air Surgeon's Office took the position that the special problems of flying personnel justified the existence of parallel units. Although the Air Surgeon had opposed the representation of dental service in his office when the Dental Division, Surgeon General's Office, noted a need for it in September 1941, a Dental Section of the Air Surgeon's Office was established in late January 1942. The program for venereal disease control in the Army Air Forces was largely autonomous, for the Air Surgeon's Office issued many directives establishing policy. (It may be noted that the office of the Army Ground Forces surgeon possessed no venereal disease control officer.) The Air Surgeon never had a Veterinary Corps officer on his staff.

Psychological Division.—The Psychological Division had supervision of the pilot-selection program, which, as pointed out previously, was in large measure decentralized to the Air Corps Replacement Training Centers. Broadly speaking, the latter were charged with administering tests for pilot candidates, whereas the Psychological Division undertook to develop the tests, partly on the basis of psychological research by the School of Aviation Medicine.

Research and Statistical Division.—Until June 1942, when the Research and Statistical Divisions of the Office of the Air Surgeon were separately established, their functions were performed by a combined Research and Statistical Division. Functions in research were: examination of any reported new findings in the field of aviation medicine; the initiation of research studies, especially in the School of Aviation Medicine and the Aero-Medical Laboratory, to inquire into special problems of human adaptation to aircraft performance; the development of special equipment, such as oxygen equipment, to enable the

flier to adjust to the special conditions of combat aloft; and supplying information to the aircraft industry on the latest physiologic data developed. The division correlated the statistical results of examinations and tests given Army Air Forces personnel with subsequent performance and made appropriate recommendations.

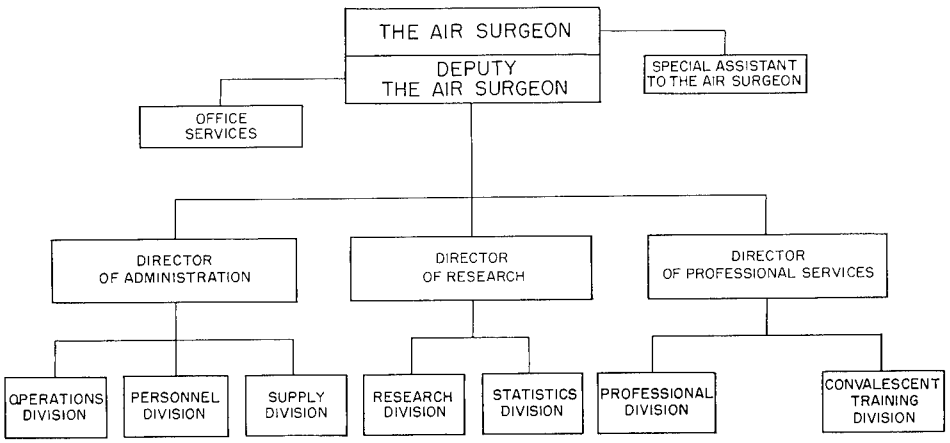
Supply Division.—In September 1942, a Supply Division was formally created in the Office of the Air Surgeon. Before that date a complete system for handling medical supply throughout the Army Air Forces had not been worked out. Since August 1941, plans for establishing medical supply sections in Air Forces depots had been underway. Five of these opened in 1942: Ogden (Utah) Air Depot; Mobile Air Depot; Warner Robins (Ga.) Air Depot; Rome (N.Y.) Air Depot; and Spokane Air Depot. But throughout the first half of 1942, top responsibility for medical supply in the Air Forces setup had fluctuated between the Office of the Air Surgeon and the Office of the Surgeon, Air Service Command, with the latter handling most of the work. The War Department reorganization of March 1942 made it desirable to clarify the relations of the Air Surgeon's Office with the Office of the Surgeon General in this field. By mutual agreement between The Surgeon General and the Air Surgeon it was decided that the Air Surgeon would prepare estimates of the quantities of medical items needed by the tactical units of the Air Forces and give them to The Surgeon General. The only items to be handled by the medical supply sections of Air Forces depots would be maintenance and field items for the Air Forces tactical units; they would not maintain any medical supplies and equipment for station hospitals or dispensaries in the United States. The Hospital Construction Division, Surgeon General's Office, would calculate requirements for Air Forces medical installations in the United States and give its figures to the Supply Service, Surgeon General's Office, which would arrange for the sending of medical supplies automatically to the Army Air Forces.[9]

July 1944 reorganization.—The Office of the Air Surgeon continued with seven or eight divisions during 1943 and the first half of 1944. Although its structure was never so elaborate as the Office of the Surgeon General, many of the organizational elements into which it was divided resembled those of the latter, both as to name and as to function. A reorganization of July 1944 decreased the number of officers reporting directly to the Air Surgeon and brought about an organization in his office of the type favored by the Army Air Forces in the latter part of the war. This was the "directorate" system. By November all the divisions of the Air Surgeon's Office were placed under three directors—of Administration, Professional Services, and Research (chart 8.) This organization existed with little significant change to the close of the war.

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[9] (1) Annual Report, Office of the Air Surgeon, 1942. (2) Medical History of the Second Air Force, January 1941–December 1943. [Official record.] (3) Coleman, Hubert A.: Organization and Administration, Army Air Force Medical Service in the Zone of Interior (1948), pp. 138–142. [Official record.]

CHART 8.—*Office of the Air Surgeon, 21 November 1944*



SOURCE: HUBERT A. COLEMAN, ORGANIZATION AND ADMINISTRATION, AAF MEDICAL SERVICE IN THE ZONE OF INTERIOR (1948), P. 156 A. HD.

Major Air Commands

At the time of the March reorganization of the War Department, four major air commands were in existence: The Air Service Command, the Ferrying Command, the Technical Training Command, and the Flying Training Command. The medical offices at their headquarters had certain organizational elements necessary to take care of special problems of aviation medical service,[10] as well as certain others which duplicated the medical organization in the Services of Supply. No great homogeneity of medical organization existed in these commands. As in the medical sections at the headquarters of most commands, such functions as personnel administration, training, and preventive medicine automatically called for the assignment of Medical Corps officers, or Medical Administrative Corps officers as substitutes.

Air Service Command.—The Air Service Command, established in late 1941, was the major command of the Army Air Forces concerned with supplies, including medical supplies, for air force troops and with the maintenance of aircraft. It was the service arm of the Army Air Forces. The most distinctive feature of its medical service was an extensive health program for the thousands of civilians working at its huge industrial facilities. In February 1942, Lt. Col. Lowyd Ballantyne, MC, became the first staff surgeon of the command. The air depots and subdepots operated under the jurisdiction of four air service area commands, each of which had a headquarters near the one of the four continental air forces which it served. By the spring of 1942 each area command had a surgeon assigned. Hospitals for the growing depots were then largely in the blueprint stage. Besides providing the usual medical care for

[10] This discussion omits reference to a number of subordinate Army Air Forces commands—some of them shortlived—whose medical work was limited to the normal responsibilities of any command.



FIGURE 35.—Lt. Col. John M. Hargreaves, MC.

troops and employees of the command, its medical officers trained personnel as members of the medical sections of two types of tactical units, air depot groups and service groups, then being developed by the Air Service Command.

In July Col. John M. Hargreaves, MC (fig. 35), became surgeon. Taking cognizance of the growing problem of industrial hazards to the rapidly mounting civilian population of the Air Service Command, he placed a Medical Corps officer in charge of Industrial Hygiene Service in the Personnel and Training Branch of his office. By the fall of 1942 the command employed from 130,000 to 140,000 civilians in the United States, largely in the air depots, and about 6,000 overseas. Late in the year a new commanding general, realizing that the command, with its large depot system and heavy preponderance of civilian personnel, was essentially an industrial organization, abolished the staff organization and reorganized the command into divisions. The surgeon became the chief of the medical section. About the end of the year his office in the command's headquarters at Patterson Field at Fairfield, Ohio, consisted of a Medical Personnel and Training Branch and a Medical Supply Branch. A surgeon was stationed at the following headquarters of each of the four air service area commands: Hempstead, N.Y., Fort Worth, Tex., Atlanta, Ga., and Sacramento, Calif. [11]

Before July 1942, the industrial health problems of civilian workers employed by the Air Corps had been handled along with those of employees of

[11] Medical History, Air Technical Service Command, 1 January 1945. [Official record.]

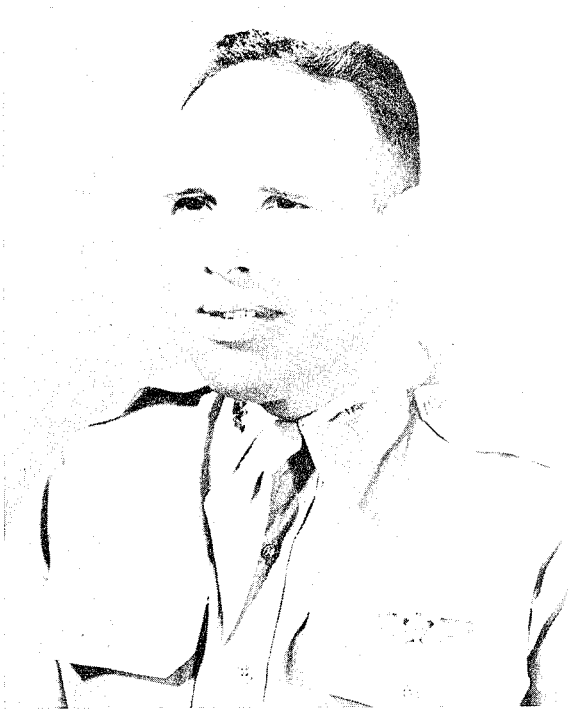


FIGURE 36.—Maj. Richard R. Cameron, MC.

the Quartermaster Corps, Ordnance Department, and other services, by officers assigned to the task in the Surgeon General's Office. Industrial medical problems of the Air Service Command depots and facilities presumably closely resembled those of Ordnance, Quartermaster, and Chemical Warfare Service facilities. By mid-1942, however, no special argument of medical problems "peculiar to the Army Air Forces" was needed to justify this duplication of the work of the Surgeon General's Office, for air force commands were now operating their medical service largely independently of the Surgeon General's Office. The latter could do no more than make recommendations on industrial hygiene matters to the medical officers of the Army Air Forces.[12]

In the spring of 1942, the new medical detachment at Warner Robins Air Depot in Georgia, an Air Service Command installation, was called on to furnish Medical Department officers for tactical units of the command. The station surgeon, Maj. (later Lt. Col.) Richard R. Cameron, MC (fig. 36), aware of the unpreparedness of doctors and dentists from civilian life for field duty, began to give instruction in field medical supply and asked for the support of the Air Surgeon and the Surgeon, Air Service Command (Colonel Hargreaves), in establishing a school for this type of training. In

[12] Cook, W. L., Jr.: Preventive Medicine, Occupational Health Division (1946). [Official record.]

the fall a Medical Training Section at Warner Robins Air Depot began training men for a newly created type of unit, the medical supply platoon (aviation), which consisted of 2 Medical Administrative Corps officers and 19 enlisted men. (The First Medical Supply Platoon (Aviation) had been created early in the year within the First Air Force.) Field tests made of this unit and experience with it overseas demonstrated its value for supplying medical equipment to rapidly moving combat air squadrons independently of the Services of Supply in forward areas where the latter had no depots. In such areas Army Air Forces general depots were furnished with the medical supply platoons (aviation) necessary to supply the combat units.

The Medical Training Section at Warner Robins Air Depot eventually developed into the Medical Service Training School of the Air Service Command. The school was formally established late in 1943 with Colonel Cameron as Commandant, and was sometimes termed, in reference to the long-established field service school of the Medical Department, "the Carlisle Barracks of the Army Air Forces." [13]

Air Training Commands.—The training commands of the Army Air Forces faced throughout the war the special medical problems concerned with testing the fitness of personnel for flying and air combat. In January 1942, an Air Corps Flying Training Command was established for the training of pilots, flying specialists, and combat crews. The three Air Corps replacement training centers, including their psychological research units which had been developed in late 1941 and early 1942, were soon put under the new command, which now had top responsibility for the psychological testing program of Air Corps candidates. The psychological research unit at Maxwell Field, Ala., developed tests of emotion, temperament, and personality, while the one at Kelly Field worked out, in cooperation with the School of Aviation Medicine (that is, the Research Section of the Department of Psychology) at nearby Randolph Field, psychomotor tests and learning measures. In the early months of 1942, these two training centers were swamped with aviation cadets. The third unit, opening in March 1942 at the newly constructed West Coast Replacement Training Center at Santa Ana Army Air Base, Calif., developed tests in the field of intellectual functions and scholastic achievements.

In March 1942, Lt. Col. (later Brig. Gen.) Charles R. Glenn, MC, who had been Surgeon of the West Coast Training Center, became surgeon on the special staff of the Commanding General, Air Corps Flying Training Command, at the latter's headquarters in Washington (later at Fort Worth, Tex.). A fourth psychological research unit, designed to develop tests of observation and attention at another replacement training center (which never came into being), was transformed into a psychological section in Colonel Glenn's office. In the spring of 1942 aircrew classification centers took the place of the replace-

[13] (1) History, Army Air Forces Medical Service Training School, Robins Field. [Official record.] (2) See footnote 11, p. 136. (3) History of the First Air Force Medical Department, January 1941–December 1944. [Official record.]

ment training centers. Aviation cadets went from basic training centers to these classification centers, whence those classified for pilot training went to preflight schools. The surgeon of the aircrew classification center became responsible for the selection of aviation cadets, with the assistance of the director of the psychological research unit and his staff of psychologists. At each classification center a faculty board, including the senior flight surgeon and the director of the psychological research unit, was established to do the actual classification.[14]

The Army Air Forces Technical Training Command, first established in March 1941 (with headquarters at Chanute Field, Ill., later at Tulsa, Okla., and finally Knollwood, N.C.), had the job of training mechanics and various specialists for ground crews to support combat teams in the air. Doctors assigned to this command rendered the usual medical service to the troops of the command. Since the psychological research units of the Army Air Forces Flying Training Command had the proper personnel and equipment for administering tests of psychomotor skills, they were given responsibility for testing personnel of the Technical Training Command, as well as the combat crews of the Flying Training Command.

In July 1943 the two training commands, flying and technical, were amalgamated into the Army Air Forces Training Command with headquarters at Fort Worth, Tex. This, the largest of the continental air force commands, had a staff surgeon's office; surgeons and medical sections existed at the headquarters of some half-dozen subcommands and surgeons at the posts of each.[15]

Air Transport Command.—The Air Transport Command, which eventually had major responsibilities for air evacuation of ill and wounded troops, was established in June 1942. Its predecessor, the Air Corps Ferrying Command, had been created in June 1941 (with headquarters in Washington) to ferry lend-lease planes to the British. Its chief route was then the South Atlantic air route, which ran from Florida through the Caribbean and Brazil and across northern Africa to Cairo. By November the President had authorized the extension of ferrying activities to whatever regions were deemed necessary in order to fulfill lend-lease obligations. In January of the following year, the first medical officer had been assigned to Air Transport Command headquarters, and shortly afterward the Air Surgeon had begun sending medical officers to domestic and foreign stations of the command. By March the command had acquired a chief surgeon, and a few medical officers and some Medical Department enlisted personnel were stationed at its bases at the following sites: Accra in British West Africa; Kano in Nigeria; Karachi in India; Morrison Field,

[14] (1) History of the Army Air Forces Flying Training Command and Its Predecessors, 1 January 1939–7 July 1943 (1 March 1945), vol. II. [Official record.] (2) History of the Army Air Forces Training Command, 1 January 1939—V-J Day (15 June 1946), vol. II. [Official record.] (3) See footnote 9(1), p. 134.

[15] (1) See footnote 14(1). (2) See footnote 14(2). (3) History of the Army Air Forces Technical Training Command and Its Predecessors, 1 January 1939–7 July 1943 (1 March 1945), vol. I. [Official record.]

Fla., and Presque Isle, Maine, jumping-off places for the South Atlantic and North Atlantic air routes, respectively; and a few other domestic bases of the Ferrying Command. In May Lt. Col. (later Col.) Fletcher E. Ammons, MC, had become Surgeon, Ferrying Command, and remained in the post until February 1943.

After June 1942 when the Ferrying Command was renamed the Air Transport Command, its task assumed global proportions. During the latter half of 1942 the following "wings," with headquarters as indicated, were established to take care of the job of ferrying planes to many quarters of the globe: North Atlantic Wing, Presque Isle; South Pacific (later Pacific) Wing, Hamilton Field, Calif.; Caribbean Wing, Morrison Field; Africa-Middle East Wing, Accra; South Atlantic Wing, Georgetown, British Guiana, later Natal, Brazil; Alaska Wing, Edmonton, Alberta; and India-China Wing, Chabua, India. Each wing had a wing surgeon stationed at or near its headquarters and flight surgeons assigned to various airbases along the routes of the wings. The wing surgeon was responsible, through the wing commander, to the Washington headquarters of the Air Transport Command.

The general structure of the Air Transport Command may be likened to the shape of a wheel, with the air routes stretching out like spokes from the United States as a hub. Its wings thus overlapped the Zone of the Interior, oversea bases and defense commands, and the theaters of operations. The medical service of the separate wings became somewhat independent of Army organization in the theaters in which they were located. Because of its highly mobile operations the Air Transport Command held that subjection of the activities of its wings to theater control was artificial and unfeasible. From its point of view the entire world was one vast theater for its own ferrying activities. In 1942 and 1943, it obtained various statements from the War Department tending to make its wings independent of theater control. Its bids for exemption resulted in conflicting claims of jurisdiction between the staff surgeon at a few oversea theater headquarters and the staff surgeon of the Air Transport Command wing in the locality, especially in areas in which the Air Transport Command wing's task of transferring men and equipment was the major Army activity in the area. Struggles of this kind developed in both Brazil—between the staff surgeons of the U.S. Army Forces in the South Atlantic and of the South Atlantic Wing, Air Transport Command—and in the Gold Coast—between staff surgeons of the U.S. Army Forces in Central Africa and of the Central African Wing, Air Transport Command.[16]

I Troop Carrier Command, established in June 1942 with headquarters at Stout Field, Indianapolis, Ind., had the task of organizing and training troop carrier units, together with personnel for replacements, and furnishing

[16] (1) Medical History, World War II, United States Army Forces, South Atlantic. [Official record.] (2) Annual Report, Surgeon, United States Forces South Atlantic, 1943. (3) Letter, Col. Don G. Hilldrup, to Col. J. H. McNinch, MC, Chief, Historical Division, Office of the Surgeon General, 8 Feb. 1950.

them to the oversea theaters.[17] These units were designed to transport troops, including gliderborne troops and parachuteborne troops together with their equipment, by air into combat. The medical section began operations in June, when Col. Wood S. Woolford, MC, was made special staff surgeon. The main task of his small office in 1942 was the recruitment of enough medical officers to supply its units. By the end of 1942, 4 wings, comprising 12 groups and 48 squadrons, had been activated; wing, group, and squadron surgeons were procured accordingly. Other major functions of the medical section were to provide medical personnel and service for the bases of I Troop Carrier Command in the United States, to handle medical supplies for tactical units and base installations of the command, and to supervise medical training of the command.

These responsibilities differed little, of course, from those of the medical section at the headquarters of any large command. The special medical function of I Troop Carrier Command came to be the development of units for evacuating casualties by air. In 1942 the Air Surgeon and Colonel Woolford developed plans for a standard unit. The training of air evacuation units undertaken in the latter half of 1942 at Bowman Field, Louisville, Ky. (near the command headquarters at Stout Field), was the genesis of the Army Air Forces School of Air Evacuation, which was established at Bowman Field in June 1943. It trained the standard medical air evacuation transport squadrons which the Air Transport Command used; these units attended patients being evacuated by air within theaters and from theaters to the United States. The medical air evacuation transport squadron, the medical supply platoon (aviation) mentioned above, and the medical dispensary detachment (aviation)—designed to provide about a dozen beds at airfields where no hospital facilities were available—and the veterinary detachment, aviation (for food inspection), were the principal medical units developed for oversea use by the Army Air Forces during the war.[18]

THE TRANSPORTATION CORPS

Within the Transportation Corps, created in July 1942 as a new service under the Services of Supply, developed certain special medical activities which operated under the command of the Services of Supply, but through the Office of the Chief of Transportation rather than the Office of The Surgeon

[17] This command was originally established in April 1942 as the Air Transport Command, but is not to be confused with the long-lived Air Transport Command discussed in this section. At the same date that this older Air Transport Command became I Troop Carrier Command, the Air Corps Ferrying Command was renamed Air Transport Command. The older Air Transport Command is not discussed here, as it had no medical section at headquarters.

[18] (1) Medical History, I Troop Carrier Command, 30 April 1942–31 December 1944. [Official record.] (2) History of the Medical Department, Air Transport Command, May 1941–December 1944. [Official record.] (3) Flight Surgeon's Handbook, Randolph Field, 30 April 1943. (4) 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, pp. 438ff.

General. The Chief of Transportation was responsible for directing the movements of Army troops and materiel by rail, highway, and water carriers (not by air) and for operating the necessary field installations and facilities. His jurisdiction embraced both the Army's carriers in the Zone of Interior and the oceangoing vessels which transported men and supplies to and from oversea theaters of operations. Army ports of embarkation were developed at Los Angeles, Seattle, New Orleans, Charleston, Boston, and other coastal cities in addition to the ones which had existed at New York and San Francisco in 1939. The port establishment included staging areas for troops going overseas, storage space, piers, and ships. The port commander directed operations in all these as well as on ships en route from his port to oversea bases.

The port surgeons at Army ports of embarkation, directly responsible to port commanders, operated within this command channel which led back, through the Office of the Chief of Transportation, to Services of Supply headquarters in Washington. The port surgeon was in charge of medical care furnished at port dispensaries and the station hospital at the port, as well as on transports carrying troops to and from oversea areas. His office had special tasks in connection with the movement of troops overseas; it gave any necessary physical examinations to departing troops and any immunizations which they lacked. It was also responsible for preventive health measures at ports and on transports; it inspected the sanitary conditions at port installations and on ships, supervised the work of disinfecting transports, and recommended the necessary fumigation.

A Veterinary Corps officer in the port surgeon's medical section directed the port veterinary detachment in the inspection of animals and foods of animal origin intended for consumption at port installations and on transports, as well as those being shipped overseas. A Medical Corps officer instructed transport surgeons in the administration of ships' hospitals; a Dental Corps officer advised on the installation of dental facilities on transports and supervised the dental service afforded troops on transports; the Veterinary Corps officer exercised a similar technical supervision over the care of animals being transported overseas. The nursing service at port installations was supervised by a chief nurse in the port surgeon's office. A personnel officer made recommendations relative to the assignment of Medical Department personnel within ports and to transports. As ports of embarkation employed large numbers of civilian employees, some of whom were engaged in hazardous occupations, an officer in charge of industrial medicine supervised a program which embraced a dispensary service for civilian employees, surveys to determine occupational hazards, and the installation of protective devices.

Some port surgeons' offices contained a medical supply officer, but at other ports the handling of medical supply was vested in a so-called "port medical supply officer" on the staff of the commanding officer of the port. This arrangement relieved the port surgeon of some of his manifold duties; it resulted in the presence of two Medical Department officers on the port commander's

staff—the port surgeon who was responsible for the health of the command, and the port medical supply officer responsible for all medical supplies.

Although the duties of the port surgeon resembled those of a post surgeon, medical administration at a large port was more complex than at most posts, and medical work more varied. At New Orleans in the latter part of 1942, for example, the port surgeon gave technical direction to the work of a camp surgeon for the New Orleans Staging Area (who supervised in his turn eight dispensaries within the staging area), as well as to the activities of the commanding officer of the station hospital located at the port. In size, organization, and functions the port surgeon's office frequently resembled that of a corps area, rather than a post surgeon. Several port surgeons had about 25 officers, representing all Medical Department corps, on their staffs. Both the preventive medicine program and the program of medical care which the port surgeon's office conducted extended over an area which, though much smaller than the corps area, was larger than that for which a post surgeon was usually responsible; in some instances it embraced subports. Like the corps area (or service command) surgeon, the port surgeon worked in close liaison with other officials engaged in public health programs. The port surgeon at the San Francisco Port of Embarkation, for example, was a member of a so-called "Joint Public Health Committee," which handled a rodent control program. Other members were the quarantine officer and other local U.S. Public Health Service officials, the naval district medical officer, and the heads of the local county and city health offices.[19]

The port surgeon was always under the technical guidance of the Office of The Surgeon General despite the fact that he was within the command channel of the Transportation Corps. In the early part of the war no medical office existed in the Office of the Chief of Transportation in Washington. That office exercised somewhat more centralized control over the medical service at ports after the spring of 1943, however, when The Surgeon General assigned a Medical Department officer to it as liaison officer.

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[19] (1) Annual reports of the various port surgeons, 1942–1945. (2) Wardlow, Chester: The Transportation Corps: Responsibilities, Organization, and Operations. United States Army in World War II. The Technical Services. Washington: U.S. Government Printing Office, 1951, pp. 55–58, 95–110. (3) Medical Department, United States Army. Veterinary Service in World War II. Washington: U.S. Government Printing Office, 1962, ch. XV.

CHAPTER V

The Wadhams Committee Investigation

In August 1942, Lt. Gen. Brehon B. Somervell, Commanding General, Services of Supply, decided to undertake an investigation of Medical Department administration. The investigation had significant repercussions not only on organization and administration of the Surgeon General's Office but on most major phases of the Medical Department's program. The fact that an investigation was ordered implied distrust of the Medical Department's effectiveness. On the other hand, certain findings of the committee became a boomerang to the Services of Supply. Irrespective of results, the investigation was of value to those concerned with Medical Department administration in bringing out into the open most of the administrative problems faced by the Surgeon General's Office at that date and the chief differences between that office and Services of Supply headquarters as to advisable methods and policies for administration of Army medical service.

REASONS FOR THE INVESTIGATION

It is clear that in undertaking an investigation, General Somervell intended to inquire into the organization and administration of the Medical Department rather than into any of the technical aspects of its work. Both General Somervell and the Chief of Staff had become doubtful of the ability of the Surgeon General's Office to cope with its mounting problems. General Marshall had become impatient of prophecies by the Surgeon General's Office that epidemics might result from the doubling up of soldiers in cantonments, as well as its objections to limitations on personnel. He took the position that The Surgeon General must devise means of dealing with all sorts of shortages and more expeditious ways of doing business.[1]

Several controversial phases of the Medical Department's program had given rise to public criticism. Although the investigation took its origin from within the War Department, public criticism may have helped to bring it about. Several heads of Government agencies handling programs related to those of the Medical Department were summoned before the committee to give their views on controversial matters, and the committee probed rather deeply into the issues involved.

Public Criticism

Controversy had developed between the Surgeon General's Office and a few civilian agencies over the handling of health problems in which civilian

[1] Minutes, Meeting of General Council, Office of Deputy Chief of Staff, vol. I, 11 Aug. 1942.

and military interests impinged upon, or were at variance with, each other. One of these problems had been the Army's handling of venereal disease in the United States. By the fall of 1942 this controversy had largely died down. There had been no basic disagreement between the U.S. Public Health Service and the Medical Department over the desirability of coupling the program for control of venereal disease with a program to repress prostitution around Army areas. Tempers had flared up because officials of the U.S. Public Health Service had attacked the Medical Department, along with line officers, the Secretary of War, and the General Staff, for an insufficient emphasis upon the effort to repress prostitution. By the summer of 1942 those concerned with the venereal disease problem were awaiting the practical results of invocation of the May Act in areas around Fort Bragg, N.C., and Camp Forrest, Tenn.

Other controversies arose over the allocation of hotels for conversion to hospitals in case of emergency and efforts to reconcile Army demands for doctors with civilian needs. In August 1942 the Chief of Staff directed the Surgeon General's Office to develop plans for converting certain hotels to hospitals in the event of sudden epidemic in the Army; General Marshall was determined that the Surgeon General's Office should not be in a position to "explain away any epidemic because of the fact that men have been doubled up in cantonments." [2] The Office of Civilian Defense, which had plans for the use of hotels as hospitals for civilians, became alarmed over the possibility of their diversion to Army use, as well as the possibility of the Army's using civilian doctors in these facilities to take care of military personnel. By comparison with some other more serious problems, the "hotels for hospitals" controversy seems something of a tempest in a teapot. Nonetheless it became the subject of a good deal of heated discussion between the Surgeon General's Office and the Office of Civilian Defense. It began shortly before the investigating committee was appointed and continued throughout the life of the committee. It was discussed at high levels, for the Executive Secretary of the Health and Medical Committee of the Office of Defense Health and Welfare Services, Dr. James A. Crabtree, informed by General Magee, brought the Army's plans for the use of hotels to the attention of the President, and General Marshall took responsibility for having directed the Surgeon General's Office to undertake the use of hotels.[3]

More serious than the controversy with the Office of Civilian Defense was disagreement with the War Manpower Commission over the procurement of medical manpower for the Army. The Surgeon General's Office was mainly concerned with getting sufficient doctors into the Army. The Procurement and Assignment Service for Physicians, Dentists, and Veterinarians of the War

[2] See footnote 1, p. 145.

[3] (1) Interview, Maj. Gen. James C. Magee, 10 Nov. 1950. (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, pp. 81–83.

Manpower Commission became concerned over the removal of doctors from civilian life and complained of the aggressiveness of the Medical Officer Recruiting Boards working in the various service commands to get doctors into the Army. Higher officials of the War Department, including the Deputy Chief of Staff, were uncertain of the validity of estimates of Army requirements for doctors by the Surgeon General's Office vis-a-vis differing estimates by the Procurement and Assignment Service and other Government agencies interested primarily in protecting civilian medical interests. The Deputy Chief of Staff directed the Inspector General to investigate the assignments of medical officers within the Office of The Surgeon General (as well as assignments to the offices of some other chiefs of services), with a view to determining whether the number so assigned could be cut. This separate investigation of medical personnel in the Surgeon General's Office went on concurrently with the general investigation of the Medical Department discussed here.[4]

In the fall of 1942, a congressional investigation of the medical manpower resources of the United States took place. A special subcommittee of the Senate Committee on Education and Labor conducted it as one phase of an inquiry into the total manpower resources of the country. At the subcommittee's hearings, presided over by Senator Claude E. Pepper, representatives of the Procurement and Assignment Service and of the Surgeons General of the Army, Navy, and U.S. Public Health Service presented their points of view on the supply of, and demand for, medical manpower. Senator Pepper's questioning throughout was directed at pointing out the lack of any governmental agency with final authority to allocate doctors as between military and civilian life.[5]

In the spring and summer of 1942 frequent complaints of the Army's discrimination against certain minority groups with medical training appeared in the public press. Various organizations representing these groups protested discrimination against women doctors, Negro doctors, and such unrecognized medical groups as the chiropractors and osteopaths. Their formal resolutions, along with letters from individuals voicing similar criticism, appeared widely in the open-forum columns of newspapers in 1942, and a number of magazine articles were written on these themes. The fact that the Medical Department was actively attempting to recruit additional doctors gave more color to the criticism of its failure to commission members of the unrecognized groups.[6]

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[4] (1) Medical Department, United States Army. Personnel in World War II. ch. VI. [In press.] (2) Memorandum, Brig. Gen. LeRoy Lutes, for Commanding General, Services of Supply, 2 Sept. 1942. (3) Memorandum, no signature, for the Inspector General, 30 Oct. 1942, subject: Report of Investigation of the Present Organization of the Surgeon General's Office. (4) Minutes, Meeting of General Council, Office of Deputy Chief of Staff, vol. I, 7 Sept. 1942.

[5] Hearings on Senate Resolution 291, 77th Congress, 2d Session, Investigation of Manpower Resources. Washington: U.S. Government Printing Office, 1942, 1943, pts. 1 and 2.

[6] (1) Committee to Study the Medical Department, Testimony, pp. 24–25, 34–37. (2) Medical Department, United States Army. Personnel in World War II, chs. V, X. [In press.]

The "yellow jaundice epidemic" had been a cause for alarm in the spring and summer of 1942. By midsummer thousands of cases had occurred among Army personnel in the United States and overseas. The cause of the apparent epidemic, certain lots of yellow fever vaccine furnished by the Rockefeller Foundation, had been suspected early. In April, The Surgeon General had recalled all yellow fever vaccine then in use, substituting for it a limited supply furnished by the U.S. Public Health Service. By late summer the Medical Department had established the cause and nature of the so-called "epidemic," but attacks on the Army for the "epidemic" continued to appear in the public press, for no official statement had been given out on the subject.

Criticism Within the War Department

Major criticisms of the Surgeon General's Office arising within the War Department revolved around feared shortages of medical supplies and personnel and certain matters which had been the subject of disagreement between Col. William L. Wilson, MC (Chief, Hospitalization and Evacuation Branch, Plans Division, Services of Supply), and staff officers of the Surgeon General's Office. Precisely how the difficulties over supply affected the decision to hold an investigation is not clear. It is significant that concern within the Surgeon General's Office over the status of medical supply reached a crescendo in the fall of 1942. While the Committee to Study the Medical Department was in session, The Surgeon General expressed extreme concern over the situation to the Chief Surgeon of the European theater, stressing the detrimental effects of exorbitant lend-lease demands and transportation difficulties. He termed the United States "the last remaining bastion of medical supply" and declared "we are heading into a catastrophic situation." He expressed fear that "we are very close to a major scandal." [7]

The part played by the disagreements on certain policies between Colonel Wilson and staff officers of the Surgeon General's Office in instigating the investigation is likewise obscure. Some of the major disagreements have already been recounted. They were thoroughly aired during the investigation as a result of charges against The Surgeon General based on the files of Colonel Wilson's Hospitalization and Evacuation Branch and were clearly of major importance in leading the Commanding General, Services of Supply, to undertake an investigation.

MACHINERY FOR THE INVESTIGATION

When General Somervell initiated the investigation in late August 1942 he apparently intended his own organization, the Services of Supply, to select members of the investigating committee and direct the inquiry. He informed the director of his Control Division, Col. Clinton F. Robinson, that he wanted

[7] Letter, The Surgeon General, to Chief Surgeon, European Theater of Operations, 18 Oct. 1942.

a thorough survey made of the Surgeon General's Office and of the Medical Department by a highly qualified group with Colonel Robinson as Executive Secretary. He asked for a survey of the following phases of the Medical Department's administration: The general organization; personnel, including the use of top medical men in the organization of the Surgeon General's Office, the use of specialists throughout the Medical Department, the procurement of medical officers and nurses, and the use of Medical Administrative Corps and Sanitary Corps officers; psychiatry, including the use of modern psychiatric methods and psychiatrists in the Medical Department, policies used by Selective Service to preclude the entry of potential neuropsychiatric cases into the Army, and provision for care of psychiatric casualties; procurement of medical supplies, including research, development, design, requirements, production followup, and inspection; operations, including operation of depots, distribution of medical supplies in the United States and overseas, mobilization, training, and plans for use of tactical units; hospital management and operation; and vital statistics.[8]

Within a few days a brief, tentative plan, including suggestions for membership on the committee, was drawn up, presumably by the Control Division, Services of Supply. The committee contemplated was to include representatives of the following groups: The "elder statesmen" of Army medicine; the leading civilian medical authorities; the Services of Supply, including representation from the offices of the Assistant Chiefs of Staff for Personnel, Materiel, and Operations; and the Surgeon General's Office. Certain names suggested for the committee were: Maj. Gen. Merritte W. Ireland, MC (fig. 37), formerly Surgeon of the American Expeditionary Forces in World War I and later The Surgeon General; Col. William L. Keller, MC (fig. 38), Consultant to Walter Reed Hospital; and Dr. Louis I. Dublin, Director of Vital Statistics of the Metropolitan Life Insurance Co.

Colonel Keller and Dr. Dublin were among the group finally chosen, but the complexion of the committee as a whole was considerably different from the one that General Somervell's Control Division had planned. Those appointed were: Col. Sanford H. Wadhams, MC, USA (Ret.) (fig. 39), Chairman; Col. William L. Keller, MC, USA (Ret.); Dr. John Herr Musser, internist, Tulane University; Dr. Evarts Ambrose Graham, professor of surgery, Washington University; Dr. Arthur Hiler Ruggles, psychiatrist, Butler Hospital, Providence, R.I.; Dr. J. Ben Robinson, Dean of the University of Maryland Dental School; Dr. James Hamilton, Superintendent of New Haven Hospital; Dr. Louis I. Dublin; Dr. Lewis H. Weed, Director, Medical School, The Johns Hopkins University; Mr. Corrington Gill, Consultant to the War Department since May 1942.[9]

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[8] Memorandum, Commanding General, Services of Supply, for Director, Control Division, Services of Supply, 25 Aug. 1942, subject: Survey of the Surgeon General's Office.

[9] Committee to Study the Medical Department, Report, Tab: Authority of Committee.

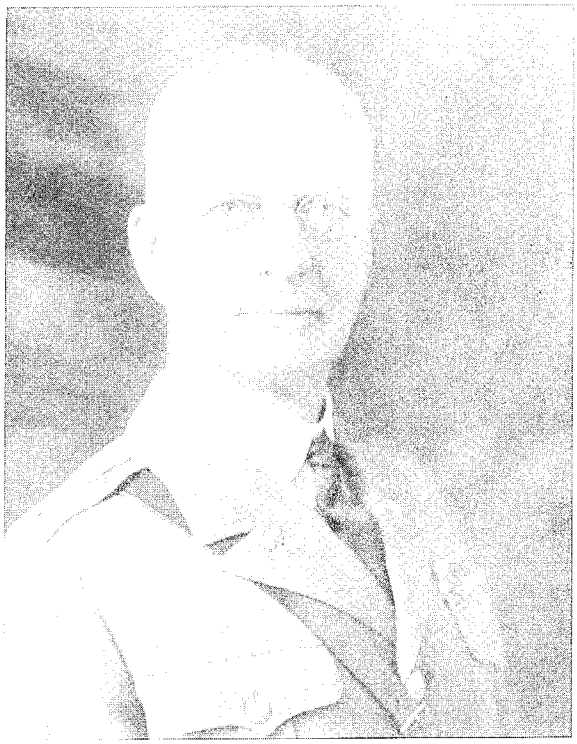


FIGURE 37.—Maj. Gen. Merritte W. Ireland, MC.

The committee thus consisted of six civilian doctors, two retired Army doctors, one hospital administrator, and only one man, Corrington Gill, who can be said to have been primarily interested in the administration of the Surgeon General's Office as it affected the Services of Supply. Mr. Gill was an economist and statistician, a specialist in unemployment problems, and a top-level Government administrator. He had held major posts in the Federal Emergency Relief Administration and the Works Progress Administration and recently in the Office of Civilian Defense. Dr. Weed acted as The Surgeon General's representative on the committee. Colonel Keller had been an operating surgeon with the American Expeditionary Forces in France in World War I; Colonel Wadhams had been Deputy to the Chief Surgeon, American Expeditionary Forces. Two members of the committee, Dr. Hamilton and Dr. Graham, had been suggested to the Secretary's office and to the Commanding General, Services of Supply, by Mr. G. K. Dorr, one of the Secretary's assistants. Former Surgeon General Merritte W. Ireland had also been consulted, at the suggestion of the Chief of Staff, in the selection of the committee.[10]

[10] (1) Memorandum, G. K. Dorr, for General Somervell and Harvey H. Bundy, 29 Aug. 1942, subject: Personnel Survey Group—Medical Situation. (2) Memorandum, Chief of Staff, for General Pershing, 27 March 1943. (3) Interview, Brig. Gen. Albert G. Love and Maj. Gen. Merritte W. Ireland, 2 Dec. 1947.

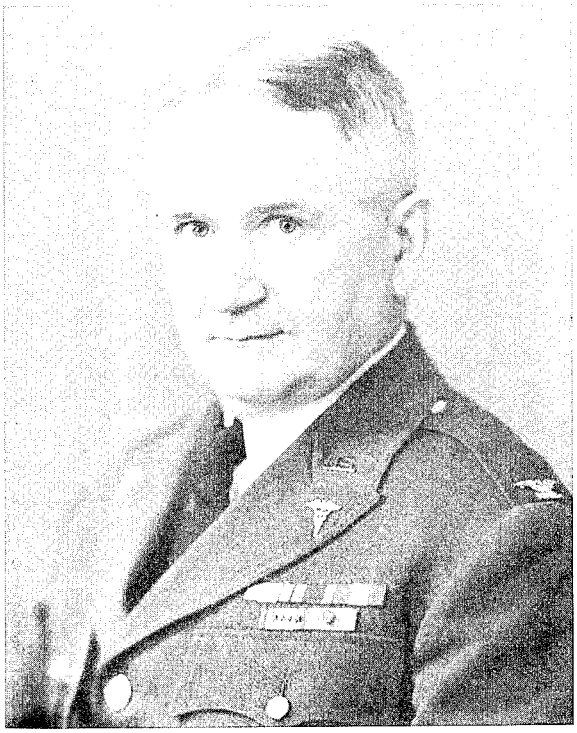


FIGURE 38.—Col. William L. Keller, MC.

On 24 September, the day before the first meeting of the committee, the Secretary of War announced to the press that he had appointed a committee of well-known medical men at the request of General Somervell and General Magee to study the medical service of the Army. He stated that the main purpose of the study was to assure Army personnel the best of medical care and to aid the Medical Department "to maintain the high standards of professional efficiency and devotion which have been the finest traditions of the American medical profession and of the Medical Department of the Army." General Magee, however, had had nothing to do with initiating the investigation and had been informed of it only shortly before the committee was actually appointed.[11]

Between 25 September and 24 November, when the Committee to Study the Medical Department submitted its final report to General Somervell, the committee held a number of sessions, some on Saturdays and Sundays. At these, about 100 witnesses, including officers of the Medical Department and representatives of various offices of the War Department and other Government agencies concerned in some way with the medical service of the Army, appeared and

[11] (1) Transcript of Press Conference of Secretary of War, 24 Sept. 1942. (2) See footnote 10(3), p. 150.



FIGURE 39.—Col. Sanford H. Wadhams, MC.

gave oral testimony.[12] Nearly all of the Army medical officers called appeared originally during the first 3 days' sessions of the committee, but The Surgeon General and a few others were recalled for questioning. Medical Department officers who appeared before the committee included, in addition to The Surgeon General and his executive officer, the chiefs of services and directors of divisions in the Surgeon General's Office; the Ground Surgeon; the Air Surgeon; the Chief of the Medical Research Division of the Chemical Warfare Service; the surgeons of the First, Second, Third, Fourth, and Fifth Service Commands; and the Chief of the Hospitalization and Evacuation Branch, Services of Supply. With some of these a few assistants, officers or civilians, also appeared. Representatives of the following organizational elements of the Services of Supply testified at committee hearings: The Control Division, the Military Personnel Division, and the Special Service Division, each represented by its director; the International Division, represented by the director and other officers; the Fiscal Division; and the Purchases Division.

The Surgeon General of the Navy, Rear Adm. Ross T McIntire, and the Surgeon General of the U.S. Public Health Service, Dr. Thomas Parran, also appeared before the committee. Selective Service was represented by its director, Maj. Gen. L. B. Hershey, and two Army medical officers assigned to that organization. Brig. Gen. F. T. Hines appeared as the Administrator of Veterans' Affairs and Chairman of the Federal Board of Hospitalization.

[12] The testimony was recorded, but extant copies show that certain subjects were discussed "off the record."

Mr. Paul V. McNutt, then Administrator of the Federal Security Agency, Director of Defense Health and Welfare Service, and Chairman of the War Manpower Commission, testified, together with a number of doctors and other assistants of the Procurement and Assignment Service. Dr. George Baehr, Director of the Medical Division of the Office of Civilian Defense, represented his organization. Miss Mary Beard, the Director of Nursing of the American National Red Cross, together with representatives of other agencies concerned with nurses, discussed nursing problems. A few doctors of the National Research Council, the Rockefeller Foundation, and the U.S. Public Health Service testified as experts on certain technical medical problems, particularly problems of disease. Another witness was Dr. Morris Fishbein, editor of the *Journal of the American Medical Association.*[13]

Some witnesses read written statements, while others made informal oral statements. All were questioned by various committee members who resummoned some witnesses and put to them formally prepared questions. Many Medical Department officers supported their statements to the committee, or furnished supplementary information, by means of organization charts, summaries of the assignments or functions of various officers, and histories of the planning and work of their divisions from the outset of the emergency. Mr. Gill instituted further inquiry into certain points made by Medical Department officers, calling for memorandums to supplement their oral statements. A document of major significance in the records of the committee was a report signed by Mr. Gill and based on the files of the Hospitalization and Evacuation Branch of the Assistant Chief of Staff for Operations, Services of Supply, which stated that the Services of Supply had found it necessary to formulate plans and policies for which The Surgeon General was responsible and had had to follow up its directives to the Surgeon General's Office repeatedly in order to obtain definitive action. A lengthy reply by The Surgeon General was of similar importance.[14]

Four administrative surveys initiated by Headquarters, Services of Supply, prior to the convening of the committee on 25 September were considered part of the investigation. About the middle of August the Director of the Purchases Division of the Services of Supply, Col. (later Brig. Gen.) A. J. Browning, had initiated a study of the Supply Service of the Surgeon General's Office. When the committee convened, some of his staff were in the midst of this survey, which included a survey of the New York and St. Louis Procurement Offices as well as of the Supply Service of the Surgeon General's Office. A Special Consultant to the Secretary of War, H. Alexander Smith, Jr., was engaged in a study of possible duplication of activities by the Surgeon General's Office and the Office of the Air Surgeon. A third survey was a study of the Control Division, Surgeon General's Office, undertaken by the Director

[13] Committee to Study the Medical Department, 1942, Report, Tab: Index of Witnesses.

[14] The Surgeon General's reply was prepared by Tracy S. Voorhees, according to Voorhees' statement to the author, 22 Sept. 1950.

of the Control Division, Services of Supply. This survey had resulted from a statement by General Somervell on 9 September that the work of the Control Division, Surgeon General's Office, had not been satisfactory and his request that General Magee remove its director on the ground of unsuitability for the position. Finally, Mr. Gill, after discussion with The Surgeon General, had assigned John C. Russell, then with the Fiscal Division, Services of Supply, and a small staff of technicians in public administration and business management to survey the following organizational elements of the Surgeon General's Office: The entire Personnel Service; the Fiscal Division, then at staff level; and one division of the Administrative Service, the Office Administration Division. These organizational units were concerned with general administrative functions rather than with medical or medicomilitary problems.[15]

In addition to its other activities, the committee visited and inspected various medical installations in the service commands, including Lovell General Hospital at Camp Devens, Mass., and LaGarde General Hospital and Livingston Station Hospital in Louisiana. At the committee's request the Special Service Division, Services of Supply, conducted a poll of some 5,000 soldiers in 14 camps to determine the opinion held by enlisted men of the medical care they were getting in the Army.[16] However, the committee appears to have relied mainly on the oral testimony, the four formal surveys, and the other supporting documents mentioned, and not to have acquired any great amount of firsthand information on the efficiency of the functioning of medical installations and the quality of medical service rendered in the United States. Nor did the committee's inquiry touch upon any phase of medical work in the theaters of operations except as it brought out policies established by the Surgeon General's Office with respect to theater medical service.

TESTIMONY ON ORGANIZATION AND ADMINISTRATION

Some of the evidence presented to the committee dealt directly with organizational matters: the internal structure of the Surgeon General's Office and the position of that office and of the offices of service command surgeons within Army structure. However, the bulk of it dealt with broad administrative policies and plans with respect to the handling of medical personnel and supplies, hospitalization and evacuation, and prevention of disease.

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[15] (1) Committee to Study the Medical Department, 1942, Testimony, pp. A–21, 193–195. (2) Smith, H. Alexander, Jr.: Proposed Transfer of the Medical Department of the Army Air Forces to the Control and Authority of the Surgeon General's Office, 15 Sept. 1942. [Official record.] (3) Memorandum, Commanding General, Services of Supply, for The Surgeon General, 9 Sept. 1942. (4) Memorandum, O. A. Gottschalk, Special Assistant, Control Division, Services of Supply, for Director, Control Division, Services of Supply, 24 Sept. 1942, subject: Report on Control Division, Surgeon General's Office. (5) Russell, John C.: Survey of Non-Technical Segments of the Surgeon General's Office, 24 Sept.–10 Oct. 1942. [Official record.]

[16] (1) Memorandum for record by Dr. Arthur H. Ruggles, no date, subject: Visit with Mr. James Hamilton to Camp Devens, Massachusetts. (2) Memorandum for record by Dr. J. H. Musser, no date, subject: Visit to Louisiana Hospital Installations. (3) Committee to Study the Medical Department, 1942, Report, Tab: Introduction.

Internal Administration of the Surgeon General's Office

The Control Division.—The Control Division was discussed before the committee by its director, Col. John Welch, MC, who summarized his 6 months' experience as head of it. He stated that he had not had sufficient civilian personnel for the key positions in his division until July. The survey by the Control Division, Services of Supply, of the Control Division, Surgeon General's Office, concluded that progress in the latter had been slow until after a July meeting of the control officers of all the services called by the Control Division, Services of Supply. The survey found that the organization, staff, and program of the Control Division, Surgeon General's Office, were now of a quality to enable it to realize substantially the objectives of the Control Division, Services of Supply, although a shortage of personnel still existed. It recommended that the personnel which the division had requested be approved at once, that its director remain in the position for 60 days, and that the division's work be reappraised at that time.[17]

The Russell Survey.—The survey under the direction of Mr. John C. Russell, which covered the Personnel Service, the Fiscal Division, and the Office Administration Division, reached certain conclusions not only on these segments, but also on the Control Division, and on administrative practice in the Surgeon General's Office as a whole. It included a study of the following phases of administrative management: Office space; personnel, including numbers, rank of officers and grades of civilians, absenteeism, and so forth; filing systems and storage problems; use of production records; procedures and use of procedure manuals; and many other phases. It found that the Fiscal Division, newly established in July 1942 and now made up of 15 officers and about 120 civilians, was on the whole the best administered of the segments surveyed. It had regular staff meetings with regular agenda. Its planning was well carried out, and its system of reporting to The Surgeon General was adequate. The chiefs of its branches understood their place in the structure. The survey, as well as oral testimony before the committee, indicated that this division had been organized, and its branch offices in the service commands set up, in such a way as to coordinate the fiscal program of the Medical Department satisfactorily with the total program of the Services of Supply.

The survey found that the organizational plan for the Personnel Service laid down in August 1942 (chart 7) had not been fully put into effect. Although head of the entire Personnel Service, Col. (later Maj. Gen.) George F. Lull, MC (fig. 40), devoted his energies almost exclusively to the Military Personnel Division. The implication that the Services of Supply pattern of organization was being willfully circumvented was probably justified to

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[17] (1) Committee to Study the Medical Department, 1942, Testimony, pp. 193–194; 1625ff. (2) Memorandum, Officer in Charge, Control Division, for Executive Officer, Office of The Surgeon General, 24 Aug. 1942, subject: Request for Additional Personnel. (3) See footnote 15(4), p. 154. (4) Memorandum, Director, Control Division, Services of Supply, for The Surgeon General, 25 Sept. 1942, subject: Approval of Report.

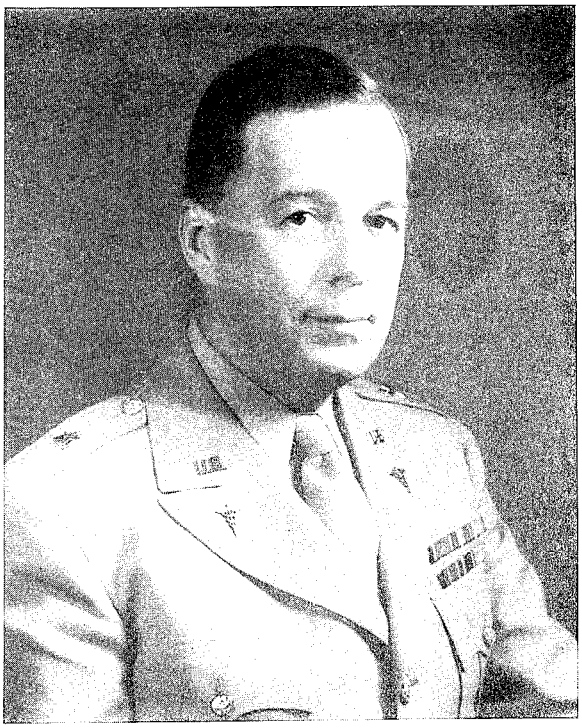


FIGURE 40.—Brig. Gen. George F. Lull, MC.

the extent that from the point of view of the Medical Department, the problem of military personnel at that time was overriding. The survey went on to show that the Nursing Division of the the Surgeon General's Office was performing duties which should have belonged to the Nursing Branch that had never been established in the Military Personnel Division. On the other hand, the old Reserve Division (chart 6) had never been abolished and still handled the procurement, classification, grading, appointment, and initial assignment of officers in the Army of the United States. Col. Francis M. Fitts, MC (fig. 41), though in name Director of the Military Personnel Division, the capacity in which Colonel Lull actually operated, in reality acted as the head of this old Reserve Division. According to the current organization chart, the latter should have been only a section of the Commissioned Personnel Branch. Colonel Lull's primary interest in the Military Personnel Division was reflected not only in his having narrowed the scope of his own activities but also in the fact that the Director of the Civilian Personnel Division reported to the Surgeon General's Executive Officer, Col. (later Brig. Gen.) John A. Rogers, MC (fig. 42), rather than to Colonel Lull. The survey found supervision of civilian personnel functions by the Executive Officer the better procedure, pointing out that the combination of military personnel and civilian

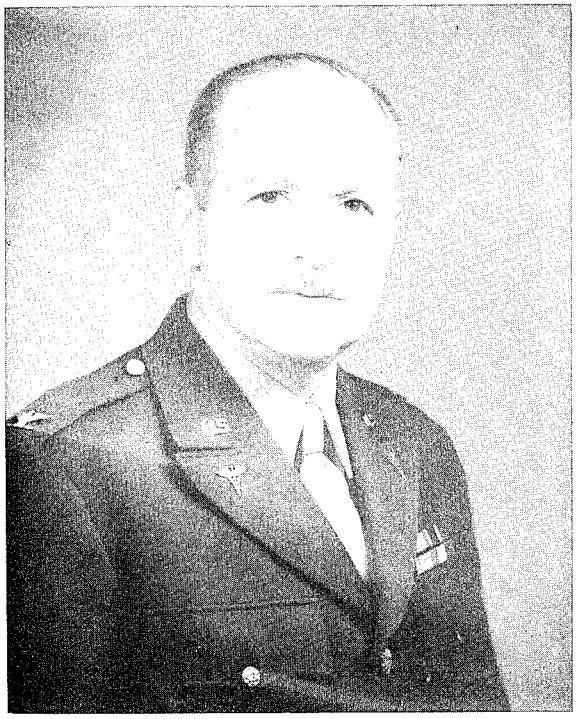


FIGURE 41.—Col. Francis M. Fitts, MC.

personnel functions in one branch was rarely effective "inasmuch as the officer in charge is almost always interested in only the military activities."

The survey found certain defects in the procedures of the Military Personnel Division: the lack of scheduled staff meetings, written procedures, clear-cut statements of responsibility of officers, and production statistics, together with the tendency of medical officers to perform routine or minor duties that could be delegated to civilian clerks. The internal organization of the newly established Civilian Personnel Division, on the other hand, was given a fairly clean bill of health on the grounds that its structure and functions, like those of the Fiscal Division, followed the standard pattern advocated by Headquarters, Services of Supply.

The Office Administration Division handled mail, records, and office supplies, and reproduced and distributed documents for circulation throughout the Surgeon General's Office. Hence the survey of this division dealt largely with the efficiency of its procedures in handling and filing large quantities of records, adequacy of the division's personnel, its use of statistics on workload and production, and like problems. Specific findings included recommendations for certain internal changes in procedures, as well as for increased personnel, higher grades for civilian personnel, additional space, and better conditions of lighting and ventilation.

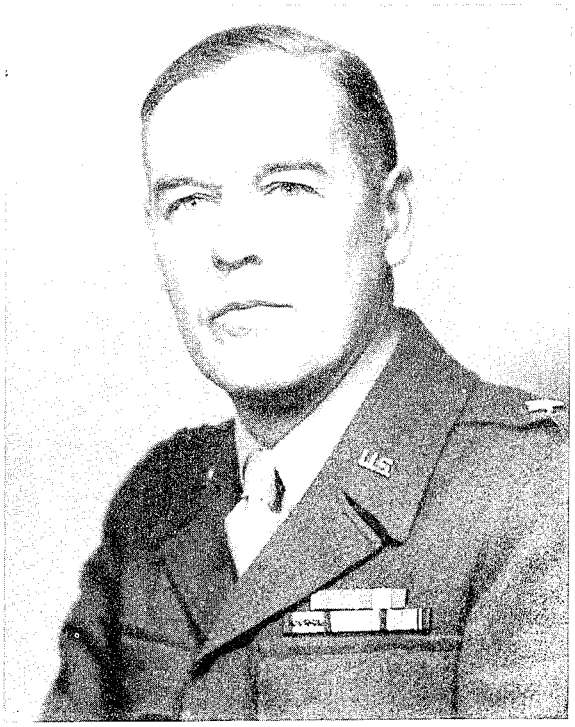


FIGURE 42.—Brig. Gen. John A. Rogers, MC.

Mr. Russell and his assistants arrived at certain conclusions as to the effectiveness of the Control Division through their contacts with officers and civilians in the divisions which they surveyed. They discovered a feeling of enmity on the part of some responsible administrators of the Surgeon General's Office toward the Control Division. Apparently Control Division personnel had emphasized the "control" aspects of their work instead of trying to convince administrators of their ability to aid in improving office procedures. The Russell Group apparently subscribed to General Somervell's belief in the potential efficacy of a control division and laid the blame for the unpopularity of the Control Division, Surgeon General's Office, at the door of its personnel.

The report of the Russell committee noted the following general defects in the administration of the Surgeon General's Office: The failure of the organization chart of August 1942 to reflect the organization accurately; the lack of coordination in the office, by means of clearly written delegations of responsibility, procedure manuals, and regular staff meetings; the lack of adequate support by higher echelons of programs developed in lower echelons; participation by medical officers in tasks not commensurate with their training; the dearth of good work records and production statistics; and inadequate staffing. A good many difficulties had developed within the office, the report stated, because of a lack of understanding of the reorganization of the Services

of Supply and a failure to arrive at satisfactory relationships with various elements of the War Department. The report recommended the following measures: The development of a logical organizational structure with written delegations of responsibility and commensurate authority; regular reports on program development and operations by the lower echelons to The Surgeon General; transmission of proposed programs by The Surgeon General to division chiefs; the development of procedural manuals in major organizational units; and restatement of functions of the Control Division in providing management techniques. It also advocated the holding of regular staff meetings by The Surgeon General and the initiation of a series of conferences with Headquarters, Services of Supply, and other offices to bring about awareness of the Army's current medical problems. It proposed a survey of requirements for personnel in the higher grades in order to determine the relative needs for medical and administrative officers.[18]

The Nursing Division.—Testimony with respect to the Nurse Corps established the fact that the Nursing Division of the Surgeon General's Office was largely an office for procuring nurses and keeping personnel records on nurses. The committee probed into the part played by the Red Cross in the recruitment of nurses for the Army Nurse Corps. The Assistant Superintendent of the Army Nurse Corps, Lt. Col. (later Col.) Florence A. Blanchfield, ANC (fig. 43, indicated some dissatisfaction with recruitment by the Red Cross; some nurses objected to enrolling with the Red Cross for fear that they would be called by this organization for relief work in case of disaster instead of for work with the Army medical service in which they were interested. The National Director of Nursing of the American National Red Cross and Miss Mary Switzer, Special Assistant to Mr. McNutt, stated their conviction that the Red Cross was doing a more effectual check on nurses' qualifications than the Army Nurse Corps was presently equipped to do. General Magee took the position that the Red Cross was doing an effective job which he did not wish to disrupt and that the assumption of direct recruitment of nurses by the Army Nurse Corps would entail an enormous amount of work.[19]

Supply Service.—With regard to medical supply, the Chief of the Supply Service, Surgeon General's Office (Col. Francis C. Tyng, MC), noted that the War Department was now faced with "a grave emergency in procurement and distribution of medical supplies." This situation he attributed to two factors: insufficient money appropriated during the emergency period as a result of public doubt that the United States would enter the war, and the lack of per-

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[18] (1) See footnote 15(5), p. 154. (2) Committee to Study the Medical Department, 1942, Testimony, pp. 617–648; 1246. (3) Memorandum, Director, Fiscal Division, Office of The Surgeon General, for Director, Historical Division, 31 Oct. 1942, subject: Report on Administrative Developments in Fiscal Division. (4) Memorandum, Brig. Gen. C. C. Hillman, MC, for Corrington Gill, 26 Oct. 1942, subject: Data for Investigating Committee. (5) Memorandum, Maj. Gen. James C. Magee, for the Secretary of War, through Commanding General, Services of Supply, 14 Sept. 1942, subject: Requirements in Personnel and Space in The Surgeon General's Office.

[19] Committee to Study the Medical Department, 1942, Testimony, pp. 563–601; 751ff.; 1135–1159; 1667–1726.



FIGURE 43.—Col. Florence A. Blanchfield, ANC.

sonnel in the Supply Service, Surgeon General's Office, the procurement offices, and the depots. Lack of personnel he regarded as the most serious current threat to the medical supply program. Any deficiencies that might exist in the records on medical supply he attributed to that factor. He asserted that a loss of civilian personnel in the New York Procurement Office had resulted from the study by the Services of Supply advocating consolidation of the New York Office with the St. Louis Office. The "freeze" on civilian personnel in the War Department had prevented obtaining the large numbers of additional civilian clerks which he had recommended for all the medical supply offices. He pointed out that his International Division handling lend-lease medical supply was operating a $200 million business with 5 officers and 17 clerks. He lacked men in the executive class, difficult to get in any case because of the financial loss they would incur if they left good positions to enter the Army, and presently impossible to get because of the limitation on the number of officers in the Surgeon General's Office.[20] Much further difficulty had come about, he stated, as a result of failure by foreign governments to state their total

[20] Mr. Gill informed the committee on the day following Colonel Tyng's statements that General Somervell had authorized the immediate commissioning of 40 additional officers for the Purchasing Division of the Supply Service.

requirements for lend-lease medical supplies. Requisitions to date had been spot demands, and some had been exorbitant. A few, indeed, had been for quantities of certain items in excess of total U.S. production, while others had been for items not procurable in any foreign market then accessible. The White House transmitted these requests as firm requirements, although they had not been reviewed by experts in medical supply.[21]

Colonel Tyng and other witnesses stated that the complicated handling of lend-lease requisitions had also hampered the medical supply program. Representatives of the International Division, Services of Supply, pointed out obstacles created by the earmarking of specific stockpiles of medical supplies for certain countries. They stated that a general lend-lease medical stockpile, to be held in the custody of The Surgeon General physically separated from Army medical stores, was being created. The system of a general stockpile had worked well for the other services, but the Medical Department had been tardy in adopting this arrangement because, according to Col. (later Brig. Gen.) John B. Banks, Director of the International Division, Services of Supply, it was "one of the last services to really appreciate the importance of lend-lease and its effect on the whole War Department program." [22]

Col. Albert J. Browning, Director, Purchases Division, Office of the Assistant Chief of Staff for Materiel, Services of Supply, and Lt. Col. (later Col.) Bryan Houston, Chief of the Purchase Service Branch of that division, agreed with Colonel Tyng that the medical supply procurement program had been understaffed both in Washington and in the procurement office and depots. Colonel Browning also agreed that exorbitant lend-lease demands had had a seriously adverse effect upon procurement. He stated that inventory records of medical supplies in the depots were not in very good shape and attributed the unsatisfactory situation largely to lack of civilian clerks for medical supply duties in the depots. (Colonel Tyng stated that the records were in good shape in all depots except the St. Louis Medical Depot.) Colonels Browning and Houston also noted that the responsibilities laid upon medical supply officers, including accountability for expenditure of large sums, were heavy in proportion to the military rank of these officers. The procurement job of Colonel Tyng was likened to that of the heads of such large concerns as Montgomery Ward & Co., Inc.[23]

Two steps toward solving the problems of the Supply Services were taken before the investigating committee made its final report. On 1 October its needs for officer personnel, established by surveys by the Services of Supply and the committee testimony, were recognized; the allotment of officers for the Supply Service, Surgeon General's Office, and for the New York and St. Louis Procurement Offices was increased by 163. Then, in November, at the sugges-

[21] (1) Committee to Study the Medical Department, 1942, Testimony, pp. 93–136. (2) Letter, Col. F. C. Tyng, MC, to Chief Surgeon, European Theater of Operations, 18 Oct. 1942.

[22] Committee to Study the Medical Department, 1942, Testimony, pp. 126–131; 1183–1214.

[23] Committee to Study the Medical Department, 1942, Testimony, pp. 1215–1245; 2074–2104.

tion of Col. Tracy Voorhees, JAGD, Director of the Legal Division, Surgeon General's Office, General Magee appointed Mr. Edward Reynolds, president of the Columbia Gas & Electric Corp., as special assistant to The Surgeon General in the procurement of medical supplies. Under ordinary circumstances, General Magee told the committee, he still believed that medical supplies and equipment could be more effectively procured by medical officers who had been given some specialized business training than by businessmen, no matter how experienced, who had no medical knowledge. But the circumstances were not ordinary, and he now thought it best to obtain a businessman of the type widely used by various Government agencies. He recognized that a man "primarily trained in executive duties of great magnitude" should act for him in all the nonprofessional aspects of procurement of medical supplies.[24]

Professional Service.—The committee inquired into the most recent reorganization of the Surgeon General's Office whereby former "Services" performing professional work had been placed under the Professional Service. Brig. Gen. Raymond A. Kelser, VC, Director of the Veterinary Division, expressed the opinion that going through an intermediary (the Chief of Professional Service) to The Surgeon General for decision might conceivably slow up the work of his division. Brig. Gen. Robert H. Mills, DC (fig. 44), Director of the Dental Division, took much the same position and added that reduction from a Dental Service to a Dental Division tended to lower the status of dentistry. The Director of the Control Division, Surgeon General's Office, defended the recent reorganization of the Surgeon General's Office, which had brought about these changes, on the grounds that it aimed at decentralization, a basic concept of General Somervell's, and had been approved by the Control Division, Services of Supply.[25]

Place of the Medical Department in War Department Structure

Much discussion took place with respect to the place of the Medical Department and of The Surgeon General within the War Department. Medical officers stressed the difficulties of the Medical Department in operating under the War Department reorganization of the preceding March and potential hindrances created by the more recent service command reorganization of August. Their statements were in part supported by the heads of other large Government medical programs. Some medical officers, particularly those of the Preventive Medicine Division, declared that negative or delayed decisions by higher War Department authority had interfered with certain of their recommendations—those aimed at maintaining standards of proper disinfection

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[24] (1) Memorandum, Col. A. J. Browning, Director, Purchases Division, Services of Supply, for Committee Appointed to Study the Medical Department of the Army, 5 Nov. 1942, subject: Surgeon General's Supply Service. (2) Committee to Study the Medical Department, 1942, Testimony, pp. 1667–1726. (3) Letter, Maj. Gen. James C. Magee, to Col. Sanford H. Wadhams, 10 Nov. 1942. (4) Interview, Tracy S. Voorhees, 22 Sept. 1950.

[25] Committee to Study the Medical Department, 1942, Testimony, pp. 508; 538–539; 1625–1666.



FIGURE 44.—Brig. Gen. Robert H. Mills, DC.

of dishes in messhalls and sufficient airspace in barracks, for example. The Surgeon General and most of his staff emphasized various difficulties created by the following developments: The subordination of The Surgeon General and his office to the Services of Supply and the consequent strengthened autonomy of medical administration in the Army Air Forces; the Services of Supply policy of decentralizing many matters to the service commands; loss by the Surgeon General's Office of control over transfer and reassignment of individual medical officers; and the subordination of the service command surgeon to a position in which he was answerable to the head of a division at service command headquarters rather than to the commanding general of the service command. Officers of the Services of Supply countered with the charge that medical officers of the Surgeon General's Office did not understand the prevailing War Department organizational structure and had not mastered the technique of accomplishing their medical aims through the proper channels.[26]

Maj. Gen. (later Lt. Gen.) Wilhelm D. Styer, Chief of Staff, Services of Supply, informed the committee that a study of the testimony showed that various officers in the Surgeon General's Office had failed to grasp the funda-

[26] Committee to Study the Medical Department, 1942. Testimony, pp. 167–193; 245; 273–280; 769–813.

mental principles of the current War Department structure. Commanding generals of service commands, he said, were direct subordinates of the Commanding General, Services of Supply, and were his field representatives. The Surgeon General was the staff agent of the Commanding General, Services of Supply, in the direction of functions relating to the health of the Army. "The authority and responsibility of The Surgeon General for the maintenance of the health of the Army and the conduct of medical activities necessary to the full accomplishment thereof is that of the Commanding General, Services of Supply." Hence, General Styer pointed out, the Services of Supply Organization Manual clearly gave The Surgeon General the authority to issue instructions to the commanding generals of the service commands in his own name under the authority of the Commanding General, Services of Supply, either with or without invoking such authority.[27]

General Styer went on to say that for the exercise of authority with respect to medical matters in the field forces (the Army Ground Forces, defense commands, and theaters of operations), The Surgeon General had to deal with the Commanding General, Services of Supply, and the War Department Chief of Staff. The Surgeon General had authority, however, to issue instructions on technical medical matters directly to the surgeons of these commands. For the exercise of authority over matters of Army-wide application, The Surgeon General similarly submitted recommendations through General Somervell to General Marshall. However, it was his responsibility at all times to call to the attention of the latter (through General Somervell) all matters requiring corrective action which were beyond his power to remedy. The Surgeon General had no authority over the internal organization of service commands, General Styer pointed out. The current scope of Army activities made direct control from Washington over movement of personnel within a service command and from one service command to another impractical. Nevertheless, in practice, he stated, the recommendations of The Surgeon General were followed on all matters involving medical activities in the field, including the transfer of medical specialists.

Service command surgeons noted their lack of control over certain medical installations and offices within the boundaries of their respective service commands, especially station hospitals controlled by the Army Air Forces and those assigned to the ports of embarkation. The Surgeon, Second Service Command, for example, thought that the staffs of these two types of hospitals should come under his control. In other words, the service command surgeons argued for control of all Army medical service within the service command to which they were assigned.[28]

Position of The Surgeon General.—As to the position of The Surgeon

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[27] (1) Memorandum, Maj. Gen. W. D. Styer, for Corrington Gill, 14 Oct. 1942, subject: Authority and Responsibility of The Surgeon General. (2) Services of Supply Organization Manual, 10 Aug. 1942, sec. 403.02.

[28] Committee to Study the Medical Department, 1942, Testimony, pp. 1341–1519.

General within the War Department structure, several witnesses, including the Air Surgeon, expressed the opinion that The Surgeon General was hampered in the performance of his duties by lack of access to the Secretary of War. They contrasted his position with that of the Surgeon General of the Navy, Admiral Ross T McIntire, who had direct access to the Secretary of the Navy. Admiral McIntire expressed the opinion that the placing of the Surgeon General's Office under the Services of Supply organization was a mistake, as it added another echelon to the channels above. He thought that, while decentralization of responsibilities for the procurement of medical supplies might work well, centralized control over personnel was vital. In the prevailing organization of the Navy, he had full power of appointment and removal of medical officers on ships and of district medical officers. Members of the committee evinced strong interest in this matter of the position of The Surgeon General within the War Department. Questioned, General Magee expressed the opinion that he should be on the War Department Special Staff.[29]

A few witnesses ventured an opinion as to the personality of the present Surgeon General. Dr. Harvey Stone of the Procurement and Assignment Service, War Manpower Commission, thought that The Surgeon General and his office had not been sufficiently aggressive in asserting their rights.

Both Lt. Col. Bryan Houston, Chief of Purchase Service Branch, Purchases Division, Services of Supply, and Col. A. J. Browning, Director, Purchases Division, Services of Supply, believed that The Surgeon General had not been aggressive enough in his requests for personnel—a failing attributed by Colonel Houston to General Magee's medical education.[30]

Relations with the service command surgeons.—The surgeons of service commands (First, Second, Third, Fourth, and Fifth), called in to give their opinion of the most recent service command reorganization, were in general agreement that the scattering of medical functions through various divisions (supply, personnel, training, and so forth) of the office of the commanding general of the service command was unsatisfactory. Some service command surgeons were placed under the chief of the supply division or the chief of the personnel division of service command headquarters instead of directly under the commanding general. Although they found their situations agreeable, as their commanding generals and chiefs of the divisions under whom they immediately functioned let them run their medical service without serious interference,[31] they agreed that the present organizational scheme was fraught with danger. They found it hard to maintain control over medical personnel assigned to divisions of the service command other than the one in which they

[29] Committee to Study the Medical Department, 1942, Testimony, pp. 128ff.; 727ff.; 906–939; 1008–1043; 2039–2074.

[30] Committee to Study the Medical Department, 1942, Testimony, pp. 730ff.; 1215–1245.

[31] Col. Sanford W. French, MC, Surgeon, Fourth Service Command, dissented from the general view. He regarded the existing organization as both theoretically and personally unsatisfactory. See Committee to Study the Medical Department, 1942, Testimony, pp. 1451–1489.

themselves were placed. An organization so wholly dependent upon close cooperation of officers immediately above them was ill-advised, they thought.

Most officers of the Surgeon General's Office agreed with this point of view. The chief of the Operations Service declared that there was no true service command surgeon in the former sense of the title. He was only a senior medical officer heading the medical branch of a division of the service command. General Magee noted that he had already recommended to General Somervell that all medical personnel in the service command be placed under the direct authority of the senior medical officer there, with the latter as head of a medical division and on the special staff of the commanding general.[32]

Officers of the Services of Supply tended to minimize the difficulties caused the Medical Department by the recent reorganization of the service commands. Col. Kilbourne Johnston of the Control Division, Services of Supply, declared that although medical responsibilities had been split among three or more divisions in the service commands, the commanding general of each service command used his senior medical officer as his adviser on all medical matters throughout the command. Colonel Johnston drew a distinction between the position of service command surgeon and post surgeon which, he stated, had been a factor in changing the position of service command surgeon, while the post surgeon had remained in staff relationship to the post commander. The work of the post surgeon, who would likely have responsibility for running a large hospital with 50 or more doctors and was charged with large medical supply and distribution functions, was an operating job. The post surgeon should therefore be on the staff of the post commander (who reported in turn to the service commander) and should set up the large medical operation under him to suit himself. The function of the service command surgeon, on the other hand, as Colonel Johnston conceived it, was almost entirely that of an inspector. He expressed doubt as to whether the incumbents of the positions of service command surgeons were the best administrative types that the Surgeon General's Office could produce.[33]

Officers of the Surgeon General's Office stressed their loss of control over certain medical matters within service commands and certain problems arising between service commands as a result of the present organization of the War Department. General Hillman, Chief of Professional Service, thought that the loss of control over personnel in the service commands by the Surgeon General's Office to the commanding general of the service command, plus the split of medical functions among service command divisions handling personnel, supply, training, and others, had resulted in separating himself from the men doing the professional work for which he was held responsible. Channels of communication were more circuitous than formerly. Letters on personnel matters arrived from the service commands without indication of any partici-

[32] Committee to Study the Medical Department, 1942, Testimony, pp. 46–47; 2039–2074.
[33] Committee to Study the Medical Department, 1942, Testimony, pp. 769–813.

pation by service command surgeons. The prevailing service command organization led to confusion and delay.[34]

The Surgeon General's staff voiced discontent at their loss of control over the assignment and use of medical personnel once the latter were assigned to a service command. The commanding general of a service command could move a medical officer assigned to his service command about within his area at will, and the Surgeon General's Office could not transfer him to another service command where he might be more needed. The Director of the Training Division stated that since the March reorganization of the War Department, The Surgeon General had no authority to order a particular individual to take a particular course of training. Nor could he specify the locality where an individual trained in tropical medicine at the Army Medical Center should go to make use of that training. Once the trainee completed his course he was returned to service command control, whether or not the service command had any use for his most recent training. Colonel Lull noted that he could send the record of a man's special qualifications with him upon the latter's initial assignment to a service command, but could not insure that these qualifications were taken into consideration in any reassignment the man received. In moving men from one service command to another, he had to specify the number of men and their grade or rank and could not request individuals by name. It was up to the service commander, presumably with the advice of his surgeon, to pick out the men to be transferred.[35]

Services of Supply officers declared that the real authority for transfer of a medical officer rested with General Somervell. They noted that the Services of Supply preferred the handling of transfers in terms of the assignments to be filled rather than in terms of individuals to be moved. It was precisely this point that the Medical Department disputed. The Surgeon General maintained consistently that his office needed to control the assignment of individual doctors in order to use their specialized training effectively. The Services of Supply, on the other hand, regarded the assignment of medical personnel as only one phase of its larger job of staffing the service commands and their installations. If The Surgeon General found a service command surgeon objectionable, he should call the commanding general of the service command on the telephone or talk the matter over with the Military Personnel Division, Services of Supply, and convince them of the need for a transfer. In the event of a disagreement between The Surgeon General and the commanding general the surgeon could be ordered out by Headquarters, Services of Supply.[36]

Col. Harry D. Offutt, MC, Director of the Hospitalization and Evacuation Division, pointed out a dual threat to the work of his division in the loss of control over personnel assigned to service commands plus the recent loss of

[34] Committee to Study the Medical Department, 1942, Testimony, p. 1803ff.
[35] Committee to Study the Medical Department, 1942, Testimony, pp. 78–79; 1738–1754.
[36] Committee to Study the Medical Department, 1942, Testimony, pp. 167–193; 769–813.

control of general hospitals to the service commands. A plan of The Surgeon General to concentrate specialists in certain diseases or injuries—of the chest, for example—in a general hospital in order to equip it to give the best possible treatment in a specialized field might be thwarted by the removal of personnel from this hospital to some other installation by the service commander.[37]

Relation with the Army Air Forces.—The semiautonomy of the Army Air Forces medical service became the subject of much discussion. In his testimony before the committee, Brig. Gen. David N. W. Grant, MC, the Air Surgeon, attempted to justify the separatist tendencies of Army Air Forces medical personnel on the usual grounds: the "peculiar" stresses to which flying personnel were subjected; the necessity for giving special training in aviation medicine to doctors who were to deal with their health problems; the need for special physical and psychological tests for air pilots, bombardiers, and gunners and for training men to devise and administer them; and, finally, the favorable atmosphere for the flowering of the new science of aviation medicine created by the independence of the medical organization of the Army Air Forces from the Surgeon General's Office. He declared that airmen needed individual medical attention, that a medical officer in the Army Air Forces should be a "loyal and integral member" of that combat arm, and that the Army Air Forces should operate its own hospitals so that flight surgeons could be intimately associated with the activities of these hospitals.[38]

General Grant maintained that his office was doing a more effective job than that of The Surgeon General, and attributed this claim to two major factors: too great subordination of The Surgeon General, as well as the service command surgeons, under the existing scheme of War Department organization and the inefficiency of certain segments of the Surgeon General's Office. Alluding to the position of the Medical Department under the Services of Supply, he justified control of hospitals by the Army Air Forces on the ground that the Surgeon General's Office was not "functioning under the medical profession" but was "controlled by the commands." He emphasized his own relatively advantageous position on the staff of the Commanding General, Army Air Forces. He also pointed to the lowly position of the service command surgeon under a supply or personnel division compared with his former position as a staff officer for the commanding general of the service command.

General Grant justified direct recruiting of medical personnel by his office on the grounds that the Surgeon General's Office had failed to furnish him with sufficient medical personnel. He charged the Military Personnel Division of the Surgeon General's Office with loss of papers relating to applicants for commissions and made similar strong charges with respect to the Nursing Division. He could not get the nurses needed by the Army Air Forces because they had been "lost in the Nurse Corps." He stated that in answer to charges

[37] Committee to Study the Medical Department, 1942, Testimony, pp. 199–215.
[38] Committee to Study the Medical Department, 1942, Testimony, pp. 814–823.

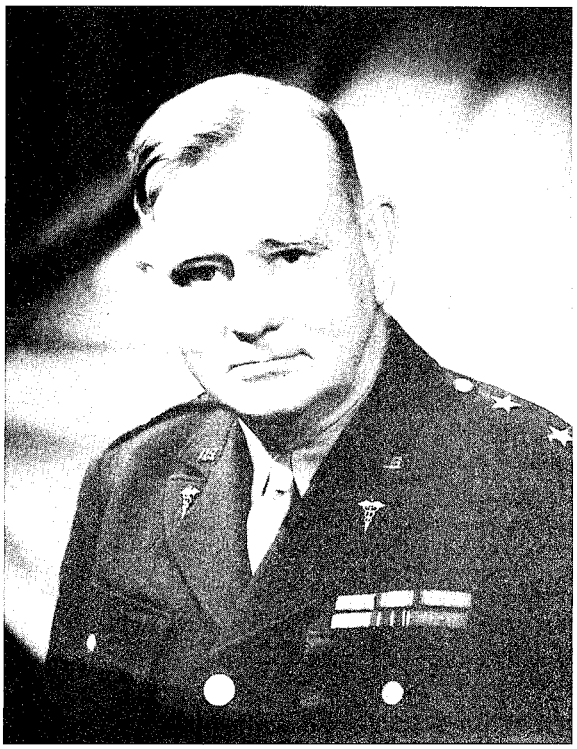


FIGURE 45.—Maj. Gen. Paul R. Hawley, MC.

sometimes made by members of the Surgeon General's Office that he had disrupted their service, he had replied that his service was working while theirs was not. He quoted a complaint of the European theater surgeon, Brig. Gen. (later Maj. Gen.) Paul R. Hawley, MC (fig. 45), that the Army Air Forces had furnished medical supplies through its own channels to air force troops by air delivery in England. General Hawley had protested that the sick doughboy was entitled to as good service as the aviator. General Grant countered with the claim that his separate furnishing of medical supplies in the European theater proved the superior functioning of the medical service in the Army Air Forces.[39]

General Magee saw no reason for the separatism of the medical service of the Army Air Forces, for only two phases of its work could be considered peculiar to the Army Air Forces—the work of the flight surgeon and the conduct of investigative medicine related to aviation—and these had been customarily delegated to the Air Forces. The treatment of sick aviators and "sick ground airmen," he thought, should be the same as that of any other soldiers. In his opinion, service command surgeons should supervise and

[39] Committee to Study the Medical Department, 1942, Testimony, p. 128ff.

direct technical procedures in hospitals at stations of the Army Air Forces as well as the Army Ground Forces.[40]

Officers of the Surgeon General's Office pointed out several difficulties which they had encountered in making their policies effective throughout the War Department and the Army. Although these were matters of medical administration in the service commands, they stemmed primarily from the top organizational structure of the War Department and the semiautonomy of the Army Air Forces. One complaint was lack of control of medical personnel assigned to the Army Air Forces. Colonel Lull, Chief of the Personnel Service, Surgeon General's Office, pointed out that he had no say as to the reassignment of medical personnel once they had been initially assigned to the Army Air Forces. In other words, no one office in the War Department was in a position to make effective reassignments in order to make the best use of medically trained men.[41]

Another problem was lack of control over activities of Air Forces medical installations. The director of the Dental Division noted that his dental officers assigned to the service command surgeon could not inspect dental installations of the Army Air Forces, although he could transfer dental personnel out of the Army Air Forces to some other jurisdiction. The Chief of Professional Services stated: "Under the current Army organization the Medical Practice Division feels decidedly out of touch with the actual professional work going on in our military hospitals." He was concerned over the effectiveness of the work of his consultants assigned to the service commands. The weakness to which he called attention was that of confusion occasioned a technical service by overlapping commands within a given geographic area. The various commands set up by the Army Air Forces (Air Service Command, Flying Training Command, and others) had their own area jurisdictions, cutting across the boundaries of the service commands. It was impossible to obtain enough highly trained specialists to assign to all the area divisions of these commands. To date, consultants in the three major specialties of internal medicine, surgery, and neuropsychiatry had been assigned to the service commands with the greatest number of hospital beds, the Fourth, Seventh, Eighth, and Ninth. Service command surgeons were uncertain as to their responsibilities for furnishing the services of consultants to hospitals variously assigned to one or another of the Army Air Forces commands. The director of the Veterinary Division, on the other hand, minimized difficulties occasioned the operations of the veterinary service by the current War Department organization and complex channels of command. He believed that the standardized training given Army veterinary personnel enabled the Veterinary Division to maintain its standards of meat and dairy food inspection uniformly throughout the various commands.[42]

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[40] Committee to Study the Medical Department, 1942, Testimony, pp. 1667–1726.
[41] Committee to Study the Medical Department, 1942, p. 244.
[42] Committee to Study the Medical Department, 1942, pp. 431; 434–438; 509–511; 539–542.

Col. Kilbourne Johnston of the Control Division, Services of Supply, maintained that the duplicate medical program conducted by the Army Air Forces in the United States was not justified, noting that the Army Ground Forces had not established a duplicate medical service. The division of responsibility for tactical medical units, whether of ground or air forces, as between the Services of Supply, on the one hand, and the Army Air Forces and Army Ground Forces, on the other, was clear enough. Field armies and air forces admittedly should train their own medical units and control their own medical personnel, for they would be going overseas where they would be under a theater commander. However, the Army Air Forces was no more justified in maintaining its own hospitals than the Army Ground Forces. Although most representatives of the Services of Supply who appeared before the committee did not take any strong stand for or against the bid of the Army Air Forces medical organization for independence, this question was one on which the point of view of the Services of Supply largely coincided with that of the Surgeon General's Office.[43]

H. Alexander Smith, Jr., consultant to the Control Division, Services of Supply, at first proposed, in his investigation into medical activities of the Air Surgeon's Office in relation to those of the Surgeon General's Office, that matters be left as they were for the duration of the war. He noted that the Army Air Forces was contemplating the eventual establishment of an Air Forces Medical Department entirely divorced from the Services of Supply to support an Army Air Forces entirely divorced from command relationship with the Army. The issue of eventual separation should not be raised while the war was in progress, he thought; the duplication of activities was not great enough to warrant interference with the Army Air Forces medical service, which was working effectively. By the end of September, however, he had apparently become somewhat more cognizant of the conflicts of authority and duplications of activities resulting from the current organization. Accordingly he proposed that the Air Surgeon be designated "Deputy Surgeon General for Air" and that his office and activities be transferred from the command of the Army Air Forces to a position directly subject to the authority of The Surgeon General. He was to act as an *adviser* to The Surgeon General on all routine medical activities of the Air Forces but to be directly responsible for all specialized medical activities peculiar to the Army Air Forces. In substance this solution was backed by a subcommittee of the Committee to Study the Medical Department, which was appointed to examine further the medical activities of the Army Air Forces.[44]

[43] (1) Committee to Study the Medical Department, 1942, Testimony, pp. 769–813. (2) Memorandum, Director, Control Division, Services of Supply, for Commanding General, Services of Supply, 21 Sept. 1942, subject: Incidents Indicating Concerted Campaign of Army Air Forces for Independence.

[44] (1) Memorandum, H. Alexander Smith, Jr., for Col. Kilbourne Johnston, 15 Sept. 1942, subject: Extent to Which the Army Air Forces Shall Control Its Medical Activities. (2) Memorandum, H. Alexander Smith, Jr., for Col. C. F. Robinson, MC, 28 Sept. 1942, subject: Proposed Transfer of Medical Department of Army Air Forces to Control and Authority of The Surgeon General. (3) Memorandum, Col. Sanford Wadhams, for Commanding General, Services of Supply, 13 Nov. 1942.

Relations with the Army Ground Forces.—Testimony with respect to the office of the surgeon of the Army Ground Forces indicated that relationships between his office and that of The Surgeon General had not led to any serious problems. Brig. Gen. Frederick A. Blesse, Surgeon, Army Ground Forces, stated that his office was primarily concerned with seeing that task forces being prepared to go overseas had everything they needed in the way of trained medical men and supplies and equipment. The question that had come up earlier in the year as to the respective jurisdiction of the Army Ground Forces and the Services of Supply over tactical medical units had by now been largely settled, he thought, as the Army Ground Forces now had control of most tactical medical units which were normally assigned to armies in an oversea theater, while The Surgeon General controlled the numbered station and general hospitals usually assigned to a services of supply. Unlike the Air Surgeon, the Ground Surgeon had done no direct recruiting of peronnel.[45]

Relations with the Hospitalization and Evacuation Branch, Services of Supply.—The committee probed thoroughly into the relations of the Hospitalization and Evacuation Branch (consisting of the Hospitalization Section and Evacuation Section) of the Plans Division, Services of Supply, with the Surgeon General's Office. A good deal of rather fruitless discussion developed over the interpretation of the following section in the Services of Supply Organization Manual of 10 August 1942. This read as follows:

> (a) The *Hospitalization Section* reviews plans for and coordinates activities related to military hospitalization overseas and within continental United States; and insures provision of adequate means for military hospitalization.
>
> (b) The *Evacuation Section* reviews plans for and coordinates activities related to evacuation of sick, injured, and other casualties from overseas and within the continental United States delivered to the control of the Commanding General, Services of Supply; insures provision of all means required for evacuation of sick and wounded; and coordinates with Commanding General, Army Air Forces, on the development and operation of air evacuation.[46]

It was the duty of Headquarters, Services of Supply, as Colonel Wilson, Chief of the Hospitalization and Evacuation Branch, conceived it, to review plans of the Surgeon General's Office, along with the plans of the other supply services, and coordinate them; for example, to attune The Surgeon General's medical plans for certain oversea operations to the available transportation. He made the point that the staff officer had the responsibility for revising plans, for example, for a certain number of hospital beds, upward or downward. He declared that he was trying to protect the interests and standards of the Medical Department, and that in taking that position he was sometimes under fire from staff officers. He advised the Assistant Chief of Staff for Operations, General Lutes, to the best of his ability, but the latter as his superior had the power of

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[45] Committee to Study the Medical Department, 1942, pp. 409–426.

[46] Services of Supply Organization Manual, 10 Aug. 1942, sec. 302.10(6).

decision. Whenever the Services of Supply lowered the standards of medical care or reduced the quantities of medical personnel or supplies, Colonel Wilson was then blamed by the Medical Department, although the circumstances were beyond his control.

Theoretical discussion revolved around the word "insure" in the passage above. Colonel Wilson interpreted the phrase "insures provision of adequate means" to mean that if the Surgeon General's Office did not make plans when it was asked to do so, it was the responsibility of his office to make them. If plans had not been properly made, it was the duty of his office to revise them. Colonel Wilson expressed the opinion that very few medical officers knew how to write papers addressed to staff officers in such a way as to insure definite decision by that body. In other words, many medical officers, he thought, had not mastered the technique of preparing memorandums and plans in the proper form for staff consideration. Thus, although the Surgeon General's Office had not failed to make plans in the broad sense, it had failed to put its proposals in standard staff terms. Colonel Wilson attributed slowness in obtaining approval of certain policies, such as immunization of all Army troops against tetanus, to this failure.

Colonel Wilson thought that the General Staff had neglected the Medical Department in the period prior to late 1940. In those days, when no Medical Department officer had been assigned to that office, a nonmedical officer had made staff decisions affecting the medical service. Colonel Wilson emphasized the fact that in order to issue a directive binding on all concerned, the Medical Department had to get staff approval. It was better for a medical officer to be assigned to a position where he could exercise influence over staff decisions on medical matters than for such decisions to be left entirely to nonmedical officers.[47]

In General Magee's interpretation, the phrase "insures provision of adequate means for military hospitalization" meant that the Hospitalization and Evacuation Branch would perform the necessary staffwork to insure that The Surgeon General's recommendations were carried out by the War Department. Presumably Services of Supply headquarters had considered it desirable to establish a Hospitalization and Evacuation Branch in order to coordinate matters relative to the hospitalization and evacuation of the sick and injured among the various services. The Surgeon General had had nothing to do with establishing the branch or with preparing the description of its duties embodied in the Services of Supply Organization Manual. He had assigned Colonel Wilson originally as a medical supply officer in G–4 and would not have appointed him to his present position. The Hospitalization and Evacuation Branch had undertaken to criticize recommendations by the Surgeon General's

[47] (1) Committee to Study the Medical Department, 1942, Testimony, pp. 1272–1340; 1869–1964. (2) Letter, Lt. Gen. LeRoy Lutes, to Director, Historical Division, Office of The Surgeon General, 8 Nov. 1950.

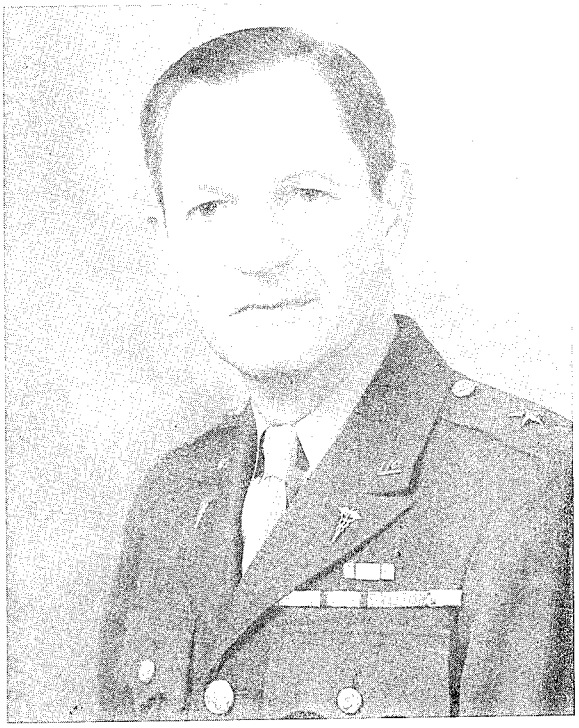


FIGURE 46.—Brig. Gen. Larry B. McAfee, MC.

Office with respect to hospitalization and evacuation, and to supersede these with recommendations of its own.[48]

The Chief of the Operations Service, Surgeon General's Office, Brig. Gen. Larry B. McAffee, MC (fig. 46), declared that his group had always tried to cooperate with the Hospitalization and Evacuation Branch, Services of Supply, on matters of hospitalization and evacuation, but that in many instances Colonel Wilson's policies had not represented those of The Surgeon General. Colonel Wilson's office had carried on actual medical operations to a certain extent, he said, and had conducted activities for which The Surgeon General was responsible, whereas in theory it was engaged in planning only. General Magee also thought that Colonel Wilson had engaged in "operations"; in his opinion an officer assigned to such a position should act as adviser only and should express the views of the Surgeon General's Office. His concept differed markedly from that of Colonel Wilson (and presumably that of Services of Supply officials), for Colonel Wilson consistently emphasized the fact that he acted under the direction of General Lutes. Undoubtedly the fact that Colonel Wilson was junior to some of the officers whose work he had criticized had added to the acrimony of the debates.[49]

[48] Committee to Study the Medical Department, 1942, Testimony, pp. 2039–2074.
[49] Committee to Study the Medical Department, 1942, Testimony, pp. 1727–1728; 2010–2022.

Charges embodied in a document, signed by Corrington Gill, consisting of briefs of memorandums from the files of Colonel Wilson's office, reviewed the major points of conflict between General Lutes' office and the Office of The Surgeon General. These included some whose origin dated back to the days when Colonel Wilson was assigned to G–4: the question of issuance of unit equipment to troops, charges that the Surgeon General's Office had failed to make adequate hospitalization and evacuation plans, and so forth. The document concluded with a statement that the summaries proved that the staff of the Services of Supply had found it necessary to formulate plans and policies which were obviously the responsibility of The Surgeon General to prepare and that it had repeatedly had to follow up directives issued to him in order to get action on them. The Surgeon General read before the committee a refutation prepared by Mr. Tracy S. Voorhees, then in charge of the legal work connected with medical supply contracts. The committee apparently reached the conclusion that this refutation, together with additional evidence obtained from Colonel Wilson and The Surgeon General in reappearances before the committee, disproved the charges.[50] No mention of the charges or of the refutation appeared in the final report of the committee.

FINAL REPORT OF THE INVESTIGATING COMMITTEE

The final report of the Committee to Study the Medical Department was submitted on 24 November 1942. It appeared in the form of sections entitled "Standards of Professional Service," "Adequacy of Medical Care," "Adequacy of Hospitalization," and the like. The three copies of the report were given to officials of the Services of Supply. No full copy of the report was sent to The Surgeon General, but the Chief of Staff, Services of Supply, forwarded to him, on 26 November, 85 of a total of 98 detailed recommendations, for specific changes in organization or policy which were within The Surgeon General's power to put into effect. Those not sent him had to do mainly with relations with the Army Air Forces and with the organizational position of The Surgeon General in the War Department; they were mostly matters for decision of higher authority.[51]

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[50] (1) Report to Committee to Study the Medical Department by Corrington Gill, no date, subject: Data From Files of Hospitalization and Evacuation Branch, Plans Division, Services of Supply. (2) Interview, H. Alexander Smith, Jr., 28 Oct. 1947. (3) Memorandum, The Surgeon General, for Col. Sanford H. Wadhams, 7 Nov. 1942, subject: Transmitting "Correcting Information to Confidential Document Submitted by Mr. Gill, entitled 'Report to Committee on Data from Files of Hospitalization and Evacuation Branch, Plans Division, Services of Supply.'" (4) Interview, Tracy S. Voorhees, 22 Sept. 1950. (5) Report of Subcommittee to Examine Col. Wilson's Criticism of the Surgeon General's Office, no signature, no date.

[51] (1) Memorandum, Col. Sanford Wadhams, for Commanding General, Services of Supply, 24 Nov. 1942. (2) Memorandum, Chief of Staff, Services of Supply, for Commanding General, Services of Supply, 25 Nov. 1942. (3) Memorandum, Chief of Staff, Services of Supply, for The Surgeon General, 26 Nov. 1942. (4) Memorandum for Record [by Corrington Gill], 12 Apr. 1943. (5) Memorandum, Director, Control Division, Services of Supply, for Chief of Staff, Services of Supply, 29 Nov. 1942. (6) Memorandum, Commanding General, Services of Supply, for Secretary of War, 16 Dec. 1942, subject: Report of Committee on the Study of the Medical Department of the Army.

In early January, General Magee asked for a copy of the complete report, stating that the extracts which he had received gave only "an incomplete and unsatisfactory idea" of the findings. The Chief of Staff, Services of Supply, replied that Services of Supply headquarters must await release of the report by Secretary Stimson. Although General Magee brought further pressure, he did not receive the report at that time. Neither had members of the committee received copies of the report, which they had signed under pressure of time without having an opportunity to read the final text. In February, Dr. Lewis H. Weed and Dr. Evarts A. Graham saw the Secretary of War and asked that the report be released. Former Surgeon General Merritte W. Ireland complained to the Chief of Staff, General Marshall, of the aggressively critical attitude toward the Medical Department exhibited during the committee sessions by the Services of Supply representative, Mr. Corrington Gill, and of the failure to release the report. General Marshall took these matters up with the Chief of Staff, Services of Supply. In the words of the latter, "General Marshall was very much alarmed at the fact that this report had not been furnished to The Surgeon General." After reaching decision on major points raised by General Somervell, Secretary Stimson approved release of the report to The Surgeon General. Copies were sent to members of the committee on 25 February, and The Surgeon General apparently received a copy at that date or soon afterward.[52]

RECOMMENDATIONS AND ACTION TAKEN

As to the position of the Medical Department within the War Department, the committee declared that the medical service was a "highly developed professional service" rather than a supply service and could not operate effectively within the present organization of the War Department. The Surgeon General should be at staff level; surgeons in the Army Ground Forces, the Army Air Forces, oversea forces, and service command headquarters should also have staff position. The committee found that the "existence of a semi-independent Medical Department within the Air Forces" had led to administrative confusion and duplication of effort. Every feasible means should be used to bring the Army Air Forces' medical service under the control of The Surgeon General or, failing this, a clear delineation of the Air Surgeon's functions under The Surgeon General should be made. The report accordingly recommended that the Office of The Surgeon General be placed on the special

[52] (1) Memorandum, The Surgeon General, for the Commanding General, Services of Supply, 12 Jan. 1943. (2) Memorandum, The Surgeon General, for the Secretary of War, through the Commanding General, Services of Supply, 12 Jan. 1943, and indorsements. (3) Letters, Col. Sanford H. Wadhams, to Dr. Lewis H. Weed, 25 Nov. 1942, 1 Dec. 1942; Dr. Weed to Col. Wadhams, 28 Nov. 1942; Dr. Evarts A. Graham to Dr. Weed, 21 Jan. 1943, 10 Feb. 1943, 3 Mar. 1943; Dr. Weed to Dr. Graham, 13 Feb. 1943. Personal file of Dr. Lewis H. Weed. (4) Memorandum, Chief of Staff, Services of Supply, for Commanding General, Services of Supply, 16 Feb. 1943, and inclosures, subject: Publicity Regarding Medical Department. (5) Memorandum, Chief of Staff, for H. H. Bundy, Special Assistant to Secretary of War, 25 Feb. 1943.

staff of the Chief of Staff, that a position of Chief Surgeon, Services of Supply (with rank and responsibilities corresponding to those of the Air Surgeon and the Ground Surgeon), be created on the staff of the Commanding General, Services of Supply, and that a unified medical division be set up in each service command, headed by a surgeon on the staff of the commanding general.

As to the internal administration of the Surgeon General's Office, the committee found that the Personnel, Administrative, and Professional Services, as well as the Fiscal and Training Divisions, deserved particular commendation. In general, the report stated, the Supply and Operations Services had done a good job in spite of their difficulties. On the other hand, the two important staff functions of vital records and medical intelligence had not been developed in proportion to their importance. The report termed the administration of the Army Nurse Corps weak, and strongly advocated the reorganization and strengthening of the Nursing Division. It praised the Office of The Surgeon General for "the excellent medical and nursing care" and preventive measures being provided the Army, and commended The Surgeon General for his "foresight in securing the cooperation and support of the medical profession and of the national medical organizations." However, the committee stated its belief that The Surgeon General had not protested strongly enough against certain financial and personnel restrictions and military orders not in consonance with the best medical practices. It believed that "aggressive presentation of the medical aspects of a military problem should always be a prime function of administration." It also found that The Surgeon General had not held frequent enough staff conferences on administrative matters, and it advocated continuing study of administrative procedures. It made certain recommendations for specific changes in the structure of the Surgeon General's Office. Finally, the committee pointed out the unique importance, among medical administrative positions, of the position of Surgeon General of the Army. It named the following qualities as those which The Surgeon General should possess in a marked degree: "Outstanding ability and experience in the medical profession," aggressiveness, and administrative ability.[53]

The report contained a detailed list of recommendations prepared by extracting from the major sections of the report, which were rather discursive, all definite statements that could be considered recommendations for specific action. In forwarding 85 of these recommedations to The Surgeon General, the Commanding General, Services of Supply, indicated those on which the Surgeon General's Office was to take immediate action and those on which a report was to be made by a specific date. Throughout most of the remaining

[53] Committee to Study the Medical Department, 1942, Report, Tab: Administration, pp. 25–30. On the other hand, the concurrent inquiry into the internal organization of the Surgeon General's Office and its use of officer personnel, which the Deputy Chief of Staff had directed the Inspector General to make, found that the Office was appropriately organized for the accomplishment of its mission and was economical in its use of commissioned personnel in supervisory positions. See Memorandum for the Inspector General, 30 Oct. 1942, subject: Report of Investigation of the Present Organization of the Surgeon General's Office.

months of General Magee's tenure as The Surgeon General, various segments of his office were engaged in replying to or following up one or another of this group of recommendations. Only those relating primarily to matters of organization and administration are discussed below.[54]

One recommendation (No. 28) stipulated that the staff of the Surgeon General's Office and of certain service commands should include a trained consultant on hospital administration. This recommendation was tied in with a more general proposal in the committee's report to make wider use of lay hospital administrators in responsible positions concerned with hospital administration. The Surgeon General's Office originally replied that it considered the work of the commanding officer of an army hospital more confined to technical medical duties than was that of the usual civilian hospital administrator. It noted that in military service many functions of hospital administration—for example, new construction, employment of personnel, solicitation of funds, and so forth—were handled by other branches of the War Department than the Medical Department or by Federal Government processes outside the War Department. However, by January 1943, the Surgeon General's Office had begun negotiations for the commissioning of Dr. Basil McLean, superintendent of the Strong Memorial Hospital in Rochester, N.Y., in order to assign him to the Surgeon General's Office to study the organization and administration of military hospitals. The office met with some difficulty in obtaining the release of Dr. McLean from several serious commitments in civilian life. After he came, he appears to have been given little responsibility; he left the following year.[55]

A recommendation (No. 33) that the Hospital Construction Division be headed by a nonmedical man experienced in hospital planning came to naught. The Surgeon General answered in his original reply to the recommendations that the Director of the Hospital Construction Division was a Regular Army medical officer of over 25 years' experience and that "only a doctor with long experience in handling patients under Army conditions can be fully aware of the needs in Army hospital units." Any plan for hospital construction would have to be reviewed "by active medical men" before The Surgeon General could approve it. The reply also noted, as proof that this division was not using medically trained officers in positions where nonmedical men would have sufficed, that the division contained three nonmedical officers, two medical officers who were overage for field duty, and a number of civilians trained in architecture or previously connected with architectural firms of national reputation. Apparently nothing further developed from this reply.

A recommendation (No. 34) that the Surgeon General's Office become more currently informed on sicknesses and casualties in oversea theaters eventu-

[54] Unless otherwise noted, the following discussion of the committee's recommendations and action taken on them is based on a notebook kept by Corrington Gill, the committee's executive secretary, entitled "Action on Recommendations of Committee to Study the Medical Department, 1942–43."

[55] (1) Interview, Dr. H. A. Press, formerly with Control Division, Office of The Surgeon General, 9 Oct. 1950. (2) See footnote 50(4), p. 175.

ally led to significant improvement in the Office's knowledge of medical developments in the oversea theaters. Before the report of the committee appeared, the Surgeon General's Office sent to each oversea theater of operations and the Eastern, Western, and Caribbean Defense Commands a request that the command forward on the 1st and 15th of each month a brief summary on the status of the following phases of the medical program within the command: Matters of organization; location of major medical units, supplies, and equipment; problems in preventive medicine; unusual diseases; and so forth. The Commanding General, Caribbean Defense Command, protested against the sending of this report on the ground that a commander ought not to be bypassed by the reporting of a special staff officer directly to a chief of service. The Office of the Inspector General agreed with this point of view. In late October 1942, the Hospitalization and Evacuation Branch of the Services of Supply had already sent to some of the same commands a request for a similar report, which met no opposition, presumably because it called for a single, not a recurrent, report.[56]

These requests not only duplicated each other in part but to some extent duplicated information already being received, although late, from established reports. They also further illustrated the prevailing confusion, if further evidence were needed, as to the mutual authority and responsibility of the Hospitalization and Evacuation Branch, Services of Supply, and the Surgeon General's Office. The General Staff called the attention of the Services of Supply to the duplication, and General Somervell ordered rescission of the request from the Surgeon General's Office, asking the office to use the proper channels henceforth. After consultation between the Hospitalization and Evacuation Branch, Services of Supply, and the Surgeon General's Office, commanders of forces outside the United States were asked in January 1943 to submit the data wanted by the Surgeon General's Office regularly in the monthly sanitary report. Purely technical information was to be extracted and sent in advance not later than the fifth day after the end of the month, by V-mail or airmail. Out of this procedure developed in July 1943 a report entitled "Essential Technical Medical Data" which to the end of the war was a regular report furnishing valuable information on medical matters overseas.

With respect to a recommendation (No. 50) that a consultant psychiatrist be assigned to each service command, the Surgeon General's Office noted that consultant psychiatrists had already been assigned to the Fourth and Eighth Service Commands and that others were being selected for all service commands except the Sixth, where the supervisory work in psychiatry did not appear to

[56] (1) Memorandum, Executive Officer, Office of The Surgeon General, for the Adjutant General, 12 Nov. 1942, subject: Request for Medical Reports. (2) Routing slip, Deputy Inspector General, to Deputy Chief of Staff, 30 Nov. 1942, subject: Reports Required of the Commanders by The Surgeon General and Reports Required of Machine Records Branch, Adjutant General's Office. (3) Memorandum, Col. William L. Wilson, for Assistant Chief of Staff for Operations, 4 Dec. 1942, subject: Reports Required of Theater Commanders.

justify full-time work by a staff of consultants. No action was taken on recommendation No. 58, calling for a unified medical division within each service command, the director to serve on the staff of the service commander. General Somervell had disapproved General Magee's request of 7 November that this scheme be adopted in the service commands, and General Magee stated that in view of General Somervell's opposition, his office would cooperate to make the existing organization work.[57]

Following up a recommendation (No. 59) that the Nursing Division be reorganized and strengthened, the Superintendent of the Army Nurse Corps asked to be retired. Her successor, Lt. Col. (later Col.) Florence A. Blanchfield, was named in February, effective 1 June 1943. The Control Division, Surgeon General's Office, began reorganizing and simplifying office procedures of the Nursing Division, and the Surgeon General's Office and the Red Cross began a concerted recruiting drive to get nurses into the Army. In 1943, one or more members of the Army Nurse Corps were assigned to the Officer Procurement Districts in the service commands to accelerate recruiting of nurses.[58]

A number of the detailed recommendations (Nos. 60, 61, 65, 67, 68, 69, and 70) of the committee's report related to the work of the Vital Statistics Division. The committee advocated the establishment of a Statistical Division to include administrative statistics as well as medical statistics; in other words, the entire field of statistics compiled by the Surgeon General's Office. This division, it maintained, should be a staff division and should be headed by an outstanding statistician versed in both fields of statistics. The Surgeon General's Office took the position that records pertaining to health of the Army constitute a specialized branch of statistics which should not be organizationally consolidated with other types. The major field in which statistics were compiled in the Surgeon General's Office, other than vital statistics, was that of medical supply. Medical supply statistics were directly related to the work of the Supply Service which was then being reorganized, and the Surgeon General's Office stated that it was more feasible to leave the handling of such records to the Supply Service. The two functions remained separate.

The Surgeon General's Office and the Services of Supply made strenuous efforts throughout the first half of 1943 to expedite the work of the Vital Statistics Division. Many changes in personnel took place. Another officer was made director of the division in February, but in April General Somervell asked that he be relieved. In June, Capt. Harold F. Dorn, SnC, previously

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[57] Memorandum, The Surgeon General, for the Commanding General, Services of Supply, 7 Nov. 1942, and 1st indorsement, Commanding General, Services of Supply, for The Surgeon General, 12 Nov. 1942.

[58] (1) Assignment No. 46, Nursing Division, Report No. 1, Recommendations re: Organization and Procedure, 15 Dec. 1942. (2) Blanchfield, Florence A., and Standlee, Mary W.: The Army Nurse Corps in World War II, vol. II, p. 430. [Official record.]

of the U.S. Public Health Service, was made director by the new Surgeon General.[59]

Some disagreement in policy on administration of the medical statistics program between the Surgeon General's Office and the Services of Supply derived from differences in concept as to the use to be made of vital statistics. The Surgeon General's Office apparently stressed the importance of these records for historical research and for long-range planning. Some officers of the Services of Supply believed that accurate statistical estimates, if they could be made promptly enough, were of value for operating purposes. These officers criticized the Surgeon General's Office for its failure to develop statistics as a tool of current operations, instead of relying upon the judgment of the medical officers concerned.[60] No examples were given, however, of any situation that could have been handled more effectively on the basis of statistical compilations than by direct personal contact. From The Surgeon General's point of view, the time factor was overriding.

Two major causes of large backlogs of work in the Vital Statistics Division were late reception of forms from overseas and lack of technically trained personnel and clerks. The report of the Committee to Study the Medical Department recognized the lack of personnel as a serious factor in delaying the work of the division. Between July 1942 and June 1943, civilian personnel in the Vital Statistics Division increased from about 220 to about 300. In July and August 1943, a few statistical experts from the Metropolitan Life Insurance Co. reported for duty in the division.[61]

Two recommendations (Nos. 62 and 75), for more aggressive presentation of the medical aspects of military problems and of medical needs, were concerned with the personality of The Surgeon General. As General Magee was then inspecting Army medical service in North Africa and the United Kingdom, his office refrained from making any comment. General Magee did not admit to any lack of aggressiveness. His concept of The Surgeon General's responsibilities was later expressed in these words: "The needs of the Medical Department were fully presented, as occasion arose, within the limits of proper military procedure. It is not contemplated that an officer in the position of The Surgeon General should be required to throw his hat on the ground and dance on it in an effort to command attention." [62]

In answer to a recommendation (No. 63) for regular staff meetings in the Surgeon General's Office, the office pointed out that all medical men recog-

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[59] (1) Office Diary, Col. Albert G. Love, MC, entries for February–June 1943. (2) Memorandum, Director, Control Division, Army Service Forces, for Commanding General, Army Service Forces, 30 June 1943.

[60] (1) Report on Vital Records Division by the Control Division, 3 Apr. 1943. (2) General Statement, Interim Report by Statistics and Progress Branch, Services of Supply, on the Vital Records Division, 3 May 1943.

[61] (1) Memorandum, Director, Medical Statistics Division, Office of The Surgeon General, for Director, Historical Division, 24 July 1943. (2) Weekly Reports by Director, Medical Statistics Division, to Executive Officer, July and Aug. 1943.

[62] Letter, Maj. Gen. James C. Magee, USA (Ret.), to Director, Historical Division, 3 Dec. 1951.

nized the value of these, as staff meetings were regularly conducted in all large hospitals. They stated that the office had only recently discontinued its weekly staff meetings of chiefs of divisions when it appeared that they interfered with the work of the office "without compensating advantages." Staff meetings were now held whenever the need arose. The Surgeon General's Office stated that regular meetings at 2-week intervals would be undertaken. These were apparently initiated by January 1943.[63]

One recommendation (No. 65) specified those divisions which the committee thought should report directly to The Surgeon General, or in the semimilitary terminology of public administration, should be at "staff level." The Public Relations Division, which had been changed to the Office of Technical Information in accordance with the nomenclature used by the Services of Supply and which had become a staff division in the August reorganization, had by November, for no apparent reason, been reduced to a branch of the Office Administration Division. The Surgeon General's Office stated that its personnel now consisted of one officer and two clerks and that no particular objective would be attained by putting it again at staff level. It was nevertheless restored to a staff position in April 1943. The office also opposed placing the Medical Intelligence Branch of the Preventive Medicine Division at staff level, on the grounds that its work was largely concerned with military preventive medicine and consequently needed correlation with the plans and policies of the Preventive Medicine Division. The organizational element handling medical intelligence continued to be a part of the Preventive Medicine Division (or Service) throughout the war.[64]

Another recommendation (No. 66) advocated the grouping of major divisions under three "services" instead of the prevailing five. The committee hoped to bring about still greater reduction in the number of officers reporting directly to The Surgeon General than the reorganizations of 1942 had theoretically effected. The scheme tallied with the existing organization insofar as the Professional and Supply Services were concerned. The major change proposed was that of grouping the Training and Fiscal Divisions, now staff divisions, and the two large Operations and Personnel Services, together with the divisions of the existing Administrative Service (Office Administration, Research and Development, and Historical), under a new and large Administrative Service. The Surgeon General's Office replied that the proposed new Administrative Service would group 11 diversified functions under 1 head. One of these, the Fiscal Division, had been placed at staff level by War Department directive. It also pointed out that the heads of only seven operating agencies now reported directly to The Surgeon General or his deputy.

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[63] Memorandum, Director, Control Division, for the Commanding General, Services of Supply, 27 Jan. 1943, subject: Investigation of Administrative Matters of the Surgeon General's Office.

[64] Morgan, Edward J., and Wagner, Donald O.: The Organization of the Medical Department in the Zone of Interior, p. 19. [Official record.]

Thus very few of these detailed changes advocated for the internal structure of the office were adopted. Not one of those recommendations which directly advised the regrouping or relocation of functions (Nos. 60 and 61, 65, 66, and 68) was put into effect. A number of changes made in the organization of the Supply Service in February 1943 show continuing efforts to cope with the problems of that service, but they were of short duration. In June another reshuffle of functions of the Supply Service was made by the new Surgeon General and his advisers.[65]

In the first half of 1943 a good many changes in procedures and a good deal of expansion in space and in personnel, especially civilian, took place in such segments of the Surgeon General's Office as the Supply Service and the Vital Statistics Division for which experience of the past year had clearly demonstrated the need. The addition of civilian personnel was perhaps the most important internal development which the investigation brought about in the office. With the advent of a new Surgeon General, some key officer personnel, including the heads of some services and divisions whose work had been criticized, were replaced by new appointees.

One result of the committee's work, which was not dealt with in its report or in any recommendations, was the decline in the activities and the eventual abolition of the Hospitalization and Evacuation Branch of the Plans Division, Services of Supply. Although it remained in existence until February 1944, a new medical officer assigned as head of this unit by General Lutes tended to minimize its activities. He took the position that the work of coordinating hospitalization and evacuation activities which the unit had attempted to effect more properly belonged to the Office of The Surgeon General or could be handled by direct liaison between the Surgeon General's Office and the other agencies concerned.[66]

The detailed recommendations not sent to The Surgeon General were concerned with the matter of his position within the War Department, his relationships with the Air Surgeon's office, and the degree of his control over medical service of the Army Air Forces. They were as follows:

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43. The Air Corps should not be permitted to establish a school for training Medical Administrative Corps personnel.

44. Medical officers attached to the Air Corps should be assigned to special courses such as tropical disease now being given in civilian institutions and in military installations.

45. The number of experienced neuropsychiatrists for work with the Army Air Forces should be increased. They should be selected directly by the Office of The Surgeon General.

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54. The Surgeon General should function as a staff adviser to the Combined Chiefs of Staff and to the Joint Chiefs of Staff.

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[65] Morgan, Edward J., and Wagner, Donald O.: The Organization of the Medical Department in the Zone of Interior, pp. 25–26. [Official record.]

[66] (1) Memorandum, Director, Planning Division, Services of Supply, for Col. Robert C. McDonald, 24 Mar. 1943. (2) Diary, Hospitalization and Evacuation Branch, Services of Supply, entry of 4 May 1943.

55. Every practicable effort should be made to bring medical service in the Air Force under the supervision, authority, and control of The Surgeon General, failing which a clear and concise delimitation of authority, responsibility, and functions of the Air Surgeon under The Surgeon General should be formulated and issued by proper authority.

56. The Office of The Surgeon General should be on the special staff of the Chief of Staff.

57. There should be created on the staff of the Commanding General, Services of Supply, the position of "Chief Surgeon," Services of Supply, with rank commensurate with the position and involving responsibility and authority corresponding to that of the Air Surgeon and of the Ground Surgeon within their respective commands.

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64. There should be a Deputy Surgeon General serving full time.

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82. The Air Surgeon should not undertake procurement of medical personnel except through the Office of The Surgeon General.

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97. Research on the physiological and psychological problems in flying should be more closely coordinated with other research problems of the Medical Department.

For the most part these recommendations called for decision by higher War Department authority. They involved three basic problems: the organizational position of The Surgeon General and his office in the War Department; relationships of The Surgeon General and his office with the medical organization of the Air Forces; and problems relative to the post of Surgeon General and his Deputy, who acted primarily as Chief of the Operations Service. General Somervell presented these matters to the Secretary of War for decision on 16 December.

Apropos of the committee's recommendations that The Surgeon General report directly to the Chief of Staff, General Somervell stated that this change would be contrary to the basic purpose of the March reorganizations; that is, to relieve the Chief of Staff of direct administrative relationship with the various services. The individualistic character of the profession of medicine, which he termed one of its best characteristics, made desirable a general administrative supervision of its work which neither the Secretary of War nor the Chief of Staff should be expected to give. On the other hand, he thought that the proposal that The Surgeon General have the same authority over medical organization in the Army Air Forces as over that in other branches of the Army was organizationally sound. He had previously discussed with the Chief of Staff the recommendation of the committee as to the appointment of a full-time deputy surgeon general to be placed in training as successor to the present surgeon general.[67]

On 16 February Secretary Stimson agreed that there should be no Army organizational change with respect to the status of The Surgeon General. "In principle" it seemed wise to him that the authority of The Surgeon General

[67] Memorandum, Commanding General, Services of Supply, for Secretary of War, 16 Dec. 1942, subject: Report of Committee to Study the Medical Department of the Army.

over Air Forces medical organization should be the same as that over other branches of the Army. Secretary Stimson did not commit himself as to the selection of a new surgeon general, but noted that the matter of an appointment at the end of the present term would "receive prompt consideration." [68]

RESULTS OF THE INVESTIGATION

It is not clear whether the investigation of the Medical Department was primarily undertaken as an effort to remove General Magee from his position as The Surgeon General.[69] If so, it failed of its purpose. Although the Surgeon General's Office began remedial action on a number of the detailed recommendations early in 1943, including those on matters of organization and administration, few changes in the internal organization of the office, other than the addition of substantial numbers of personnel to some divisions of the office, occurred before General Magee's 4-year term as The Surgeon General ended. The committee's ideas as to the improvement of the position of the Medical Department within the War Department structure received short shrift from the Commanding General, Services of Supply, and the Secretary of War, and presumably were similarly disapproved by the Chief of Staff. Hence the problems inherent in the position of The Surgeon General in War Department structure and the scattering of medical responsibilities throughout a number of elements of the War Department and Army remained. Nevertheless the investigation had the effect of stimulating awareness by both the Medical Department and the War Department of some of the Department's most pressing problems and spurring on development of measures to cope with them.

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[68] (1) Memorandum, Secretary of War, for Chief of Staff, 16 Feb. 1943. (2) Memorandum, Chief of Staff, Services of Supply, for Commanding General, Services of Supply, 16 Feb. 1943. It is clear from (2) that General Somervell and General Marshall had a candidate for General Magee's successor under consideration, but Secretary Stimson was not so informed.

[69] Maj. Gen. Howard McC. Snyder and Mr. Tracy S. Voorhees stated in interviews with the writer on 25 May 1948 and 22 September 1950, respectively, that the removal of General Magee was the primary purpose of the investigation.

CHAPTER VI

The Surgeon General's Office, 1942–1945

Aside from the relatively small number of changes in organization made as an immediate outgrowth of the Wadhams Committee investigation, the structure and functions of the Surgeon General's Office evolved gradually in response to the growing requirements of the war. Neither General Magee nor his successor was able to reassert effective control over the Air Forces medical service, nor to escape entirely the pattern of relationships imposed by the Services of Supply, but these failures were only administrative roadblocks to be worked around, not irrevocable disasters. There were substantial gains before the end of 1942 in other areas, the most notable of them being in preventive medicine.

PREVENTIVE MEDICINE, SEPTEMBER 1942–JUNE 1943

During the latter part of General Magee's administration, development of measures and organizational elements to handle several major programs—malaria control, typhus control, quarantine at ports, and the health program for civilians in occupied countries—went on as part of the normal planning of the Surgeon General's Office. The investigation of the Medical Department probably gave some impetus to the planning for malaria and typhus control, for Secretary Stimson had stressed disease problems in oversea areas in his opening remarks to the committee. In the latter part of 1942, the Epidemiology Branch of the Preventive Medicine Division planned the "special organization for malaria control" to be sent to theaters of operations where malaria presented a serious threat to troops. A new agency, the United States of America Typhus Commission, was established to combat possible outbreaks of typhus, and another to cope with problems of quarantine caused by the entry of large numbers of U.S. Army troops into foreign areas. Planning for these programs had been done by the Preventive Medicine Division, Surgeon General's Office, from the years of the emergency period. Finally, the last 5 months of General Magee's administration (January–May 1943) witnessed further developments in planning for medical work among citizens of occupied countries. This last program, however, was still largely planned, as previously, at War Department staff levels rather than in the Surgeon General's Office.

Malaria Control

The "special organization for malaria control" devised by the Surgeon General's Office in 1942 was a flexible organization consisting of one malariologist, one or more assistant malariologists, one or more survey units, and one or more control units. It was designed to plan and put into effect malaria control measures for a theater of operations and was to be available for assign-

ment to a theater on request. It would instruct troops on antimalaria measures, survey areas for the occurrence of mosquitoes, determine the prevalence of all mosquitoborne diseases, including filariasis, dengue, and yellow fever as well as malaria, and undertake measures to control them. The malariologist was to have immediate administration of the program under the direct supervision of the theater surgeon and to act as consultant to the latter on all problems. The assistant malariologists were to be active in administering all phases of the program, particularly in developing individual preventive measures on the part of soldiers.

The malaria survey unit consisted of an entomologist and a parasitologist (both Sanitary Corps officers) and 11 enlisted men. It would act as a mobile malaria laboratory, making surveys to determine the prevalence of mosquitoes in various areas, or their breeding places, and would investigate the occurrence of malaria parasites among troops and civilians. The malaria control unit consisted of a sanitary engineer (a Sanitary Corps officer) who had had special experience in malaria control, and 11 enlisted men. Its task was to plan the control measures, supervising the drainage and larvicidal work in areas where the surveys had determined antimosquito work to be necessary. Civilian antimalaria gangs were to be hired to do the drainage and larvicidal work if they were available in the area; if not, medical sanitary companies were to be used.

This machinery for malaria control was proposed by the Surgeon General's Office on 21 September 1942; G–1 gave its approval on 9 October. On 24 October the Surgeon General's Office informed the surgeons of oversea theaters in which malaria was a serious threat of the plans for this network for control, asking them to send in their requests for the malariologists and units they needed. By the middle of December the office had received requests from the South and Southwest Pacific Areas. Malariologists and units were not available, however, until February and March of 1943. After that date they were sent not only to the Pacific areas, where the majority were located, but also to the China-Burma-India theater, North African theater, the Africa-Middle East theater, and to U.S. Army Forces in the South Atlantic (in Brazil). By April 1945, 70 survey units and 153 control units were working in the oversea theaters. In the course of the war 76 malaria survey units were created; 72 were sent overseas or were organized in oversea areas. A total of 161 control units were organized and sent overseas (or activated overseas); 16 others organized and trained in the United States were still there when the Japanese surrendered. About two-thirds of each group served in one of the Pacific areas.[1]

[1] (1) Memorandum, The Surgeon General, for Commanding General, U.S. Army Forces in the Middle East, 24 Oct. 1942, subject: Malaria Control. Similar memorandum for commanding generals of other oversea theaters. (2) Memorandum, Executive Officer, Office of The Surgeon General, for Commanding Generals of Theaters of Operations and Service Commands, 24 Mar. 1943, subject: Special Organization for Malaria Control. (3) Simmons, J. S.: Control of Malaria in the United States Army. *In* Boyd, Mark F., ed.: Malariology. Philadelphia: W. B. Saunders, 1949, vol. II, pp. 1455–1468. (4) Medical Department, United States Army. Preventive Medicine in World War II. Volume VI. Communicable Diseases: Malaria. [In press.]

The United States of America Typhus Commission

In the late months of 1942 there was a growing awareness, further stimulated by the Wadhams Committee investigation, of the magnitude of the Army's problem in disease prevention. Reports that louseborne epidemic typhus was on the increase in North Africa and other Mediterranean areas, as well as in eastern Germany, had reached the Surgeon General's Office just as preparations for the Allied invasion of North Africa were getting underway. These reports had precipitated a conference of Army, Navy, and U.S. Public Health Service representatives in August 1942, at which plans for a typhus commission were discussed, and personnel from the three services tentatively selected.

The United States of America Typhus Commission was established by Executive Order No. 9285 on 24 December 1942. It was created as an interdepartmental organization in the War Department to be staffed by personnel of the Army, Navy, and U.S. Public Health Service, and civilians to be appointed by the Secretary of War, who was also to name the Commission's Director. Under the overall direction of the Secretary of War, the Typhus Commission was to serve with the Army of the United States to prevent and control typhus fever wherever it was or might become a threat. Although as a special agency of the War Department the Commission was in a sense placed at a level above the Surgeon General's Office, there was never any conflict of authority. After the first month of its operation, the headquarters of the Commission were located in the Preventive Medicine Service of the Office of The Surgeon General. Its second and third directors and its Field Director were all brigadier generals in the Medical Corps. The Director was given broad responsibilities for making arrangements for the study of typhus fever by establishing field groups overseas for the purpose and maintaining research units at Government laboratories. The aid of other U.S. Government agencies with equipment and personnel was assured to the Secretary of War and the director of the commission. The Executive order also established a United States of America Typhus Commission Medal, "including suitable appurtenances," to be awarded, by the President or at his direction, to persons who should "render or contribute meritorious service in connection with the work of the Commission."

The original membership of the Commission, as of the end of 1942, consisted of 16 representatives, mostly medically trained men of the Army, Navy, U.S. Public Health Service, and the Rockefeller Foundation. Capt. Charles S. Stephenson of the Navy was made director and given the rank of rear admiral in order to bestow on him the prestige desirable for dealing with state and military authorities of foreign countries. The administrative affairs of the Commission were handled by a rear echelon in Washington headed by Maj. Gen. LeRoy Lutes, then Assistant Chief of Staff for Operations, Services of

Supply, and including a representative of each of the three Federal medical services. The remaining members, the so-called "field group" headed by the director, went to Cairo early in 1943 to collect strains of typhus virus and experiment with control by means of various antilouse powders. The membership of the two Rockefeller Foundation experts was to be only temporary; they were specifically assigned by the foundation to develop methods for the control of typhus in civilian populations.[2]

The organization of the U.S.A. Typhus Commission underwent significant changes from the date of its establishment to its discontinuation in 1946. Although members of the Medical Department who had been active in creating the Commission had originally pooled the resources of a number of agencies, civil and military, the long-range trend was toward greater control of the Commission by the War Department and Army, with less by the other agencies represented. The Commission remained interdepartmental in membership, having some representatives of the Navy and the U.S. Public Health Service as members to the end of its existence, but the Medical Department (with the Preventive Medicine Division, Surgeon General's Office, taking the lead) largely assumed direction of its work. After the Navy director became ill, a number of Army officers connected with the Commission pointed out that typhus was primarily an Army, not a Navy, problem since larger numbers of ground troops would come into contact with civilians infected with typhus in invaded areas. Col. (later Brig. Gen.) Leon A. Fox, MC, was made director of the Commission in February 1943 and undertook supervision of the field group in Cairo as his predecessor had done. He was instrumental in making substantial changes in the character of the membership by arranging for removal of some members of the Cairo group, particularly several Navy officers. The commissioning of one typhus expert from the Rockefeller Foundation by the Army and the departure of the other to head a separate typhus control program in the North African theater, previously planned by the foundation, made the field group largely an instrument of the Medical Department by mid-1943.

Centralized control of the Commission's work in the Surgeon General's Office in Washington—rather than, as in the early months, in Cairo—came about as the need developed for suppressing dissension in the Cairo office and as it became clear that additional field offices in other typhus-ridden areas would be necessary. About mid-1943, the deputy director of the Preventive Medicine Service, Col. Stanhope Bayne-Jones, MC (fig. 47), assumed the duties of director and General Fox was made field director at his own request. General Fox had been moving rapidly about the world since 1940 in several medical capacities and was thus able to continue various duties of a liaison nature in the typhus control program, particularly in connection with the allocations of typhus vaccine by the United States to foreign governments.

[2] Letter, Dr. Fred L. Soper, to Director, The Historical Unit, 10 Aug. 1955.

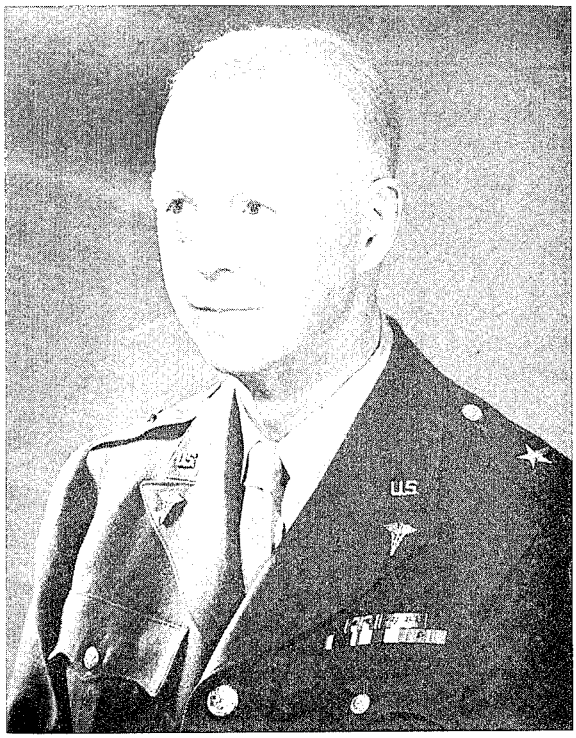


FIGURE 47.—Col. Stanhope Bayne-Jones, MC.

From then on to the close of the war, control of the Commission's field groups was exercised from Washington.

During the early months of the Commission's existence, a strong desire for individual recognition and a good deal of rivalry developed among its members. The rivalry was in part personal or professional and in part factional by reason of the various organizations, civilian and military, represented. It sprang up chiefly among the field group in Cairo, where jealousy developed between Army and Navy members and between Army and Rockefeller Foundation members. Nevertheless, the rivalry, which, along with the lack of accessible typhus epidemics, delayed accomplishments by the Cairo field group, only seems to have spurred the Commission on to greater efforts whenever serious epidemics were encountered. General Fox stated on the eve of the Naples epidemic in the winter of 1943: "This is no time for fights over jurisdiction. There will be more typhus control before spring than all can handle * * *."[3] Success in Naples by means of widespread spraying of the population with antilouse powder settled the difference of opinion which had previously existed as to the relative merits of antilouse powder and typhus vaccine for controlling epidemics. From that date on a good deal more cooperation was in evidence.

[3] Coded Message CM–IN–8358, Teheran to Cairo and AGWAR, 13 Dec. 1943.

Field groups of typhus experts worked effectively in most of the major theaters of operations. The field party of the Commission in a theater was administratively subject to theater control, but assignments were made to the various theaters by the Washington office of the Commission. The Cairo group worked in various countries of the Africa-Middle East theater, as well as in the Naples area of the Mediterranean theater during the winter of 1943–44 and in the Balkans in the spring of 1945, effectively checking a number of incipient epidemics among the civil populations and thus protecting the health of Allied troops. Other groups of typhus experts served in the European theater, where large-scale outbreaks in the Rhineland and Austria were suppressed; in the China-Burma-India theater and Southwest Pacific Area, where important work was done on scrub typhus; and later in Korea and Japan. The medal was awarded by June 1945 to 35 individuals, including not only officers of the Army, Navy, and U.S. Public Health Service and Rockefeller Foundation experts who were assigned or attached to the Commission but also a few British Army medical officers, several Egyptian public health officials, and the American Ambassadors to Italy and Turkey.[4]

Port Quarantine

During the last months of General Magee's administration the Medical Department also embarked upon a program of cooperation with the U.S. Public Health Service as to quarantine procedures at ports. An interdepartmental quarantine commission was first discussed early in 1943 at the instance of U.S. Public Health Service officials. The U.S. Public Health Service was responsible for preventing the carriage of certain diseases (cholera, smallpox, plague, epidemic typhus, yellow fever, and leprosy) into the United States and its territories by ships and planes. The increased volume of war traffic, particularly of planes, the necessary secrecy of movements of military ships and planes, their entry into areas which had no quarantine regulations, and the breakdown of quarantine systems in some areas under wartime conditions had led U.S. Public Health Service officials to a realization that revision of quarantine procedures was necessary.

The U.S. Public Health Service lacked sufficient personnel to cope with its wartime quarantine problems. To tackle the problem, the Surgeons General of the Army, Navy, and U.S. Public Health Service formed the Interdepartmental Quarantine Commission, appointing a representative from each of their respective services in mid-1943. The Commission did special work in coping with the threat of the transfer of *Anopheles gambiae* to Brazil from West Africa by planes. By mid-1944, when it submitted its final report, it had worked out the mutual responsibilities of the Army, Navy, and U.S. Public

[4] A fully documented account of the organization and activities of the U.S.A. Typhus Commission, prepared by Brig. Gen. Stanhope Bayne-Jones, USA (Ret.), is included in a forthcoming volume, Medical Department, United States Army. Preventive Medicine in World War II. Volume VII. Communicable Diseases: Arthropodborne Diseases Other Than Malaria. [In preparation.]

Health Service for various phases of quarantine procedure in oversea areas. The Secretary of War made The Surgeon General responsible for establishing and supervising quarantine procedures of the Army in foreign countries. The Surgeon General appointed an Army quarantine liaison officer to keep in touch with the program of the U.S. Public Health Service and the Navy and to integrate the Army's quarantine procedures with those of foreign countries and areas beyond the domain of the U.S. Public Health Service. Modernization of the military regulations relating to quarantine, especially of Air Force regulations, resulted. The fieldwork of the quarantine liaison officer's unit—the Quarantine Branch of the Epidemiology Division, Preventive Medicine Service—included many studies of quarantine procedures and problems at U.S. Army facilities and on U.S. Army carriers at home and abroad.[5]

Major developments in the planning of medical programs for civilians in occupied countries also took place in the first half of 1943. Throughout the emergency period and the first year of war, the Surgeon General's Office had participated in medical aspects of the planning for the Army's conduct of civil affairs in occupied countries which various elements of the War Department had undertaken. In 1942 it had assigned personnel to lecture on public health at the School of Military Government at Charlottesville, Va. (under the direction of the Provost Marshal General), and supplied the school with its basic medical intelligence data on foreign countries. As the training for military government progressed with the establishment of similar schools at various universities, the Surgeon General's Office aided in organizing whole courses in public health. It sent to the schools for training, Medical Department officers of the several corps who applied through military channels, U.S. Public Health officers assigned to the Army, and medically trained civilians commissioned by The Surgeon General specifically for civil affairs work.

In January 1943, major responsibility for recruiting personnel to handle the medical aspects of civil affairs and for developing a medical program was vested in Col. Ira V. Hiscock, SnC (fig. 48), who had previously worked on the program both in the Preventive Medicine Division, Surgeon General's Office, and at the School of Military Government. He was assigned to the Office of the Provost Marshal General to select, in conjunction with the Director of Personnel, Surgeon General's Office, and the Director of the Military Government Division, Provost Marshal General's Office, medically trained personnel to be given training as public health officers at the schools operated by the Provost Marshal General. He also assembled material to aid the Army, Navy, and various agencies in planning their relief and rehabilitation work in occupied countries.

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[5] (1) Final Report, Interdepartmental Quarantine Commission, 10 June 1944. (2) Knies, P. T.: Quarantine and Disinsectization of Aircraft. Air Surg. Bull. 1: 16–18, October 1944. (3) Medical Department, United States Army. Preventive Medicine in World War II. Volume II. Environmental Hygiene. Washington: U.S. Government Printing Office, 1955, pp. 278ff.

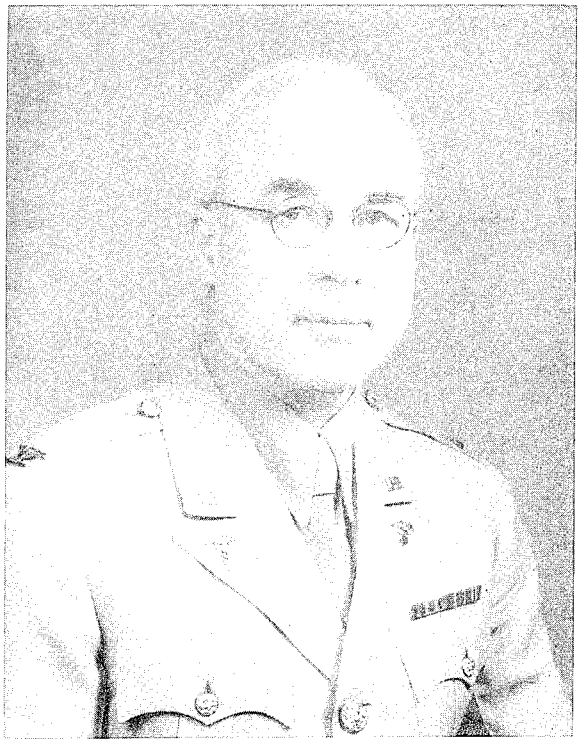


FIGURE 48.—Col. Ira V. Hiscock, SnC.

In March 1943 the War Department established the organization to handle the total program for administering civilian affairs in occupied areas by creating a Civil Affairs Division on the War Department Special Staff. In April, Colonel Hiscock was reassigned to this division to take charge of what was later called the Public Health Section, and chief responsibilities for the medical phases of the civil affairs program were vested in him. He continued the activities he had engaged in at the Office of the Provost Marshal General, selecting personnel and assembling material for planning. He maintained liaison with many agencies which shared the responsibility for planning the civil affairs program and initiated conferences with members of the Supply Division, Surgeon General's Office, and other agencies to discuss the probable requirements of medical and sanitary supplies for civilian use. A medical supply board was organized in the Surgeon General's Office to prepare estimates of requirements, but it was not until early 1944 that the responsibilities of the office were broadened to include aspects of the medical program other than supply and that an organizational unit to handle the program was established in the office.[6]

[6] For full discussion and more complete documentation, see Medical Department, United States Army. Preventive Medicine in World War II. Volume VIII. Civil Public Health Problems and Activities. [In preparation.]

EFFORTS TO REGAIN CONTROL OF MEDICAL SERVICE IN THE ARMY AIR FORCES

At another level the Air Surgeon's bid for autonomy met with reinforced resistance as a result of the Wadhams Committee's recommendation that every effort be made to bring the medical service of the Army Air Forces under the control of The Surgeon General or, if this could not be done, that a clear official statement of the respective responsibilities of the Air Surgeon and The Surgeon General be issued. The whole question was reopened in March 1943 by Maj. Gen. Wilhelm D. Styer, General Somervell's Chief of Staff, who asked bluntly whether existing directives furnished a satisfactory basis for a working relationship between The Surgeon General and the Air Surgeon.[7]

The Air Surgeon was simultaneously taking steps to add another increment to his power, proposing that he be officially designated thereafter as the Air Surgeon General, a title he regarded as no more than commensurate with the added responsibilities imposed by increased size of the Air Forces. General Magee retorted tartly that it was "inconsistent that the title of a subordinate responsible for a part of the Army should be that of his superior who is responsible for the whole"; nor could he see how a change in title could increase the efficiency of the Air Surgeon's Office. Replying to General Styer a few days later, General Magee cited specific areas of duplication, including efforts by the Army Air Forces to establish hospitals which were in effect, though not in name, general hospitals. He noted that this effort aggravated the Army-wide demand for highly specialized personnel and for medical supplies. He recommended that hospitalization of Army Air Forces personnel be made a responsibility of the service commands, that only Medical Department personnel attached to field units of the Army Air Forces be directly responsible to the Air Surgeon, and that the Chief of Staff issue an official statement delineating the responsibility of The Surgeon General for the health of the entire Army.[8]

The struggle over control of hospitals was the most important phase of the total struggle between the Surgeon General's Office and the Air Surgeon's Office in 1943. The earlier phase of the conflict had revolved primarily around direct recruitment and subsequent control of medical personnel by the Army Air Forces, which by 1943 had recruited the specialized medical personnel to staff a system of hospitals. It established under its control installations which, although not termed general hospitals, were equipped to give the same type of

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[7] Memorandum, Chief of Staff, Services of Supply, for Assistant Chief of Staff for Operations, Services of Supply, 20 Mar. 1943, subject: Relationship Between The Surgeon General and the Air Surgeon.

[8] (1) Memorandum, Chief of Air Staff, for Chief of Staff, 25 Mar. 1943, subject: Change in Title of Special Staff Officers, Headquarters, Army Air Forces. (2) Memorandum, The Surgeon General, for Assistant Chief of Staff, G–1, 7 Apr. 1943. (3) Memorandum, Assistant Chief of Staff for Operations, Services of Supply, for The Surgeon General, 30 Mar. 1943, subject: Relationship Between The Surgeon General and the Air Surgeon, and 1st indorsement, The Surgeon General, for Commanding General, Army Service Forces, 12 Apr. 1943.

definitive medical and surgical care. Success in the effort to have these installations recognized as general hospitals would have made it possible for the Army Air Forces to treat in hospitals under its control many patients who would normally have been treated in the general hospitals of the Army Service Forces and would have encroached upon the latter's hospital system.

Prompted by General Lutes, General Somervell pointed out to the Chief of Staff the increasing confusion over the responsibilities of the Surgeon General's Office and those of the Air Surgeon's Office and certain respects in which their activities duplicated each other. He cited instances of the use of station hospitals controlled by the Army Air Forces as general hospitals and efforts of that command to have patients from overseas sent directly to these instead of to the regular general hospitals maintained by the Army Service Forces. He emphasized various recommendations of the Committee to Study the Medical Department as to the desirability of greater control by The Surgeon General over the medical service of the Army Air Forces, especially Recommendation 55 calling for a clear official delineation of their respective responsibilities, and proposed that the Chief of Staff issue a directive reaffirming the authority of The Surgeon General. Although this authority, he noted, had not been changed by any official utterance since the reorganization of March 1942, it had not been definitely affirmed since that date.[9]

Brig. Gen. David N. W. Grant, the Air Surgeon, objected to the recommendations with respect to Army Air Forces medical service which had been made in the report of the Committee to Study the Medical Department. He declared that no member of that committee had had more than a slight familiarity with aviation medical problems, or indeed, with any aspect of aviation. He considered a few members ignorant of the problems, or prejudiced against the esprit de corps, of the Army Air Forces. Members of the investigating committee had made only a superficial survey of one or two Army Air Forces installations. He noted that The Surgeon General had had a representative on the committee, while the Air Surgeon had had none. Finally, the committee's full report had never been given to the Air Surgeon.

The Air Surgeon agreed with the thesis of the report that there should be a surgeon general on the special staff of the Chief of Staff. Under the present organization of the Army, however, he stated, the medical service of the Army Air Forces could not be brought under the control of The Surgeon General without violating command channels; the Army Service Forces could not be given command powers over the Army Air Forces, since the two were on the same level of command.

General Grant emphasized once more the many medical cases—those of flying stress, aeroneurosis, and occupational rehabilitation following injuries—

[9] (1) Memorandum, Assistant Chief of Staff for Operations, for Commanding General, Army Service Forces, 30 Apr. 1943, subject: Relationship Between The Surgeon General and the Air Surgeon. (2) Memorandum, Commanding General, Army Service Forces, for Chief of Staff, 30 Apr. 1943, subject: Unification of Medical Service of the Army by The Surgeon General, and tabs A through L.

requiring treatment by medical officers familiar with Army Air Forces operations and problems. He declared that a close understanding between patient and doctor was characteristic of the medical service of the Army Air Forces and contrasted this outlook with the doctrine he attributed to The Surgeon General and the Army Service Forces, that all medical officers should be pooled and dealt out from time to time like so many trucks from Army Service Forces warehouses. Administrative control of medical personnel by the Commanding General, Army Air Forces, had resulted, General Grant claimed, in the proper assignment of medical officers to their specialties. This feature, he maintained, was peculiar to the medical service of the Army Air Forces.[10]

As might be expected, the Air Surgeon's position, including the thesis that the Army Air Forces medical service was more efficient than that administered by The Surgeon General, was loyally supported by his superior officers within the Army Air Forces. The general staff, however, was divided in its preferences, and inclined to temporize. For example, Brig. Gen. R. G. Moses, Assistant Chief of Staff, G–4, saw merit in the claims of both sides. He defined the choice as one between "a definition of authorities which appears to achieve complete unification but which will work effectively only with the enthusiastic concurrence of all concerned and with a considerable improvement in the medical service of the Army, and, on the other hand, a definition of authorities which will certainly achieve more efficient medical care for one part of the Army but which is a trend definitely away from unification." The latter alternative he considered preferable, admitting that his choice was partly dictated by expediency but stating that greater efficiency in one part of the Army should serve as an incentive to the remainder. He favored reaffirming the responsibility of The Surgeon General and limiting any additional authority granted to the Army Air Forces to authority over individualized care of combat personnel.[11]

The Deputy Chief of Staff, Lt. Gen. (later Gen.) Joseph T. McNarney, himself an Air Corps officer, tended to favor the claims of the Air Surgeon. General McNarney's office issued a statement on 20 June 1943 to the effect that existing regulations outlined the functions of The Surgeon General satisfactorily. The statement held that a highly centralized system of medical service would not be sufficiently flexible to adjust overall policies to the special needs of the oversea theaters and the three major commands. The Surgeon General should procure medical personnel, decentralizing this function to the major services insofar as they thought necessary, but the Army Air Forces should control station hospitals at its own posts, camps, and stations. Finally, General

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[10] Memorandum, the Air Surgeon, for Commanding General, Army Air Forces, no date (but commenting on a directive of 30 Apr. 1943 prepared by the Commanding General, Army Service Forces, for the signature of the Chief of Staff).

[11] (1) Memorandum, Assistant Chief of Air Staff, for Commanding General, Army Service Forces, 25 May 1943, subject: Unification of Medical Service of the Army by The Surgeon General. (2) Memorandum, Assistant Chief of Staff, G–4, for Chief of Staff, 15 June 1943, subject: Medical Service of the Army.

McNarney's office announced that general hospitals necessary to meet the needs of aviation medicine and give medical treatment to air combat crews would be assigned to the Army Air Forces upon approval by the Chief of Staff.[12]

Both The Surgeon General and the Commanding General, Army Service Forces (as the Services of Supply was rechristened in March 1943), objected strongly to the transfer of any general hospitals to the Army Air Forces. The Surgeon General, in particular, argued that centralized control of general hospitals, providing as they did the ultimate in professional care in the United States, was absolutely necessary for the proper assignment of all ground and air combat patients evacuated from overseas to the particular hospital with the specialized personnel therein which could best meet the individual's need for special treatment. He recognized that air combat crews needed special reconditioning but maintained that the general hospitals of the Army Service Forces should provide them both hospitalization and reconditioning. Reconditioning should be given them by medical personnel trained in aviation medicine but within special facilities established in the general hospitals.[13]

General Somervell agreed and so informed the Chief of Staff. He did not believe it was intended to establish two Medical Departments and "two distinct streams for the evacuation of the sick and wounded." He had suggested to the Deputy Chief of Staff that a satisfactory solution would be the assignment of General Grant, to be redesignated Deputy Surgeon General for Aviation Medicine, to the Office of The Surgeon General where his specialized knowledge and point of view would help to improve the entire medical service. He did not admit any superior efficiency on the part of the Army Air Forces medical service, but he emphasized the point that the new Surgeon General (General Magee's term having expired on 31 May) was being held responsible for good administration of the Medical Department on an Army-wide basis, as well as for correction of deficiencies of the previous administration. He implied that the transfer of general hospitals to the Army Air Forces would undermine at the outset this total responsibility.[14]

The Secretary of War, after conferring with the Deputy Chief of Staff, the Commanding General, Army Service Forces, and representatives of the Army Air Forces, directed that no general hospitals be turned over to the control of the Army Air Forces, but would continue to operate under the Army

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[12] Memorandum, Assistant to Deputy Chief of Staff, for Commanding Generals, Army Air Forces, Army Ground Forces, and Army Service Forces, 20 June 1943, subject: Medical Service of the Army, January–July 1943.

[13] (1) Memorandum, Director of Operations, Army Service Forces, for Commanding General, Army Service Forces, 24 June 1943, subject: Medical Service in the Army. (2) Memorandum, The Surgeon General, for Chief of Staff, 29 June 1943.

[14] (1) Memorandum, Commanding General, Army Service Forces, for Chief of Staff, 30 June 1943. According to General Grant, General McNarney actually offered him the position suggested by General Somervell of Deputy Surgeon General for Aviation Medicine, with the rank of major general, but General Grant, still convinced this expedient would not work, refused. (2) Letter, Maj. Gen. David N. W. Grant, USAF, to Director, The Historical Unit, U.S. Army Medical Service, 11 Aug. 1955, commenting on draft manuscript of this volume.

Service Forces. Oversea casualties, including combat crews, returned to the United States by air or water, would be taken care of in these hospitals according to the general procedures established by the Surgeon General's Office. However, flying personnel needing treatment for air fatigue, as well as all Army Air Forces personnel recovered after treatment in a general hospital, would be cared for in "convalescent centers" under control of the Army Air Forces. To meet another of the Air Surgeon's arguments, a flight surgeon was to be assigned to The Surgeon General to advise on specialized treatment, transfer, and disposition of combat crews. Flight surgeons would also be assigned to those general hospitals in which flying combat crews were being cared for to give advice on the special techniques of aviation medicine to be used in the care of this group.[15]

Thus the move initiated by General Styer to effect the recommendation of the Committee to Study the Medical Department that The Surgeon General be given more control over the medical service of the Army Air Forces gradually narrowed down to a controversy over the control of general hospitals proper and ended with a statement by the Secretary of War officially maintaining the status quo as to control of these hospitals. The course of events here included the following steps, which seem to form a pattern for similar struggles for control between The Surgeon General and the Air Surgeon: Action by the Army Air Forces to achieve a fait accompli; pressure by the Army Service Forces and The Surgeon General to get an official directive reasserting control by The Surgeon General; statements by Army Air Forces representatives that their organization had done nothing contrary to official directives and regulations; under continued pressure by the Army Service Forces and The Surgeon General, open counterbids by the Army Air Forces for official recognition of their fait accompli, bolstered by claims of superior medical service; resistance by The Surgeon General, put in his turn on the defensive, and by the Army Service Forces; and finally a decision by the Secretary of War officially maintaining the status quo in large part, but having little restraining effect upon a renewal of effort by the protagonists. These paper wars ended in a temporary truce whenever the Secretary of War ordered the combatants to cease fighting.

Some generalization may also be made with respect to the usual position of higher War Department authorities in these controversies. With the exception of the Deputy Chief of Staff, who showed a tendency to favor claims of the Air Surgeon's Office, The Surgeon General's superiors, including the Secretary of War, the Chief of Staff, and the Commanding General, Army Service Forces, were usually inclined to give The Surgeon General some backing in his efforts to reestablish greater control over medical service of the Army

[15] (1) Letter, Maj. Gen. Norman T. Kirk, USA (Ret.), to Col. Roger G. Prentiss, MC, Chief, Historical Division, Office of The Surgeon General, 19 Nov. 1950. (2) Memorandum, Assistant Deputy Chief of Staff, for Commanding Generals, Army Air Forces, Army Service Forces, and Army Ground Forces, 9 July 1943, subject: Hospitalization.

Air Forces. However, they were consistently unwilling to disturb the reorganization of the War Department of March 1942, which, so far as medical service was concerned, abetted the separatism of the Army Air Forces.

APPOINTMENT OF A NEW SURGEON GENERAL

While the battle over the powers and positions of the Air Surgeon was in full swing, another and not altogether unrelated battle was in progress over the choice of a new Surgeon General, for the 4-year term beginning 1 June 1943. Before the end of February, General Marshall made his recommendation to Secretary Stimson, listing at the same time the factors on which his choice was based. These were: professional and technical qualifications in medicine and surgery; military qualifications; administrative and executive ability; high standing among members of the civilian medical profession; training, experience, and reputation among military men as a military doctor or surgeon; record of accomplishment in the Army; and high efficiency rating. On the basis of these factors he listed 11 officers in the grade of colonel or brigadier general as the best qualified candidates for the position and presented them in the order of his preference. General Magee, Brig. Gen. Howard McC. Snyder, and Brig. Gen. Morrison C. Stayer (then Chief Health Officer, Panama Canal Zone) were included in the list of those qualified but were ruled out on the ground that they would attain the statutory age of retirement before the completion of the 4-year term. He stressed the importance of "wide military experience" and the "ability to organize and administer a widespread and complex medical service." He noted that future problems of the new surgeon general would result largely from military operations in "many foreign theaters under diverse and severe conditions of combat service." With this consideration in mind he deemed Brig. Gen. Albert W. Kenner, then theater surgeon in North Africa, the best qualified candidate on the list. He pointed particularly to General Kenner's record as surgeon of the Western Task Force with General Patton in the North African invasion and to his promotion, with General Eisenhower's concurrence, to brigadier general on the basis of that service.[16]

The Chief of Staff was "determinedly opposed to" the reappointment of the present surgeon general. He considered himself very familiar with Medical Department matters, for he had "maintained a Medical general officer in the Inspector General's Department" for the purpose of keeping in close touch with conditions and had talked the situation over, as had the Secretary of War, with a "number of the leading Medical officers and surgeons of this country."

[16] Memorandum, Chief of Staff, for Secretary of War, no date but approximately 21 Feb. 1943, subject: Appointment of Surgeon General.

In the efforts to locate the proper man, the Secretary of War personally searched through the entire service records of a number of officers and talked with some of the medical officers mentioned for consideration. On 25 February the Secretary recommended that President Roosevelt appoint General Kenner. He repeated in much the same language as General Marshall's the belief that in the coming months the chief problems of the medical service would arise from combat operations and that the new surgeon general should have had "actual service in foreign fields under combat conditions." He urged General Kenner's early appointment and his return to Washington.[17]

The President concurred in the appointment of General Kenner but wanted to defer to 1 April the sending of his name to the Senate. He had no objection to General Kenner's return to familiarize himself with problems of the Surgeon General's Office. He added: "I should particularly like him to make a study of the relationship of the Medical Corps of the United States Army to the General Staff." Many outstanding civilian members of the medical profession, he stated, thought that the present setup was not good. He had received various indications that "the Surgeon General of the Army does not have certain responsibilities which might more profitably go with the Office of The Surgeon General rather than with the General Staff, on which I understand no medical officer—or at least a very junior medical officer—sits." President Roosevelt also inquired, rather by the way, as to the "responsibility on the part of the Army for conditions which might result from a general epidemic throughout the country" and as to where the General Staff fitted in on this.[18]

The Secretary informed the President that the nomination of General Kenner would be submitted about 1 April and that he would be brought to Washington in order to acquaint himself with the general problems in the Surgeon General's Office. Early selection had been urged so that the new incumbent might become familiar with the very problems that the President had mentioned. General Kenner returned to Washington in March, and on 7 April was asked by General Somervell to study the report of the Wadhams Committee. The following day the President wrote the Secretary of War:

"I want you to reconsider the tentative selection made two or three weeks ago for Surgeon General of the Army. My best advice is that he is a good Doctor but that he would not be regarded as an outstanding choice by the medical profession.

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[17] (1) Memorandum, Chief of Staff, for General Pershing, 27 Mar. 1943. (2) Memorandum, Secretary of War, for the President, 25 Feb. 1943, subject: Recommendation for Appointment of Surgeon General, U.S. Army.

[18] Memorandum, Franklin D. Roosevelt, for the Secretary of War, 1 Mar. 1943. The President's "very junior medical officer" was presumably Col. William L. Wilson, who was not, of course, on the General Staff but in the Office of the Assistant Chief of Staff for Operations, Services of Supply. Civilian doctors and others who complained of the setup had not apparently enlightened him as to organizational relationships within the War Department or the role of the Services of Supply in Medical Affairs.

"As you know, I am in much closer touch with the medical profession in all its ramifications than most people are, and I believe that some other selection could be made which would do more credit to all of us." [19]

In reply the Secretary noted that "a man with an outstanding reputation for ability and character in the Medical Corps" would not always have had the opportunity to become well known in the civilian profession. He reiterated his belief that General Kenner was "the surgeon with the most outstanding record in the Army today and a man holding a virtually unique position among our fighting forces from his performances in Europe in 1918 and in Africa this year." However, he proposed the nomination of Brig. Gen. Norman T. Kirk, then commanding officer of the Percy Jones General Hospital at Battle Creek, Mich. He cited comment by Col. William L. Keller, MC (under whom Kirk had served at Walter Reed Hospital), as well as by General Ireland, as to General Kirk's ability in orthopedic surgery and by other officers under whom he had served at various general hospitals as to his energy, aggressiveness, and administrative ability. He further stated in noting that General Marshall concurred in the selection: "I have emphasized the comments on his vigor, initiative, aggressiveness because in the opinion of the Chief of Staff and myself those qualities are the ones at present most needed in the administration of the Surgeon General's Office." [20]

General Kirk's appointment was announced in early May. Thus the choice of the new surgeon general represented a concession to the insistence of certain members of the civilian medical profession, backed by the President, upon a candidate acceptable to the profession, as the committee's report had strongly recommended. The Secretary of War and the Chief of Staff did not prevail in their effort to appoint a man who had had combat experience in World War II. However, both sides demanded a surgeon general of vigor and administrative ability, and both appear to have been convinced that General Kirk possessed these qualities. Although he did not read the Wadhams Committee report, General Kirk shortly set about the reorganization of the Surgeon General's Office in consonance with certain suggestions by General Somervell.[21]

INTERNAL ORGANIZATION OF THE SURGEON GENERAL'S OFFICE

General Kirk inherited an office organization that the previous administration had had to create, and methods of dealing with problems that had been devised in an atmosphere of confusion and scarcity. In the Zone of

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[19] (1) Memorandum, Secretary of War, for the President, 6 Mar. 1943, subject: Brig. Gen. Albert W. Kenner. (2) Letter, Franklin D. Roosevelt, to the Secretary of War, 8 Apr. 1943.

[20] Letter, Secretary of War, to the President, 10 Apr. 1943.

[21] Letter, Maj. Gen. Norman T. Kirk, USA (Ret.), to Col. Roger G. Prentiss, Jr., MC, Director, Historical Division, Office of The Surgeon General, 24 Nov. 1950.

Interior the service command surgeons and the surgeons of tactical and area commands of both ground and air troops were well established, while overseas a medical organization was in being in each of the theaters that was to exist during the war. The supply problem was largely solved, and necessity had already enlarged the sphere in which a solution of the personnel problem would be worked out. A fund of experience was now available, transmitted from the various theaters, that could be applied to the benefit of all. On the other hand, new problems were emerging such as heavy loads of evacuees to care for, a rise in neuropsychiatric cases, reconditioning, rehabilitation, public health in occupied territory, and ultimately problems of demobilization.

The Office of The Surgeon General did not settle down into a static organizational pattern which would have indicated that some desirable structure had at last been achieved, but continued to undergo many changes. Few were the months from June 1943 to the end of June 1944 that did not witness some alteration, in the divisional level or above, in the office structure. Although many changes were piecemeal, they may be conveniently grouped into the early innovations made by General Kirk, consisting chiefly of the selection of new officers for many of the key positions in the office, and two major reorganizations which took place roughly about February 1944 and August 1944.

Early Changes of General Kirk's Administration

General Kirk's earliest revisions in the structure of his office and changes in key personnel were in large measure designed to counteract criticism emanating from Headquarters, Army Service Forces. Some changes accorded with recommendations made by the Committee to Study the Medical Department and a few with specific suggestions made by the Commanding General, Army Service Forces. The reorganization of this period was closely observed by the latter and by the Chief of Staff and the Secretary of War.[22]

Control Division.—An important appointment made by General Kirk was that of Col. Tracy S. Voorhees, as Director of the Control Division. Colonel Voorhees had had experience with the legal aspects of the medical supply program since mid-1942 and had gained an insight into the relations of the Surgeon General's Office with Army Service Forces headquarters through his preparation of an answer to the charges brought against the previous Surgeon General in the course of the investigation of the Medical Department. He was apparently considered by both the Surgeon General's Office and the Army Service Forces to be a good potential mediator between these two organizations and thus assumed the role of "troubleshooter" for General Kirk. The latter made it clear at the outset that he would give Colonel Voorhees strong support. One medical officer commented: "It seemed to me

[22] Memorandum, Commanding General, Army Service Forces, for Chief of Staff, 11 Aug. 1943.

that General Kirk directly implied that he would accept the recommendations of Colonel Voorhees 'lock, stock, and barrel' * * *." [23]

The new director of the Control Division did not subscribe to the previous concept of that division's sphere of action, noting the opposition which its delving into the internal operations of other divisions had aroused. From now on, the Control Division concentrated on such office-wide problems as standardizing Medical Department forms, expediting mail through the office, decentralizing fiscal work to field offices, and keeping personnel in the Surgeon General's Office at a minimum number, and so forth. Although Colonel Voorhees remained in charge of the division until August 1945, he himself concentrated upon the solution of certain major problems. He gave General Kirk advice on the reorganization of various elements of the office and appraised for him individuals in key positions. Colonel Voorhees was in part responsible for hiring civilians with wide administrative experience. Most of the year 1944 he spent overseas, looking into problems of medical administration in the theaters of operations for The Surgeon General, particularly the handling of medical supply. He backed General Kirk strongly in the latter's efforts to gain more control over the assignments of individual Medical Department officers. Colonel Voorhees frequently supported the Surgeon General's Office in negotiations with other elements of War Department organization, acting as mediator with Army Service Forces headquarters on several occasions and actively backing General Kirk in his struggles with the Army Air Forces medical organization. Although he encountered criticism on the part of some Medical Department officers who maintained that administrators of medical programs should have had medical training, he himself at times drew a line of demarcation between those problems on which he considered himself capable of giving advice and those whose technical nature called for solution by the medically trained. He was, on the whole, a partisan of The Surgeon General and Medical Department, while he continued to press for greater efficiency within the Surgeon General's Office and in Army medical administration overseas.[24]

The personnel situation in the Surgeon General's Office posed a problem to the new Surgeon General and the chief of his control division from the outset. In early July 1943, the Surgeon General's Office had 1,877 employees. Of these, 1,549 were civilians, 304 Medical Department officers, 13 officers on special or temporary duty, and 11 were enlisted men. The office had seriously

[23] (1) Memorandum, Director, Control Division, Army Service Forces, for Commanding General, Army Service Forces, 30 June 1943. (2) Office Diary, Historical Division, by Col. Albert G. Love, MC, entry for 27 June 1943.

[24] (1) Annual Report of Control Division for Fiscal Year 1945. (2) Interview, Tracy S. Voorhees, 22 Sept. 1950. (3) Letter, Maj. Gen. Norman T. Kirk, USA (Ret.), to Col. Roger G. Prentiss, Jr., Director, Historical Division, Office of The Surgeon General, 19 Nov. 1950. (4) Office Order No. 197, Office of The Surgeon General, 17 Aug. 1945. (5) Memorandum, Director, Control Division, Office of The Surgeon General, for Director, Control Division, Army Service Forces, 6 June 1944. (6) Interview, Dr. H. A. Press, 9 Oct. 1950. (7) Memorandum, Tracy S. Voorhees, for Executive Officer, Office of The Surgeon General, 29 Dec. 1943, subject: Necessity for Regulation of New Organizations Setup in the Supply Service.

exceeded its officer allotment. At the same time some important and growing functions were either inadequately staffed or not staffed at all; for example, hospital management, neuropsychiatry, and the reconditioning service for hospital patients. Officers engaged in supply, fiscal, and control activities constituted about 40 percent of the officer allotment. Additional officers to staff the more technical functions could be obtained under the allotment by moving out of the Surgeon General's Office business activities which could as easily be carried on elsewhere, for elements moved out of Washington would not be subject to the limitations of the allotment and the large numbers of qualified civilian personnel needed to carry on business activities could be more readily obtained in other localities. A good deal of the reorganization of the Surgeon General's Office from 1943 on was engineered by the director of the Control Division with these considerations in mind.

On 10 July 1943, The Surgeon General issued an organization chart (chart 9) which had received the approval of General Somervell. With the exception of the Office of Technical Information and the Control Division, all elements of the office were grouped under the five services. These were about the same as the services that had existed since August 1942, but their internal organization underwent some changes, and The Surgeon General replaced with other officers several heads of services and divisions—particularly, though not exclusively, those who had been under fire during the investigation of the Medical Department.

Deputy Surgeon General.—In accordance with a recommendation of the Committee to Study the Medical Department, General Kirk appointed a full-time deputy surgeon general—that is, without responsibility for the Operations Service. Brig. Gen. George F. Lull, former Chief of the Personnel Service, was given this post.[25]

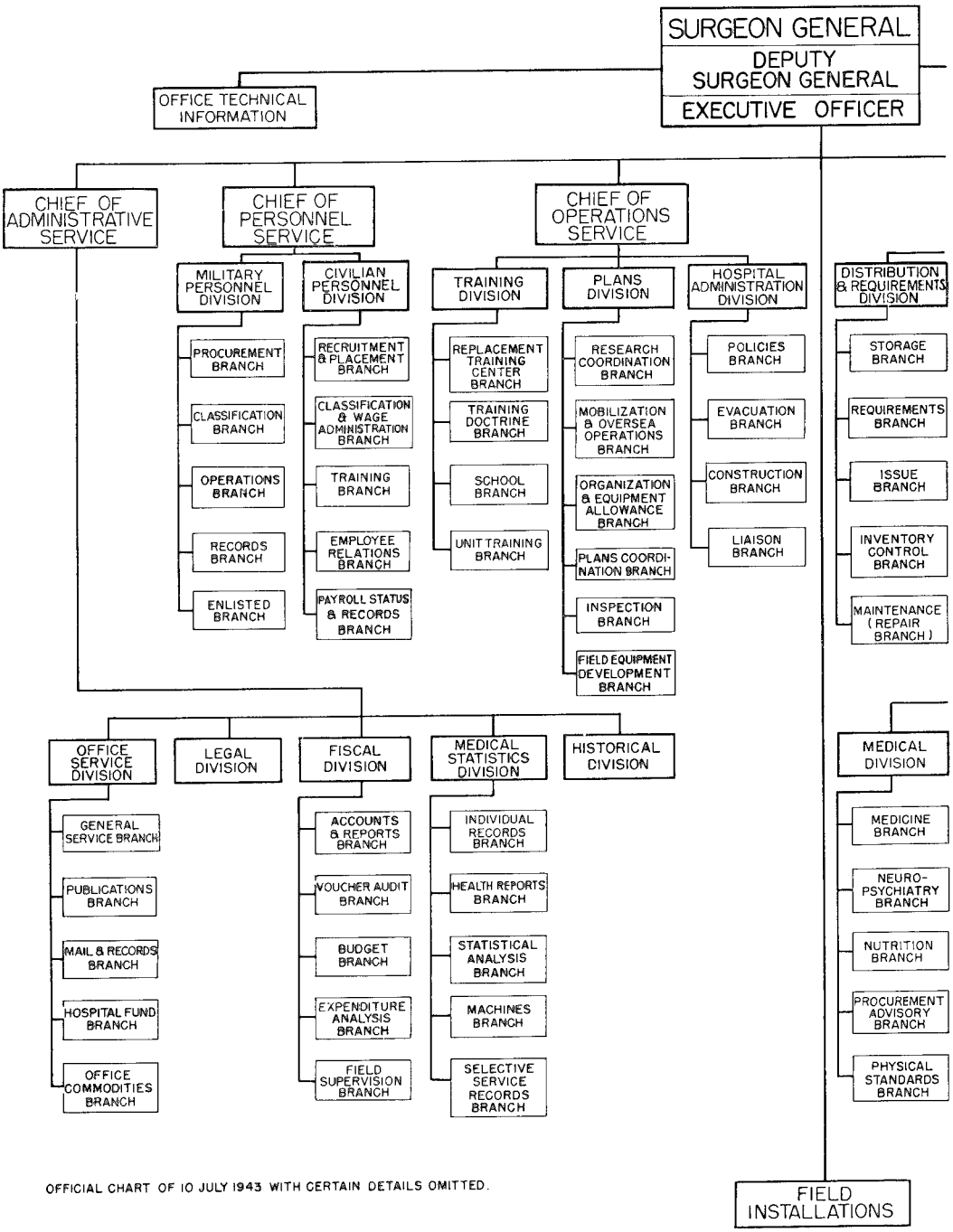
Operations Service.—For Chief of the Operations Service General Kirk chose Col. (later Brig Gen.) Raymond W. Bliss, MC, previously Surgeon, Eastern Defense Command. From the outset of General Kirk's administration the Operations Service assumed a leading role in the administration of the office, especially in coordinating the work of various elements of the office, as well as the operations of the Surgeon General's Office with those of other War Department agencies concerned with Army medical service. The Training Division was added to the Operations Service, the Plans Division expanded, and the former Hospitalization and Evacuation Division and the Hospital Construction Division were amalgamated into the Hospital Administration Division.[26]

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[25] Memorandum, The Surgeon General, for Commanding General, Army Service Forces, 10 Aug. 1943, subject: Interim Progress Report.

[26] (1) Office Order No. 351, Office of The Surgeon General, 4 June 1943. (2) Memorandum, The Surgeon General, for Commanding General, Army Service Forces, 18 June 1943, subject: Organization of The Surgeon General's Office. (3) 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, pp. 176ff.

CHART 9.—*Office of the Surgeon*



OFFICIAL CHART OF 10 JULY 1943 WITH CERTAIN DETAILS OMITTED.

General, 10 July 1943

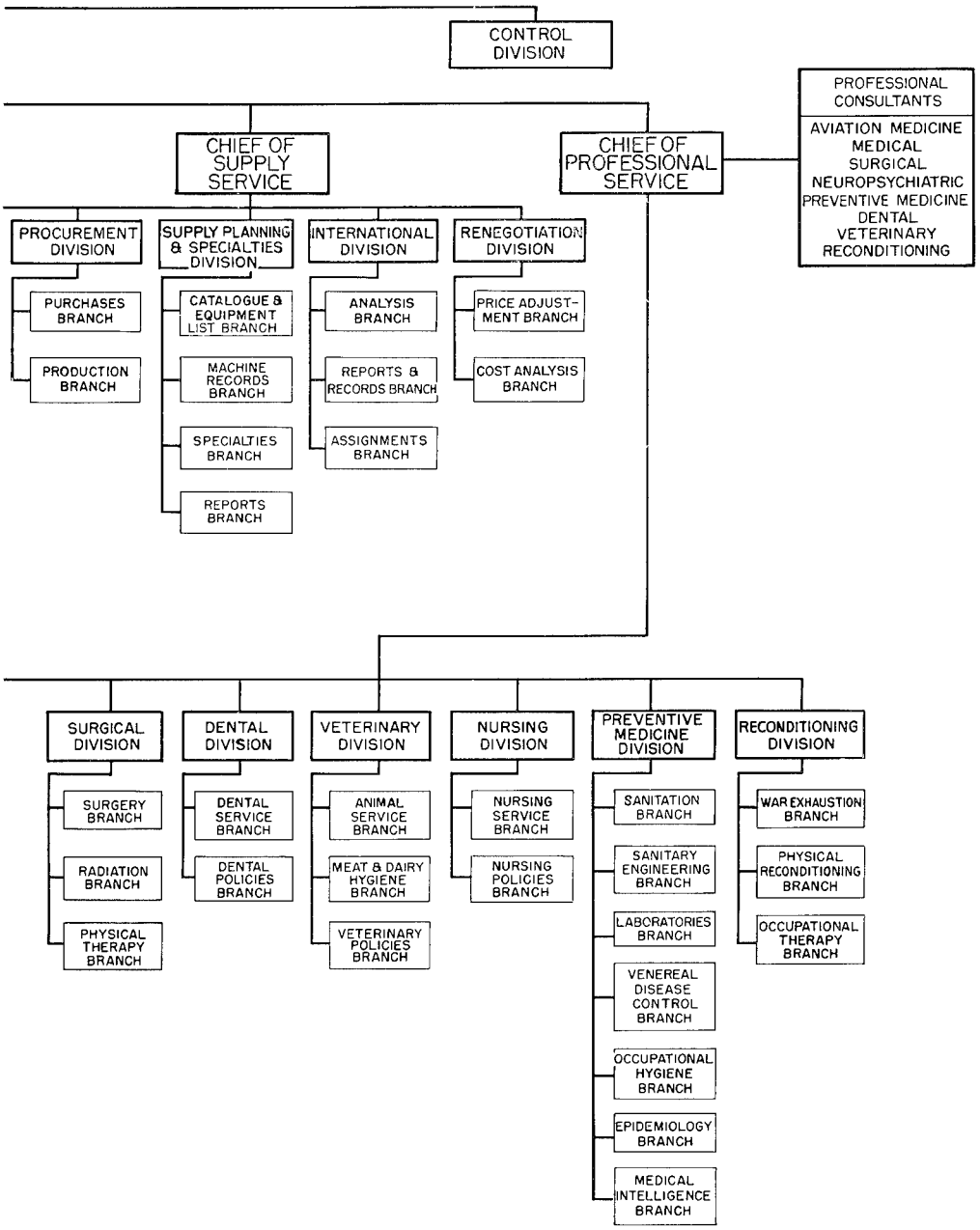




FIGURE 49.—Col. Albert H. Schwichtenberg, MC.

The latter change was made at the request of General Somervell, and special measures, including the assignment of additional personnel, were taken to strengthen this division. Colonel Bliss (made brigadier general in September 1943) brought with him into the office Col. Albert H. Schwichtenberg, MC (fig. 49), a Medical Corps officer who had most recently commanded an Air Forces hospital at Westover Field, as Director of the Hospital Administration Division. Colonel Schwichtenberg's appointment was made in accordance with the decision early in July that a flight surgeon would be assigned to the Surgeon General's Office in the effort to achieve better coordination with the medical service of the Army Air Forces; Colonel Schwichtenberg headed the Hospital Administration Division to the end of the war. Early in the following year, General Kirk and Colonel Voorhees also obtained for the Hospital Administration Division Dr. Eli Ginzberg (fig. 50), an economist and statistician, then assigned to the Control Division, Army Service Forces. Dr. Ginzberg had previously written reports critical of Army hospital administration, and his appointment was in part an attempt to draw the fangs of the Control Division, Army Service Forces.[27] Both appointments brought into

[27] Voorhees, Tracy S.: Recollections of My Work for The Surgeon General, October 1945. Voorhees' personal file.



FIGURE 50.—Eli Ginzberg, Ph. D.

the office men who had been recently working in the field of Army hospital administration and, in the case of Dr. Ginzberg, a civilian with experience in making the type of statistical estimate of future needs on which Army Service Forces headquarters placed great reliance.

Within the Hospital Administration Division the Liaison Branch was established (chart 9) in recognition of the need for closer liaison with certain elements of War Department organization in order to maintain more effective control within the Surgeon General's Office over the provision of hospitalization for three classes of individuals other than the soldier stationed at a regular Army camp. These special groups were the members of the Women's Army Corps, prisoners of war, and troops passing through staging areas or ports. This branch put liaison officers on duty with the Women's Army Corps headquarters, the Office of the Provost Marshal General, and the Office of the Chief of Transportation to handle problems connected with these three classes.

The assignment of a liaison officer to the Office of the Chief of Transportation was the most important of the three, since the Transportation Corps controlled Army hospitals at ports; medical duties at ports were increasing

with the transfer of more and more troops overseas and the return of patients to the United States. In April 1943 General Magee had noted the need of some element in his Operations Service to insure the adoption of, and adherence to, uniform medical policies at the scattered port installations maintained by the Transportation Corps and had emphasized the importance of port surgeons' dealing directly with his office on technical medical matters. Representatives of his office, the Office of the Chief of Transportation, and the Hospitalization and Evacuation Section, had concurred in his ideas and it was decided to assign a medical officer as liaison officer with the Office of the Chief of Transportation. An officer who had been working on sea evacuation in the Hospitalization and Evacuation Section, Army Service Forces, was given this assignment. At this date the task was conceived of as largely that of coordinating the movements of hospital trains operated by the Transportation Corps in the United States and giving technical supervision to the medical service afforded at ports and staging areas. The work done by the Liaison Branch, Surgeon General's Office, and the officer assigned to the Office of the Chief of Transportation eventually came to include most of the activities in connection with the evacuation of the wounded from overseas formerly carried on by the Hospitalization and Evacuation Section, Army Service Forces. The new setup provided effective machinery for planning large-scale evacuation of patients from the theaters of operations to United States ports by ship and from ports to general hospitals by train.[28]

Supply Service.—Extensive changes were made in the Supply Service, both in personnel and in internal organization. The Committee to Study the Medical Department had advocated the appointment of men with training in industry (instead of doctors) to key positions in the Supply Service (as well as in the procurement offices and depots). Mr. (later Brig. Gen., MAC) Edward Reynolds (fig. 51), who had come into the office from industry as a special assistant to the chief of the Supply Service, was now made acting chief. About a year later he was made chief and served in that capacity until the end of the war. Civilians with extensive managerial experience in industry were also placed in two other important positions in the Supply Service. Before the end of 1943 the services of Mr. Charles Harris, who had had responsible experience in warehousing operations with large industrial concerns, were obtained for the Supply Service by the Director of the Control Division and Under Secretary of War Patterson. Mr. Harris was made deputy chief of the service and given direct responsibilitity for operating the medical supply

[28] (1) Memorandum, Maj. Gen. LeRoy Lutes, for The Surgeon General, 18 May 1943, subject: Coordinated Medical Service for Ports of Embarkation. (2) History, Medical Liaison Office to the Office of Chief of Transportation and Medical Regulating Service, Surgeon General's Office. [Official record.] (3) 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, part IV.

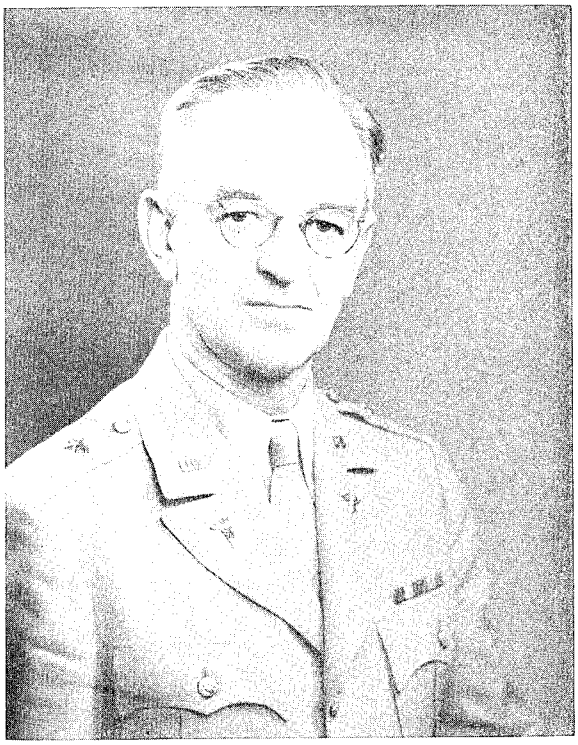


FIGURE 51.—Brig. Gen. Edward Reynolds, MAC.

depots. The services of Mr. H. C. Hangen (fig. 52), who had worked temporarily with the Supply Service in solving stock control problems in 1942, had been reenlisted early in 1943, also through the instrumentality of the director of the Control Division and the Under Secretary of War. Mr. Harris and Mr. Hangen accompanied the director of the Control Division on oversea missions in 1944 to deal with problems of medical supply in the theaters of operations.[29]

The Supply Service, under fire throughout most of 1942, had had to expand greatly to meet the demands for medical supplies and equipment confronting it. By April 1943, it consisted of 7 divisions with 27 branches. By the beginning of June its personnel amounted to 114 officers and 524 civilians, far more than that of any other of the services in the office. An examination of chart 9 shows that by 10 July the number of divisions was reduced to 5 and the number of branches to 16. While not all this reduction was clear gain (since some functions had to be transferred to other segments of the office),

[29] (1) Office Order No. 92, Office of The Surgeon General, 1 May 1944. (2) See footnote 27, p. 208. (3) Director, Control Division, Office of The Surgeon General, Report as to Depot Operations, 6 May 1944.



FIGURE 52.—Mr. H. C. Hangen.

by late August the personnel of the Supply Service was reduced to 83 officers and 452 civilians.[30]

Additional reductions in the numbers of officers assigned to supply duties in the Surgeon General's Office were brought about by shifts of various supply functions from Washington to New York, N.Y., although in the case of some transfers it was necessary to leave liaison elements in Washington. In September, direct supervision of all Medical Department procurement of supplies and equipment was centered in the New York procurement office, newly named the Army Medical Purchasing Office; the separate St. Louis procurement district was abolished. Branch offices were established in both St. Louis and Chicago, but from the fall of 1943 to the end of the war the buying of medical supplies and equipment remained concentrated in New York. On the recommendation of Colonel Voorhees and Mr. Reynolds, the greater portion of stock control activities were also moved to New York and Mr. Hangen was put in

[30] Memorandum, Acting Director, Control Division, Office of The Surgeon General, for Director, Control Division, Army Service Forces, 23 Aug. 1943.

charge. Other work connected with procurement, such as legal work on renegotiation and termination of contracts, was transferred to New York during 1944 and 1945.

The process of adjusting the organization and procedures of the Supply Service, Surgeon General's Office, to conform with the operations of Headquarters, Army Service Forces, continued. At the request of the latter, new units were formed to make inspections of medical supply and to report on progress in procurement and distribution. An important development in the field of medical supply was the creation of a board to make plans for medical and sanitary supplies for civilian use in occupied territories. During the early months of 1943, the Public Health Officer of the Civil Affairs Division of the War Department Special Staff and the International Division, Army Service Forces, had held conferences with the staff of the Surgeon General's Office on this matter, and before the end of June, General Kirk had appointed a Civil Affairs Division Board to engage in planning in this field.[31]

Professional Service.—The early months of General Kirk's administration witnessed continued expansion of the Professional Service (still headed by Brig. Gen. Charles C. Hillman) and the network of consultants who prepared technical instructions on medical matters for issue by the office. The elaboration of the Surgical Branch into a division with Surgery, Radiation, and Physical Therapy Branches and the establishment of a Reconditioning Division (with branches as shown on chart 9) were the chief developments. An Army-wide program for reconditioning convalescent soldiers had been inaugurated by the Surgeon General's Office early in 1943, and by April the program was theoretically underway in hospitals. Only a few hospitals had developed good programs, however, and plans for reconditioning took substance only after the new division began to assume direction of the total program in August. The Reconditioning Division was strengthened by the addition of personnel, including civilian women trained in occupational therapy, late in 1943 and in 1944. Further impetus was given the program in March 1944 when, after a conference held by the Chief of Staff, Army Service Forces (General Styer), Army Service Forces headquarters ordered the service commanders to establish a reconditioning branch in the offices of surgeons at their headquarters and authorized personnel to staff them. At the same date, reconditioning programs and personnel were authorized for all hospitals controlled by the Army Service Forces.

Planning undertaken by the Reconditioning Division, Surgeon General's Office, was affected by various shifts of policy. Throughout 1943 and 1944 the scope of the Army's responsibilities toward convalescent soldiers was much bruited; not until the end of the latter year did policy in this field crystallize.

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[31] (1) Memorandum, Headquarters, Army Service Forces, for The Surgeon General, 9 Aug. 1943, subject: Inspection Manual. (2) Medical Department, United States Army. Preventive Medicine in World War II. Volume VIII. Civil Public Health Problems and Activities, pt. III. [In preparation.]

The reconditioning program was one to which the General Staff and Army Service Forces headquarters, as well as the President and other highly placed Government officials—all sensitive to the public's growing interest in convalescent veterans—paid continued attention. The reconditioning of patients for return to military duties and the rehabilitation of those incapable of further duty for return to work in civilian life were usually conceived of as two distinct tasks, the Army to be responsible for the former and the Veterans' Administration for the latter. Early planning was done with this principle in mind.

For several reasons this neat distinction was not adhered to, and the difference between so-called "reconditioning" and "rehabilitation" came to be largely one of emphasis. In the first place, the Army was responsible for giving its wounded all possible benefit of medical treatment before it discharged them. In some cases training aimed at rehabilitation could profitably be given to men who had not yet received full medical treatment; the giving of vocational training at as early a stage as possible was a good morale builder. Moreover, the Veterans' Administration was not yet staffed or equipped to undertake a full program of rehabilitation, and the Army was obliged to assume responsibility. The final policy established by President Roosevelt and his advisers, including the Secretary of War, took the trend of placing rather full responsibility upon the Army Medical Department. In December 1944 the broadening of the Army's program for convalescents was clinched by a letter from President Roosevelt to Secretary Stimson. The President decided that before discharge all oversea casualties should receive from the Army the benefit of "physical and psychological rehabilitation, vocational guidance, prevocational training and resocialization." Consequently the Medical Department developed a fairly extensive program for convalescent soldiers, including special programs for the blind and deaf.[32]

Reorganization During 1944 and 1945

Other than new organizational units established to handle new functions, the principal changes made in the organization of the Surgeon's Office by the new administration in the fall of 1943, as outlined above, were aimed at achieving more economical operation of the fiscal, personnel, and supply activities of the office—fields of administration which Army Service Forces headquarters had especially emphasized. The changes of 1944 followed a similar pattern, bringing additional activities together under the Operations Service and freeing the Professional Service of certain activities of an administrative character. Although developments were piecemeal, the changes may be grouped for the sake of convenience into two major reorganizations, one in February 1944 and the other in August of that year.

[32] (1) Letter, President Roosevelt, to Secretary Stimson, 4 Dec. 1944. (2) Annual Reports, Reconditioning Division, Office of The Surgeon General, fiscal years 1944, 1945. (3) Medical Department, United States Army. Reconditioning in World War II. [In preparation.]

Reorganization of February 1944

The reorganization of early 1944 (chart 10) embodied a number of features advocated in a survey of the Surgeon General's Office made by the new Director of the Control Division, who took into account the opinions of senior staff officers. In this reorganization the Preventive Medicine Service was separated once more from the Professional Service. The task of keeping tab on the manifold activities of the Professional and the Preventive Medicine Services was made easier by the appointment of deputy chiefs and assistants to aid the heads of these two services. The Deputy Chief of the Preventive Medicine Service, for instance, acted as Director of the U.S.A. Typhus Commission, relieving his chief of responsibility for this part of the preventive medicine program. General Simmons, besides supervising the Preventive Medicine Service, had to direct the work of the Army Epidemiological Board, which, through its commissions located at universities and philanthropic foundations, investigated many epidemic diseases.[33]

Professional Service.—The rise of the Neuropsychiatry Branch to divisional status, the major change in the Professional Service at this date, marked the increase in neuropsychiatric problems facing the Medical Department as a result of increasing numbers of troops in combat areas. Late in 1943 on the death of Colonel Halloran, Lt. Col. (later Brig. Gen) William C. Menninger, MC (fig. 53), formerly medical director of the Menninger Psychiatric Hospital at Topeka, Kans., and more recently a neuropsychiatric consultant in the Fourth Service Command, came into the office as Chief Neuropsychiatric Consultant and head of the new division, remaining in that capacity till the end of the war.[34]

The Surgery Division of the Professional Service was elaborated by the addition of three new branches, Orthopedic, Transfusion, and Chemical Warfare. To the Reconditioning Division, a Blind and Deaf Rehabilitation Branch was added in order to handle special problems related to these two types of war casualties. The Chief of the Professional Service continued to direct the work of the technical elements of the Surgeon General's Office. These were headed by consultants who now represented the following fields: Aviation medicine, internal medicine, surgery, neuropsychiatry, reconditioning, dentistry, veterinary medicine, and tuberculosis.

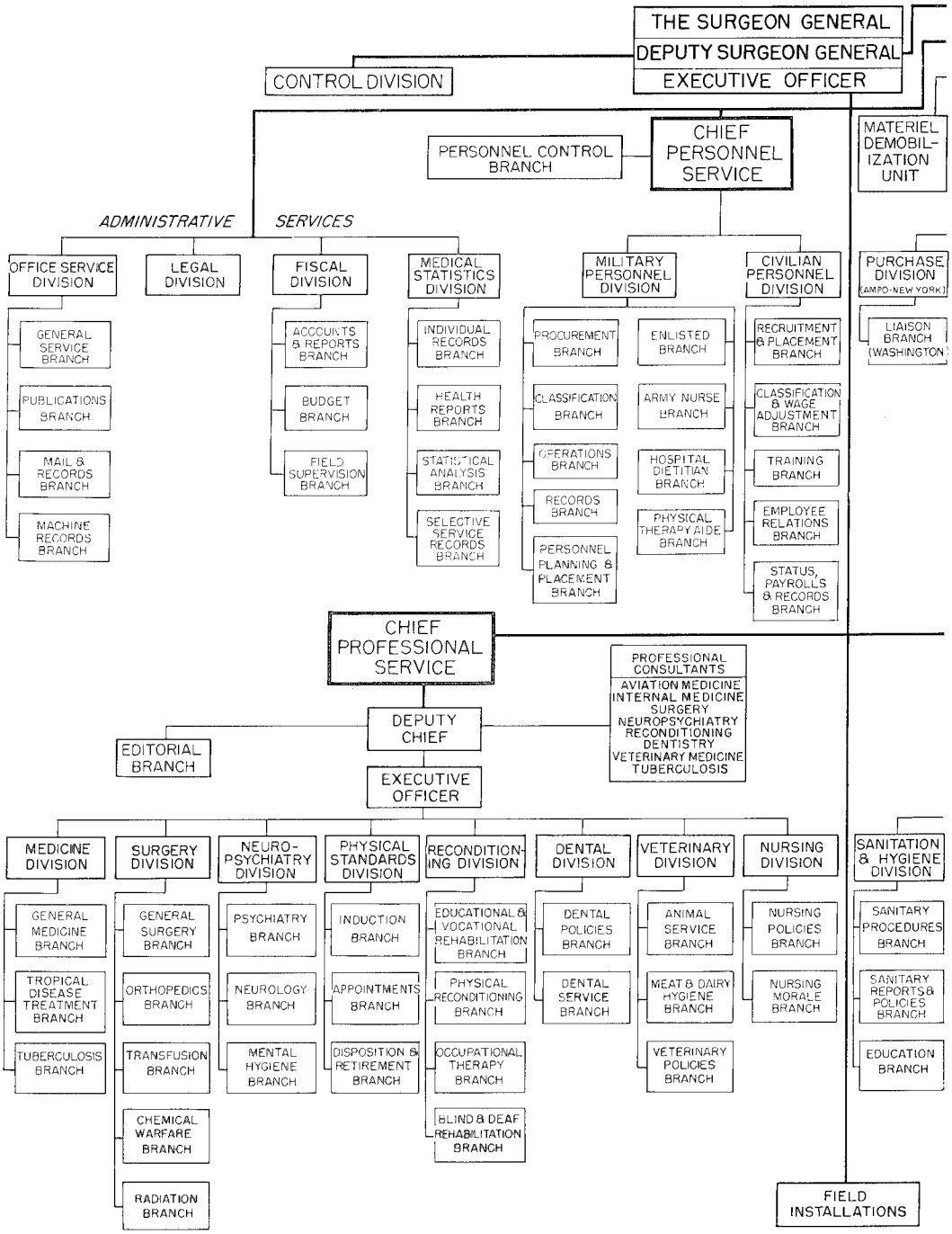
Preventive Medicine Service.—In the reestablished Preventive Medicine Service, in which branches were once more raised to the status of divisions, some new divisions appeared. These were: the Tropical Disease Control Divi-

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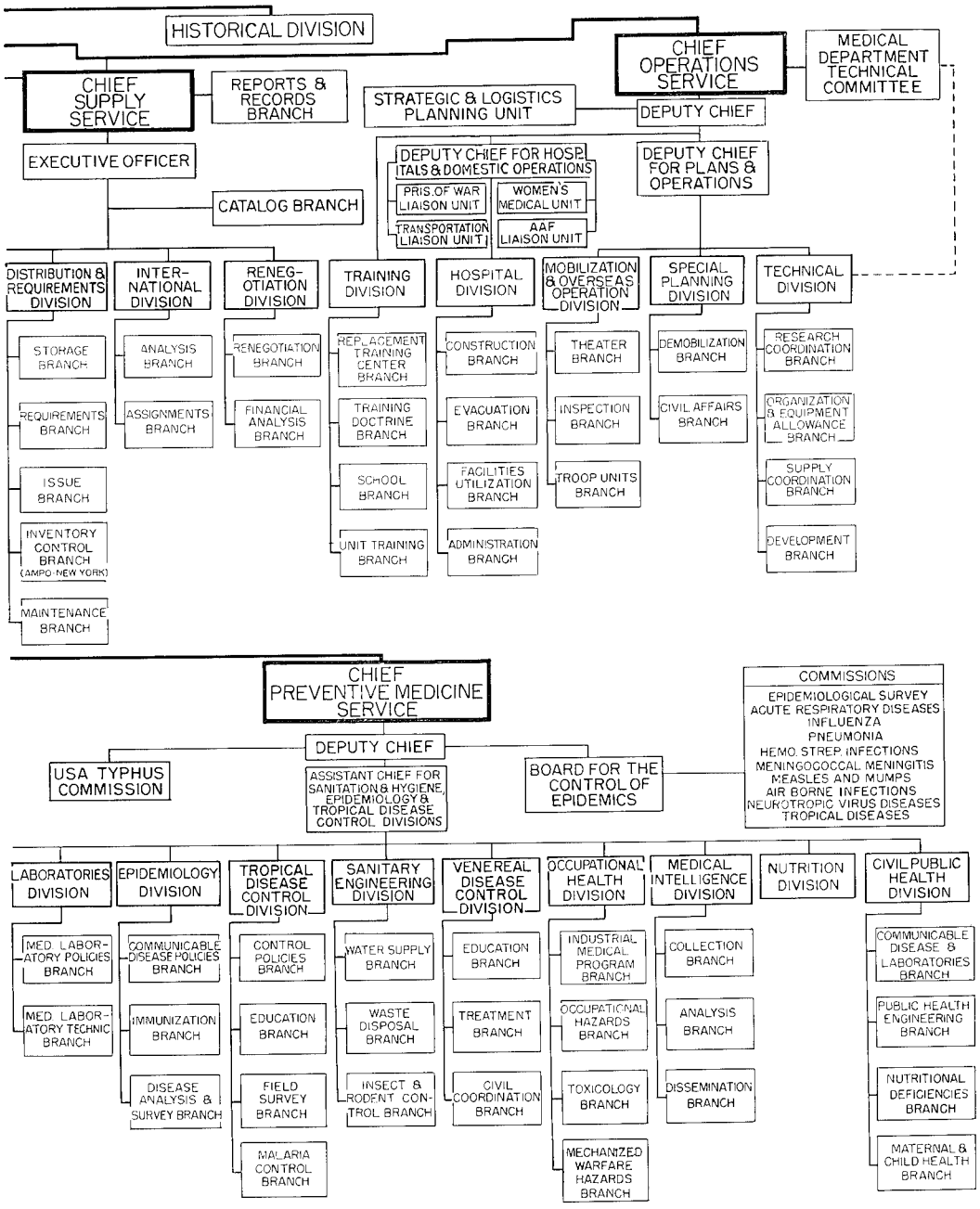
[33] (1) Memorandum, Director, Control Division, for The Surgeon General, 13 Jan. 1944, subject: Proposal for Overall Plans for Most Effective Utilization of Officer Allotment, Civilian Personnel, and Space in The Surgeon General's Office for Modifications in the Present Organization. (2) Office Order No. 4, Office of The Surgeon General, 1 Jan. 1944.

[34] Annual Report, Neuropsychiatric Division, Office of The Surgeon General, for fiscal year 1944.

CHART 10.—*Office of The Surgeon*



General, 3 February 1944



OFFICIAL CHART OF 3 FEBRUARY 1944 WITH CERTAIN DETAILS OMITTED.



FIGURE 53.—Brig. Gen. William C. Menninger, MC.

sion, which had functioned as a branch of the Preventive Medicine Division in 1943; the Nutrition Division, which had functioned as a branch within the Professional Service; and the Civil Public Health Division, newly created.

Officers in the Tropical Disease Control Division worked during the latter war years to strengthen the machinery for malaria control overseas. Until mid-1943 the task had been one of demonstrating to theater commands the value of the malaria control and survey units which the Surgeon General's Office had designed and recommended for theater use. By the date when General Kirk took office, the malaria control organization had proved itself overseas, and the Tropical Disease Control Division concentrated on the task of estimating the numbers of malariologists and units that would be needed at future dates, improving the training of these units and reinforcing the responsibility of unit commanders for malaria control. Higher officials of the War Department were now more active than previously in warning oversea commanders of the dangers of tropical disease to the success of campaigns. In July 1943, the Chief of Staff warned General Eisenhower in North Africa of the menace which malaria posed to troops in that region, stating: "Most confidentially we have had grave difficulties in the Pacific and a considerable

number of divisions are temporarily out of action as a result, two of them for more than six months." [35]

The work of the Tropical Disease Control Division was effectively supplemented by the efforts of a number of agencies. Toward the close of 1943, Army medical officers and other doctors with the U.S.A. Typhus Commission and the Rockefeller Foundation had dramatically demonstrated in Naples the value of the newly developed DDT in preventing the spread of typhus. This insecticide proved a valuable agent in control of several tropical diseases, and upon recommendations by The Surgeon General and the Director of the Office of Scientific Research and Development for production of DDT in large quantities, the Army Service Forces directed the creation of the DDT Committee. The appearance of bubonic plague among the populations of northern Africa—particularly at Dākar, where an epidemic broke out among civilians in midsummer of 1944—pointed to the need for special effort to control rodents. Accordingly, an Army Committee on Insect and Rodent Control superseded the DDT Committee in November 1944. Besides representatives of the Army (Office of the Director of Materiel, Army Service Forces, several technical services, and the offices of the Ground and Air Surgeons), it included officials of a few other interested agencies of the Federal Government. To the end of the war this committee worked on research problems in control of both insects and rodents, the training of personnel in control, and the preparation of manuals outlining methods.[36]

The establishment of the Civil Public Health Division marked the first time that full machinery was set up in the Surgeon General's Office to undertake large-scale medical work among civilians in the occupied countries. Since mid-1940 the office had done some planning in that field and had prepared courses of training in public health work at schools of military government which the Army maintained at various universities, but in the intervening years chief responsibility had rested with a Sanitary Corps officer, Col. Ira V. Hiscock, assigned first to the Office of the Provost Marshal General and later to the Civil Affairs Division of the War Department Special Staff. As early as May 1943, when the problem was sharply posed by the final conquest of North Africa, Colonel Hiscock had insisted that machinery would have to be set up to insure the medical and sanitary supplies necessary to an effective public health program overseas, and General Kirk had appointed a board of officers to implement such a program. In November 1943, the President himself urged the importance of planning relief work for civilians in occupied countries. The Civil Public Health Division set up in the Surgeon General's

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[35] Letter, General Marshall, to General Eisenhower, Allied Force Headquarters, Algiers, 13 July 1943.

[36] (1) Medical Department, United States Army. Preventive Medicine in World War II. Volume II. Environmental Hygiene. Washington: U.S. Government Printing Office, 1955, pp. 251–269. (2) Office of the Chief of Military History: Historical Report of Services of Supply Troops in Dakar, July 1944. [Official record.] (3) War Department Memorandum No. 40–44, 8 Nov. 1944. (4) War Department Circular No. 163, 4 June 1945.



FIGURE 54.—Col. Thomas B. Turner, MC.

Office on 1 January 1944, and transferred to the Preventive Medicine Service by the February reorganization, was a logical followup. At the same time a Civil Affairs Branch was established in the Special Planning Division of the Operations Service, with functions that included estimating requirements and developing medical supply kits for various purposes.[37]

The Civil Public Health Division was headed by Col. Thomas B. Turner, MC (fig. 54), Professor of Bacteriology at The Johns Hopkins University. Colonel Turner was made Director of the new Civil Public Health Division in the Preventive Medicine Service, Surgeon General's Office. He spent the early months of 1944 in the Mediterranean and European theaters reviewing the Army's setup for public health programs for populations of the colonies and countries of North Africa and Europe. From then on responsibility for planning public health work in the occupied areas was concentrated in the Surgeon General's Office. The Civil Public Health Division shared its responsibilities with other parts of the office, for the nature of the program made it necessary to get advice and aid from specialists in other fields as well as from members of the Personnel and Supply Services.[38]

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[37] (1) Office Order No. 419, Office of The Surgeon General, 28 June 1943. (2) Letter, President Roosevelt, to Secretary Stimson, 12 Nov. 1943. (3) Daily Diary, Civil Affairs Branch, Office of The Surgeon General, 5 Feb. 1944–30 Sept. 1944.

[38] Medical Department, United States Army. Preventive Medicine in World War II. Volume VIII. Civil Public Health Problems and Activities, pt. III. [In preparation.]

Operations Service.—The emphasis upon the Operations Service, which characterized General Kirk's administration, continued with the reorganization of February 1944. The reorganized Operations Service had a chief, Brig. Gen. Raymond W. Bliss, and two deputies. The divisions of the Operations Service were placed directly under the two deputies, except for the Training Division, which reported directly to the chief. The Deputy Chief for Plans and Operations, Col. Arthur B. Welsh, MC, was responsible for providing hospitals for the oversea theaters. All three divisions under Colonel Welsh developed from former branches. The Mobilization and Overseas Operations Division, of which Colonel Welsh himself acted as head, coordinated the planning for field operations, working closely with two higher elements of the War Department, the Planning Division of Army Service Forces headquarters and the Operations Division of the War Department General Staff. The Special Planning Division of the Operations Service coordinated Medical Department activities in two fields—demobilization and supply for the public health program in occupied areas—which demanded the cooperation of several divisions. The third division supervised by the Deputy Chief for Plans and Operations was the Technical Division; it coordinated all steps involved in the development, modification, and classification of items of Medical Department supplies and equipment, determined the amounts, types, and schedules of issue to units and installations, and prepared and reviewed tables of organization and equipment, Medical Department equipment lists, and tables of basic allowances.

All functions having to do with hospitalization and evacuation within the United States were placed under the Deputy Chief for Hospitals and Domestic Operations, Colonel Schwichtenberg, who also acted as chief of the lone division under his direction, the Hospital Division. The Facilities Utilization Branch of this division—headed by Dr. Eli Ginzberg, who had been brought into the division early in the year—was of special importance to long-range planning for hospitalization in the United States. It investigated ways of making more efficient use of hospital facilities and personnel and hence was in accord with the thinking of Headquarters, Army Service Forces, which consistently sponsored long-range studies aimed at achieving more effective use of the personnel and facilities of all the technical services. The new branch, for example, made studies on the number of evacuees to be expected from overseas, on an integrated plan for hospitalization in the United States irrespective of command channels. The scope of its work was later expanded to a more comprehensive one of appraising the current and prospective mission of the Medical Department.

Medical Regulating Unit.—Of the four liaison units under the direction of the Deputy Chief for Hospitals and Domestic Operations, the most important was the one in the Office of the Chief of Transportation, which was enlarged in May 1944 into the Medical Regulating Unit. In anticipation of the return of heavier loads of wounded from overseas, it was vital to maintain

in a single office all records of bed vacancies in the general hospitals in the United States and regulate the transfers of patients to them. Hence the Evacuation Branch of the Hospitalization Division, Surgeon General's Office, which had had control over the allocation of beds, was transferred to the new Medical Regulating Unit. Located within the Office of the Chief of Transportation, but under the direction of the Deputy Chief for Hospitals and Domestic Operations, Surgeon General's Office, the Medical Regulating Unit became the nerve center for the distribution of patients from overseas to the general and convalescent hospitals. Its personnel worked closely with a medical regulating officer in the Air Surgeon's Office, with service command surgeons, port surgeons, and hospital surgeons. The orderly transfer of patients from ports to hospitals called for the amassing and transmission of much data—on capacities of hospital ships and trains, and of transports and planes used in evacuation, on numbers of patients arriving on specific dates, as well as on the numbers of beds available in the general hospitals. The existence of the Medical Regulating Unit and its authority to deal directly with the surgeons of the various commands concerned with the return of patients from overseas made it possible to carry out transfers of patients more speedily and efficiently than would have been the case if command decisions had had to be obtained at each step.[39]

The emphasis placed upon coordinating a number of activities under the label of "operations" led to an increase in the number of officers assigned to the Operations Service. Of 321 Medical Department officers serving with the office in early September 1944, 76 were allotted to the Operations Service, whereas the large Preventive Medicine Service and elements of the Supply Service in Washington had only about 50 each.[40]

Control of assignments.—The effort to achieve more centralized control over assignment of Medical Department personnel continued. Success in the efforts to improve the Army's hospital system depended ultimately, The Surgeon General argued, upon the power to place in any key position the man with the most suitable medical training and experience. Control over assignments of Medical Department personnel, except those assigned to the Surgeon General's Office and to installations under command control of The Surgeon General, was exercised by the commanders of service commands, defense commands, oversea theaters, and other commands. The debate between higher War Department authority and The Surgeon General over the latter's degree of control over assignments continued throughout 1943 and 1944. General Kirk's efforts resulted only in limited gains in centralized control over the assignments of certain specialized personnel within the Army Service Forces chain of command.

[39] (1) Army Service Forces Circular No. 147, 19 May 1944. (2) History of Medical Liaison Office to the Office of the Chief of Transportation and Medical Regulating Service, Office of The Surgeon General. [Official record.]

[40] Office Order No. 186, Office of The Surgeon General, 7 Sept. 1944. A number of elements of the Supply Service were in New York by this date.

Personnel Service.—The Director of the Control Division (Colonel Voorhees) emphasized the development of a more effective Personnel Service as a key to more centralized control by The Surgeon General over all Medical Department personnel. He stated that many officers at Headquarters, Army Service Forces, as well as senior officers in the Office of The Surgeon General, lacked confidence in the Personnel Service's records on the assignments of specialists and that Army Service Forces officials doubted that the Surgeon General's Office had prepared adequate plans for more effective use of Medical Department personnel. They considered assignments by the Personnel Service without recourse to other services in the Surgeon General's Office inadvisable. Colonel Voorhees concluded that more general confidence in the working of the Personnel Service was an indispensable preliminary to the success of The Surgeon General's efforts to obtain more thorough control over the assignments. Consequently late in 1943 several steps were taken to strengthen the Personnel Service. A branch was set up in the office of the chief to work for a more effective use of personnel in the Office of The Surgeon General and in the field installations. A Personnel Planning and Placement Branch was created to do long-range planning on the placement of key military personnel. Finally, three branches—the Army Nurse, Hospital Dietitian, and Physical Therapy Aide Branches—were added to the Military Personnel Division to handle matters related to the procurement and use of personnel in the three chief professional fields in which women were used.[41]

Supply Service.—In midsummer another reorganization of the Supply Service took place. At that time two deputy chiefs were assigned to the Supply Service, one for storage operations and the other for supply control. The latter had the task of coordinating the work of the Supply Service in Washington with the activities of the Army Medical Purchasing Office in New York. In accordance with the long-range trend toward shifting medical supply functions to New York, the Renegotiation Division was transferred to the New York office, only a liaison unit remaining in Washington. Elements of the Supply Service remaining in Washington had now declined considerably in size; before the close of 1944 the large New York office had a staff of 182 officers and 547 civilian employees.[42]

Historical Division.—The year 1944 witnessed the expansion of the Medical Department's historical program, which had been deliberately restricted in scope to avoid duplicating work projected by the National Research Council. The Council's Division of Medical Sciences had undertaken an ambitious plan for producing a history of wartime medicine in the United States, which would include the more technical or "clinical" aspects of the Medical Department's wartime work. In 1944, however, responsibility for writing the history of all the Medical Department's wartime experience, "administrative" and "clinical,"

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[41] See footnote 33(1), p. 215.

[42] Yates, Richard E.: The Procurement and Distribution of Medical Supplies in the Zone of Interior During World War II (1946), p. 63. [Official record.]

was shifted to the Historical Division of the Surgeon General's Office. By that date War Department officers directing the historical program, including some Medical Department officers, had concluded that the Medical Department's history should conform to the Government-wide historical program committing each agency to produce its own history.[43]

Reorganization of August 1944 and later developments

The second major reorganization of the Surgeon's General's Office in 1944 had taken place, for the most part, by August (chart 11). It stemmed in large measure from proposals made by Colonel Voorhees, Chief of the Control Division, who felt that since some of the changes made as a result of the Wadhams Committee investigation had proved unsatisfactory, The Surgeon General need no longer be bound by the committee's recommendations. Colonel Voorhees proposed the appointment of an assistant surgeon general (in addition to the deputy surgeon general already functioning); the placing of the Military and Civilian Personnel Divisions directly under the Administrative Service instead of maintaining a separate Personnel Service; and the separation of the advisory functions of the heterogeneous, unwieldy Professional Service from its variety of operating functions. Only the first proposal went into effect without modification, the Chief of the Operations Service being given the additional title of Assistant Surgeon General, with power to act for The Surgeon General in all internal affairs of the Surgeon General's Office.[44]

The second and third proposals met with objections from the Control Division, Army Service Forces. Colonel Voorhees had advocated the abolition of the Personnel Service and the removal of the Military and Civilian Personnel Divisions to the Administrative Service on the ground that their work should be limited to issuing assignment orders and keeping personnel records. The Army Service Forces, however, refused to make an exception to its fixed policy for combination of military and civilian personnel activities within each technical service under a single head. The Personnel Service remained an entity, but a stipulation that it might make assignments of key personnel only with the concurrence of the service or division concerned with, or having special knowledge of, the qualifications of the officer proposed for the assignment (as well as of the special requirements of the job) limited its power over assignments.

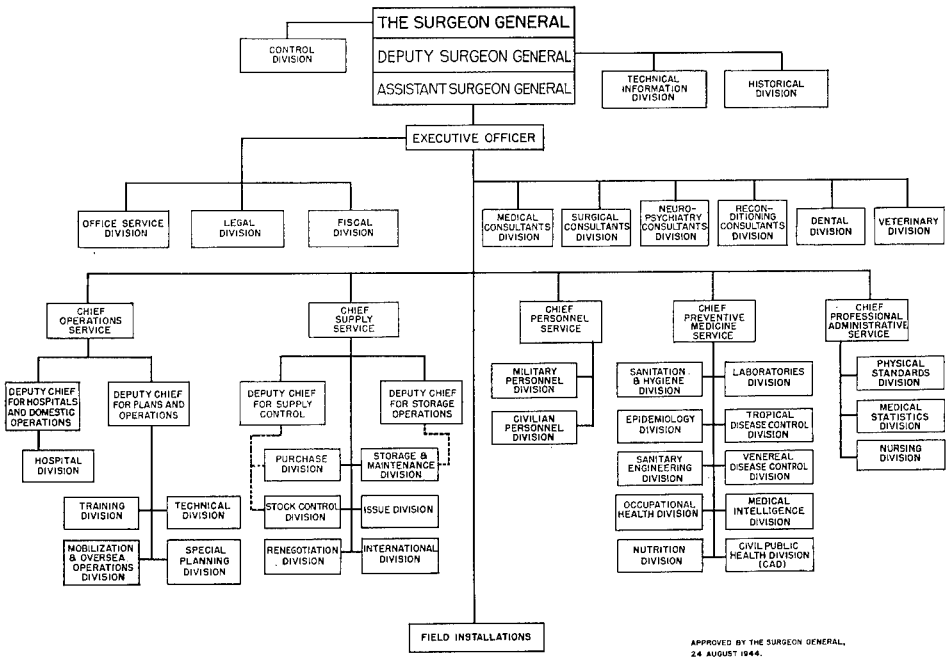
The third proposal, for separation of the advisory and operating functions of the Professional Service, called for a thoroughgoing breakup of that service. Since the Control Division, Army Service Forces, objected to this on the

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[43] (1) Love, Albert G.: The Historical Division, 1 Aug. 1941–28 July 1945. [Official record.] (2) Fulton, J. F.: Prospectus of a Medical History of the War, 1941 to 19——. War Med. 2: 847–859, September 1942. (3) A New Approach to the Medical History of World War II. Bull. U.S. Army M. Dept. 77: 67–72, June 1944.

[44] Memorandum, Tracy S. Voorhees and Eli Ginzberg, for The Surgeon General, 17 Aug. 1944, and inclosure 1, subject: Proposal for Changes in Office Organization of the Surgeon General's Office, 19 June 1944 (draft No. 2).

CHART 11.—*Office of The Surgeon General, 24 August 1944*



ground that the report of the Committee to Study the Medical Department had advocated maintaining it as a separate service, a compromise was adopted. Both the Professional and Administrative Services were dissolved, and a more clear-cut distinction was made between professional and administrative duties. The Professional Administrative Service was set up to embody the three divisions shown on chart 11. From the old Professional Service were formed four divisions embracing the work of major groups of consultants: Medical Consultants, Surgical Consultants, Neuropsychiatric Consultants, and Reconditioning Consultants Divisions. These and the Dental and Veterinary Divisions were all advisory in function and were made staff divisions. In General Kirk's opinion the elimination of the Chief of Professional Service would make possible a closer integration of the professional consultants with the Hospital Division and consequently more effective application of the expert technical knowledge of consultants to treatment of all hospital patients, especially battle casualties.[45]

This change was directly contrary to General Somervell's theory that the number of officers reporting to a superior should be strictly limited. A glance at the chart shows that in addition to these six professional advisory divisions, six other divisions, as well as the five services, were at top level. On the other

[45] Memorandum, The Surgeon General, for Commanding General, Army Service Forces, 8 Aug. 1944, subject: Visits to Field Installations.

hand, The Surgeon General now had in his immediate office both a deputy and an assistant to aid him in dealing with all these elements.[46]

The major elements of the Surgeon General's Office—that is, of division level or above—remained unchanged between August 1944 and the end of the war. In October the Resources and Analysis Division (the former Facilities Utilization Branch of the Hospital Division) was established. Headed by Eli Ginzberg, who reported directly to the chief of the Operations Service, this division engaged in personnel planning on a broad scale and planning for the most effective use of Medical Department facilities. Its predecessor, the Facilities Utilization Branch of the Hospital Division, had been limited to planning the use of domestic resources; the new division kept records on the distribution of Medical Department personnel and evaluated the current and prospective programs of the Medical Department in major commands both in the United States and overseas. It also undertook some planning of the internal organization of the Surgeon General's Office and worked out certain recommendations for the internal organization of a theater surgeon's office. The latter had formerly been a matter for decision by the theater surgeon and the theater command, and the Surgeon General's Office had not engaged in much planning in that field. During 1944, as well as in early 1945, theater surgeons and Medical Department officers returning from theater assignments or special missions had stressed the lack of centralized control of medical service from a high level and inadequate staffing of theater surgeons' offices. From early 1945 on, the Surgeon General's Office made special efforts to enlarge the staffs of theater and Services of Supply surgeons overseas with the best personnel available.[47]

Even the end of the war led to no immediate major changes in the structure of the Surgeon General's Office. With the reduction in size of the Army, retrenchment in the Operations Service, particularly in training activities, was in order. The gradual consolidation of organizational elements of the Surgeon General's Office, urged by Army Service Forces headquarters from and after September 1945, to suit its mission in the expected years of peace, took place in the postwar years.

Responsibility for medical defense against special methods of warfare

No formal organizational element was ever officially set up in the Surgeon General's Office in the course of the war with major responsibility for either of two special fields of military medicine, chemical warfare and biological (or bacteriological) warfare medicine. Both were nevertheless regarded as functions of military preventive medicine, and the Preventive Medicine Service was

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[46] (1) Office Order No. 175, Office of The Surgeon General, 25 Aug. 1944. (2) Annual Report of the Control Division, Office of The Surgeon General, for fiscal year 1945.

[47] (1) Weekly Diary of Resources Analysis Division for week ending 2 June 1945. (2) Letter, Eli Ginzberg, to Col. Calvin H. Goddard, MC, Editor-in-Chief, History of the Medical Department, U.S. Army in World War II, 5 Nov. 1951, and inclosure. See also the chapters of this volume dealing with the oversea theaters.

concerned with studies of chemical and biological warfare, and with preparations for combating them, throughout the war. Since the use of poisonous gases or germ-disseminating agents by the enemy was a potential threat to the civilian population of the United States, primary responsibility for inquiry into methods of defense against them rested during the early war years with special agencies set up for the purpose outside military channels. However, when concern over potential use of these agents by the enemy increased late in 1943 and early 1944—spurred on in the case of biological warfare by reports from the Office of Strategic Services that the Germans were planning to conduct germ warfare—the War Department assumed a more active role in these two fields. Although the Medical Department consistently refrained from participation in the offensive aspects of gas and germ warfare, Medical Department officers participated in most of the defensive aspects—research, development of ways and means of protection, training, procurement of items used in prevention, and treatment of casualties.

Chemical warfare.—Until mid-July 1943, medical research on chemical warfare medicine had been carried out by a group at Edgewood Arsenal, Md., a field installation of the Chemical Warfare Service. Outside the War Department both the National Research Council and the Office of Scientific Research and Development conducted investigations into chemical warfare medicine. In the spring of 1943, when it appeared that a staff officer was needed in the Chemical Warfare Service to coordinate the activities of the various agencies, it was decided to establish in that service a Medical Division at staff level. General Magee and the Chief of the Chemical Warfare Service reached agreement as to the responsibilities of the new division which was created soon after General Kirk assumed office. Among its functions was the preparation of reports on methods of treating casualties caused by chemical warfare agents and the study of hazards to the health of personnel doing research on these agents or engaged in producing them. The division also prepared official War Department manuals and handbooks for the treatment of gas casualties among workers at Chemical Warfare Service arsenals and plants and among troops in the field, and developed special items and kits for treatment of such casualties. Two laboratories at Edgewood Arsenal, the Medical Research and Toxicological Laboratories, were under its direction, as were similar laboratories established at a few other Army posts in the United States.

A Chemical Warfare Branch of the Surgical Consultants Division, Office of The Surgeon General, maintained liaison with the Medical Division of the Chemical Warfare Service. The Surgeon General's Office made all contracts for procuring items and kits used in the treatment of gas casualties. During the period September 1942–April 1945, nearly 2,000 Army doctors received training in all aspects of the care of gas casualties at the Chemical Warfare School at Edgewood Arsenal. Veterinary Corps officers and laboratory workers trained in veterinary techniques made studies of the toxicologic effects of chemical warfare agents on animals and foods. They also undertook to de-

velop protective devices for military animals and food supplies (or to improve upon old ones) and methods for their decontamination or treatment.[48]

Biological warfare.—Study of the potentialities of biological warfare had been informally made the responsibility of the Chemical Warfare Service in 1941 at the instance of the Secretary of War; a small unit of the agency and several civilian organizations of the Federal Government had engaged in research in this field. By 1943 the need for more direct military participation had become apparent and the War Research Service, the civilian agency of chief responsibility had charged the Chemical Warfare Service with the military phases of the programs. Early in 1944 Secretary Stimson placed direct responsibility for preparation for biological warfare on the Chemical Warfare Service (the War Research Service was dissolved) and called for the cooperation of The Surgeon General in the defensive aspects of this type of combat.

After this date the Medical Department took a somewhat more active part in the program, although the Chemical Warfare Service had chief responsibility for both the offensive and defensive aspects of biological warfare. The chief participation by the Surgeon General's Office consisted of a Biological Warfare Committee which The Surgeon General established in the office to advise him on policy, and a Special Protection Unit in the Preventive Medicine Service to coordinate medical aspects of biological warfare, including procurement and storage of biological supplies which the Chemical Warfare Service had developed for protection of personnel against biological agents. Special protective clothing and masks, chemical decontaminating agents, chemotherapeutic agents, disinfectants, antibiologicals, vaccines, and toxoids—all these became the means of antibiological warfare which emerged from the joint effort. Many of them were the same means with adaptations, used to prevent infectious diseases occurring in nature and hence were closely kin to the preventive medicine program. As in the case of chemical warfare, some of the methods and supplies and equipment developed to protect workers at the plants and laboratories producing the means of offensive warfare were later developed into instruments of protection for the soldier in the field. Various handbooks dealing with means of defense against biological warfare were issued, and 70 Medical Department officers were trained, along with Navy medical officers and Chemical Warfare Service officers, in antibiological warfare Service at the school maintained for the purpose by the Chemical Warfare Service at Camp Detrick, Md. As for direct contribution to research findings in the field, a major contribution of the Army Medical Department was the work done by Veterinary Corps officers and veterinary technicians at Chemical Warfare Service installations doing special research on the threat of animal disease,

[48] (1) Cochrane, R. C.: Medical Research in Chemical Warfare (1 Mar. 1947), pp. 56ff. [Official record, Office of the Chief of Military History.] (2) Brophy, Leo P., and Fisher, George J. B.: The Chemical Warfare Service: Organizing for War. U.S. Army in World War II. Washington: U.S. Government Printing Office, 1959, pp. 34–36, 104–106.

particularly rinderpest.[49] As neither gas nor germ warfare was employed in World War II, despite repeated reports of its imminent use in various oversea theaters, the adequacy of the Medical Department's participation in the defensive program never received a sure test.

Atomic warfare.—A third field of special warfare—atomic—developed for the first time in World War II. Throughout the history of the Manhattan Project on the atomic bomb until the bomb was used in Japan, the Surgeon General's Office had no responsibility for studying or obtaining information on the medical and physiologic effects of the new weapon on the human body. In the fall of 1943 a few Medical Department officers were assigned the task of selecting and commissioning doctors to care for the health of personnel working on the secret project, but no organizational element was set up in the Surgeon General's Office to handle any phase of atomic energy medicine. A liaison officer in the Surgeon General's Office handled requests for additional personnel and requisitions for medical supplies which the Army Medical Department furnished; in the early months of 1944 about 25 Medical Department officers were on duty with the project. After the atomic bomb explosions in Japan, The Surgeon General took action to obtain all available information and to start special investigation of medical problems connected with atomic warfare.[50]

POSITION OF THE SURGEON GENERAL AND HIS OFFICE WITHIN THE WAR DEPARTMENT

Relations With the Army Service Forces

During General Kirk's administration, relations between the Surgeon General's Office and elements of the Army Service Forces organization were somewhat more cordial than they had been during the previous administration. The decline and dissolution (in February 1944) of the Hospitalization and Evacuation Branch at Headquarters, Army Service Forces, removed one source of friction. The assignment of some of its medical officers to the Surgeon General's Office gave the latter a few officers with experience in the adjustment of Medical Department needs to Army Service Forces requirements.[51]

[49] (1) Report, George W. Merck, Special Consultant to the Secretary of War, 24 Oct. 1945, attached as Tab D to Final Report to U.S. Biological Warfare Committee. (2) Memorandum, The Surgeon General, for Commanding General, Army Service Forces, 5 May 1944, subject: Progress Report on "X" Toxoid. (3) Brophy, Leo P., Miles, Wyndham D., and Cochrane, Rexmond C.: The Chemical Warfare Service: From Laboratory to Field. United States Army in World War II. Washington: U.S. Government Printing Office, 1959, pp. 101–122. (4) Statement of Brig. Gen. Stanhope Bayne-Jones, MC, USA (Ret.), to the editor, 12 Oct. 1961.

[50] (1) Transcript, conference of staff members, Office of The Surgeon General and Corps of Engineers, 21 Sept. 1943. (2) Memorandum, Executive Officer, Medical Section, Corps of Engineers, for The Surgeon General, through the Chief of Engineers, 9 Nov. 1943, subject: Procurement and Transfer of Medical Corps Officers. (3) Memorandum, The Surgeon General, for the Chief of Staff, 13 Sept. 1945, subject: Commission on the Medical Aspects of Atomic Bombing.

[51] (1) Letter, The Surgeon General, to Col. Roger G. Prentiss, Jr., Editor-in-Chief, History of the Medical Department, U.S. Army in World War II, and attachment, 19 Nov. 1950. (2) Army Service Forces Administrative Memorandum, No. S–85, 10 Nov. 1945.

The record for the period from June 1943 to the end of the war shows a good deal more personal contact between The Surgeon General and the Commanding General, Army Service Forces, than in the period from March 1942 to May 1943. General Kirk and General Somervell conferred frequently on the Medical Department's personnel problems and various aspects of the hospitalization and rehabilitation programs. General Somervell noted any criticisms of Army medical service that had come to his attention, and from time to time asked General Kirk to submit a list of current and anticipated problems. In early 1944, for example, he requested to be kept informed on the progress of the Surgeon General's Office in solving major problems with respect to physical standards, the Army Specialized Training Program, the assignment and control of medical personnel, and hospitalization. His list of specific tasks and problems with respect to hospitalization indicates the importance which he attached to the efficient handling of oversea casualties: estimate of hospital requirements for the United States and oversea areas, especially the European theater; prompt removal from hospitals of personnel not in need of hospitalization; improvement in hospital administration; the possibility of moving casualties directly from ports to hospitals where they could be treated, thus bypassing the hospitals at ports; and the program for rehabilitating the sick and wounded.[52]

General Kirk nevertheless experienced the same handicaps in serving under the Army Service Forces instead of at the War Department Special Staff level that General Magee had complained of, and disagreements between Army Service Forces headquarters and the Surgeon General's Office over matters of policy and procedures continued to spring up. In the case of some, no solution satisfactory to both parties was ever reached. Controversies developed, for example, over the handling of medical supplies and equipment. The problems of large-scale procurement, about which many debates between Army Service Forces headquarters and the Surgeon General's Office had revolved during 1942 and early 1943, had largely been solved. But late in 1943 disagreement arose over efforts by Army Service Forces headquarters to improve the system of storing and issuing supplies handled by all the services. In the interest of greater efficiency, Army Service Forces headquarters wanted to make the Quartermaster Department responsible for storing and issuing as many items as possible in its general depots and to consolidate responsibility for the remainder, insofar as feasible, within a few of the technical services. It proposed, for instance, that the Signal Corps be responsible for some items of electrical equipment used by the Medical Department—X-ray machines, cardiographic units, and radiographic units. Under this system, the Medical

[52] (1) Memorandum, Chief of Staff, Army Service Forces, for The Surgeon General, 15 Jan. 1944, subject: Current and Anticipated Medical Problems. (2) Memorandum, Commanding General, Army Service Forces, for The Surgeon General, 18 Jan. 1944. (3) Memorandum, The Surgeon General, for Commanding General, Army Service Forces, 19 Jan. 1944, subject: Current and Anticipated Army Service Forces Problems. (4) Memorandum, Chief of Staff, Army Service Forces, for The Surgeon General, 1 Mar. 1944.

Department's separate depot system would have been greatly curtailed, and the medical sections would no longer have been maintained as distinct entities in the general depots.[53]

The Director of the Surgeon General's Control Division, Colonel Voorhees, strongly supported by the group of experts in retail merchandising from civilian life then assigned to the Supply Service, led the opposition to this move on the part of Army Service Forces headquarters. Using the idiom of Ring Lardner, he called the attention of the Director of the Control Division, Army Service Forces, Brig. Gen. Clinton F. Robinson, to the delays and mixups in the distribution of medical supplies which would result from this "switching of the signals" by Army Service Forces headquarters. He complained to "Robbie" that "our team dont get much chanct any more to pittch or to play against the Black Sox [the Germans] or the Yellow Sox [the Japanese] because we have to keep pittchin all the time to them Big League players from the Headquarters Club what owns us, just so they can take battin practice out of us." General Robinson replied in opposing tenor but similar vein. To his way of thinking there was only one team, with the technical services constituting the infield and the outfield. The Medical Department, which he termed the "left fielder who wears skin fitting rubber gloves" (and one such player, he said humorously, was enough), was apparently trying to set up a club of its own.[54]

While conflicts of this sort were similar to those that had occurred during General Magee's administration, the Surgeon General's Office now handled them somewhat differently. In the first place, General Kirk was, like General Somervell, both quick and forthright in asserting his views. Moreover, he had the aid of a small group of administrators from civil life in key positions in his office to lead the counterattack whenever he opposed policies and procedures which the Army Service Forces headquarters urged as more economical or efficient. Instead of arguments based on the necessity for control of the medical supply system by those who had had medical training, the group from industry advanced arguments based on the practicability or efficiency of the proposed changes. Not only did they have reputations as experts in management techniques; in some controversies with the Army Service Forces they were in a position to appeal to the Under Secretary of War. The possible abolition of Medical Department depots, for example, was called to the attention of Mr.

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[53] (1) Memorandum, Col. Tracy S. Voorhees, Director, Control Division, Office of The Surgeon General, for Director, Control Division, Army Service Forces, 15 Oct. 1943, subject: Atlanta Experiment in Depot Operations. (2) Memorandum, Director of Supply, Army Service Forces, for Chiefs of Services, 9 Dec. 1943, subject: Review of Present Organizational Structure of the Army, and related documents. (3) Memorandum, Col. Tracy S. Voorhees, for Brig. Gen. C. F. Robinson, 16 Dec. 1943, subject: Distribution System Plan, etc. The medical depots, it will be recalled, were the chief type of installation under the command of The Surgeon General, and a large proportion of the personnel commanded by him were in the depots.

[54] (1) Letter, Col. Tracy S. Voorhees, to Brig. Gen. Clinton F. Robinson, 10 Dec. 1943. (2) Letter, Brig. Gen. Clinton F. Robinson, to Col. Tracy S. Voorhees, 16 Dec. 1943.

Patterson by Colonel Voorhees, who pointed out the embarrassment to the Under Secretary if the large system of medical depots were abolished at a time when the Under Secretary had just succeeded in persuading a reluctant company (Butler Bros.) to release its operations vice president (Mr. Charles Harris) to the Army for the purpose of managing those depots. This factor seems to have contributed to the demise of the Army Service Forces, "Distribution System Plan." [55]

During General Kirk's administration the installations commanded by The Surgeon General remained about the same, in type and number, as those which his predecessor had commanded after August 1942 when the general hospitals were removed from his control and put under service command jurisdiction. In March 1944, field installations under General Kirk's direct command were the Army Medical Center, including its general hospital, the schools, and laboratories; the Army Medical Museum and Army Medical Library; the Medical Field Service School at Carlisle Barracks, Pa.; three laboratories; the Army Medical Purchasing Office in New York, and its Chicago branch; and eight medical depots. The Center had as a subsidiary activity the Biologic Products Laboratory at Lansing, Mich. The Army Medical Library had a branch at Cleveland, Ohio, while the Medical Field Service School included the Medical Department Equipment Laboratory. The three laboratories commanded by The Surgeon General (besides the installations at the Army Medical Center, in Lansing, and Carlisle Barracks) were the Army Industrial Hygiene Laboratory at The Johns Hopkins University, Baltimore, Md.; the Armored Medical Research Laboratory at Fort Knox, Ky.; and the Respiratory Diseases Commission Laboratory at Fort Bragg, N.C. The eight medical depots which he commanded were at Binghamton, N.Y., Chicago, Denver, Kansas City, Los Angeles, Louisville, St. Louis, and San Francisco. The large general hospitals, under service command control, amounted to more than 60 at the peak of their development during General Kirk's administration.

This situation underwent little modification to the end of the war except as certain of the medical depots were closed. The Surgeon General's command over installations was substantially enlarged only in April 1946 when his command control over general hospitals was restored and when all hospital centers and convalescent hospitals in the United States were transferred to his command. By this date a general contraction of the Army's hospitalization system in the United States was well underway.[56]

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[55] Voorhees, Tracy S.: Recollections of My Work for The Surgeon General, October 1945. [Official record.]

[56] (1) Office Order No. 59, Office of The Surgeon General, 21 Mar. 1944. (2) Office Order No. 183, Office of The Surgeon General, 4 Sept. 1944. (3) Morgan, Edward J., and Wagner, Donald O.: The Organization of the Medical Department in the Zone of the Interior, ch. VII and XII. [Official record.] (4) 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, pp. 281–282.

Relations With the Army Ground Forces and the Army Air Forces

Conflicts with other echelons of the War Department (or with the offices of their surgeons), stemming from The Surgeon General's position of subordination to Army Service Forces headquarters, continued. The solution of such problems as could not be resolved by agreement or compromise was attained only by War Department decision. Some opposition developed within the Army Ground Forces in July 1943 when General Kirk assigned Brig. Gen. Albert W. Kenner as his assistant to inspect the training of medical units in the ground forces. Army Ground Forces headquarters did not recognize any inherent right by the chief of a technical service to make any type of inspection of troops or installations of the Army Ground Forces. The official War Department document which straightened out the matter provided for "visits" by representatives of chiefs of the technical services at installations of the Army Ground Forces, Army Air Forces, service commands, and defense commands in continental United States. Such visits could be made only by arrangement of the chief of the technical service with the commanding general of the major command concerned, and the visiting representatives were to be concerned only with "technical matters." [57]

The difficulty over inspections appears to have been one of the very few problems to arise in connection with the medical service of the ground troops, partly because of a cooperative nature and disinterest in empire building on the part of the men who filled the position of Ground Surgeon. On the other hand, problems of relationships between The Surgeon General and the Air Surgeon's Office continued unabated. In December 1943 the Commanding General, Army Air Forces, recommended to the Chief of Staff of the Army that the Air Surgeon (Maj. Gen. David N. W. Grant) be made a member of the Federal Board of Hospitalization, an advisory agency to the Bureau of the Budget which consisted of the Surgeons General of the Army, Navy, and U.S. Public Health Service, and other officials handling large Federal hospital programs. He also wanted the Air Surgeon made his representative, with the same status as the three surgeons general, at meetings of the executive committee of the Procurement and Assignment Service of the War Manpower Commission. He based his request on the numbers of Medical Department personnel and the magnitude of the hospital program for which, he stated, he was solely responsible.[58] The Surgeon General's Office opposed the suggested

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[57] (1) Memorandum, Commanding General, Army Ground Forces, for Chief of Staff, 7 Sept. 1943, subject: Technical Inspection of Troops and Installations of the AGF and of the AAF, etc. (2) Office Order No. 480, Office of The Surgeon General, 17 July 1943. (3) Memorandum, The Surgeon General, for Commanding General, Army Ground Forces, 7 Aug. 1943, subject: Technical Inspections of Medical Troops and Installations of AGF. (4) Memorandum, Commanding General, Army Service Forces, for Chief of Staff, 27 Aug. 1943, subject: Technical Inspection of Troops and Installations of the AGF and the AAF by Representatives From the Chiefs of Technical Services of the ASF. (5) War Department Memorandum No. W265–1–43, 22 Sept. 1943.

[58] The Air Surgeon's figures included 239 station hospitals with a total of 75,461 beds, 146 dispensaries, and 324 infirmaries. Of the 16,000 Medical Corps officers then on duty with the Army Air Forces, the Air Surgeon stated that he had procured and assigned about 10,000.

appointments for the Air Surgeon on the ground that The Surgeon General could handle matters of hospitalization for all air and ground forces, calling upon the Air Surgeon or the Ground Surgeon for aid whenever necessary. Officers assigned to G–1, War Department General Staff, stated that The Surgeon General could represent the War Department adequately at the meetings of both these organizations and recommended that he ask the Air Surgeon to attend any meetings at which he wished his aid in discussion of problems relating to Army Air Forces medical installations. The Air Surgeon did not receive either of the appointments requested; he attended, by invitation, some of the meetings of the executive committee of the Procurement and Assignment Service.[59]

For The Surgeon General, a chief problem continued to be the divided responsibility for Army hospital administration in the United States, mainly as between the Army Service Forces and the Army Air Forces. The general hospitals were run by the Army Service Forces; they were under the immediate jurisdiction of the commanding generals of the service commands. The station hospitals were about equally divided between the Army Service Forces and the Army Air Forces, although those of the latter were considerably smaller on the average than those of the former. Those assigned to the Army Service Forces were directly under its various subordinate commands, while the station hospitals of the Army Air Forces were located at airbases assigned to a number of subordinate air commands. The Army Ground Forces controlled only a few hospitals, while the defense commands, which were directly subordinate to the War Department General Staff, also operated a few, mainly at the Atlantic bases which were a part of the Eastern Defense Command.

The Surgeon General could not make estimates of the requirements of men and supplies for hospitals assigned to the Army Air Forces or allocate these medical means suitably among hospitals in the United States. Difficulties increased with renewed efforts by the Air Surgeon to extend the Air Forces' sphere of control over hospitals. He made a consistent attempt to add general hospitals, or hospitals approaching these in scope of treatment, to the hospital system of the Army Air Forces in the United States and to place hospitals under the Air Forces chain of command in the oversea theaters. The struggles between the Air Surgeon and The Surgeon General over these two problems were settled as to major points by the spring of 1944.

The effort to gain control of general hospitals, or hospitals which gave similarly definitive treatment, within the United States continued until the Air Forces medical group partially attained its ends. By placing highly specialized medical personnel in station hospitals at airbases, the Army Air Forces had made of some of its station hospitals institutions which could give

[59] Letter, Maj. Gen. David N. W. Grant, MC, USAF (Ret.), to Col. John Boyd Coates, Jr., MC, Director, The Historical Unit, U.S. Army Medical Service, 11 Aug. 1955, subject: Comments on preliminary draft of this volume.

treatment of the scope of that theoretically within the province of general hospitals only. Air force medical officers were in a position to refuse to send air force patients to the regular general hospitals of the Army Service Forces, since these patients could receive all necessary treatment in Army Air Forces station hospitals. A protracted struggle ensued between The Surgeon General and the Army Service Forces, on the one hand, and the Air Surgeon and the Army Air Forces, on the other. General Kirk and the commanding generals of some service commands took the view that all fixed hospitals, including the station hospitals controlled by the Army Air Forces, should be under the command control of the commanding generals of service commands. A board of officers, with experience as service command surgeons, appointed by The Surgeon General to study problems of medical administration in the service commands advocated making the commanding general of the service command responsible for all medical service (including hospitalization, evacuation, and sanitation at all fixed installations) within the service command's boundaries. Under this recommendation, which would have removed the fixed medical installations of the Army Air Forces from the chain of Army Air Forces command, The Surgeon General would have had more direct technical control of this large group of hospitals, with the service command surgeon exercising immediate technical control as he now did over the general hospitals. This recommendation for highly centralized control of medical installations in the United States on an area basis went a step beyond the Medical Department's usual position in that it positively advocated removing from Army Air Forces' supervision the station hospitals which that command had controlled since it was established in June 1941.

A report by the medical adviser, Maj. Gen. Howard McC. Snyder, of the Inspector General's Office, recognized that the Army Air Forces had succeeded in developing hospitals which could give advanced treatment and recommended that arrangements be worked out for hospitalizing patients of other arms and services, as well as of the Air Forces, in them. The upshot was that in the spring of 1944 both the Army Air Forces and the Army Service Forces were given the right to operate in the United States "regional hospitals" which would receive patients from all station hospitals (whether under command of the Army Ground Forces, the Army Air Forces, or the Army Service Forces) within a 75-mile radius.

The regional hospitals gave treatment of a type formerly given only by the general hospitals but could receive only patients from station hospitals in the United States and not oversea patients. The latter were to be sent to the general hospitals, operated exclusively by the Army Service Forces, for definitive treatment. At the same time it was stipulated that all four main types of fixed hospitals—station, convalescent (also established as a type to be operated by both Army Service Forces and Army Air Forces at this date), regional, and general—were to serve all troops on an area basis, regardless of the command to which the patient or the hospital was assigned, and a hospital was to

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transfer patients to another hospital only if it could not provide the requisite medical care. The result of these arrangements was to weaken somewhat the position of The Surgeon General. The Army Air Forces had now succeeded in getting recognition of its jurisdiction over installations giving treatment of the type afforded by the general hospitals. As the Army Air Forces at one time operated 30 regional hospitals (compared with 32 operated by the Army Service Forces), giving treatment of the type formerly given only by the general hospitals, it had achieved a significant advance in establishing what the Army Service Forces termed in retrospect "a duplicating medical and hospital service in the United States." [60]

The victory of the Army Air Forces medical group had been gained once more through obtaining official War Department recognition of a fait accompli. The assignment of specialists to hospitals already under its control had given the Army Air Forces a distinct advantage. From now on those who were unwilling to allow the Army Air Forces hospitals to give definitive treatment could be accused of indifference to the effective use of specialized personnel. The addition of "regional hospitals" to Army Air Forces jurisdiction was not only a step toward autonomy of the medical service administered by the Air Surgeon but also toward the severance of the Air Forces and its medical service from the rest of the Army, a development which was completed in the postwar years pursuant to the National Security Act of 1947.[61]

The effort of the Army Air Forces to gain control of station hospitals at air force bases overseas was kept alive by the Air Surgeon during visits to various theaters in 1944, being given further impetus by a questionnaire which he sent in the spring to the surgeons of numbered air forces overseas. Among the rather leading questions put to each air force surgeon were the following: What percentage of bases operated by his air force were not within 50 miles of a hospital maintained by the theater services of supply; did he have any difficulty in keeping in contact with hospitalized troops of his air force; was it satisfactory that the date of releasing air force patients and the dispositions made of them (that is, their return to duty, evacuation to the United States, or other kind of discharge) should be determined by a surgeon of the service forces. In July 1944 the Air Surgeon asked for an estimate on the savings in personnel time that would result from control by the oversea air forces of hospitals for air force patients. He received replies of varying tenor. While most air force surgeons agreed with him on the theoretical advantages of con-

[60] (1) Report, Army Service Forces, Logistics in World War II, 1 July 1947. (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, pp. 103–104, 182ff.

[61] (1) Millett, John D.: Organizational Problems of the Army Service Forces, 1942–1945. [Official record, Office of the Chief of Military History.] (2) See footnote 51(1), p. 229. (3) Memorandum, Chief, Hospitalization and Evacuation Section, Army Service Forces, for Executive Officer, Office of The Surgeon General, 1 June 1943, subject: Conference of Surgeons of Service Commands. (4) See footnote 60(1). (5) Transcript, Army Service Forces Conference of Commanding Generals of Service Commands, 22–24 July 1943, Chicago, Ill. (6) Transcript, Army Service Forces Conference of Commanding Generals of Service Commands, 17–19 Feb. 1944, Dallas, Tex.

trol of hospitals overseas by the Army Air Forces, some pointed out certain factors in their own theaters which argued against it. The Army Air Forces never succeeded in getting official authorization from the War Department for such a system, but for various reasons and by various devices some air forces elements overseas succeeded in having a few hospitals assigned to them. Out of the oversea experience of the medical officers assigned to the air forces evolved the strongest argument for air force control of all types of hospitals: that in order to return the flyer to duty with all possible speed and thus make the maximum use of its highly trained personnel in combat, the Air Forces must retain continuous control of the patient throughout the days of his evacuation and hospitalization.[62]

Efforts to Regain Staff Position for The Surgeon General

At some indeterminate date in 1944 the War Department General Staff began to reassume some of the functions which it had turned over to the Army Service Forces in March 1942. The control of the Army Service Forces over the Surgeon General's Office was somewhat weakened as more direct contact began to take place between elements of the General Staff and the Surgeon General's Office, particularly as G–1 became increasingly concerned with the problem of worldwide allocation of Army doctors. The problem was highlighted by General Kirk himself who informed General Somervell that he had frequently been "amazed and perplexed" by the numerous War Department agencies involved in "strategic decisions" affecting the Medical Department. He listed only the most important of these agencies, omitting—perhaps unintentionally—the Operations Division of the War Department General Staff: The Deputy Chief of Staff; the War Department Manpower Board; the Assistant Chiefs of Staff G–1, G–3, and G–4; the Inspector General; the Director of Plans and Operations, Army Service Forces; the Military Personnel Division, Army Service Forces; the Ground Surgeon; and the Air Surgeon. He gave several examples of discussions of Medical Department problems at some of these higher level offices at which no Medical Department representative was present, and noted mistaken conclusions reached on the basis of insufficient or inaccurate information.[63]

An opportunity to reopen the question once more, this time at the highest level, came early in 1945 when The Surgeon General was asked by the Secretary of War to gage the adequacy of the medical personnel and facilities at his disposal for a prolonged war in Europe and the Pacific. General Kirk's answer stressed the problems posed for him by the coequal status of the Army

[62] (1) Memorandum, The Surgeon General, for the Chief of Staff, Army Service Forces, 1 Nov. 1943, subject: Hospitalization of Air Corps Battle Casualties and Casual Sick. (2) Memorandum, Col. E. C. Cutler, MC, for Col. J. C. Kimbrough, MC, 11 Sept. 1943, subject: Relationship Between Our Hospitals and the 8th Air Forces. (3) See footnote 51(1), p. 229. (4) Letter, Maj. Gen. Norman T. Kirk, to Brig. Gen. Guy B. Denit, 28 Nov. 1944. (5) Letter, Brig. Gen. Denit to Maj. Gen. Kirk, 8 Dec. 1944. See also the chapters of this volume dealing with the oversea theaters.

[63] Memorandum, The Surgeon General, for Commanding General, Army Service Forces, 4 Oct. 1944, subject: The Determination of Policies Affecting Hospitalization and Evacuation.

Ground Forces and the Army Air Forces. Without having a position on the War Department Staff, General Kirk argued, he could not effectively supervise hospitals assigned to these two commands or to various commands scattered throughout the oversea theaters. He dwelt again on the lack of central command control at the staff level over the assignment and reassignment of highly skilled Medical Department personnel, emphasizing the difficulty of reassigning skilled officers to a command more in need of their services. In necessity for fitting skilled personnel into allotments by rank, he saw only a waste of scarce specialists and a loss of efficiency.[64]

The Secretary of War asked the commanding generals of the Army Service Forces, Army Ground Forces, and Army Air Forces, as well as elements of the General Staff, to comment on General Kirk's appraisal of his position. He professed himself satisfied with current Army medical service in the European theater on the basis of his observation during a recent visit there, but expressed concern over prospective heavy demands on medical service in both Europe and the Pacific. A conference was held in January of officers representing the commanding generals of the Army Air Forces and Army Service Forces, The Surgeon General, the Air Surgeon, the War Department Manpower Board, and G–3, G–4, and the Operations Division of the War Department General Staff. At the end of January, General Bliss, acting under instructions of the conference, prepared the draft of a circular which The Surgeon General proposed for issue by the War Department in order to reestablish his position on the War Department Staff as it had existed before the War Department reorganization of March 1942. The draft emphasized the position of The Surgeon General as the chief medical adviser to the Secretary of War and the Chief of Staff, and authorized direct channels of communication between The Surgeon General, on the one hand, and the Chief of Staff, the General and Special Staffs, and major components of the Army, on the other. Numerous written comments, telephone conversations, and revisions of the draft favorable to their own positions and purposes ensued on the part of the participants. The Director of the Control Division, Surgeon General's Office, and the Assistant Surgeon General (Brig. Gen. Raymond W. Bliss) conducted the negotiations to elevate the position of The Surgeon General.[65]

In arguments over the wording of the circular, the Army Air Forces and the Air Surgeon's Office continued to insist that the medical organization and hospital system within the Army Air Forces were functioning efficiently. They blamed most of The Surgeon General's difficulties upon his position within the Army Service Forces organization and the consequent necessity for clearing all his plans with the various organizational elements at Army Service Forces

[64] Memorandum, The Surgeon General, for the Secretary of War, 10 Jan. 1945, subject: The Medical Mission Reappraised.

[65] Draft for circular marked as submitted to the Chief of Staff (through Commanding General, Army Service Forces), 29 Jan. 1945. There are numerous other drafts in the files of the various agencies represented.

headquarters; that is, with the latter's various staff directors of plans and operations, of supply, of materiel, and so forth. In their opinion a small group of qualified medical officers, representing the three major commands equally, headed by an "assistant chief of staff for medical services of the Army," and located on the War Department General Staff, should direct Army-wide medical service. The commanding general of each of the three major commands and of each theater, who should be responsible for the organization and operation of the medical service of his particular command, should have a senior medical officer on his staff to advise him on medical matters and exercise technical control over the medical service within the command.

The Surgeon General agreed with the Army Air Forces and the Office of the Air Surgeon as to the desirability of having a Surgeon General located at the general staff level. However, neither the General Staff nor Army Service Forces headquarters was willing at that date to revise substantially the War Department structure established in March 1942. The Army Service Forces organization was particularly averse to being bypassed by granting The Surgeon General the right of direct access to the General Staff.

Nevertheless, participants in the January conference had agreed that The Surgeon General should be recognized as staff adviser to the War Department and that direct communication should be authorized between The Surgeon General and higher War Department authority on health matters of Army-wide scope. Additional strength accrued to The Surgeon General's position in that the Secretary of War had asked for his views and indicated from the outset that he intended to give them serious consideration. Moreover, various elements of the Medical Department had succeeded by this date in popularizing to some extent their dissatisfaction with the position of The Surgeon General within the War Department. The Director of the Control Division of the Surgeon General's Office called attention to the "unmistakably rising tide of criticism of the present unsound position of the Medical Department in the Army" appearing in the popular press and the medical journals.[66]

War Department Circular No. 120 was finally issued on 18 April 1945. It announced that The Surgeon General was the chief medical officer of the Army and the chief medical adviser to the Chief of Staff and the War Department. He was to make recommendations to the Chief of Staff and the General and Special Staffs on matters pertaining to the health of the Army, prepare for publication War Department directives on general policies and technical procedures on health matters of Army-wide application, exercise technical staff supervision to assure the maximum use of available medical resources, and make technical inspections relative to matters pertaining to health of the Army. All plans and policies of medical import with Army-wide application were to be cleared with The Surgeon General. Communications on plans and poli-

[66] (1) Memorandum, Director, Control Division, for Col. John R. Hall, 4 Feb. 1945, and attached documents. (2) Davis, L.: Organization of the Red Army Medical Corps. Surg., Gynec. & Obst. 79: 329–332, September 1944. (3) Remarks, Rep. Frances P. Bolton (R., Ohio), 12 Dec. 1944. Cong. Rec., 78th Cong., 2d sess., pp. 9422–9425.

cies were to be addressed to the Chief of Staff or to The Surgeon General and were to be sent through the Commanding General, Army Service Forces, who was to forward them with appropriate recommendations with the least possible delay. Direct communication among The Surgeon General, the War Department, and the three major commands on routine medical matters was authorized. Nevertheless, the fact that The Surgeon General was under the command of the Commanding General, Army Service Forces, was reaffirmed, and the commanding generals of the major forces, commands, departments, or theaters were to be held responsible for the internal organization and the efficient operation of the medical service of their respective commands.

The wording of the circular followed a draft proposed by G–1 and was a document of compromise. It contained an essential contradiction in that the organizational subordination of The Surgeon General to the Commanding General, Army Service Forces, was maintained, while it authorized direct communication between The Surgeon General and commands coordinate with the Army Service Forces or higher. At the same time the limitation of this direct communication to "routine medical matters" seemed to weaken its force. Shortly before it was issued, the Secretary of War issued the following statement: "I consider that the care of the sick and wounded and the character of the hospitalization in the Army are matters for the direct responsibility of the Secretary of War; also that The Surgeon General should be his principal adviser in regard to these vital matters. To that end I wish it clearly understood that I am to have direct access to him and he to me on such matters whenever either of us deems it to be essential." The letter seems to represent a recognition of the essential weakness of the circular and at the same time the Secretary's determination to make clear his personal sympathy with the attitude of The Surgeon General. In October 1945 the new Secretary of War, Robert P. Patterson, assigned Colonel Voorhees to his office to aid him in "carrying out the responsibilities of the Secretary of War as outlined in his memorandum dated 6 April 1945, with reference to the care of the sick and wounded and the character of the hospitalization in the Army and matters relating thereto." Mr. Voorhees, who later became Assistant Secretary of War, acted as the Secretary's adviser on matters of administration of the Army Medical Department in the postwar period.[67]

The practical effect of Circular No. 120 and of the Secretary of War's letter is difficult to gage. Although The Surgeon General apparently did not make use of his power of access to the Secretary of War, the fact that he had the right of access gave him some bargaining strength. Both the Surgeon General's Office and the Army Service Forces organization regarded the

[67] (1) Memorandum, Deputy Chief of Staff, for Commanding Generals, Army Air Forces, Army Ground Forces, and Army Service Forces; for Assistant Chiefs of Staff, G–1, G–3, and G–4; for Operations Division; and The Surgeon General, 13 Apr. 1945, subject: War Department Circular Clarifying Responsibilities of The Surgeon General, and Related Papers. (2) Memorandum, Secretary of War, for Deputy Chief of Staff, 15 Oct. 1945, subject: Col. Tracy S. Voorhees. (3) Memorandum, Secretary of War, for Deputy Chief of Staff, 12 Dec. 1945.

circular and the Secretary's letter as a partial victory for The Surgeon General and a corresponding loss of authority by the Army Service Forces, although the latter minimized its practical effect.[68]

MEDICAL ORGANIZATION IN THE SERVICE COMMANDS

At the beginning of his administration, General Kirk continued to attack, as General Magee had done, the problem of the position of the service command surgeon within service command headquarters. Since the reorganization of August 1942, the service command surgeon—or chief of the medical branch, as he was now termed—had been subordinated to either the supply or the personnel division of service command headquarters and reported to the commanding general of the service command only through the director of the division in which he was placed. At the same time some officers of the medical branch had been placed in divisions other than the one to which the chief of the branch was assigned. Obviously the chief of the medical branch had no direct control over their work, and the so-called "medical branch" could hardly operate as an entity. Nothing had come of either General Magee's efforts to reestablish staff position for the service command surgeon or of the recommendation of the committee which had surveyed the Medical Department late in 1942 that his position be restored. Although a Services of Supply organization manual of December 1942 had made it clear that the surgeon was still responsible for advising the commanding general of the service command on health matters affecting personnel of the command, it had not changed outright his status or that of his medical branch.

Shortly after taking office General Kirk renewed the struggle. At the suggestion of General Somervell, he called a conference of service command surgeons to discuss the matter. A board of three officers, appointed to make recommendations on medical administration in the service commands, proposed that the medical branch be made into a division of the office of the commanding general. General Somervell raised the problem at the regular conference of commanding generals of service commands in Chicago in July, but although he had expressed tentative concurrence with the plan proposed by The Surgeon General's board, he finally disapproved it. His main objection was that it threatened, by giving all the technical services a similar claim to the right of reporting directly to the commanding general of the service command, to nullify the benefits gained by the reorganization of service command headquarters in August 1942; that is, a reduction in the number of officers reporting directly to the commanding general.

In spite of his refusal at this date to interfere with the formal organization of service command headquarters, General Somervell stressed to the command-

[68] (1) Letter, Chief, Personnel Service, Office of The Surgeon General, to theater and defense command surgeons, 17 May 1945. (2) Memorandum, Commanding General, Army Service Forces, for Chief of Staff, 6 Aug. 1945, subject: Position of Army Service Forces in the War Department. (3) See footnote 60(1), p. 236.

ing generals of service commands the importance of their keeping in close touch with their respective chief surgeons. As he put it, "certainly you have got to talk to your doctor." Probably this remark indicated some shift in his point of view, for in November Army Service Forces headquarters indicated its desire that each service command headquarters be reorganized to conform as closely as possible with the parent headquarters. The chiefs of technical services, including the service command surgeon, were thus given staff position and put in direct line of communication with the commanding general of the service command and his chief of staff. They bore the same relation to the commanding general at their headquarters that the chiefs of technical services in Washington bore to General Somervell. The service command surgeon thus reachieved staff position and retained it to the end of the war. Post surgeons, it may be noted, had never lost staff status.[69] The Army Service Forces did not again attempt to put into effect a functional scheme of organization at service command headquarters, nor in its own headquarters. Throughout the war the organization of Headquarters, Army Service Forces, retained at staff level both the chiefs of the technical services and the chiefs of its functional elements such as the Personnel and Supply Divisions. Abandonment of the functional scheme of organization for service command headquarters—and with it, any strict limitation on the number of officers reporting to a superior—was probably due in some measure to the Medical Department's continued protest against it.

The reorganization of service command headquarters at the end of 1943 offered an opportunity to reorganize the offices of the service command surgeons on a uniform basis. The pattern proposed was the same division into five "services" that then existed in the Office of The Surgeon General, but few service command surgeons adopted the scheme. As we have seen, the Office of The Surgeon General itself underwent other major reorganizations before the end of the war, and service command surgeons' offices made little attempt to keep pace with these . A general exception was the addition of a reconditioning branch to parallel the Reconditioning Division, Surgeon General's Office, after early 1944.

Variations in medical problems from one service command to another logically led to considerable diversity in organization and variations in size of their surgeons' offices. The geographic area of the service command, its Army strength, its climate, the disease pattern, concentration of population, industrialization, the presence of prisoner-of-war camps, the presence of ports of embarkation—all these factors affected the work of the surgeon's office. A strong industrial hygiene program for civilians working in war plants developed in the Second, Seventh, and Eighth Service Commands. The venereal disease control program, important in all service commands, was more serious in those with highly industrialized areas or with heavy troop concentrations.

[69] Morgan, Edward J., and Wagner, Donald O.: The Organization of the Medical Department in the Zone of the Interior, chs. IX and X. [Official record.]

Large-scale efforts at malaria control were primarily limited to the Fourth, Seventh, and Ninth Service Commands. The responsibility of medical care for prisoners of war fell mainly upon the surgeons' offices of the Second, Fourth, Sixth, and Seventh Service Commands, since prisoner-of-war camps were concentrated in these areas. Surgeons of the service commands along the coast cooperated with medical men of the Navy and the Coast Guard, as well as with Army port surgeons, in attempting to maintain sanitary conditions in coastal areas and in receiving Army and prisoner-of-war patients evacuated from overseas. In the Ninth Service Command, many Medical Department officers received training at the Civil Affairs Staging and Holding Area (established in June 1944) at Fort Ord, Calif., later at the Presidio of Monterey, Calif., to prepare them for medical work among civilian populations in the Far East.[70]

In all service commands, some officers had to be assigned to liaison duties with various health agencies, including the U.S. Public Health Service and State and local health departments, and with the medical sections of some of the commands whose jurisdictional boundaries coincided with, or overlapped, those of the service commands—defense commands, air force commands, field armies, and air forces. Special efforts were made in some service commands to pool the highly trained Medical Department personnel of the various commands. The Seventh Service Command, for example, reached an agreement with the Army Air Forces Training Command, the Troop Carrier Command, the Air Transport Command, and the Second and Third Air Forces that these commands would use the chiefs of medicine, surgery, neuropsychiatry, and dermatology at the general hospitals of the Army Service Forces and at the regional hospitals of the Army Air Forces, as regional consultants in their respective station hospitals. Consultants in the various service command headquarters continued to advise the service command surgeons on the proper assignments of specialists on the basis of their observations of the latters' work. In 1945, dietitians and physical therapists were assigned as consultants to the staffs of service commands and gave similar advice on the assignments of personnel in these fields.[71]

The status of the service command surgeon remained unchanged from late 1943 to June 1946, and his functions were changed only slightly. Pursuant to demobilization plans drawn up by Army Service Forces headquarters, he had to make plans for hospitalization and evacuation and, along with the chiefs of the other technical services, participate in disposing of surplus installations and property in the service commands and in establishing a reserve of training equipment for redeployment training in the United States. In

[70] See footnote 38, p. 220.

[71] (1) Annual Reports of the Service Command Surgeons, 1942–1945. (2) Memorandum, Chief, Occupational Hygiene Branch, for Deputy Chiefs of Service Commands, 29 Sept. 1943, subject: Procedures for Industrial Hygiene Inspections and Surveys in Ordnance Explosives Plants. (3) Memorandum, The Adjutant General, for Commanding Generals of Service Commands, Chief of Ordnance, Chief of Chemical Warfare Service, 29 Nov. 1943, subject: Procedure for Industrial Hygiene Inspections and Surveys in Army-Owned Ordnance and Chemical Warfare Service Explosives Plants.

June 1946, when the Army Service Forces was abolished, a major reorganization of the regional structure of the Army, which marked a return to the prewar area organization of the Army within the United States, took place. When the nine service commands under the Army Service Forces were abolished, six army areas were created to operate directly under the War Department. Like the prewar corps areas, these were mixed tactical and service organizations, and the duties of the new army area surgeons closely resembled those of the former corps area surgeons. Moreover, the elimination of the Army Service Forces organization above The Surgeon General put the army area surgeon in the same position with respect to The Surgeon General as the corps area surgeon had been before March 1942. Shortly before these Army-wide changes went into effect the control of general hospitals, as well as hospital centers and convalescent hospitals, was returned to The Surgeon General. This move restored the channels of control of these installations which had prevailed before August 1942.

CHAPTER VII

The Mediterranean Theater of Operations

The Mediterranean Theater of Operations—originally called the North African theater, since it was established before the final decision was taken to extend Allied operations into Italy and southern France—was the only oversea theater to be formed as a result of an Allied invasion of a large land area held by hostile forces. No long-term buildup prefaced combat activities in the area. The medical officers who first held the chief administrative posts in the theater came with the invasion forces, from the European theater and from the United States.

The organization and activities of the Medical Department in the Mediterranean theater followed closely the pattern laid down in the Army field manuals during the years immediately preceding World War II. It was a doctrine developed largely out of the experience of World War I, but it proved flexible enough to be readily adapted, in the hands of imaginative men, to the varied conditions of World War II, not only in the Mediterranean but in Europe, Asia, and the Pacific as well. A brief recapitulation of the prewar doctrine will make this and the following chapters more understandable.

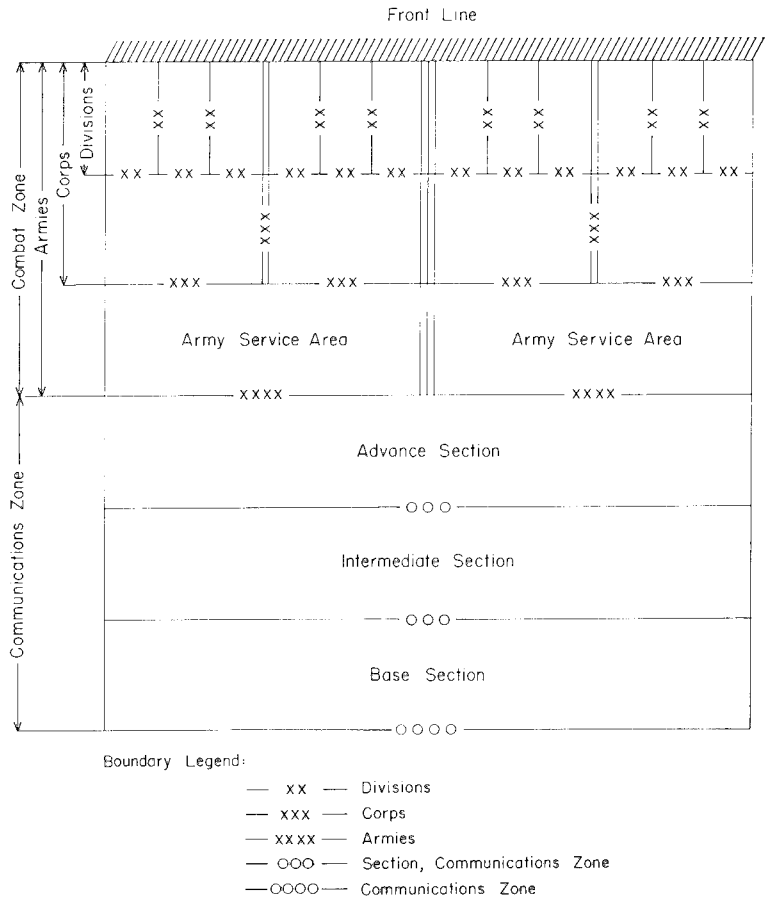
PREWAR ARMY DOCTRINE FOR THEATER MEDICAL ORGANIZATION

The chief functions of the Medical Department in a theater of operations were broadly conceived of as evacuation, hospitalization, and sanitation and other measures for the prevention of disease; the procurement, storage, and issue of medical supplies and equipment; and the preparation of medical records and reports. Responsibilities for evacuation and hospitalization extended to animals as well as men and included the provision for, and the operation of, the necessary units, installations, and means of transport. Sanitary measures included the inspection of meats, meat foods, and dairy products. Responsibilities for prevention of disease in an oversea theater comprehended the direction and supervision of public health measures among civilian inhabitants of the territories occupied.[1]

The term "theater of operations" was defined in the field manuals as the land and sea areas to be invaded or defended, including areas necessary for administrative activities incident to the military operations (chart 12). In accordance with the experience of World War I, it was usually conceived of as a large land mass over which continuous operations would take place and was

[1] Unless otherwise noted, this section is based on War Department Field Manual 100–10, Field Service Regulations, Administration, 9 Dec. 1940.

CHART 12.—*Typical organization of a theater of operations as envisaged by War Department doctrine, 1940*



Source: War Department Field Manual 100-10, Field Service Regulations, Administration, 9 December 1940 (Adaptation.)

divided into two chief areas—the combat zone, or the area of active fighting, and the communications zone, or area required for administration of the theater. As the armies advanced, both these zones and the areas into which they were divided would shift forward to new geographic areas of control.

It was recognized that the chronologic development of these elements would vary from theater to theater. In theaters where a long buildup period was possible before the field forces went into combat, a fairly elaborate system of communications zone sections or bases would develop well in advance of the rest of the theater elements. On the other hand, where the Army built up a theater of operations by invasion, it might develop its communications zone setup simultaneously with, or after, the combat area.

The commanding general of a theater of operations was directly subordinate to the War Department Chief of Staff. In addition to his own general staff, he was served by a special staff, of which the chief of medical service of the theater, generally called the "Chief Surgeon" or simply "Surgeon" followed by designation of the command, was a member.[2]

The duties of the special staff surgeon of any command were broadly defined as follows: Acting as adviser to the commander and staff on all matters pertaining to the health and sanitation of the command, the training of troops in military sanitation and first aid, operations of the evacuation service, and location and operation of hospitals and other medical establishments; supervising, within limits prescribed by the commander, the training of medical troops and the operation of elements of the medical service in subordinate units; determining the requirements for, and procuring, storing, and distributing medical, dental, and veterinary supplies and equipment; preparing reports and maintaining custody of records of casualties; and examining captured medical equipment. In certain instances, the commander might delegate to his staff surgeon authority over the Medical Department troops, units, or installations of the command.[3]

In carrying out these diversified duties, the staff surgeon of a command in an oversea theater dealt with all elements of the general staff of his command. Although the broad phases of medical service on which he dealt with each element of the general staff were about the same as those on which The Surgeon General dealt with elements of the War Department General Staff in Washington, D.C., they differed greatly in detail. The staff surgeon overseas had to make estimates and reestimates of the medical requirements of his command, medical plans for coming combat operations and advance calculations of casualties, and surveys of sites for housing Medical Department installations and units. He dealt with G–1 not only on broad matters relating to personnel, but also on sanitation and measures for the control of communicable diseases of men and animals. Intense activity in enemy intelligence in an oversea command called for collaboration with G–2 in inquiry into the organization and operations of the enemy's medical service, communicable diseases in enemy troops, and casualty-producing agents employed by the enemy. The staff surgeon overseas took up with G–3 problems of coordinating medical service with the tactical situation, future plans, and troop movements. In addition to the usual matters that called for clearance with G–4, a stipulation that the staff surgeon deal with G–4 on all other matters not specifically allotted to another general staff section, or concerning which jurisdiction was in doubt, made clear the thoroughgoing involvement of G–4 in matters medical.[4]

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[2] (1) See footnote 1, p. 245. (2) War Department Field Manual S–10, Medical Service of Field Units, 27 Nov. 1940. (3) War Department Field Manual 101–5, The Staff and Combat Orders, 19 Nov. 1940.

[3] See footnote 2 (3).

[4] War Department Field Manual S–55, Reference Data, 5 Mar. 1941.

The theater surgeon was responsible for keeping the commander informed of the condition, responsibilities, and needs of the medical service. He had authority to confer or correspond with the surgeons of higher or lower echelons on matters of general routine and on technical matters. He supervised the medical service of the theater by conferences and visits and by making recommendations to the theater commander. When his recommendations were approved, they were issued in the name of the theater commander as policies or orders.

The field armies (or army groups, if two or more field armies were organized into a group headed by a commanding general) and the communications zone organization, or Services of Supply, were the principal types of subordinate commands directly under the theater command; they held position parallel to each other in the chain of command. The headquarters of both the communications zone organization and of armies and army groups would have, like the theater headquarters, a surgeon on the special staff. The subordinate area commands of the communications zone (the advance, intermediate, and base sections) and subordinate commands of the field army (division and corps) likewise had staff surgeons.[5]

The staff surgeon of the communications zone command was referred to in the 1940 manuals as the "chief of medical service, communications zone," but soon came to be called "Surgeon, Services of Supply," or "Surgeon, Communications Zone."

Although the manuals did not make this clear, if the theater surgeon was located at communications zone headquarters rather than at theater headquarters, he would presumably be communications zone surgeon in addition to his theater assignment. This dualism prevailed in Europe in the latter part of World I, and existed from the beginning in the European Theater of Operations in World War II.

The staff surgeon of a theater headquarters was not expected to occupy himself with the immediate operations of Medical Department units and installations since most of these were assigned either to the Services of Supply for work in the communications zone or to the field elements for serving troops engaged in combat. His primary concern, it was believed, would be coordinating the medical work of the Services of Supply, or the communications zone, organization and that of the field elements—armies and air forces and their subcommands. By virtue of his position at the top of the theater structure he would issue, over the theater commander's signature and after clearance with the proper elements of the General Staff, medical policies which would be put into effect on a theaterwide basis; that is, in both the communications zone and the combat zone.

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[5] See footnotes 1, p. 245 ; and 2(3) p. 247.



FIGURE 55.—Col. Earle Standlee, MC.

MEDICAL ORGANIZATION IN THE NORTH AFRICAN THEATER

The organization of medical service in North Africa, like that of the other technical services, employed British and American personnel in the highest command, AFHQ (Allied Force Headquarters). The Allied headquarters was originally established in London as a planning headquarters for the North African invasion and was under the direction of the Commander in Chief of the Allied Forces, Lt. Gen. (later Gen. of the Army) Dwight D. Eisenhower. The headquarters medical section began work in London at Norfolk House on 14 August 1942. The chief surgeon was a British "Director of Medical Services," Brigadier (later Maj. Gen.) Ernest M. Cowell. Col. John F. Corby, MC, became the chief American medical representative at Allied Force Headquarters. As Colonel Corby was outranked by Brigadier Cowell, he became deputy to the latter. This subordination of the American chief surgeon to the British chief surgeon in the Allied command of the North African theater prevailed throughout the war. Three other American medical officers, including an executive officer to Colonel Corby—Lt. Col. (later Col.) Earle Standlee, MC (fig. 55)—joined Brigadier Cowell and the British-American staff in London.

During the London days, before the invasion of North Africa got underway, the responsibilities of the American members of the medical section of Allied Force Headquarters were very limited. Their activities were restricted to the framing of broad policies on preventive medicine, evacuation, and supply and to coordinating the American effort in England with that of the British. Having received little in the way of instructions from the top, this small American medical group (four officers and four enlisted men) tended to believe that the tactical forces and the base sections would be responsible for actual operations in the area to be invaded and that Allied Force Headquarters would not be concerned with these details. American doctrine emphasized policy-making rather than operations at the theater level, which would not call for a large staff. In October, Brigadier Cowell suggested that two more officers and one enlisted man be added to the American component of the medical section when it went to Africa, but even with this addition the American component was only half the size of the British. With 12 officers, 1 warrant officer, and 10 enlisted men, the British component of the medical section was able to make specific assignments of personnel to administer and supervise evacuation, supply, preventive medicine, professional treatment, and maintenance of records.[6]

Medical Support of the Task Forces

Plans for the invasion provided for a simultaneous strike by three task forces, two of which consisted exclusively of U.S. Army troops, at the coastal regions of western French Morocco and northern Algeria in the vicinity of Casablanca, Oran, and Algiers. The Western Task Force, landing in the Casablanca area with a strength of 35,000 men, was organized in the United States. Col. (later Maj. Gen.) Albert W. Kenner, MC, who had seen service in World War I as regimental surgeon of the 26th Infantry and had most recently served as surgeon of the Armored Force at Fort Knox, Ky., was the Western Task Force surgeon. The Center Task Force, composed of 39,000 American troops of the U.S. II Corps, staged in the United Kingdom and landed in the vicinity of Oran. The II Corps surgeon, Col. Richard T. Arnest, MC (fig. 56), served also as Center Task Force surgeon. The third task force, designated Eastern Assault Force, sailed from the United Kingdom with predominantly British personnel and landed 33,000 troops in the Algiers area.

Medical plans for the task force from the United States and for the forces from the United Kingdom were drawn up separately, with little apparent co-

[6] (1) History of Allied Force Headquarters, Part I, Aug.–Dec. 1942. [Official record.] (2) Munden, Kenneth W.: Administration of the Medical Department in the Mediterranean Theater of Operations, United States Army (1945). [Official record.] (3) Annual Report, Medical Section, North African Theater of Operations, U.S. Army, 1943. (4) Interview, Brig. Gen. Earle Standlee, MC, 10 Jan. 1952. (5) See also Wiltse, Charles M.: The Medical Department: Medical Service in the Mediterranean and Minor Theaters. United States Army in World War II. The Technical Services. [In preparation.]



FIGURE 56.—Col. Richard T. Arnest, MC.

ordination among them even after the landings in North Africa. Nor was significant coordination achieved between the surgeons of the three task forces, on the one hand, and the American medical staff at Allied Force Headquarters, on the other. In the United States, Medical Department officers of Western Task Force made plans in conjunction with the Hospitalization and Evacuation Branch, Services of Supply, and the staff of the Surgeon General's Office for adequate medical supplies to accompany troops; these groups also made arrangements to have medical personnel and facilities at the American ports at which evacuees wounded in the invasion would arrive. Colonel Kenner and the surgeon of the Western Naval Task Force drew up the joint formal medical plan for the Moroccan landings. The Center Task Force surgeon achieved a limited coordination with the medical group at Allied Force Headquarters in London on broad policy issues.

Penetration of an 800-mile coastline by the approximately 107,000 troops of the task forces a few days after landing on 8 November secured the area from Safi, French Morocco, to a point close to the Tunisian border. After the consolidation of the landings, and with the arrival of the Services

of Supply organizations of the task forces, the headquarters for two base sections, including medical offices, were established in Casablanca and Oran.[7]

Medical Section, Allied Force Headquarters

Allied Force Headquarters, which briefly operated from a command post at Gibraltar, was at the St. George Hotel in Algiers 2 weeks after the invasion. The personnel of the medical section arrived at Algiers in late December 1942 and the following January. The deputy force surgeon, Colonel Corby, and his staff were established with the British medical component in a building near the St. George Hotel.

The inexperienced American branch with its vaguely defined duties was immediately confronted with responsibility for operational details of hospitalization, evacuation, and medical supply, as well as swamped with an accumulation of medical reports and records from lower headquarters (the tactical elements and the growing base sections). It attempted during December and January to establish more effective control over U.S. Army medical service in North Africa, but a clarification of responsibilities did not occur until the American theater of operations, known as NATOUSA (North African Theater of Operations, U.S. Army) was created in February 1943. Nor could an estimate of personnel requirements for the medical section be made until a well-defined plan of organization had been adopted. Expansion of the American component was proposed twice in January—once with a plan for the creation of 8 subsections and again with a proposal for a 10-division office, composed of 13 officers and 25 enlisted men—but both plans failed to develop. The office allotment was temporarily expanded in January to include six more officers, but by the end of the month a new limitation of the section to five officers and five enlisted men was announced. Several months elapsed before any substantial allotment of personnel was made.[8]

However, in the opinion of Brig. Gen. Howard McC. Snyder of the War Department Inspector General's Office, the problem was not one of numbers. On an inspection trip to North Africa during December 1942 and January 1943, he stated: "Any faulty administration of Medical Department service anywhere in North Africa was not chargeable to lack of personnel. . . . Where initiative and aggressiveness have been combined with adequate pro-

[7] (1) See footnote 6(4), p. 250. (2) Interview, Maj. Gen. Albert W. Kenner, MC (Ret.), 10 Jan. 1952. (3) Annual Report, Medical Section, North African Theater of Operations, U.S. Army, 1943. (4) Kenner, A. W.: Medical Service in the North African Campaign. Bull. U.S. Army M. Dept. No. 76; 76–84, May 1944. (5) Letter, Col. Clement F. St. John, MC, to Col. John Boyd Coates, Jr., MC, Director, The Historical Unit, U.S. Army Medical Service, 3 Nov. 1955, commenting on preliminary draft of this volume. (6) Clift, Glenn: Field Operations of the Medical Department in the Mediterranean Theater of Operations, U.S. Army (1945). [Official record.] (7) Annual Report, Surgeon, II Corps, 1942. (8) Annual Report, Medical Section, Atlantic Base Section, 1943. (9) Biennial Report of the Chief of Staff of the United States Army, July 1, 1941, to June 30, 1943, to the Secretary of War. Washington: U.S. Government Printing Office, 1943. (10) See footnote 6(5), p. 250. (11) Howe, George F.: Northwest Africa: Seizing the Initiative in the West. U.S. Army in World War II. Washington: U.S. Government Printing Office, 1957.

[8] See footnotes 6(2), p. 250; and 7(3).

fessional capabilities, good judgment, and tact in the person of the responsible medical officer, the results have been excellent." He noted a lack of understanding between General Cowell and Colonel Corby. The American officer found it "difficult to satisfactorily operate in his present status with the Force Surgeon." One element in the clash of personalities was that General Cowell was only a "Territorial," equivalent to the U.S. National Guard, whereas Colonel Corby had 25 years in the Regular Army. Disagreements between the two officers led to the relief of Colonel Corby early in February 1943. Colonel Corby's successor, Brig. Gen. Albert W. Kenner, later observed that American prerogatives were being assumed by General Cowell, who ignored the American surgeon. For his part, General Kenner believed that neither General Cowell nor Colonel Corby had any definite knowledge of what was going on in the theater, since neither man had gotten out of headquarters in Algiers.[9]

Early disagreements between American and British medical officers at Allied Force Headquarters and uncertainty as to mutual responsibilities were natural, since these had to be worked out step by step without the benefit of preplanned doctrine. Respective British and American responsibilities, assignments, and contributions of medical facilities, personnel, and supplies had to be determined during this formative stage. This process was to be repeated at many levels of command in the North African theater, as well as in other theaters where combat operations were directed by an Allied command.

The Base Sections

When two American base sections, evolving from the Services of Supply organizations attached to the Western and Center Task Forces, were established in December, they took over the service functions temporarily carried on by the task forces and undertook to furnish services to the troops on an area basis. Out of the Services of Supply attached to the Center Task Force the first North African base section, termed Mediterranean Base Section, was activated on 8 December at Oran. A nucleus of its medical section, attached to the office of the Surgeon, Center Task Force, arrived in North Africa 3 days after the landings. By the date when the base section was activated, additional personnel had arrived, and the medical office for Mediterranean Base Section was organized. By the first of the year 20 officers, 1 nurse, and 31 enlisted men were on duty. The second base section, Atlantic Base Section, grew out of Services of Supply, Western Task Force. By January the surgeon's staff, which had arrived in echelons, was fully organized. A total of 10 officers and 4 enlisted men were assigned.

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[9] (1) Memorandum, Brig. Gen. Howard McC. Snyder, MC, for the Inspector General, 23 Feb. 1943, subject: Special Inspection of Medical Department Service in Western Theater of North Africa. (2) Memorandum, Brig. Gen. Howard McC. Snyder, for the Inspector General, 8 Feb. 1943, subject: Inspection of Medical Service, Eastern Sector, Western Theater of North Africa. (3) See footnotes 7(2), p. 252; and 6(4), p. 250.

Both base sections were removed from task force control on 30 December 1942, when Allied Force Headquarters placed them directly under its own command.[10] However, the medical section at the Allied headquarters gained no authority over American Forces in its early days other than that of determining broad policies, and the medical sections of the base sections developed more or less independently. Only when the North African theater was established in February did the American component at Allied Force Headquarters achieve, in its capacity as Headquarters, NATOUSA, effective supervision over the two base sections.[11]

Medical Support of the Twelfth Air Force

The role of the American Twelfth Air Force in the invasion was to attack enemy targets in eastern Algeria and Tunisia. Formed partly of personnel in the United States and partly of personnel of the Eighth Air Force in the United Kingdom, it was, like the base sections, a subordinate command of Allied Force Headquarters. Its staff medical section, headed by Col. Richard E. Elvins, MC (fig. 57), was provided with six additional officers—an executive officer, a medical inspector, a dental officer, a medical supply officer, a veterinarian, and a headquarters squadron surgeon—and six enlisted men. With three other officers of the medical section, Colonel Elvins left England in late October, arrived at St. Leu, Algeria, on 8 November with a D-day convoy, and 2 days later set up a temporary office at Tafaraoui Airdrome near the city of Oran which had just surrendered. His office moved to Algiers on 19 November, and started operating there by the end of the month.

The medical organization of the Twelfth Air Force included, in addition to the surgeon's office, medical sections of a bomber command, a fighter command, an air service command, and a troop carrier wing, each having a surgeon and medical staff assigned, as well as surgeons and other Medical Department personnel with wings, groups, and squadrons. The largest of these medical sections was that of the air service command headquarters. In early 1943 it consisted of a surgeon, an executive-medical inspector, a dental surgeon, a veterinarian, 2 supply officers, and from 7 to 10 enlisted men. Medical supply and veterinary food inspection functions had been removed from the Twelfth Air Force surgeon's office shortly after its arrival in North Africa and placed at the service command level where these functions were usually handled. The

[10] The Assistant Chief of Staff for Operations, Services of Supply, General Lutes, had expressed concern in mid-November over the fact that General Eisenhower had not established an "overall SOS" in North Africa. The lack of a Services of Supply in the developing theater appeared to him to threaten coordination of activities in evacuating the wounded of the three task forces, as well as coordination of the oversea stage of evacuation with responsibilities of the Services of Supply of the War Department. Memorandum, Maj. Gen. LeRoy Lutes, for Lt. Gen. Brehon B. Somervell, 13 Nov. 1942, subject: Hospitalization and Evacuation Overseas.

[11] (1) Logistical History of NATOUSA–MTOUSA, 30 Nov. 1945. Naples: G. Montanino, 1945. (2) Annual Report, Medical Section, Mediterranean Base Section, 1943. (3) See footnote 7(8), p. 252; and 6(3), p. 250. (4) Report, Medical Supply Activities, NATO (Nov. 1942–Nov. 1943). (5) Report of Inspection Trip to North Africa and the United Kingdom by Col. Ryle A. Radke, MC, 28 Apr. 1943. (6) Interview, Maj. Gen. Albert W. Kenner, MC, USA (Ret.), 11 Jan. 1952.

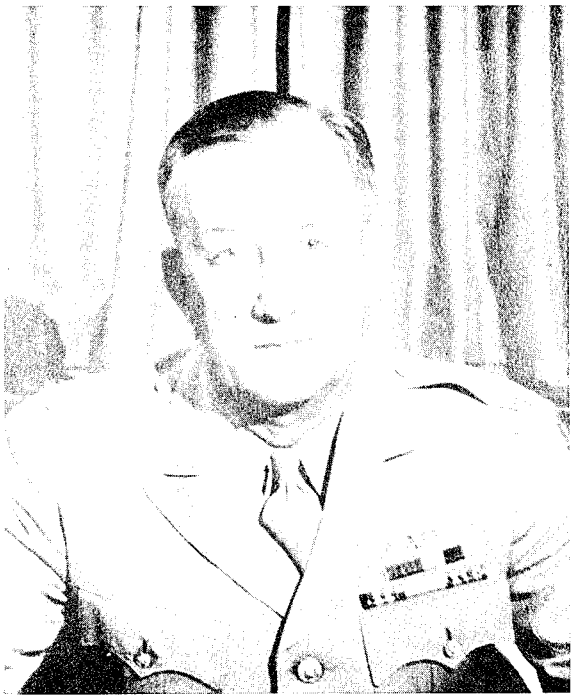


FIGURE 57.—Col. Richard E. Elvins, MC.

air service command established three area commands, comparable to base sections, to operate from subheadquarters in Casablanca, Oran, and Constantine. The medical sections of the area commands operated with a surgeon and two enlisted men each; a veterinarian was later assigned to each to inspect meat and dairy products for air force troops.

Shortly after the landings in North Africa, the Twelfth Air Force was absorbed by an Allied (American, British, and French) air command, created in December 1942 and after early February 1943 called Northwest African Air Forces. It was subordinate to the Allied Commander in Chief for all its operations. During most of 1943 the status of the Twelfth Air Force within this command was one of half-existence and "served mainly to mystify all but a few headquarters experts," for most of its component commands were combined with a similar British or French unit. The Twelfth Air Force surgeon continued to direct the medical service of the American component of the Northwest African Air Forces.[12]

[12] (1) Craven, Wesley Frank, and Cate, James Lea, eds.: The Army Air Forces in World War II. Volume II, Torch to Point Blank. Chicago: University of Chicago Press, 1949, pp. 41–206. The quotation in the text is on page 167. (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, pp. 419–527. (3) History of the Twelfth Air Force Medical Section, August 1942 June 1944. [Official record.] (4) Medical Department, United States Army. Veterinary Service in World War II. Washington: U.S. Government Printing Office, 1962, pp. 249–269.

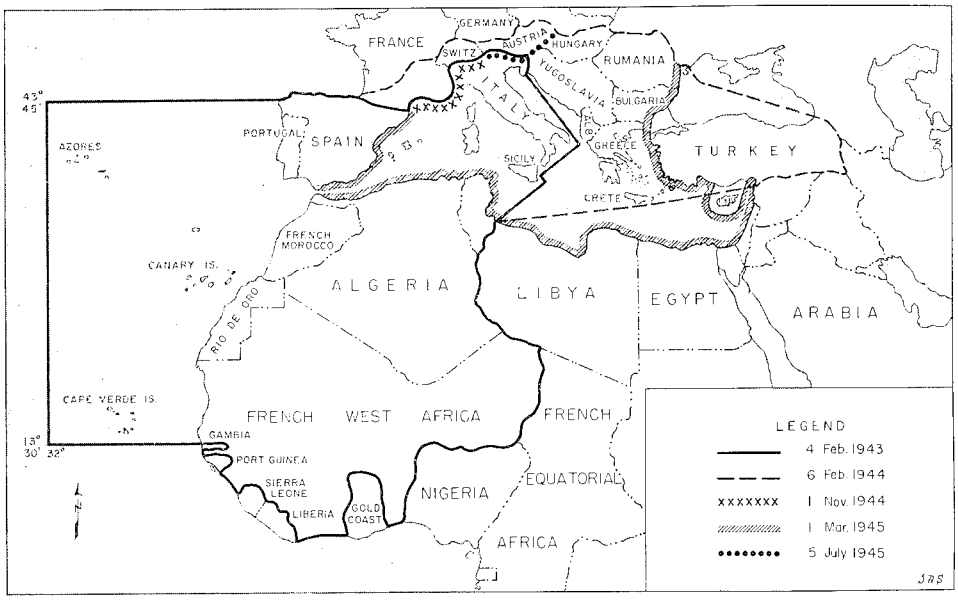
THE NORTH AFRICAN THEATER AND SERVICES OF SUPPLY FEBRUARY 1943–JANUARY 1944

Theater Medical Section

The need for a headquarters with a staff to administer purely American affairs in North Africa was met by creating NATOUSA on 4 February 1943 (map 1). Previously, because of higher rank, senior British officers at Allied Force Headquarters had had control over United States personnel assigned to the various staff sections. When General Eisenhower became theater commander as well as Allied commander, the senior U.S. Army officer of each Allied Force Headquarters staff section became the chief of the corresponding section of the theater headquarters. General Eisenhower's deputy theater commander, Maj. Gen. Everett S. Hughes, exercised immediate jurisdiction over the American theater staff. Accordingly, the chief American medical officer of Allied Force Headquarters doubled as chief of the medical section, North African theater. His medical section served as theater medical section and also as the American element of the Allied Force Headquarters medical section. It functioned mainly in its North African theater capacity, having administrative and operational supervision of all medical services of the U.S. Army in the North African theater. When acting as part of the Allied Force Headquarters medical section, the group was concerned jointly with the British component with formulating policy and plans. The dual assignment served to prevent the use of too large a number of Medical Department officers in administrative work in higher commands and worked out well in practice. Only five American officers and a few enlisted men were actually assigned to the medical section of Allied Force Headquarters; a much larger number were eventually assigned to that of the theater headquarters. However, the individual's assignment had little effect upon duties performed. The preventive medicine officer, for example, might draft a directive for Allied Force Headquarters even though he was assigned to the theater headquarters, and the American medical section functioned as a unit in either capacity.[13]

Brig. Gen. Albert W. Kenner, formerly chief surgeon of Western Task Force, had joined the Medical Section, AFHQ (Allied Force Headquarters), in late December 1942 as medical inspector. Earlier that month he had been promoted to brigadier general by General Patton, the Western Task Force commander. General Patton had been impressed by General Kenner's prompt and efficient handling of 400 burned and mangled men at the town of Fedala, French Morocco, the night of 12–13 November after a U-boat attack on vessels still in the area. As Medical Inspector, AFHQ, Kenner had later made trips throughout the theater of operations observing medical treatment, medical supply matters, personnel problems, and the tactical situation. His assignment

[13] (1) History of Allied Force Headquarters, pt. II, sec. 1. (2) See footnote 6(2) and 6(4), p. 250. (3) Interview, Brig. Gen. Earle Standlee, 25 Feb. 1952.



MAP 1.—North African-Mediterranean theater boundaries, 1943–45.

had accorded with the standard British concept of medical inspector. (The medical inspector in the U.S. Army was limited essentially to the inspection of sanitary conditions.) His work was of Allied scope; one of his first undertakings had been a field inspection during which he had examined the operations of all types of medical installations, British and American, from general hospitals in rear areas to smaller medical units near the Tunisian front. He had also inquired into such nonmedical matters as rations, morale, ammunition, and discipline; thus for a short time he had assumed what amounted to the duties of an "inspector general" of the Allied forces for General Eisenhower. When Headquarters, NATOUSA, was formed on 4 February 1943, he became theater surgeon. He retained his position as medical inspector of the Allied forces and automatically became deputy chief surgeon under General Cowell in Allied Force Headquarters.[14]

Although he remained in the theater only until late March, General Kenner was especially interested in carrying out changes in the tables of organization of tactical medical units and their tables of basic allowances which he deemed advisable, on the basis of experience during the invasion, for future campaigns in North Africa. His plans had the backing of General Eisenhower, who appointed General Kenner, his deputy surgeon (Colonel Standlee), and the surgeons of Fifth U.S. Army, II Corps, and 1st Armored Division as members

[14] (1) Memorandum, Maj. Gen. George S. Patton, Jr., for Commanding General, American Expeditionary Force, 20 Nov. 1943. This document, loaned to the author by General Kenner, has since been destroyed along with the rest of General Kenner's personal files. (2) See footnote 7(2), p. 252; and 11(6), p. 254.

of a board to study the field medical service and make recommendations for revision in the organization and equipment of units.[15]

For more than a month after the activation of the North African theater headquarters and its medical section, the small American medical group already serving at Allied Force Headquarters functioned as the North African theater medical section, working from morning until late at night. The deputy theater surgeon proposed organizing four operational sections within the medical section, to be labeled administration, preventive medicine, operations and planning (divided into hospitalization, evacuation, and training divisions), and consultants. The personnel required was estimated as 23 officers and 30 enlisted men. By the end of April his plan was approved, and the Medical Section, NATOUSA, was formally established the following month.[16]

With the return of General Kenner to the United States in April, the former surgeon of the Fifth U.S. Army, Brig. Gen. Frederick A. Blesse (previously surgeon of Army Ground Forces), who had been on temporary duty at North African theater headquarters during March, was named theater surgeon on the recommendation of the Fifth U.S. Army commander, Lt. Gen. Mark W. Clark. General Blesse also became deputy chief surgeon and subsequently medical inspector of Allied Force Headquarters as well, taking over all of General Kenner's former responsibilities. Like General Kenner, General Blesse was a thoroughgoing student of the medical service of the combat zone.

In June the staff of the theater medical section moved, along with their British partners, to larger offices in Algiers. The British and Americans were situated in separate offices, but coordination was maintained by informal conferences and weekly meetings of the entire medical staff. According to the remarks of one observer, the position of General Blesse in relation to General Cowell, "is one which demands considerable tact but they seem to be entirely *en rapport* and I believe that it would be difficult to find more cooperation . . . under the present complex overall setup."[17] The expansion of the theater medical section during 1943 saw the addition of many new functional subsections and a substantial increase in personnel (chart 13). By December the Medical Section, NATOUSA, contained 70 officers and enlisted men; its British counterpart now amounted to 82.

In addition to close liaison with the major theater commands and with the other staff sections of the North African theater headquarters, as well as the British component of Allied Force Headquarters, the theater medical section undertook coordination with the medical service of the French Army during 1943. Representatives of the medical services of the Americans, British, and French held an Allied medical conference in Oran during November; it pre-

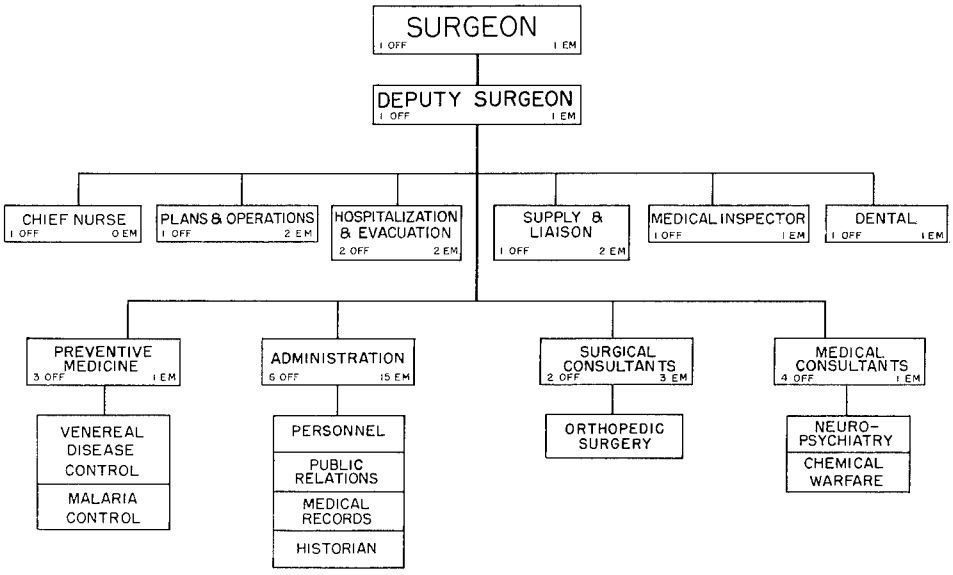
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[15] (1) Special Order No. 3, Headquarters, North African Theater of Operations, 8 Feb. 1943. (2) Memorandum, Maj. Gen. Brehon B. Somervell, for The Surgeon General, 20 Feb. 1943.

[16] (1) History of Allied Force Headquarters, pt. II, sec. 1 and 4. (2) See footnotes 6 (2), (3), and (4), p. 250; 7(2), p. 252; 11(1), p. 254; and 13(3), p. 256.

[17] Memorandum, Brig. Gen. Fred W. Rankin, for The Surgeon General, 2 Nov. 1943, subject: Remarks on Recent Trip Accompanying Senatorial Party.

CHART 13.—*North African theater medical section, August 1943*



[ADAPTED FROM CHART, P.380, ANNUAL REPORT, MEDICAL SECTION, NATOUSA, 1943]

sented the participants with information on recent advances in the medical field in the North African theater. The consulting surgeon of the French Army made frequent visits to the North African theater surgeon's office.

A small and flexible group of consultants was developed within the medical section. A surgical consultant, a medical consultant, and a consulting psychiatrist gave professional advice on the treatment of patients and the most suitable assignments for specialists in their respective fields on the basis of proficiency, training, and experience. Additional consultants, particularly in various surgical subspecialties such as maxillofacial surgery, orthopedic surgery, and anesthesia, were used at the headquarters of base sections and tactical commands. Some were assigned within the allocation for the headquarters staff, but for the most part men who served as consultants in the base sections or with army or corps medical sections were specialists whose primary assignments were as staff members of hospitals. They were shifted to various army, corps, or base section headquarters as needed. Thus, without a large assigned staff of specialists, the theater medical section profited from the effective use of men who had had training and experience in both the specialties and the subspecialties. Both II Corps (when operating independently of the field armies) and Fifth and Seventh U.S. Armies had consultants assigned during the Tunisian, Sicilian, and Italian campaigns.

During 1943, the theater surgeon's office undertook the preparation of several important theater reports and publications. In March, it initiated a series or circular letters which resembled those regularly issued by the Surgeon

General's Office. These, giving instructions on theater medical policy and technical procedures established by the consultants, were distributed to all medical installations and offices in the theater. The report of Essential Technical Medical Data, or so-called ETMD—initiated early in the year and submitted by all theater surgeons—to The Surgeon General beginning in July, was a résumé of theater medical experience (obtained by consolidating the reports of separate Medical Department units, installations, and offices) which became useful in evaluating past planning and in making new plans. It contained information on climate, organization of the medical service, surgery, medicine, nutrition, rehabilitation, preventive medicine, medical supply and equipment, medical records, and dental, nursing, and veterinary activities. The report was frequently supplemented by statistical data on evacuation, hospital admissions, types of wounds, rates of disease and injury, and similar matters. In January 1944, the theater surgeon's office began to publish a theater professional journal, *The Medical Bulletin of the North African Theater of Operations*, which appeared regularly for the next 17 months.[18]

Services of Supply Medical Section

A Services of Supply was created in February 1943 in less than 2 weeks after the establishment of the theater command, with headquarters at the important port and rail center of Oran, Algeria. Although it was subordinate to the recently created theater headquarters, as initially organized it differed greatly from the theater SOS (Services of Supply) organization as contemplated in War Department doctrine, as well as that in most other theaters, which conformed for the most part to the doctrine. Its activities were restricted to supply and maintenance and did not comprehend the full scope of activities of the technical services within a communications zone as outlined in Army manuals. The work of its medical section, created by the end of the month, was accordingly restricted to the control of medical supply for the North African theater. Its role was thus markedly different from that of the medical sections of other oversea Services of Supply, which had as an important function the operation of general and station hospitals in the communications zone. Col. Charles F. Shook, MC (fig. 58), who had handled procurement planning in the Surgeon General's Office during the emergency period, became head of the Medical Section, SOS, NATOUSA, in August and remained in charge throughout the existence of the command.

In the command structure of the theater, the Services of Supply was intermediate between the theater command and the base sections in matters of supply, to which it was itself limited. It directed supply activities of the base sections and supervised base section personnel assigned to supply work. Located at the Oran headquarters, the Medical Section, SOS, consisting of

[18] (1) See footnote 6 (2) and (3), p. 250. (2) Annual Report, Medical Section, Mediterranean Theater of Operations, United States Army, 1944.



FIGURE 58.—Col. Charles F. Shook, MC.

about a half dozen Medical Corps and Medical Administrative Corps officers and a few enlisted men, prepared all medical supply requisitions made upon the Zone of Interior, regulated shipments between bases, adjusted medical depot stocks, and generally supervised the activities of medical depot companies. It made frequent inspections of installations handling medical supplies. Colonel Shook was responsible to the Commanding General, Services of Supply, NATOUSA, for the status of theater medical supplies and the maintenance of medical supply records. The medical section of Headquarters, NATOUSA, at Algiers formulated medical supply policies and was the higher agent which kept in contact with the Surgeon General's Office on matters of medical supply. Hence, Colonel Shook's office at Oran maintained liaison with the medical supply officer in the theater surgeon's office.

In the spring of 1943, the Services of Supply medical section directed its supply planning at support of the Sicilian campaign. During the summer it initiated a continuing study of the records on issue and consumption of medical supplies in order to arrive at revisions, based on experience in the theater, of the maintenance factors published by the Surgeon General's Office. Colonel Shook's office found that the standard medical maintenance unit (a carefully selected group of medical supplies intended to suffice for a force of 10,000 men for 30 days) automatically shipped to the theater contained too low a proportion of some items and excessive amounts of others. It returned some

excess stocks to the United States, transferred others to Allied military forces, and turned over some to civil public health representatives of the Allied military government for the treatment of civilian populations. Some surplus stocks were used to fill French lend-lease demands before the medical section forwarded the French requisitions on to the United States.

As the theater achieved a stable organization, it abandoned (as did other theaters) the system of automatic supply by means of the medical maintenance unit and changed over to the system of specific requisitions of supplies from the United States to accord with its own needs. Meanwhile the Medical Section, SOS, worked out several types of medical supply units for use in support of combat operations in the theater, including an "operational medical maintenance unit," designed to suffice for 10,000 men in combat for 30 days: and a "beach medical unit" (for 5,000 men for 30 days) packed in waterproof bags and designed to support troops in beach assault. With the progress of the Sicilian and Italian campaigns in the latter half of 1943, the Services of Supply medical section became responsible for furnishing medical items to newly created base sections in Sicily, Italy, and Corsica, as well as those in North Africa. Personnel of the section also aided the armies of the Allies, notably the French, in establishing their medical supply depots.[19]

The Base Sections

From February 1943 through January 1944, base sections in the North African theater were responsible to Headquarters, NATOUSA. Each base section commander was in charge of his own troops and facilities. Except for their supply activities, directed by the Services of Supply, the medical work of base sections was supervised by the medical section at theater headquarters. The base section surgeons, although subordinate to their respective commanders, followed medical policies and techniques formulated by the theater surgeon. In addition to the surgeon and his deputy or executive officer, the medical offices of the base sections usually included subsections for hospitalization, evacuation, supply, medical records, dental, veterinary, nursing, personnel, preventive medicine (including venereal disease and malaria control), fiscal and administration. Base section surgeons collaborated with the other staff sections at base section headquarters, particularly with the following: G–4 and the Engineers in connection with hospital construction, the Transportation Corps for procedures and problems in the movement of patients within the

[19] (1) History [Annual Report], Medical Section, Services of Supply, North African Theater of Operations, United States Army, February 1943–January 1944. (2) See footnotes 6 (2) and (3), p. 250; and 11(5), p. 254. (3) Annual Report, Medical Section, Eastern Base Section, 1943. (4) Memorandum, Inspector General, for Deputy Chief of Staff, 10 Aug. 1943, subject: Survey of the Organization and Operations of the Medical Department Facilities in NATOUSA and Sicily. (5) Interview, Col. Charles F. Shook, MC, 31 Mar. 1952. (6) Memorandum, Col. Charles F. Shook, MC, for Col. R. E. Hewett, MC, Office of The Surgeon General, 2 Oct. 1943. (7) Tates, Richard E.: The Procurement and Distribution of Medical Supplies in the Zone of Interior During World War II. Chapter X. [Official record.] (8) Report on visit to AFHQ by Col. J. K. Davis, Assistant Chief Medical Officer, Supreme Headquarters Allied Expeditionary Force [SHAEF], 1 Apr. 1944.

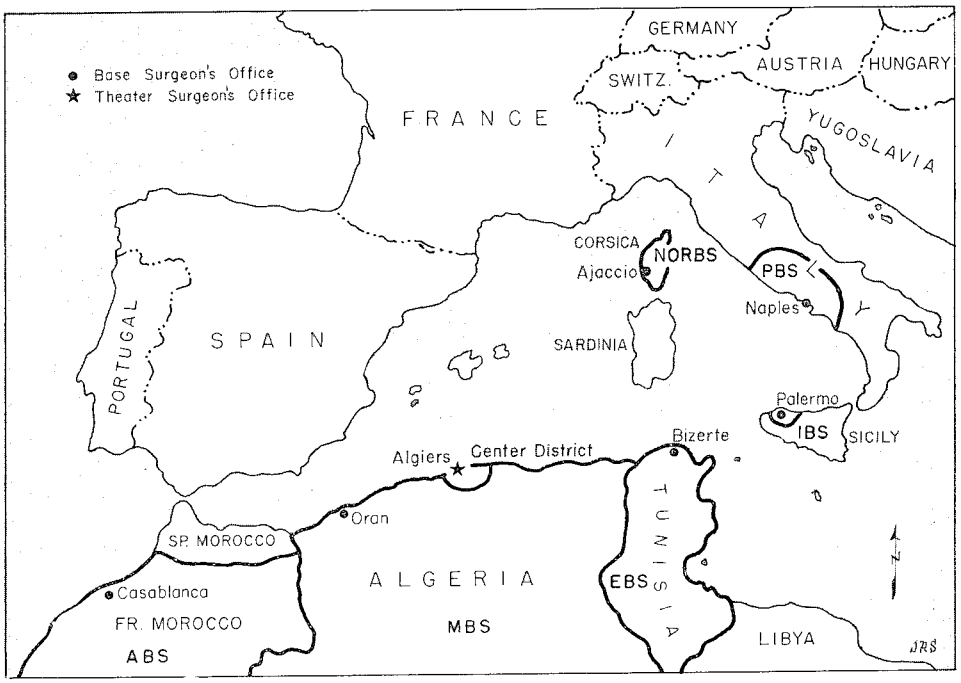
theater (except by air) and to the United States by hospital ship, Quartermaster Corps and Corps of Engineers for malaria control, and G–3 for matters of planning and training. The base section surgeon's office informed medical units and installations under the base section command of prevailing theater policies. The chief Medical Department installations operated by a base section were station and general hospitals, medical supply depots, and a laboratory.

Between February 1943 and January 1944, four additional base sections were established in the theater; the original two, Mediterranean and Atlantic Base Sections, continued to operate as rear areas in the communications zone. Eastern Base Section, established in February 1943 to support II Corps during the Tunisian campaign, was first located in Algeria in the rear of the forces fighting in Tunisia and later in Tunisia as the base section closest to Sicily during the campaign for that island. After the beginning of the Italian campaign, it was a base between the forward and rear of the communications zone—the equivalent of an intermediate section, although not so termed. Island Base Section was activated in Sicily on the first of September, in the wake of the Sicilian campaign. On 1 November, about 2 months after the invasion of Italy, what was to be the major base section of the theater, Peninsular Base Section, was created on the Italian mainland; it operated in support of the Fifth U.S. Army throughout the Italian campaign. Finally, on 1 January 1944, Northern Base Section was established in Corsica, chiefly to support air force units located there (map 2, chart 14).

During 1943, Mediterranean Base Section became the key base section for storing theater supplies and for building up the adjoining Eastern Base Section. By the end of its first year of operation, it had a large concentration of fixed hospitals; it became the major area of fixed hospitalization in North Africa. A subcommand designated Center District, Mediterranean Base Section, with a headquarters medical section was established within the base section early in June to take over service functions being carried on by Allied Force Headquarters within a large enclave around the city of Algiers (extending approximately 150 miles east to west and 200 miles south). Two station hospitals and several smaller medical units were located there.

Medical activities in Atlantic Base Section reached a peak in June and July and dropped off sharply during the remainder of the year. At the end of 1943 its fixed hospitalization represented only a small fraction of the total in North Africa, but it continued to be used as a collecting point for transport of evacuees by sea and air back to the United States.

The mission of Eastern Base Section, established in February 1943, was supply, hospitalization, and evacuation of local and II Corps troops during the Tunisian campaign. After the close of the campaign many fixed hospitals were located there, the number of fixed beds amounting to almost half the theater total in July 1943. With succeeding campaigns to the north, a heavy volume of patients passed through the base section, first from Sicily and later from Italy. Near the end of the year the number of its medical units and in-

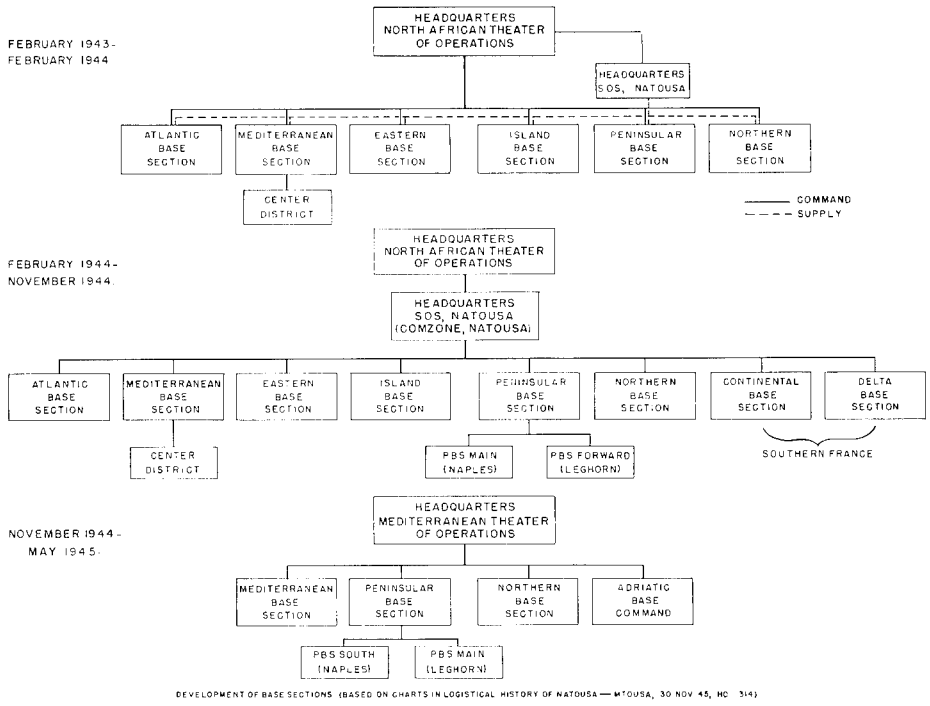


MAP 2.—North African theater base sections and important surgeons' offices, July 1944.

stallations decreased, but the number of patients in its hospitals reached a peak in December. The staff medical section at its headquarters in Constantine, Algeria, originally consisted of a surgeon and a few enlisted men transferred from Mediterranean Base Section and four officers obtained from Atlantic Base Section. With the arrival in July of a new surgeon, the medical section was expanded, reorganized, and moved to the new location of the base section headquarters in Mateur, Tunisia. It made its final move the following month when the headquarters was transferred to Bizerte.

Island Base Section was established in Sicily from the nucleus of a base section known as the 6625th Base Area Group, which had gone there with the Seventh U.S. Army. Its headquarters medical section was formed in late August and started operating when the base section was activated at Palermo in September. The territory under Island Base Section control consisted of the region around Palermo and Termini Imerese and other sites where U.S. Army depots were located. By October, the base section had taken over from the Seventh U.S. Army the usual administration of hospitals, the handling of medical supply, and maintenance of sanitary conditions for troops assigned to the base section. At the end of the year, all the base section medical installations were centered in and around Palermo. No significant concentration of medical units occurred in Sicily, for few evacuees from combat in Italy went to North Africa by way of Sicily, and for these the stopover was brief.

CHART 14.—*Development of base sections, North African (Mediterranean) theater*



DEVELOPMENT OF BASE SECTIONS (BASED ON CHARTS IN LOGISTICAL HISTORY OF NATOUSA — MTOUSA, 30 NOV 45, HC 314)

The unit that was to become the headquarters for Peninsular Base Section on the Italian mainland—the 6665th Base Area Group—was activated in August 1943. It obtained a medical section, made up of 8 officers, 1 warrant officer, and 14 enlisted men, from Atlantic Base Section. This group left Casablanca in three echelons, all arriving in Naples by early October. Until that time the Fifth U.S. Army Surgeon, Col. (later Brig. Gen.) Joseph I. Martin, MC (fig. 59), had acted as a base surgeon, supervising hospitalization, evacuation, supply, and sanitation, as the task force surgeons had done in the North African invasion before base section personnel arrived. The base area group medical section worked closely with General Martin's staff. When the Peninsular Base Section was established in November with headquarters in Naples, Colonel Arnest, former surgeon of II Corps, became surgeon.

Table 1, indicating numbers of personnel in the medical sections of the various base sections at the end of 1943, shows that the surgeon's office of Peninsular Base Section was already larger than that of any other base section in the theater. With the advances into Italy, the North African bases had diminished in importance and Peninsular Base Section had become the chief base section in the theater. It furnished medical support to the Fifth U.S. Army throughout the Italian campaign.



FIGURE 59.—Brig. Gen. Joseph I. Martin, MC.

TABLE 1.—*Number of personnel in medical sections, base sections, NATOUSA, 1943*

Base section	Officers	Warrant officers	Enlisted men	Women's Army Corps	Total
Mediterranean	[1] 15	0	15	0	30
Atlantic	10	0	8	0	18
Eastern	12	1	12	0	25
Island	9	1	10	0	20
Peninsular	17	1	10	9	37
Total	63	3	55	9	130

[1] Includes 3 attached.

Northern Base Section, comprising the island of Corsica, with headquarters at Ajaccio, became the sixth base section in the theater on 1 January 1944. The original medical section had only two medical officers and depended for the first month of its operations upon a few additional attached personnel (chart 14).[20]

[20] (1) See footnotes 6(3), p. 250; 7(8), p. 252; 11(1), p. 254; 18(2), p. 260; and 19(4), p. 262. (2) Annual Report, Medical Section, Mediterranean Base Section, 1943. (3) Annual Report, Medical Section, Center District, 1943. (4) Annual Report, Medical Section, Peninsular Base Section, 1943. (5) Annual Report, Northern Base Section, 1944.

The Field Army Medical Sections

Fifth U.S. Army.—Elements of both Center and Western Task Forces were merged to form General Clark's Fifth U.S. Army, the first American army activated overseas during World War II. When it was established, on 5 January 1943, with headquarters at Oujda, French Morocco, a headquarters medical section was organized, composed of personnel obtained from both U.S. Army task forces and from the United States. While Fifth U.S. Army was stationed in Morocco, during the Tunisian and Sicilian campaigns, the medical section was chiefly occupied with training. Headed briefly by General Blesse, who was succeeded by Colonel Martin in April, it consisted of nine officers and a few enlisted men assigned to veterinary, preventive medicine, operations, supply, and administrative functions. General Blesse and his staff inquired into standards of sanitation in the Army units, the health of troops, and the status of training and equipment of Medical Department personnel. They participated in exercises at several training centers organized in the theater and attended two large-scale command post exercises held during March and April. During the Tunisian campaign, members of the medical section served on temporary duty with the British First and Eighth Armies, observing the organization of the British medical service and its methods of hospitalization and evacuation.

Pursuant to plans in the fall of 1943 for invading Italy, a planning group of Fifth U.S. Army, including Colonel Martin and a few other Medical Department officers and men, went to Algiers to coordinate their plans with Allied Force Headquarters and North African theater headquarters. After the invasion near Salerno in September, Colonel Martin's office was located at rear headquarters of Fifth U.S. Army at various sites on the Italian mainland. When Naples was occupied early in October, the army surgeon made a survey of the medical and sanitary situation in that city. By the end of 1943, the Fifth U.S. Army medical section had added seven officers, additional enlisted men, and three members of the Women's Army Corps to its staff, as well as an Italian medical officer who worked in a liaison capacity with medical officers and units serving Italian tactical elements operating under the Fifth U.S. Army.

The largest segment of the surgeon's office was the operations section, which directed training, hospitalization and evacuation, and medical supply activities. It formulated medical training policies and programs, directed the assignment, movement, and location of Fifth U.S. Army medical units (in cooperation with the Army G–4 and the staff Engineer section), carried out hospitalization and evacuation policies, and administered medical supply. The preventive medicine section was responsible for field sanitation in all army units, the direction of programs for insect control and venereal disease control, and the prevention of cases of trenchfoot which harassed Fifth U.S. Army troops in the winter of 1943. A surgical consultant and a neuropsychiatric

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consultant in Colonel Martin's office evaluated, through personal observation, the professional capabilities of medical officers assigned to surgical and neuropsychiatric work in the different army elements and kept them informed of advanced techniques in their respective fields. Consultants of the theater surgeon's office, as well as some from the European theater surgeon's office, visited Fifth U.S. Army.

The personnel section under the direct control of the executive officer carried out the usual duties of a personnel section—promotion, assignment, classification, replacements, and maintenance of personnel records—with the advice of officers heading the various professional services of the office, as well as that of commanding officers of Medical Department units. The dental section reported on the current status of the dental service in the army, advised the surgeon on the dental health of Fifth U.S. Army troops, inspected the Army's dental units, prepared statistical studies, and made recommendations for improving the dental service. Besides its usual task of supervising the inspection of the Army's food supplies, the veterinary section had greater responsibilities for animal care than did the veterinarians of most armies, for Fifth U.S. Army used thousands of horses and mules during the Italian campaign. The veterinary section arranged the movement of the Army's veterinary units and the evacuation of its animals, recommended sites for the location of veterinary hospitals, and checked requisitions for veterinary supplies and equipment.[21]

Seventh U.S. Army.—Lt. Gen. George S. Patton's Seventh U.S. Army came into being in July 1943. The nucleus of what was to be its staff medical section had functioned first as a part of Western Task Force headquarters and later as the staff medical section for I Armored Corps (when the task force had been given that redesignation). By April the medical section had been split between a forward echelon headquarters in Mostaganem, Algeria, and a rear echelon headquarters in Oran. The surgeon, Col. Daniel Franklin, MC (fig. 60), together with two officers, performing executive and hospitalization and evacuation functions, and two enlisted men at Mostaganem had made medical plans for the invasion of Sicily, while rear echelon medical personnel, amounting to three officers and nine enlisted men, had attended to matters of medical supply, preventive medicine, and routine administration.

The surgeon and his staff at forward echelon sailed aboard the headquarters ship of the invasion force and arrived in Sicily as the medical section of Seventh U.S. Army, those at rear echelon following within a few days. At the conclusion of the Sicilian campaign on 17 August, the office was located in Palermo. It was organized in a fashion similar to that of the Fifth U.S. Army surgeon's office; after the addition of a few personnel late in the year, it totaled 9 officers and 18 enlisted men. Since Seventh U.S. Army's duties

[21] (1) Annual Report, Surgeon, Fifth U.S. Army, 1943. (2) Annual Report, Surgeon, Fifth U.S. Army, 1944.



FIGURE 60.—Col. Daniel Franklin, MC.

in the post-campaign period were of an occupational nature, a relatively small medical section sufficed.[22]

II Corps.—During the Tunisian campaign, where II Corps (commanded successively by Maj. Gen. (later Lt. Gen.) Lloyd R. Fredendall, Lt. Gen. George S. Patton, Jr., and Maj. Gen. (later Gen.) Omar N. Bradley) operated independently, the corps surgeon's office functioned in the same manner as the surgeon's offices of Fifth and Seventh U.S. Armies. With a peak strength of close to 100,000, II Corps was in fact as large as many field armies. It is not, therefore, surprising that the staff of the II Corps surgeon—11 officers and 16 enlisted men at its maximum—was larger than that of most corps.[23]

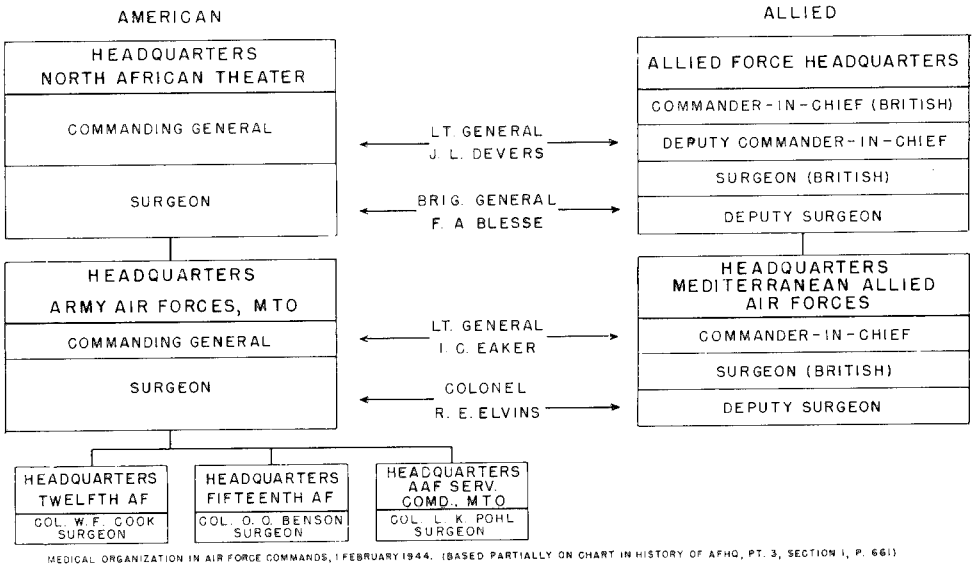
The Army Air Forces

The air force setup in North Africa grew elaborate during the first year of the theater's existence. American elements of the Northwest African Air Forces, while remaining under this Allied command's operational control, were reconstituted as the Twelfth Air Force just before the invasion of Italy in September 1943. After the fall of Naples early in October, the Twelfth

[22] Annual Report, Surgeon, Seventh U.S. Army, 1943.

[23] (1) See footnote 7(7), p. 252. (2) Annual Report, Surgeon, II Corps, 1943.

CHART 15.—*Medical organization in Air Force commands, 1 February 1944*



MEDICAL ORGANIZATION IN AIR FORCE COMMANDS, 1 FEBRUARY 1944. (BASED PARTIALLY ON CHART IN HISTORY OF AFHQ, PT. 3, SECTION I, P. 661)

Air Force became a primarily tactical force designed to support the Fifth U.S. Army's ground operations. Its heavy bombardment elements were removed to form the nucleus of a strategic air force, the Fifteenth, activated in November.

Early in 1944, these two air forces were subordinated to a higher American air command for the theater, the AAF/MTO (Army Air Forces, Mediterranean Theater of Operations) which was in turn subordinate to the theater command (chart 15). At the same time the Air Service Command, MTO, was established as one of its subcommands. In the preceding month the name of the Allied air command had been changed from Northwest African Air Forces to MAAF (Mediterranean Allied Air Forces); it remained subordinate to the Allied Commander in Chief. Thus, at the beginning of 1944, the following American medical sections existed at the major air headquarters of the theater: A small medical section which served not only the top American air command (AAF/MTO) but was also the American medical component of the Allied air command (MAAF) and a medical section at each of the three commands subordinate to the Army Air Forces, MTO—the Army Air Forces Service Command, MTO, and the Twelfth and Fifteenth Air Forces. This organization prevailed to the end of the war.

Although Twelfth Air Force had lost its identity in early 1943 when it was absorbed by the Allied air command, its administrative elements had been retained within the larger organization and continued to serve Twelfth Air Force units. The surgeon's office, formerly at various sites in Algeria and Tunis, moved to Foggia, Italy, in November. The major segments of the office were as

follows: Executive, including personnel and sick and wounded; medical inspection, including professional services, physical examinations and venereal disease control; dental surgeon; neuropsychiatry, including medical disposition board and statistics and records; care of flier; and physiology, including personal equipment and nutrition. The veterinary and medical supply services were not within the Twelfth Air Force medical section after early 1943, but were placed within the medical section of Twelfth Air Service Command, the normal place for these activities.

The functions of most of the subsections in the Twelfth Air Force surgeon's office are self-explanatory. The physiology, neuropsychiatry, and care-of-flier subsections had more distinctive functions than the rest. The first of these investigated physiological problems pertaining to flying, including the danger of anoxia, the effects of cold temperature, and problems of night vision. Its physiologist tested new items of clothing and protective equipment and armament, while its personal equipment officer directed the maintenance of emergency, flying, and oxygen equipment; gave instructions in the proper use of it; and supervised the medical care of fliers who survived crashes or forced landings at sea. The neuropsychiatry subsection formulated policy on neuropsychiatric problems; the psychiatrist who headed it instructed unit flight surgeons in neuropsychiatric matters, made recommendations to air force staff sections regarding morale, and participated in the proceedings of a medical disposition board which reviewed cases of men whose physiological or psychological fitness for flying was under question. The care-of-flier subsection, which became a typical element of the office of an air force surgeon, devoted itself to consideration of all the elements, including type of plans and nature of the mission flown, as well as the physiological and neuropsychiatric conditions which affected the health of fliers. On the basis of reports which the care-of-flier subsection obtained from unit surgeons as to the flying status of their men, hours lost from flying, cause, and so forth, it evaluated the health of Twelfth Air Force fliers. This unit then worked toward the reduction of stresses on the individual flier to a minimum and the establishment of standards for rotation or relief of fatigued fliers from duty.

By the end of November 1943, the Fifteenth Air Force, with headquarters at Bari, had built up steadily in southeastern Italy, where its operations were based until the end of the war. From early 1944 on, its heavy bombardment groups aided with the strategic bombing of targets in Axis-held territory within the boundaries of the European theater, and for this purpose were directed by the U.S. Strategic Air Forces based in ETO. The administration of the Fifteenth Air Force, however, including its medical service, was handled within the Mediterranean theater's chain of command. The organization of its surgeon's office resembled that of the Twelfth Air Force surgeon's office and its functions did not differ appreciably from those of the latter.

The surgeon's office of AAF/MTO, the top coordinating American air command, was a small one; it was headed by Col. Richard E. Elvins, MC, former

surgeon of the Twelfth Air Force. Its duties involved "coordination and policymaking" rather than administrative functions, for the latter became the responsibility of the Office of the Surgeon, Army Air Forces Service Command, Mediterranean Theater of Operations.

Within the headquarters of Mediterranean Allied Air Forces, close liaison was maintained between the American medical component headed by Colonel Elvins (Medical Section, AAF/MTO) and its British counterpart. The senior medical officer of Headquarters, Mediterranean Allied Air Forces, a British officer, did not assume any administrative control over medical activities of the Twelfth and Fifteenth Air Forces but restricted his action to coordination of his own medical plans with those of the American medical section. The latter maintained liaison with American medical officers at Allied Force Headquarters by means of conferences.[24]

Designed to perform administrative functions for the Twelfth and Fifteenth Air Forces, the medical staff of Army Air Forces Service Command, MTO,[25] handled matters of health and sanitation, venereal disease and malaria control, medical care, evacuation, medical plans and training, dental care, food inspection, rest camp operation, and medical supply. The air service command also supervised the operation and maintenance of certain general, station, and field hospitals turned over to air force control after December 1943. Most were in the Bari-Foggia area of southeastern Italy and served troops of the Twelfth, then of the Fifteenth, Air Force. A few hospitals on the islands of Pantelleria, Sardinia, and Corsica were also under air force control. Officially attached to AAF/MTO (though remaining assigned to the Services of Supply), these hospitals were directly supervised and administered by the surgeon of the air force service command organization. This was the first time that substantial responsibilities for fixed hospitalization had been given to the Army Air Forces in a theater of operations. The fact that the Bari-Foggia area was under the control of British military forces and not within the territory of any North African theater base section accounts in part for the attachment of the hospitals to the air forces. The theater surgeon (General Blesse), as well as the surgeons of the Twelfth and Fifteenth Air Forces, recognized the air forces' need for direct supervision of the fixed hospitals which served air force troops—stationed at some distance from Services of Supply hospitals and widely dispersed. The surgeon of the Fifteenth Air Force expressed his approval to the Deputy Air Surgeon in Washington: "Our relationship with the hospitals is excellent and they have been most cooperative. However, *this is an unusual*

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[24] (1) See footnotes 12 (2) and (3), p. 255; and 11(1), p. 254. (2) Medical History, Fifteenth Air Force, November 1943–May 1945. [Official record.] (3) Annual Report, Medical Section, Army Air Forces Service Command, Mediterranean Theater of Operations, 1944. (4) Organization and Functions of the Medical Section, Army Air Forces Service Command, Mediterranean Theater of Operations, through 1 October 1944. [Official record.] (5) History of Allied Force Headquarters, pt. II, sec. 1; pt. III, sec. 1.

[25] Personnel formerly assigned to the Twelfth Air Force Service Command were used to staff this overall theater air service command. The Twelfth Air Force Service Command was resupplied with personnel from one of the Twelfth Air Force's air service area commands.

setup as you well appreciate. In the usual ASF hospital arrangement there are numerous objectionable characteristics that you and your people seem well aware of." [26]

The office of the Surgeon, Army Air Force Service Command, MTO, was relatively large, amounting by mid-1944 to 15 officers, 18 enlisted men, and 4 enlisted women. It was the technical channel for the distribution of medical information from the theater surgeon to surgeons of major air force echelons. Early in 1944, the medical section was split between advance headquarters at Bari, Italy, and rear headquarters in Algiers. By February, the entire section was at Naples, the new location of the air force service command's headquarters.[27]

The Air Transport Command in North Africa

The Air Transport Command entered the scene in the North African theater soon after the Allied landings. The extension of its established Africa-Middle East Wing (a segment of the South Atlantic air route from the United States through Brazil and across central Africa into the Middle East) into the coastal areas of northern Africa was marked by the arrival of the first transport plane from Accra, Gold Coast, at Oran on 17 November 1942. During the following month the wing inaugurated a transport route from Dākar, French West Africa, via Casablanca to England. Daily Air Transport Command service through northern Africa began in late January 1943 via the following towns: Accra, Bathurst, Atar, Tindouf, Marrakech, Casablanca, Oran, and Algiers. Territory covered by the wing was expanded considerably with this northward extension; by the end of 1943, the Africa-Middle East Wing had been split into the North African Wing, with most of its stations within North African theater boundaries and some within the Middle East theater, and Central African Wing following the more southerly route, with all its stations within the boundaries of the Middle East theater.

The North African Wing, later termed North African Division, with headquarters at Casablanca, covered not only points along the coast of northern Africa and French West Africa, but also most of the Middle East, extending from Dākar on the extreme west coast of Africa to the eastern border of Iran. By the end of January 1944, it included the following stations: Dākar, Atar, Tindouf, Marrakech, Casablanca, Oran, Algiers, Tunis, Naples, Tripoli, Bengasi, Cairo, Abadan, and Bahrein Island.

In the early part of 1944, 15 Medical Department officers and 53 enlisted men, supervised by the wing surgeon, served these stations. The first wing surgeon was Lt. Col. (later Col.) Clarence A. Tinsman, MC (fig. 61). He was succeeded by Col. Frederick C. Kelly, MC (fig. 62), in July 1944. Within

[26] (1) Letter, Col. Otis O. Benson, Jr., to Col. Walter S. Jensen, Deputy Air Surgeon, 9 Apr. 1944. (2) Letter, Col. Otis O. Benson, Jr., to Director of Administration, Office of the Air Surgeon, 30 Sept. 1944. (3) Letter, Brig. Gen. Frederick A. Blesse, to Maj. Gen. Norman T. Kirk, The Surgeon General, 6 Feb. 1944. (4) Annual Report, Medical Section, Army Air Forces Service Command, Mediterranean Theater of Operations, 1944. (5) See footnotes 6(5), p. 250; and 12(2), p. 255.

[27] See footnote 24 (4) and (5), p. 272.

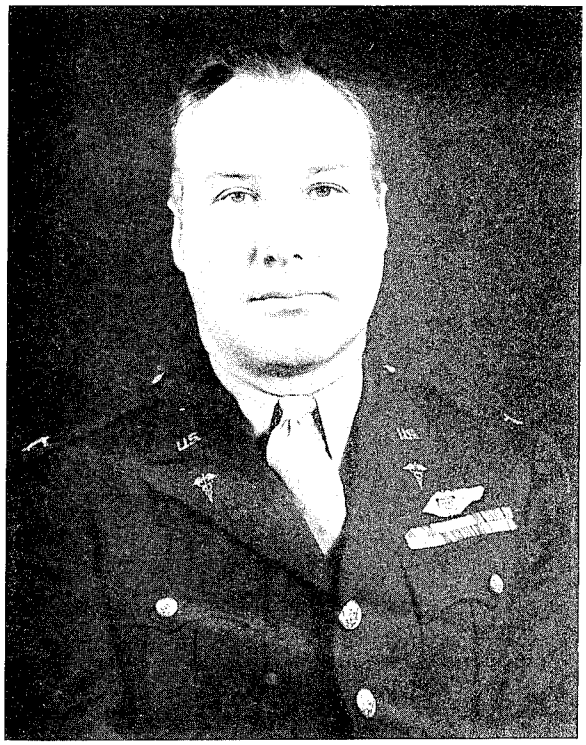


FIGURE 61.—Col. Clarence A. Tinsman, MC.

the first 6 months of 1944, the number increased to 42 officers and 131 enlisted men. The scattered stations of the wing were usually served by a dispensary, which customarily maintained a few beds, with at least one medical officer present. Nearby station or general hospitals maintained by the base sections, or service commands of the Middle East theater, received and treated Air Transport Command personnel whenever necessary. Sanitation, the control of malaria, venereal disease, and the dysenteries among troops, and efforts to prevent troops from contracting many other diseases existent in the local population constituted the major work of the wing surgeon's staff. It was responsible not only for the health of the military population of each station but also for that of many transient personnel who were under Air Transport Command control while en route. The wing had to furnish care to patients transported along its route, including evacuees from the China-Burma-India theater, toward the United States. During 1944, the North African Wing was responsible for the return of over 6,000 patients by air. Immediate control of the wing was exercised by the wing commander, responsible to the commanding general of the Air Transport Command in Washington, in turn subordinate to the Commanding General, Army Air Forces. Although the wing commander had exclusive control over his personnel, he was responsible for adherence to the

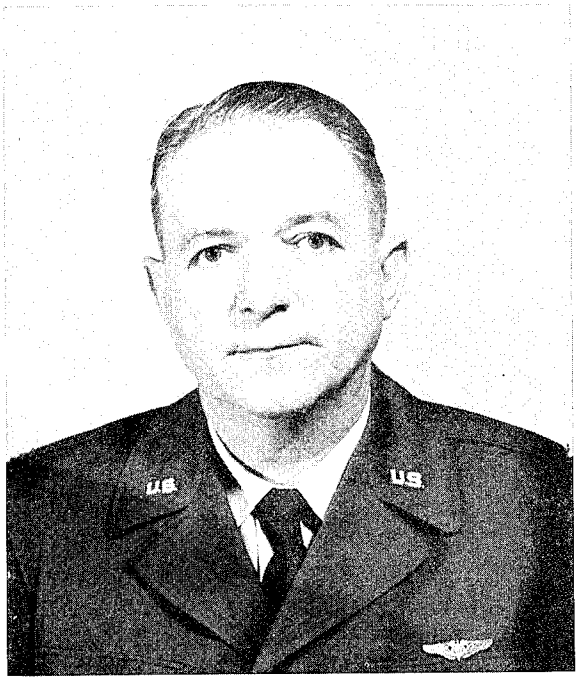


FIGURE 62.—Col. Frederick C. Kelly, MC.

administrative policies of the commanders of the theaters in which the stations of his wing were located.[28]

PERIOD OF GROWTH AND REORGANIZATION FEBRUARY–DECEMBER 1944

Reorganization of February 1944

With southern Italy, Sicily, Sardinia, and Corsica under Allied control, theater boundaries were expanded in February 1944 to include almost all territories bordering on the Mediterranean Sea. The African boundaries remained unchanged, but the theater now included (in anticipation of an invasion of southern Europe from North Africa) southern France, Switzerland, Austria, the Balkans, Turkey, and the Aegean Islands with the exception of Cyprus (map 1). Troop strength of the theater in February 1944 amounted to more than 640,000. A major reorganization of the theater setup took place at this date as the result of a survey made in 1943 which had revealed some duplica-

[28] (1) Administrative History of the Air Transport Command, June 1942–March 1943 (1945). [Official record.] (2) Administrative History of the Air Transport Command, March 1943–July 1944 (1946). [Official record.] (3) History of the Medical Department, Air Transport Command, May 1941–December 1944. [Official record.] (4) See footnote 24(5), p. 272. (5) History, Medical Section, Africa-Middle East Theater of Operations, September 1941–September 1945.

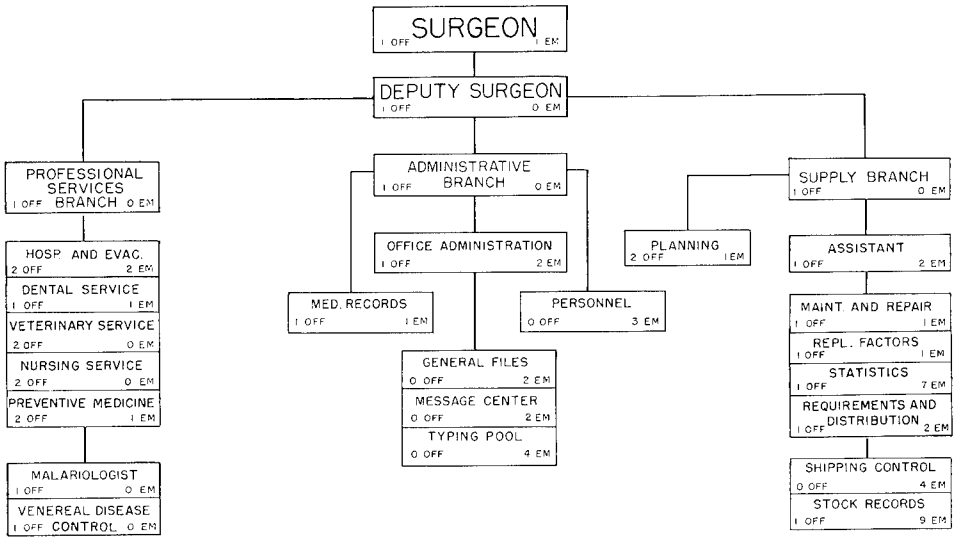
tion of functions and excess personnel in three high commands: Allied Force Headquarters, North African theater headquarters, and Services of Supply headquarters. The functions normally assigned to a communications-zone commander by field service regulations were transferred from theater headquarters to Headquarters, Services of Supply (renamed Communications Zone in October), and the base sections became subordinate to the Services of Supply, in accordance with Army doctrine for organization of an oversea theater.

The principal effect of this reorganization upon medical administration was an expansion of the responsibilities of the Services of Supply medical section, which had previously been concerned only with the handling of medical supply. From February to November 1944, it had broad medical responsibilities within the communications zone, the most important of which was supervision of the fixed hospitals operating in the base sections. It thus became more nearly the orthodox Services of Supply medical section of the type existent in other theaters.

The theater medical section was still responsible for making plans and formulating policies, including those in dental and veterinary medicine. It coordinated these with the various staff elements of the combined theater and Allied headquarters and the medical offices of the Services of Supply, NATOUSA, of the armies (or task forces), the air force commands, the Allied armies, and Allied Military Government. It acted as the channel of communication with the War Department on all matters of policy. A significant responsibility which it retained was that of recommending allocation of Medical Department troops and units among the Services of Supply, the armies, air forces, and other commands.

The functions of the Services of Supply medical section, one of the special staff sections of that headquarters, pertained to medical activities within the communications zone and its base sections, where the larger, relatively fixed, medical installations were located. It administered the fixed hospitals; after an expansion of June 1944 these amounted to 17 general hospitals of 1,500 or 2,000 beds each, 34 station hospitals most of which provided 500 beds each, and 4 field hospitals of 400 beds each. The medical section, SOS, now selected hospital sites, and was responsible for evacuating the sick and wounded by land from the combat zone to the communications zone and within the communications zone, and for sea evacuation from the communications zone to the United States. It made medical inspections in the communications zone and compiled data on the sick and wounded in that zone. It controlled and trained Medical Department units assigned to the communications zone. It continued to direct the supply activities of the base sections and issued items of medical supply and equipment in excess of tables of basic allowances and tables of equipment to troop units in the communications zone. This division of medical responsibilities between the theater headquarters and Services of Supply headquarters, whereby the medical section of theater headquarters had responsibility for making theaterwide plans and establishing policies

CHART 16.—*Medical Section, Services of Supply, North African theater, May 1944*



[ADAPTED FROM CHART, P. 7A, SEC. L (COMZONE MEDICAL SECTION), ANNUAL REPORT, MEDICAL SECTION, MTOUSA, VOL II, 1944]

while the medical office at Services of Supply headquarters supervised the handling of medical supply, the operation of fixed hospitals as well as medical supply depots, and the extensive preventive medicine program which were the responsibilities of the communications zone, prevailed in most of the oversea theaters.[29]

With the assumption of new responsibilities, the medical section of the Services of Supply was reorganized (chart 16). The old Services of Supply medical section as it had functioned from February 1943 through February 1944 became merely the supply branch within the new medical section with a structure similar to its former organization.

After February 1944 the theater medical section reduced its personnel, since fewer numbers were needed for the planning and coordinating activities to which it was now restricted; some of its members were transferred to the Services of Supply medical section. On 1 March, Maj. Gen. Morrison C. Stayer, the former surgeon of the Caribbean Defense Command, became head of the theater medical section, replacing General Blesse; he served as theater surgeon (and Deputy Surgeon, AFHQ) until mid-July 1945.

An important development in theaterwide administration of medical service in the spring of 1944 was the establishment of a veterinary section in the theater surgeon's office. This was the only major phase of the Medical Department's work in the theater which had not received central direction from the theater surgeon's office. Apparently supervision of veterinary service from

[29] (29) History of Allied Force Headquarters, pt. III, sec. 2. (2) See footnotes 6(2), p. 250; 18(2), p. 260; and 19(7), p. 262.

the Services of Supply level had originally been contemplated, for a Veterinary Corps officer attached to the theater surgeon's office had been shifted to Services of Supply headquarters early in 1943. However, the medical section of the Services of Supply had performed only supply functions, and the theater medical section had not shown any strong interest in directing the work in food inspection. Nor had the medical offices at the headquarters of the base sections developed any permanent veterinary elements.[30]

Veterinary officers commanding veterinary food inspection detachments and others assigned to Quartermaster Corps depots and refrigeration companies and to ports as port veterinarians carried out the tasks of food inspection and made arrangements for protecting food against contamination. Food inspections took place at many command levels and at many stages of procurement, storage, and issue of foods: the unloading at ports of foods shipped to the theater; storage of shipped foods at Quartermaster depots; butchering of locally bought cattle at local abattoirs; purchase of fish, eggs, fruits, vegetables, and processed foods locally; placement of foods in cold storage rooms and mobile refrigerating units; and handling at unit messes. These inspections called for close coordination with the Quartermaster Corps and Transportation Corps because of the responsibilities of these two services in storing and transporting food supplies. The obvious lack of uniform procedures for inspection and standard measures for conservation, together with the condemnation of foods needlessly by some Veterinary Corps officers, led the preventive medicine officer at theater headquarters, Col. William S. Stone, MC (fig. 63), to emphasize the need for a veterinarian in that office.

In the fall of 1943, 12 Veterinary Corps officers, requisitioned by the Quartermaster Corps to supervise abattoirs for the slaughter of cattle to be furnished the U.S. Army by the French under reverse lend-lease procedure, arrived in the theater. As this program had failed to develop, the veterinarians had no assignments and were temporarily put in replacement pools. At this point, General Blesse, the theater surgeon, assigned Lt. Col. Duane L. Cady, VC, to the task of surveying the work of veterinarians throughout the theater and making recommendations with respect to the veterinary service. Colonel Cady found that the lack of any central organization to make the proper distribution of veterinary officers where they were needed had led to a maldistribution of veterinary personnel and had affected the quality of veterinary service afforded in the theater. He planned a theaterwide system of supervision by veterinarians assigned to the staffs of all major commands, including the theater command, the base sections, the Fifth U.S. Army, and the Twelfth

[30] (1) History of Allied Force Headquarters, pt. II, sec. 4. (2) See footnote 12(4), p. 255. The absence of any veterinary component in the theater medical section may have been because the British medical section at Allied Force Headquarters had no veterinarians. The British Royal Army Veterinary Corps was not a part of the British Army Medical Services; at Allied Force Headquarters the British Veterinary and Remount Services formed an element of the office of the British Assistant Deputy Quartermaster General. See Blackham, R. J.: The American Army Medical Services in the Field. J. Roy. Army M. Corps 80: 201–207, May 1946.



FIGURE 63.—Col. William S. Stone, MC.

Air Service Command. He also emphasized the need for centralized supervision over the work of caring for animals, for Fifth U.S. Army was using mules and horses in increasing numbers in its northward push in the mountains of Italy. The use of Italian veterinarians and veterinary units in divisional veterinary service, as well as at remount stations (operated by Peninsular Base Section) which furnished thousands of mules and horses for the animal pack trains of Fifth U.S. Army, made the standardization of policies and procedures even more imperative. After the assignment of a Veterinary Corps officer to theater headquarters early in March 1944, a theaterwide system was worked out, standard procedures adopted, and the mutual responsibilities of the Quartermaster Corps and the Medical Department for care and conservation of food supplies delineated.[31]

Movement and Further Reorganization

In July 1944, Allied Force Headquarters and Headquarters, North African Theater of Operations, moved from Algiers to Caserta, Italy. Here for

[31] (1) Memorandum, Lt. Col. Duane L. Cady, VC, for Surgeon, NATOUSA, 21 Dec. 1943, subject: Investigation and Survey of Veterinary Activities in North African Theater of Operations. (2) See footnote 12(4), p. 255.

the first time the British and American components were in separate buildings, the American component, including its medical section, being housed in the Royal Palace, a short distance from the town. The medical section of AAF/MTO [32] also had quarters in the Royal Palace, and Headquarters, Services of Supply, had established its offices in the town of Caserta, moving from Oran in July. The close proximity of the theater and Services of Supply medical sections afforded greater opportunity for coordinating their respective programs. The 200-mile distance between Oran and Algiers had been a distinct disadvantage. It now appeared feasible to simplify staff procedures and reduce the number of officers in administrative positions by having the general and special staffs of the two headquarters function in a dual capacity. A proposal to combine the two headquarters was soon in the offing; after the invasion of southern France in August 1944—the month during which troop strength in the North African theater reached its peak of 742,700—a development to that effect took place.

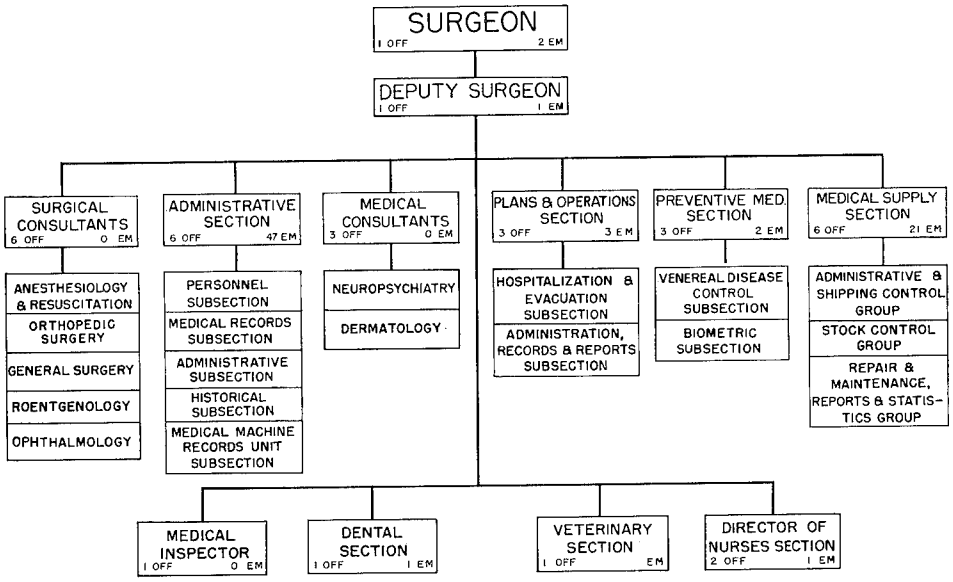
The Services of Supply, NATOUSA (renamed Communications Zone, NATOUSA, on 1 October 1944), became responsible for support of the U.S. Seventh and French First Armies which invaded southern France from the North African theater. An advance echelon of its headquarters staff, set up at Lyon in September, moved north to Dijon in October. Communications Zone, NATOUSA, established two sections in southern France. The first, Coastal Base Section, was renamed Continental Base Section and then, on 1 October, Continental Advance Section when it moved forward in direct support of the tactical forces. On the same date Delta Base Section was established, with headquarters at Marseille, taking over a portion of the territory previously under Continental Base Section. The headquarters of both these area commands had medical sections from the start.

The invaded area of southern France was transferred to the European theater in mid-September, but control of supply and administration in this area remained until November with Communications Zone, NATOUSA, which had extended its administrative and supply responsibilities from one theater to the other and was now chiefly concerned with the operation in southern France. On 1 November, Communications Zone, NATOUSA, was renamed Communications Zone, MTOUSA. On 20 November, Communications Zone, MTOUSA, was dissolved, its functions so far as southern France was concerned passing to SOLOC (Southern Line of Communications), a new command subordinate to European theater headquarters. At the same time Colonel Shook, former Surgeon of Communications Zone, NATOUSA and MTOUSA, became Surgeon of Southern Line of Communications, taking most of his staff with him. The base sections in southern France, together with their medical offices, fixed hospitals, and other medical installations, likewise passed to the control of the European theater.

[32] It will be remembered that the Army Air Forces had substituted Mediterranean Theater for North African Theater in February 1944—some 9 months before the same change was made at the headquarters level.

The North African Theater of Operations, U.S. Army, was renamed, effective 1 November 1944, the Mediterranean Theater of Operations, U.S. Army, and within the month its medical section assumed the functions of the former medical section of the Communications Zone (except those for southern France) in addition to its own theaterwide functions. It took over only 5 officers and 16 enlisted men from the Communications Zone medical section; Southern Line of Communications headquarters had to retain sufficient personnel for its operations in southern France. The reorganization simplified medical administration in the new Mediterranean theater considerably, since orders could now pass directly from theater headquarters to the base sections without the intermediate Communications Zone command. The November reorganization restored to the theater medical section all the functions it had had before February 1944, including the administration of evacuation and hospitalization in the base sections, and added an important new one in the form of a complex supply section. The medical section acting at theater headquarters and Allied headquarters in Caserta was now responsible for all medical functions of theaterwide scope.[33]

CHART 17.—*Mediterranean theater medical section (American medical component of Allied Force Headquarters), April 1945*



[ADAPTED FROM CHART, PP. 153–55, ADMIN. OF THE MED. DEPT. IN THE MTO, BY R. W. MUNDEN, OFF. OF SURG., MTOUSA, 10 NOV. 45]

After the reorganization of November 1944, the theater surgeon's office underwent only a few changes in organization. It attained its most elaborate structure in the spring of 1945 (chart 17), and the number of personnel author-

[33] (1) See footnotes 6 (2) and (5) p. 250; 11(1), p. 254; and 18(2), p. 260. (2) Coakley, Robert W.: Administrative and Logistical History of the European Theater of Operations, Organization and Command in the ETO, pt. II, ch. 7. [Official record in the Office of the Chief of Military History.]

ized for the office reached a peak about the same time (table 2). The increase in size of the theater medical section at this late date when troop strength had declined below 500,000 was due to the fact that the office had assumed all the former duties of the Services of Supply medical section, as well as the normal responsibilities of a medical office at theater headquarters.

TABLE 2.—*Authorized allotment of personnel, Medical Section, AFHQ-MTOUSA, October 1942–October 1945*

Date	Officers	Army Nurse Corps	Enlisted men	Total
1942				
17 Oct	3	0	0	3
19 Nov	4	0	4	8
1943				
25 Jan	5	0	5	10
6 June	22	0	30	52
28 Nov	29	3	30	62
20 Dec	29	3	36	68
1944				
3 Mar	24	1	29	54
29 June	24	4	31	59
8 July	24	3	31	58
17 Aug	24	3	61	88
19 Aug	24	2	61	87
23 Nov	29	2	77	108
24 Dec	30	2	80	112
1945				
18 Apr	33	2	80	115
9 June	31	2	72	105
18 June	31	2	68	101
30 Aug	20	2	50	72
15 Oct	16	2	40	58

Source: Adapted from a tabulation in Munden, Kenneth W.: Administration of the Medical Department in the Mediterranean Theater of Operations, United States Army (1945), p. 157. [Official record.]

The Base Sections

By the end of November 1944, the Mediterranean theater had only three base sections, the Island Base Section on Sicily having been disbanded in July 1944, and Atlantic and Eastern Base Sections having been absorbed by Mediterranean Base Section following the transfer of facilities to southern France. The base sections had operated directly under Services of Supply (Communications Zone) throughout most of 1944, the period of heaviest responsibility of

the Services of Supply. With the November reorganization and the abolition of the Services of Supply, the three remaining base sections—Peninsular Base Section, Mediterranean Base Section, and Northern Base Section, in order of importance—again came under the direct control of theater headquarters. During 1944, Army installations in North Africa had declined in number and importance, while base section facilities had become concentrated in Italy.

The geographic territory of Peninsular Base Section increased in 1944 with the movement of Fifth U.S. Army northward. After the occupation of Rome in June, five hospitals were moved there, and a separate Rome Area Command, with a small headquarters medical section, responsible directly to the theater command, directed the hospitals in the area during 1944. When Leghorn was occupied in July, Peninsular Base Section hospitals were shifted there and to the coastal towns north of Rome. During the preparations for the invasion of southern France, some medical installations in Peninsular Base Section were turned over to Continental Base Section, which was to support the Seventh U.S. Army in its landings. Peninsular Base Section was responsible for medical support of the Seventh U.S. Army while the latter was staging in Naples, and from August through November, after the Seventh U.S. Army invaded southern France, the base section received large numbers of patients from that area.

By August, Leghorn had become a major supply base and port; the headquarters of Peninsular Base Section, Forward, was located there, its larger half—Peninsular Base Section, Main—remaining at Naples. The base section surgeon accordingly maintained medical staffs in both cities. In late November, the more important headquarters—Peninsular Base Section, Main—was shifted from Naples to Leghorn, and the Naples area was thereafter known as Peninsular Base Section, South. Near the end of the year, half of the fixed medical installations in southern Italy had been moved up to the Leghorn-Florence area. The base section surgeon now had his office in Leghorn but was represented by a deputy surgeon at Naples.

At Bagnoli in the Neapolitan suburbs, certain hospitals and related medical units were formally activated as a "medical center" in February 1944 (fig. 64). Three (later four) general and three station hospitals and one evacuation hospital were included, along with a supply depot, dental laboratory, general medical laboratory, and other units. A common message center and a general utilities section were established, and the 4744th Medical Center (Provisional) was created as the centralized administrative headquarters of the medical units at Bagnoli. The Bagnoli concentration constituted something atypical in organization, being a more comprehensive grouping of Medical Department units than the "hospital center" prescribed in the Army field manuals. A hospital center normally consisted of three or more general hospitals, a convalescent camp, detachments of the Quartermaster and Finance Departments, and other branches; station and evacuation hospitals were not included. The Bagnoli medical center included these, as well as the medical

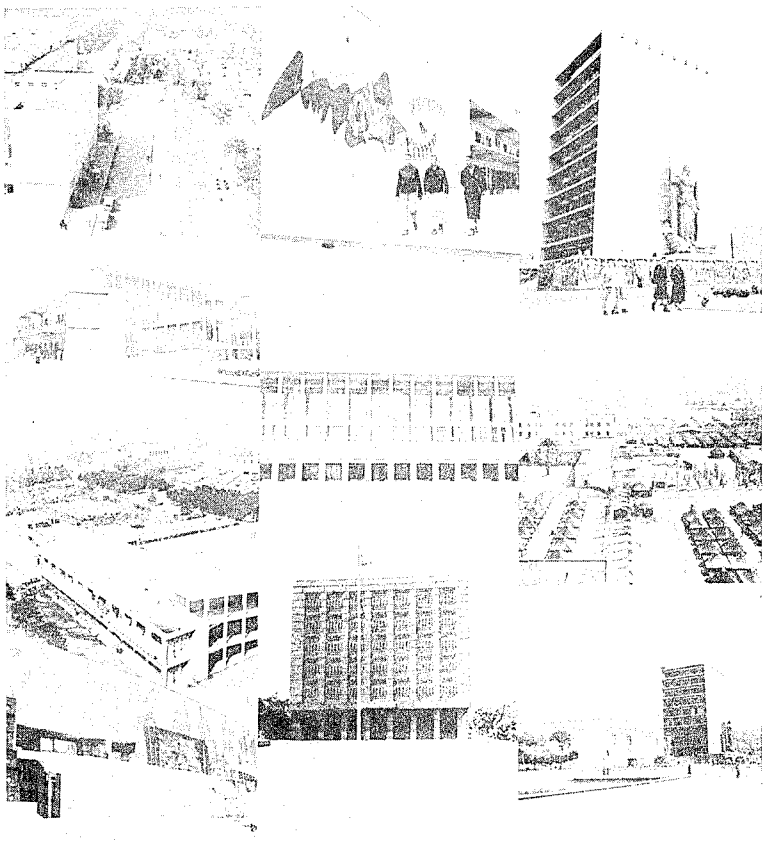


FIGURE 64.—Views of the Bagnoli medical center, near Naples.

supply depot and laboratories. It resembled the hospital center, however, in carrying out the field manual doctrine for obtaining, by means of pooling, economy in the use of personnel and facilities, and increased specialization in treatment of patients. This center, the only one formally organized in the theater, operated continuously to the end of the war.

The work of the Mediterranean Base Section's medical office, which had been very active during the first half of 1944, underwent sharp reduction toward the close of the year. Responsibility for evacuating American patients to the United States on transports from the ports of Oran and Algiers continued, but hospitals assigned to the base section decreased from 14 to 4 by the close of the year. The base section took over the medical units and hospitals (with less than a thousand beds) of Atlantic and Eastern Base Sections when it absorbed those two commands in mid-November. In December the medical section moved with the base section headquarters from Oran to a new site at Casablanca.

The third base section to continue in operation throughout 1944 was Northern Base Section in Corsica. The surgeon's office here amounted to only six officers and seven enlisted men. Only one field and two station hospitals were on the island. With the station hospitals divided into detachments and field hospitals into their component platoons, these medical units served air force and service troops at several scattered locations on Corsica.[34]

At the beginning of 1945, the theater had three base sections and a depot area: In North Africa, the recently consolidated Mediterranean Base Section; in Corsica, Northern Base Section; in western Italy, Peninsular Base Section; and in eastern Italy, the Adriatic Depot (under the Air Service Command), which served the air forces located in that area. At the end of February 1945, the Mediterranean Base Section was discontinued, and the entire geographic area of North Africa was transferred to the jurisdiction of the Africa-Middle East theater. The three station hospitals then operating in North Africa passed to the control of the latter theater. The boundaries of the Mediterranean theater were redefined by this move to include the entire Mediterranean area other than North Africa, with the exception of Cyprus and a few of the small islands off the coast of Turkey (map 1).

Early in 1945, a new Adriatic Base Command at Bari, Italy, took over service functions previously performed by Adriatic Depot for elements of the Twelfth and Fifteenth Air Forces located along the east coast of Italy, an area in which the British had primary responsibility. It was decided to turn over the hospital units which had been attached to the AAF/MTO to the Adriatic Base Command for administration. The air force headquarters strongly opposed the move, insisting that hospitals servicing air force troops should remain under air force control. A study of the problem directed by the theater surgeon granted that the control over hospitalized air force personnel which the attachment of the hospitals to the air forces had afforded had been an advantage to air force medical service. However, since air force units would be redeployed soon after the cessation of hostilities in Europe, it was decided to reassign the hospitals to the more sedentary Adriatic Base Command.

Base section medical service underwent further retrenchment in the spring of 1945 with the departure of the two hospitals serving air force troops in the Northern Base Section in Corsica and the closeout of the base section in May. The Peninsular Base Section in Italy, responsible for supporting the Fifth U.S. Army during the brief Po Valley campaign, contained at the

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[34] (1) Annual Report, Surgeon, Mediterranean Base Section, 1944. (2) Annual Report, Surgeon, Northern Base Section, 1944. (3) Annual Report, Peninsular Base Section, 1944. (4) See footnotes 11(1), p. 254; and 18(2), p. 260. (5) Zelen, A. I.: Hospital Construction in the Mediterranean Theater of Operations, U.S. Army (1945). [Official record.] (6) War Department Field Manual 8-5, Medical Department Units of a Theater of Operations, May 1945.

end of August about four-fifths of the fixed hospital beds in the Mediterranean theater.[35]

The Combat Forces

The duties of medical officers of Army Air Forces, Mediterranean Theater of Operations, and Army Air Forces Service Command, Mediterranean Theater of Operations, did not change appreciably during the latter part of 1944 and 1945. With the cessation of hostilities in Europe on 8 May 1945, some duties increased, particularly those concerned with the disbandment of some units and the formation of others to render adequate medical service during redeployment and the departure of some Medical Department personnel for the United States. Several new surgeons were appointed to the two top air force headquarters during 1945, but both these headquarters were disbanded by the end of November.[36]

The staff medical sections of Fifth and Seventh U.S. Armies were occupied during 1944 with planning and supervising medical service during periods of active combat. After a period of reduction in strength following the close of the Sicilian campaign, Seventh U.S. Army headquarters, including its medical section, was occupied in planning the invasion of southern France. Planning was carried on in Algiers, Oran, and Mostaganem successively until July, when the entire Army headquarters moved to Naples for final preparations. After the assault on southern France in mid-August and the rapid advance up the Rhone Valley, the Seventh U.S. Army was included, by November, in the European theater and under the control of that command. By that date its medical section, headed by Col. Myron P. Rudolph, MC (fig. 65), from June 1944 on, had enlarged considerably. New positions added during the year included an operations officer and an assistant, a surgical consultant, a veterinarian, a personnel officer, a director of nurses, a neuropsychiatric consultant, a liaison officer with the French forces, a historian, and two medical records officers.

Fifth U.S. Army was engaged throughout 1944 in the Italian campaign. Its headquarters medical section received a few additional assigned personnel: a malaria control officer, a chief nurse, and a historian. A consultant in psychiatry and an Italian liaison officer were attached to the office. The army surgeon, General Martin, maintained close liaison with the surgeon of the Peninsular Base Section throughout the campaign, keeping the latter informed of the offensive plans of the army, so that fixed hospitals of the base section could move forward and occupy sites previously used by hospitals assigned

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[35] (1) See footnotes 6(2), p. 250; and 11(1), p. 254. (2) Final Report, Plans and Operations Section, Office of the Surgeon, Mediterranean Theater of Operations, U.S. Army, 10 Nov. 1945. (3) Final Report, Surgeon, Northern Base Section, 1945.

[36] (1) Annual Report, Army Air Forces Services Command, Mediterranean Theater of Operations, January–November 1945. (2) See footnotes 6(5), p. 250; and 12(2), p. 255. For personnel changes, see appendix A.



FIGURE 65.—Col. Myron P. Rudolph, MC, Seventh U.S. Army Surgeon (center), with his evacuation officer, Lt. Col. Robert Goldson, MC (left), and Col. Joseph Rich, MC, his operations officer.

to the army. The two surgeons rotated doctors between forward and rear area hospital units. Centers for the rehabilitation of psychiatric casualties near the front, a neuropsychiatric center in the corps or army area, and a gastrointestinal and a venereal disease center in the army zone were developments in specialized medical service of the Fifth U.S. Army.[37]

The rapid progress of the Po Valley campaign in the spring of 1945 confronted the Fifth U.S. Army medical service with the problem of hospitalizing prisoners of war. As they were enveloped, German hospitals were taken over intact and kept in operation under American supervision. As prisoner-patients were discharged to the prisoner-of-war camps after the war ended, German hospital units were consolidated, and with the repatriation of some 12,000 long-term cases by September, were closed out. Anticipating that Fifth U.S. Army would occupy Austria, the army surgeon's office drew up a complete plan for medical support of this operation. As Fifth U.S. Army was not given this task (II Corps, with six divisions, assumed control of the American zone of Austria in June 1945), General Martin's office was mainly occupied during the remainder of 1945 with the medical aspects of the redeployment program, including the operation of medical service in rest centers maintained for Fifth

[37] (1) Annual Report, Surgeon, Seventh U.S. Army, 1944. (2) Annual Report, Surgeon, Fifth U.S. Army, 1944. (3) See footnotes 6(5), p. 250; and 18(2), p. 260. (4) Interview, Maj. Gen. Joseph I. Martin, MC, 21 Feb. 1942.

U.S. Army troops in Italy. Teams from Fifth U.S. Army's hospitals operated dispensaries at each center, and the Fifth U.S. Army medical inspector supervised sanitary conditions in hotels and restaurants in the vicinity of each. In July 1945, General Martin left the theater for an assignment in the Pacific, and in September Fifth U.S. Army headquarters ceased operations.[38]

ORGANIZATION FOR MALARIA CONTROL

In northern Africa many natives in the coastal areas, where most of the military operations took place, were infected with malaria; they served as a potential source for transmission of malaria to U.S. Army troops. A similar reservoir of infection existed in Italy, Sardinia, and Corsica; native refugees, demobilized Italian troops who had previously been infected in the Balkans, Ethiopia, and other malarial combat areas, and Slav laborers who had been impressed into service by the Axis were living under conditions which promoted the spread of malaria. Foxholes, shell and bomb craters, stretches of land flooded by the Germans, and demolished bridges and hastily built fords which obstructed natural drainage—all these fostered the rapid breeding of anopheline mosquitoes.

Control of malaria among U.S. Army troops in North Africa was eventually carried out under the aegis of the type of theaterwide organization planned for the purpose by the Surgeon General's Office. The theater organization initiated its own efforts at control early in 1943. It obtained information on the incidence of malaria in northern Africa, held conferences of American, British, and French malaria control officers, made arrangements with civilian health agencies for environmental control measures outside troop areas, and worked out plans for using Atabrine as a suppressant among troops. Requests for special antimalaria personnel and supplies were placed with the War Department. Exploratory surveys of mosquito-breeding areas were begun, and some drainage and larviciding were undertaken in year-round breeding areas. Medical and Sanitary Corps officers working under the supervision of base section medical inspectors directed the early antimalaria work in the theater.

Personnel of malaria control and survey units began coming into the theater in March 1943. By the end of May, four complete survey units and four control units had arrived and were assigned to all three North African base sections. A group of malariologists who had served with U.S. Army troops in Liberia since mid-1942 were transferred to North Africa; in June 1943 one of them, Col. Loren D. Moore, MC (fig. 66), became theater malariologist. He was succeeded in September by Col. Paul F. Russell, MC, who served until March 1944. Col. Justin M. Andrews, SnC (fig. 67), followed Russell

[38] (1) Annual Report, Surgeon, Fifth U.S. Army, 1945. (2) See footnotes 6(5), p. 250; and 36(2), p. 286.



FIGURE 66.—Lt. Col. Loren D. Moore, MC.

as theater malariologist, and Maj. Thomas H. G. Aitken, SnC, served in the post from January 1945 to the end of the war.

After the organization was stabilized, malaria control policy and administrative procedures originated in the medical section of theater headquarters. The theater malariologist served under the chief of preventive medicine in the theater surgeon's office. He maintained liaison with the Allied Control Commission, in charge of the public health program among civilians, and with the British consultant malariologist of Allied Force Headquarters. On his recommendation, malariologists and control and survey units were transferred to areas where their work was most needed, serving with ground force and air force commands, as well as the base sections. At its peak strength in August 1944, during the malarial season, the malaria control organization consisted of 14 malariologists, 6 survey and 17 control units, and a group of men from a ferrying squadron of the Mediterranean Air Transport Service. The latter sprayed and dusted extensive areas with antimalaria materials from planes operating under the technical direction of the theater malariologist.

An Allied Force Malaria Control School in Algiers gave concentrated training in malaria control in courses of a few days' duration to officers concerned with the administrative aspects of control, to laboratory officers and

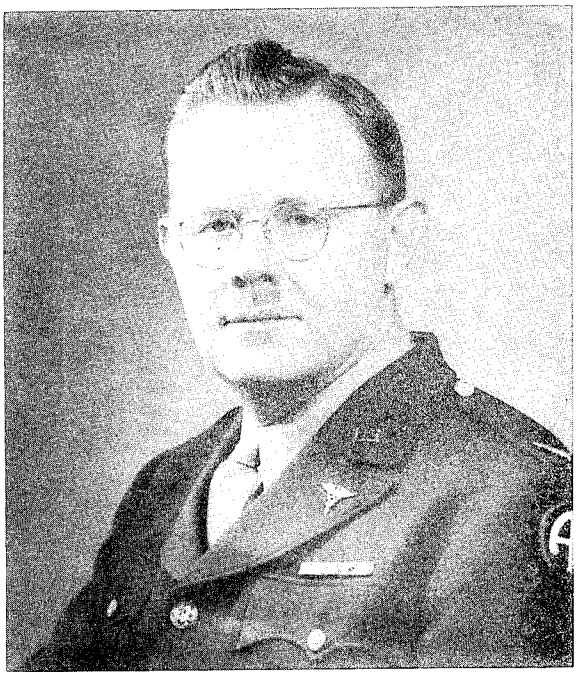


FIGURE 67.—Col. Justin M. Andrews, SnC.

technicians, and to enlisted men. The U.S. Army malariologists in the theater served as instructors of the American branch of the school; they repeated the training courses in more than a dozen locations of troop concentration in Algiers, Sicily, and Italy, including the hospital area at the Anzio-Nettuno beachhead.

Within the ground combat forces each company, battery, or similar unit maintained malaria control details made up of enlisted men. In Fifth U.S. Army, confronted with the necessity for large-scale efforts in the swamps of southern Italy before malariologists and units of Peninsular Base Section could undertake control, a feature of the malaria control program was the use of antimalaria officers and malaria control committees. In each corps, division, regiment, battalion, and company, a line officer was made responsible for malaria control and served as a member of a malaria control committee. At the corps and division level, the medical inspector and the engineer served as the other members of the committee; regimental and battalion committees were composed of the surgeon and the antimalaria officer. The committees brought together information on antimalaria activities and reported findings to their respective commanding officers. The effectiveness of the committees consisted in their bringing together representatives of command, the engineers, and the doctors in the common effort.

In the Mediterranean theater, noneffectiveness resulting from malaria reached proportions significant enough to impede military operations only during the Sicilian campaign. In August 1943, the malaria rate for the theater was 176 per 1,000 men per year, but was far in excess of that for the troops in Sicily. By August 1944, with the bulk of the theater troops in relatively healthy areas of Italy and southern France, the rate had been reduced to 91. The 1945 malaria season found the war over and conditions so altered as to make any valid comparison impossible. While the much higher incidence of malaria in the Southwest Pacific Area was caused mainly by more difficult environmental and combat conditions, many observers, as we shall see in a later chapter, attributed the higher rates there in part to faulty organization. In contrast to the situation in the Pacific, control over antimalaria work in the Mediterranean theater was rather highly centralized, and the lines of responsibility were clear. Secondly, not only was command responsible for enforcement of the program, as Army regulations required, but line officers were made a part of the machinery which carried out control measures.

Nevertheless, certain questions raised with respect to the most efficacious means of control were never fully resolved in the Mediterrean theater. The question of how much control work the standard malaria control units should accomplish and how much troops could do for themselves was never settled. Some personnel responsible for malaria control considered the standard control and survey units too small to accomplish their objectives efficiently and too dependent upon larger units for rations and quarters; moreover, a relatively high proportion of their enlisted men were needed for administrative purposes within the unit. A plan for a medical battalion headquarters which could have been used to consolidate antimalaria units was drawn up in 1945, but it was too late to test such a unit in the Mediterranean theater.[39]

TYPHUS CONTROL DURING THE NAPLES EPIDEMIC

The chief locality in which Army Medical Department officers came to grips with typhus during World War II was the Naples area. Efforts to prevent the spread of typhus to troops during the progress of the epidemic which occurred in the population of Naples in late 1943 were marked at first by some confusion as to responsibilities and later by the successful teamwork of a number of agencies.

When the epidemic developed, the only representatives of the U.S.A. Typhus Commission overseas were in Cairo, headquarters of the neighboring Africa-Middle East theater. In the North African theater the Office of the

[39] (1) See footnotes 6(3), p. 250; 11(1), p. 254; and 18(2), p. 260. (2) Final Report, Preventive Medicine Officer, Surgeon's Office, Mediterranean Theater of Operations, U.S. Army, 1945. (3) Andrews, J. M.: Malaria Control in the Mediterranean Theater of Operations in 1944. J. Mil. Med. in Pac. 1(3): 33–38, November 1945. (4) Report of Malariologists' Conference, Naples, 1–11 November 1944. (5) Medical Department, United States Army. Preventive Medicine in World War II. Volume VI. Communicable Diseases: Malaria. [In press.]

Surgeon, NATOUSA, a Rockefeller Foundation typhus team, and the Pasteur Institute had made joint preparations to combat outbreaks of the disease during the summer and fall, working in close cooperation. Members of the Rockefeller Foundation typhus team had worked out and demonstrated in Algiers during the summer of 1943 methods of mass delousing in prisoner-of-war camps, Arab villages, and a civilian prison. They used U.S. Army louse powders which had been developed in the United States by various Government agencies in collaboration with the Preventive Medicine Service of the Surgeon General's Office.

Before Allied troops entered Naples in the first days of October, the theater preventive medicine officer, Colonel Stone, had requested large quantities of the newly developed insecticide, DDT, from the United States, but because of the limited supply the highly effective powder was not shipped in quantity until late in the year. Colonel Stone had also arranged for members of the Rockefeller Foundation team to demonstrate to officers in base sections, hospitals, and divisional areas the methods of mass delousing which they had found most rapid and effective.

Early in December, Allied Force Headquarters received information of an incipient epidemic of typhus in Naples. The theater surgeon's office exerted pressure on the military government heads in Allied Force Headquarters to organize the civil health agencies in Italy to cope with the outbreak. The director of public health of the military government organization in Italy reported that his organization was aware of the danger in the Naples area and was taking steps to avert it. However, the typhus control program got under way slowly because of unsatisfactory organization of the civil health service and lack of experience on the part of military government personnel. Dr. Soper and Dr. Davis of the Rockefeller Foundation team were sent to Naples on 8 December to undertake typhus control work under the direction of the Allied Military Government in Naples. Confronted by a poorly functioning civilian health setup and inadequate support, the Rockefeller group experienced difficulties in obtaining personnel and transportation for the mass dusting of the Neapolitan population with insecticides.

The theater preventive medicine officer arrived in Naples on 18 December and worked out arrangements for the cooperation of the Peninsular Base Section surgeon and the Allied Military Government of Naples to intensify the work of the Rockefeller Foundation team in bringing the epidemic under control. The Typhus Commission officially entered the scene with the arrival of its field director, General Fox, in Naples on 20 December. General Fox and Colonel Stone cooperated in making forceful representation to the theater command, the Fifth U.S. Army commander, and the Allied Military Government and made arrangements in the latter part of December for additional supplies and personnel. The Typhus Commission was put in temporary charge, and



FIGURE 68.—Col. Harry A. Bishop, MC.

Col. Harry A. Bishop, MC (fig. 68), of the theater surgeon's office, was made coordinating and executive head. Peninsular Base Section supplied the much needed transportation and an effective program got underway.

The system of control employed consisted partly of case finding, followed by isolation of cases in order to remove the sources of infection, but large-scale dusting of the population in order to destroy the louse vector was the chief means of dealing with the epidemic. The campaign soon proved successful, and U.S. Army troops in the Naples area escaped typhus. The success of the program substantiated the position taken by those experts—mainly the theater preventive medicine officer, certain members of the Preventive Medicine Service of the Surgeon General's Office, and members of the Rockefeller Foundation typhus team—who had insisted on mass delousing by insecticides as a better means of control than immunization by vaccine. It also validated the use of chemical insecticides in preference to the older means of delousing by steam or dry heat.

The subsequent controversy among participating groups over who stopped the epidemic is beyond the scope of this volume. As expressed by Brig. Gen. Stanhope Bayne-Jones, who was both director of the Typhus Commission and deputy chief of the Preventive Medicine Service in the Office of The Surgeon

General, the accomplishment was great enough to confer distinction on all who took part in it.[40]

ORGANIZATION FOR PUBLIC HEALTH ACTIVITIES

The standard way of organizing the civil affairs program, including its public health work, within the oversea theaters was to establish a civil affairs division, frequently called G–5, which contained a subelement termed "public health," as a general staff element of the Allied, theater, and various lower commands, both area and tactical. In the Mediterranean theater, the area in which the U.S. Army first undertook a civil affairs program during the war, this design was not so fully carried out as in the European theater and the Southwest Pacific Area. The less elaborate organization and the more restricted scope of the Army's program in the Mediterranean area were due to several factors. This theater was the first in which the Army was faced with responsibility for civil affairs; only after experience here did it refine its organization in other theaters and standardize procedures. Moreover, the French were chiefly responsible for public health in the area initially invaded by the Allies—the French colonies of northern Africa; hence the U.S. Army developed no elaborate civil health organization there. As for Italy, political and diplomatic considerations dictated a large measure of civilian, rather than military, sponsorship of civil activities undertaken by the U.S. Government in that area.

U.S. Army participation in the public health program for civilians in French Morocco, Algeria, and Tunisia took place under the aegis of a Civil Affairs Section, a special staff section created at Allied Force Headquarters, just before the invasion of northwest Africa. This section, consisting of both civilian and military personnel (chiefly Americans), had broad political and economic functions, serving as an American diplomatic mission to French authorities in Algiers as well as exercising military functions as a staff section of the Allied command. Its Economic Subsection constituted the nominally independent North African Economic Board, a special agency which formulated policy on economic matters in the invaded areas; it was responsible for importing and distributing medical supplies for relief purposes. A group of U.S. Public Health Service officers were assigned to the Board early in 1943, others being added in July. They made surveys to determine the status of hospital facilities for civilians in the French colonies, the need for medical supplies for relief purposes, the nutritional status of the population, the presence of epidemic diseases, and the possibility of the introduction of new disease by insect vectors on planes and by returning refugees.[41]

[40] The text follows the more detailed account by General Bayne-Jones *in* Medical Department, United States Army. Preventive Medicine in World War II. Volume VII. Communicable diseases: Arthropodborne Diseases Other Than Malaria. [In preparation.] See also footnote 6(5), p. 250.

[41] (1) History of Allied Force Headquarters, pt. I. (2) Williams, Ralph C.: The United States Public Health Service, 1798–1950. Washington: U.S. Public Health Service Commissioned Officers Association, 1951, pp. 695–698.

The combat operations of the Allies produced relatively little devastation in northwestern Africa, and U.S. Army participation in the public health program there was largely limited to the aid which these few men trained in public health work gave to the French authorities after combat had ceased.

The organization for health work among civilians in occupied areas received its first significant test in the Italian campaign. Although the general civil program for Italy received direction from the highest level of Allied command, no medical subelement was ever established in the Military Government Section, a special staff section created in June 1943, and redesignated G–5 in May 1944 when it was made an element of the General Staff, AFHQ. Hence the public health work in Italy lacked the direction from the top command headquarters that the more limited program in northwest Africa, guided by the Civil Affairs Section, had had. Control over public health activities in Sardinia, Sicily, and Italy was affected to some extent by the confused situation that prevailed during the period when political control of these areas was divided between the King's government in Brindisi and the German-dominated government in Rome. Bad local conditions—inoperative public health facilities and power plants, shortages of food, clothing, and medical supplies, accumulated garbage, decomposing dead, and several incipient epidemics—complicated the problem of recovery in specific areas. In Naples the Army encountered all these problems, including the typhus epidemic among the civilian population.

The Allied Military Government, established in May 1943 to operate under the Commanding General, Fifteenth Army Group (General Sir Harold Alexander), had a public health division headed by a British Army medical officer; Lt. Col. Leonard A. Scheele, USPHS (fig. 69), and other officers of the U.S. Public Health Service were assigned to it. It gave central supervision to the work undertaken in each local area after the period of control by Army combat elements had passed. Its planning staff assembled at Chrea, in the Atlas Mountains near Algiers, in a training and holding center. Because of the lack of medical men in the Military Government Section, AFHQ, the medical staff of Allied Military Government dealt directly with the Director of Medical Services (British) of Allied Force Headquarters. The medical training at Chrea and at nearby Tizi Ouzou during the last half of 1943 continued the type of training given at schools of military government in the United States.

Within the U.S. Army tactical elements the prescribed organization for supervising health work among civilians during the period when tactical units controlled the various areas was fairly consistently carried out. The headquarters of both Seventh U.S. Army (during the Sicilian invasion) and Fifth U.S. Army had public health service officers assigned to G–5, and they were assigned at times of need to the lower tactical elements. In addition to these staff officers, civil affairs teams or detachments which included medical officers were assigned to invasion forces landing in Sicily and Italy and later to each



FIGURE 69.—Lt. Col. Leonard A. Scheele, USPHS.

army when a stabilized front was formed. The fact that they were assigned at a late date and in inadequate numbers made it difficult for them to maintain liaison with the regular Medical Department officers of the armies and divisions responsible for the health of troops. More effective cooperation came about later, but the problem of ineffective liaison at all levels between the Army's public health personnel and officers responsible for the health of troops remained one of the outstanding difficulties facing civil affairs authorities throughout much of the Italian campaign.

In November 1943, an Allied Control Commission (later termed simply Allied Commission) was created. Like Allied Military Government which it eventually absorbed, the Allied Commission was subordinate to Allied Force Headquarters. It assumed direction of civil affairs as rapidly as direct control through military government became unnecessary and local authority was restored. The commission had a public health group assigned to it including most of the U.S. Public Health Service officers who had served with the Allied Military Government in North Africa. In late 1943 and early 1944, when it created and took over certain "regions" or local areas, some degree of centralized authority over public health activities ensued. The commission's responsibility for administering public health work in Italy was vested in Brigadier

G. S. Parkinson (British), the director of its Public Health and Welfare Subcommission; his deputy was an American, Lt. Col. Carter Williams, MC. The subcommission was located at Naples after late December 1943. It exercised public health, veterinary, medical supply, and welfare functions. During the period when an increasing number of regions were being established the subcommission suffered from a shortage of medically-trained men. The director attempted to keep his own staff small and assigned as many specialists as possible to the "regions." [42]

Fifth U.S. Army turned over the Italian provinces under its control to the Allied Control Commission in step with the progress of military operations; the commission organized these into "regions" and eventually returned control of them to the Italian Government. By September 1944 the Public Health Subcommission, Allied Control Commission, was working largely through Italian channels. In its northward advance Fifth U.S. Army found more nearly normal conditions than had prevailed in southern Italy; local public health and welfare organizations were active. Throughout Italy the Allied Military Government and the Allied Control Commission (with the later help of the United Nations Relief and Rehabilitation Administration) had to give medical care to thousands of displaced persons, some at camps and others en route to their homes or other areas where better care could be afforded. These included, besides the northern Italian refugees who had fled southward, thousands of other European nationals, particularly Yugoslavs. By the end of May 1944, more than 20,000 Yugoslavs had been moved from Italy to camps in the Middle East. As the war came to a close, the responsibility continued with the rapid transfer of repatriated Italians southward and German prisoners of war northward through the Brenner Pass.

The public health program of the theater suffered from several serious administrative defects, pointed out by the director of the Civil Public Health Division (Col. Thomas B. Turner, MC) of the Surgeon General's Office, who visited the Mediterranean area early in 1944. The outstanding deficiency, he thought, was the lack at Allied Force Headquarters of any one medical officer solely devoted to the public health program. He found that some key personnel had been poorly selected and that liaison between public health officers and the surgeons of field forces in charge of the health of troops had been inadequate. The civil health program had been characterized by "administrative confusion," which had resulted from "ill-defined chains of command, over-lapping responsibilities, and jurisdictional disputes." An additional hindrance to the program had been the lack of adequate transportation facilities and medical

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[42] (1) Report of the Public Health Subcommittee, Allied Control Commission, for April 1944. (2) Monthly reports of the Allied Control Commission, beginning with January 1944. (3) Report to the War Department, History of Civil Affairs in Italy, by John A. Lewis, Jr., 7 Dec. 1945. (4) Komer, Robert W.: Civil Affairs and Military Government in the Mediterranean Theater of Operations. [Official record in the Office of the Chief of Military History.] (5) History of Allied Force Headquarters, Pts. II, III. (6) Medical Department, United States Army. Preventive Medicine in World War II. Volume VIII, Civil Public Health Activities. [In preparation.]

supplies very much in evidence during the early days of the occupation of Naples when typhus spread among the civil population.

By the date of the Normandy invasion, the European theater was in a position to profit from the Army's experience in the Mediterranean. Colonel Turner made several recommendations to The Surgeon General for improving the organization in northwestern Europe based on his observations in the Mediterranean. He suggested that a single individual be charged with top technical responsibility for public health; this man should be directly responsible to the chief medical officer of the theater or major field force. A public health officer assigned to the headquarters of each army and each corps would be responsible to the chief public health officer for technical matters. The program should be organized on a territorial basis, with major political divisions as the units and a public health administrator heading the program in each territorial unit. This administrator would have technical responsibility for civil health in all the territory actually occupied by Allied troops, regardless of whether a tactical commander or a military government organization controlled the area.[43]

REDEPLOYMENT AND CLOSEOUT OF ACTIVITIES

In planning for the redeployment of troops in the Mediterranean theater to the Pacific and China-Burma-India theaters, the theater surgeon's office arranged for disposing of Medical Department property, provided for hospitalization and evacuation for troops still in staging and training areas in Italy, and planned the movement of Medical Department units out of the theater. Medical and surgical consultants of the theater surgeon's office arranged special technical training for U.S. Army doctors who had been serving long periods with combat units or who had been performing administrative duties; they were given refresher courses on medical and surgical techniques in the general hospitals remaining in the theater.

The Fifth U.S. Army medical staff continued its main function—medical support to the army—and at the same time rendered service to the redeployment centers established in the summer of 1945. Fifth U.S. Army doctors administered physical examinations to troops in the redeployment centers to determine their fitness for further oversea duty. The Fifth U.S. Army surgeon appointed teams of officers for attachment to the staffs of the redeployment training centers. Each team had three medical officers: one of field grade who served as an "area surgeon" and supervised sanitation and the medical care of troops stationed at the centers; a medical records inspector who checked all unit medical records and helped the units to complete their final reports and histories; and a medical supply inspector.[44]

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[43] Letter, Col. T. B. Turner, MC, to The Surgeon General, 21 Feb. 1944, subject: Report of Civil Affairs Public Health Activities in NATOUSA, inclosures 1 and 2.

[44] See footnotes 6(2), p. 250; 36(2), p. 286; and 39(1), p. 291.

As theater strength dropped from its August 1944 peak of 742,700 to 404,242 in June 1945, and 55,349 at the end of the year, theater headquarters personnel was correspondingly reduced. Retrenchment embodied separation of the theater medical section from Allied Force Headquarters and its gradual abolition, with a transfer of its essential functions to the surgeon's office of Peninsular Base Section in Leghorn. Colonel Standlee, theater surgeon, who succeeded General Stayer as theater surgeon in July, retained responsibility for the formation of all major policy until the complete dissolution of his medical section. Certain specialized elements, such as the consultants sections, were discontinued. By October, when theater headquarters was formally separated from Allied Force Headquarters, the transfer of essential medical functions and elements of the office to Leghorn had been largely accomplished. British and American medical personnel who had previously functioned at the Allied headquarters level were now assigned exclusively to their respective American (Mediterranean theater of operations) and British (Central Mediterranean Force) headquarters organizations. When the theater medical section was disbanded on 10 November, the surgeon's office of Peninsular Base Section assumed full control of all theater medical functions.[45]

At the end of 1945 and during 1946, most of the few remaining medical installations and units were clustered around Leghorn and Naples. The Peninsular Base Section surgeon acted as both base section surgeon and theater surgeon. In the spring of 1947, after Peninsular Base Section was disbanded, the remaining medical responsibility in the theater was vested in the surgeon of the Port of Leghorn, where most remaining U.S. Army installations and activities were concentrated. Before the end of the year, all medical installations were inactivated or turned over to other commands, and in December 1947, with the departure of the last U.S. Army troops from Italy, the Mediterranean theater was disbanded.[46]

As the experience in the Mediterraneon theater indicates, the organization of medical service in a theater of operations was largely determined by the theater organization, by the changes in its structure, and by the functions and scope of responsibility of the various commands in the theater. All these, in turn, derived largely from the shifting tactical situation, which caused the swift creation of many new commands, the abolition of old ones, and rapid revisions in the structure, location, and jurisdiction of others in accord with their increasing or declining importance. A medical office was established in the headquarters of any newly created command, took the same relative place in theater structure as the headquarters, moved with its headquarters or was split into groups to accompany moving echelons of the headquarters, usually varied in size with the strength of the command, and died with the abolition of

[45] (1) See footnote 6 (2) and (5), p. 250. (2) Strength of the Army, 1 Feb. 1946.

[46] (1) Phase-out Report of Evacuation of Italy, Mediterranean Theater of Operations, Commanding General, MTOUSA, to Chief of Staff, 3 Dec. 1947. (2) See footnote 6(5), p. 250. (3) Summary of Supply Activities in the Mediterranean Theater of Operations, 30 September 1945. [Official record.]

the command or its headquarters. Certain geographic, social, economic, and political factors also indirectly influenced the administration of medical service through the effect which they had upon Army command structure in the area. The organization to cope with certain special problems—such as disease problems of theaterwide scope and the public health program for occupied areas—developed in part according to standard plans drawn up in the United States by the War Department and the Surgeon General's Office.

As the Mediterranean theater developed out of a large-scale invasion, the chronologic order of developments in medical administration differed from that in other theaters. In the European theater and Southwest Pacific Area in particular, as well as in some other areas, the medical service for a communications zone (including fixed hospitals, medical supply depots, and other medical installations used in a communications zone) was built up many months before the major combat period. In contrast with the situation in the Southwest Pacific Area and the European theater, medical planning for the invasion of North Africa was done in the United States and in another theater—the European theater—and base section medical service was built up only in the wake of the advancing troops.

In one respect, the organization of medical service in the Mediterranean area varied markedly from the standard pattern taught in the manuals. The functions of the staff medical section of the theater's Services of Supply during the year February 1943 to February 1944—a period including its combat operations in Tunisia and Sicily and the early stages of the Italian campaign—were restricted to those concerning medical supply. Neither the concepts on which the Services of Supply in the United States had been reared nor the standard doctrine for organizing a theater Services of Supply prevailed during this period. In other theaters, organized according to the doctrine, the Services of Supply medical section and the surgeons' offices of its area commands (advance, intermediate, and base sections) administered the system of fixed hospitals and the movements of evacuees within the communications zone. The retention of responsibility for evacuation and hospitalization at Headquarters, NATOUSA, meant that for about a year in the North African theater evacuation and hospitalization were handled by a single agency as a continuous operation throughout both the combat and communications zones; that is, from front to rear.

A unique feature of medical administration, which prevailed throughout the theater's existence, was the development of a fairly complete American medical section at the Allied headquarters and the dual assignment of one officer as chief American medical representative at that headquarters and as theater surgeon. This position of the theater medical section and the theater surgeon in the Mediterranean theater appears to have been to the liking of Medical Department personnel there. The lack of adverse comment among senior medical officers in key command or staff assignments within the theater with regard to the command system under which they operated, by compar-

ison with the many criticisms recorded by surgeons and observers in some other theaters, shows a more general satisfaction with the organization of medical service within theater structure in the Mediterranean area than elsewhere. Nevertheless, the situation whereby the American theater medical section could operate from the level of the top command—Allied Force Headquarters—was never repeated in the other theaters, since the American theater headquarters and the Allied headquarters were never similarly combined elsewhere.

CHAPTER VIII

The European Theater of Operations

The bulk of U.S. Army forces employed in World War II were concentrated in the United Kingdom for invasion of the European Continent. The cross-channel assault of June 1944 was followed by the establishment and buildup of a main lodgment area, and finally the breakthrough, advance to the east, and subjugation of the enemy. In combat on the Continent large armies and air forces operated over an extensive, relatively unbroken land mass. As this was the type of warfare contemplated in prewar planning, organization of the European theater accorded rather closely with Army doctrine.

At the time of the German surrender, 61 American divisions—two-thirds of the U.S. Army ground troop strength employed throughout the world during World War II—were in Europe; during the months before the surrender the total Army strength in the theater, including service and air as well as ground troops, reached over 3 million. The concentration of troops in Europe, compared with the situation in theaters of vaster extent, made it possible to use Medical Department officers, enlisted men, units, and installations to better advantage than in areas of greater troop dispersion. Nevertheless, because of the magnitude of the operation, theater organization grew highly complex. A large number of higher headquarters with medical administrative offices sprang up, but liaison among staff surgeons remained physically easy because of their close proximity. Indeed it was often possible to save administrative personnel by the employment of a single officer for similar staff positions at two or more headquarters.

THE BEGINNINGS

A few Army medical officers, together with medical men of the Navy and the U.S. Public Health Service, were sent to Great Britain in 1940 to observe the British medicomilitary effort. One of the Army officers—Col. (later Brig. Gen.) Raymond W. Bliss, MC—reported briefly on certain phases of British medical experience during the Battle of Britain; the handling of air-raid casualties; the organization of the Emergency Medical Service, the central authority which directed the hospital, ambulance, and first aid service for both British fighting forces and civilians; medical and psychological hazards of aviators, and so forth. When the United States and Great Britain reached an agreement for continued collaboration through an exchange of missions, a representative of the Medical Department, Maj. (later Col.) Arthur B. Welsh, MC, went to England with the Army's Special Observers Group.

Major Welsh represented the Army Medical Department on the mission from May until September 1941. Like the other members of the mission, he worked directly with the British services corresponding to his own and continued to inform the Surgeon General's Office on British experience. After inspection of areas likely to be occupied by American troops, he made recommendations as to the location of, and suitable specifications for, U.S. Army hospitals. He estimated the medical facilities, personnel, and supplies which would be needed if American troops were stationed in the British Isles and discussed with British representatives their requirements for lend-lease medical supplies from the United States.

Col. (later Maj. Gen.) Paul R. Hawley, MC, became the medical representative on the Special Observers Group in the fall of 1941. Colonel Hawley had seen service in France as the sanitary inspector of Intermediate Section, Services of Supply, in World War I. He had served as chief of the medical service at Fort Riley Station Hospital, Kans., and had held various assignments at the Army Medical School in Washington, D.C., and the Medical Field Service School at Carlisle Barracks, Pa. His work with the Special Observers Group bridged the transition from the emergency period to the entry of the United States into war.[1]

When the USAFBI (U.S. Army Forces in the British Isles) was created in January 1942 as the top U.S. Army command in the area, the officers of the Special Observers Group were made staff officers of the command. As a member of the special staff, USAFBI, Colonel Hawley served under Maj. Gen. James E. Chaney, who was responsible (through General Headquarters in Washington) to the Chief of Staff, U.S. Army. The U.S. Army Forces in the British Isles endured until mid-1942, when ETOUSA (European Theater of Operations, U.S. Army) was organized.[2]

Throughout this 6-month period the problems which the Surgeon, USAFBI, encountered in administering medical service for U.S. Army troops in the British Isles were largely typical of those faced by the entire headquarters staff during the first months after the United States entered the war. The status, mission, and organization of the theater were still not fully determined or generally understood; key assignments were temporary and changing and staff-trained officers were insufficient in number. The token force of 3,000 troops increased to over 54,000 by mid-1942. Colonel Hawley and his small staff—until late April he had in his office only three officers, all young and inexperienced Reserves—were chiefly occupied with inspecting areas where

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[1] (1) Parran, T.: Medicine in England Now. Ann. Int. Med. 14: 2184–2188, 1940–41. (2) Bliss, R. W.: Compiled Reports of G–2 From Medical Observer, October–December 1940. [Official record.] (3) Special Observers Group General Orders, 19 May 1941–8 Jan. 1942. (4) Thurman, S. J., and others: The Special Observers Group Prior to Reactivation of the European Theater of Operations, October 1944. [Official record.] (5) U.S.-British Staff Conversations Report, 27 Mar. 1941, in 79th Cong., 1st sess., Hearings of the Joint Committee on the Investigation of the Pearl Harbor Attack, pt. 15, exhibit 49.

[2] Rupperthal, Roland G.: The European Theater of Operations: Logistical Support of the Armies. United States Army in World War II. Washington: U.S. Government Printing Office, 1953, vol. I.

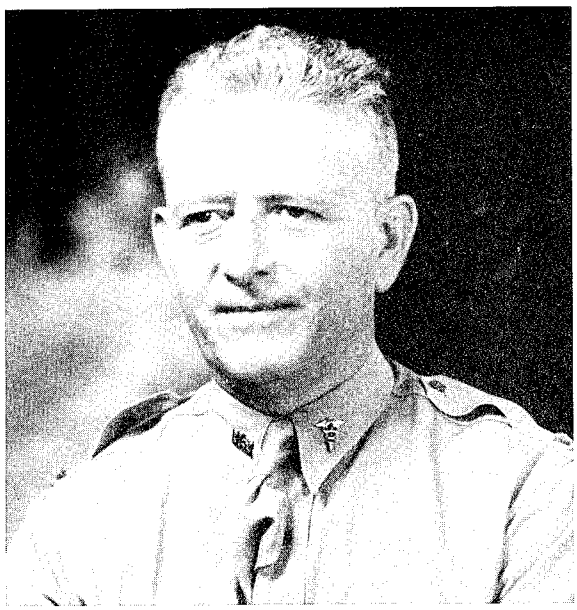


FIGURE 70.—Col. Malcolm C. Grow, MC.

troops were to be stationed, arranging for their immediate care in British hospitals, and negotiating with British civil and military authorities for the construction of hospital facilities under reverse lend-lease agreements.

Responsibilities were somewhat clarified in the spring of 1942; the activation of subordinate commands relieved the USAFBI medical section of some of the duties connected with the reception of the first troops. The staff surgeon of the U.S. Army Northern Ireland Forces, which was established in January 1942 to include V Corps (the first contingent of U.S. Army forces in the theater), was responsible for the medical service, including medical functions normally assigned to a base command, for Army ground troops in northern Ireland. Col. (later Maj. Gen.) Malcolm C. Grow, MC (fig. 70), became staff surgeon for the Eighth Air Force which was built up after May 1942. (The Eighth Bomber Command had preceded it in February.) Assumption of responsibility for the medical care of tactical elements by these surgeons enabled Colonel Hawley to spend more time in the medical aspects of long-range planning for the buildup of men and supplies in the British Isles (War Plan BOLERO) and in planning for the invasion of the Continent (War Plan ROUNDUP). The increase of his group to eight officers by the middle of May enabled him to staff six of the nine divisions he had planned for his office. From the spring of 1942 to the end of the year (6 months after the organization of the theater took place), he continued to press the Surgeon General's Office to send him additional officers with administrative training and experience. Himself a graduate both of the Command and General Staff School at

Fort Leavenworth and the Army War College, Colonel Hawley emphasized his need for officers with training at senior service schools.[3]

THEATER MEDICAL ORGANIZATION JUNE 1942–JANUARY 1944

After Maj. Gen. (later Lt. Gen.) John C. H. Lee arrived in England in May with a Services of Supply staff, the theater organization began to take shape. When the chiefs of services of the U.S. Army Forces in the British Isles were called on to comment on the organization proposed by General Somervell's staff in Washington, Colonel Hawley advised against any subordination of the chief of medical service of the theater to a Services of Supply. He voiced his belief that theater organization should provide for a unified and centralized technical control of medical service throughout the theater. He especially emphasized the importance of vesting a single chief of medical service with the following responsibilities: Technical supervision of the operations and training of medical units and personnel; coordination of evacuation among several echelons of command; control of the technical aspects of communicable diseases in all echelons of command and responsibility for requiring, consolidating, and forwarding all medical records and reports. Centralized control over the operations and training of personnel and over the coordination of the stages in evacuation was necessary, he argued, because evacuation and medical care of the sick and wounded was a continuous operation. As a corollary, central responsibility for planning the steps in the process and the means of execution was also necessary. With respect to disease control Colonel Hawley pointed out that communicable diseases recognized no echelons of command and that the responsibility for establishing uniform technical standards and a coordinated organization to carry them out should rest with a single chief of medical service. He also considered it important that the theater chief of medical service have sole responsibility for liaison with the British in connection with the care of the sick of all U.S. Army commands; otherwise the British would be confused by the overlapping U.S. Army commands within the same area and Army surgeons might bid against each other for the same British facilities.

Although, like the chiefs of the other services, Colonel Hawley considered location of his office at theater headquarters advisable, he emphasized that his chief concern was not with the physical location of his office—whether at

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[3] (1) General Order No. 3, Headquarters, U.S. Army Forces in the British Isles, 24 Jan. 1942. (2) Memorandum, Chief Surgeon, U.S. Army Forces in the British Isles, for G–1, 17 Apr. 1942, subject: Plan for Base Area. (3) General Order No. 5, Headquarters, U.S. Army Forces in the British Isles, 24 Jan. 1942. (4) [Elliot, Henry G.]: Administrative and Logistical History of the European Theater of Operations, Part I, the Predecessor Commands: BPOBS and USAFBI. [Official record in Office of the Chief of Military History.] (5) Annual Report of Medical Department Activities, Eighth Air Force, 1942. (6) Letter, Col. Paul R. Hawley, to Chief Surgeon, General Headquarters, 19 Apr. 1942. (7) Letter, Colonel Hawley, to Col. George F. Lull, 28 Aug. 1942.

Services of Supply or theater headquarters—but that he considered it imperative that the chief of medical service exercise control over certain essential functions. He pointed out that if he were to be located within the Services of Supply he could exercise these functions properly only if the commanding general of the Services of Supply was given clear authority to issue orders or directives to the commanders of other subordinate commands in the theater; otherwise he (Colonel Hawley) would have no means of making medical directives effective within commands outside the Services of Supply.[4]

On 8 June 1942, the European theater command was established, superseding the U.S. Army Forces in the British Isles (map 3).[5] Its chief subordinate commands in 1942 and 1943 were V Corps, the Eighth Air Force, the Services of Supply, and, after the autumn of 1943, First Army, which became the chief ground force command, absorbing V Corps. Medical Department personnel and units were assigned to all three elements—ground, air, and service forces. Colonel Hawley became chief surgeon on the special staff of the theater commander. On 13 June he was instructed, along with the chiefs of most of the other services, to operate under Maj. Gen. John C. H. Lee, Commanding General, Services of Supply (which had been established on 24 May).[6]

In July 1942, Services of Supply headquarters was established at Cheltenham, Gloucestershire, about 100 miles northwest of theater headquarters in London. Colonel Hawley's main office was moved to Cheltenham along with those of the other chiefs of supply services and remained there until March 1943. Since the Cheltenham location hindered contact of the chiefs of service with the theater headquarters in London which they also served, each chief of service was given a representative at theater headquarters. Col. (later Brig. Gen.) Charles B. Spruit, MC (fig. 71), the former chief of Colonel Hawley's Operations Division, was made Colonel Hawley's representative at General Eisenhower's headquarters in London.

Colonel Hawley's Office

At the time of the move to Cheltenham, Colonel Hawley's office was composed of 22 officers and 14 enlisted men. By the end of 1942 it consisted of 51 officers, 56 enlisted men, and 62 civilians, and practically all its major organ-

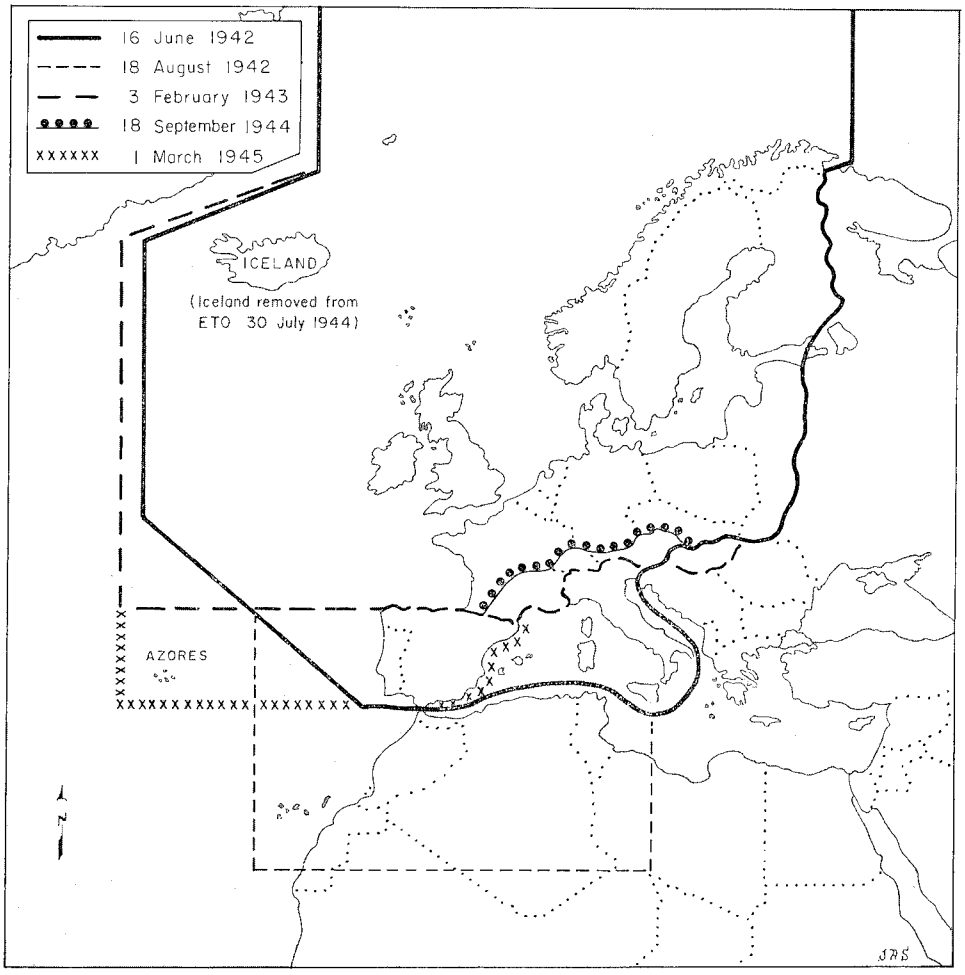
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[4] (1) Memorandum, Chief Surgeon, U.S. Army Forces in the British Isles, for the Adjutant General, 1 June 1942, subject: Comments on Draft of General Order Establishing the Services of Supply. (2) Memorandum, Colonel Hawley, for G–1, USAFBI, 8 June 1942, subject: Comments on "Directive for SOS, USAFBI." (3) [Coakley, Robert W.]: Administrative and Logistical History of the European Theater of Operations, Part II, Organization and Command. [Official record in the Office of the Chief of Military History.]

[5] Although Iceland was included in the European theater at this date, administrative and logistic matters, including medical service, for troops there were handled by the Iceland Base Command, which operated directly under the War Department.

[6] (1) General Order No. 2, Headquarters, European Theater of Operations, U.S. Army, 8 June 1942. (2) Circular No. 2, Headquarters, European Theater of Operations, 13 June 1942. (3) See footnote 4(3).

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MAP 3.—Territorial limits of the European theater, 1942–45.

izational segments had been established, although they later underwent refinements in structure.[7]

The work of the Administrative, Personnel, and Medical Records Divisions of the office are self-explanatory. The Operations Division had charge of the movements of Medical Department units, made medical plans, and supervised medical training. It allocated medical units among the various commands in the theater and assigned and staged units for the North African invasion.

[7] (1) History of Medical Service, SOS, ETOUSA, From Inception to 31 December 1943. [Official record.] (2) Annual Report, Administrative Division, Office of the Chief Surgeon, European Theater of Operations, 1942. (3) [Larkey, Sanford H.]: Administrative and Logistical History of the Medical Service, Communications Zone, European Theater of Operations. [Official record.] For a comparison of the organization and functions of General Hawley's office at the end of December 1942 with those of May 1945, see appendix B, p. 562.



FIGURE 71.—Col. Charles B. Spruit, MC.

After the drain of the North African venture had subsided, this division reassumed the task of planning medical support of the buildup in the British Isles, calculating the numbers of hospital beds needed in accordance with the increases in troop strength planned for the theater and determining the locations of Medical Department installations to suit changes in troop density in the various localities.

In carrying out its responsibilities for training, the Operations Division created the First Medical Demonstration Platoon which displayed throughout the theater the methods of training medical units. The division made arrangements for many Medical Department officers in the theater to attend courses in the various medical specialties at British institutions—both the Royal Army schools for doctors and dentists at Aldershot, Hampshire, and at the London School of Hygiene and Tropical Medicine and other medical schools, as well as at British hospitals. It planned and supervised the training of doctors and nurses at two schools within the Army's American School Center organized at Shrivenham, Berkshire, in February 1943. The Medical Field School emphasized courses in chemical warfare medicine, hygiene and sanitation, and combat medicine and surgery, while the Army Nurse School trained nurses in the military aspects of their work. The Operations Division also planned special courses for officers and enlisted men in various specialties at selected general and station hospitals. Those who had been sent to the theater without sufficient training could make up the deficiency in the United Kingdom, and those previously trained benefited from instruction in medical problems peculiar to the theater. Training during the long months of preparation for the invasion proved a morale builder.

The planning of evacuation within the theater and to the United States was also supervised by the Operations Division. (During part of the time this function was exercised by the Hospitalization Division, and for a time by a separate Evacuation Division.) Even in the preinvasion period the evacuation system grew complex because of the number of commands concerned—naval elements assigned to the theater, as well as subcommands of the air forces and the Services of Supply—and the variety of means employed. Although the theater's ground troops were not suffering combat casualties during this period, the theater medical service had to evacuate and care for Air Force casualties, as well as for some of the wounded from the invasion of North Africa and the early months of the Tunisian campaign, brought to the United Kingdom in British hospital ships.[8]

The duties of the Dental, Nursing, and Veterinary Divisions of Colonel Hawley's office were all concerned with supervision of their respective services; training of personnel and control of their transfer among the base sections, preparing the necessary reports, and maintaining liaison with similar elements in the British Army. The dental and veterinary service suffered from a lack of personnel in 1942, but the Army Nurse Corps grew rapidly, increasing from 359 nurses in the theater in July 1942 to 4,627 by the end of 1943. A significant accomplishment of the Dental Division was the creation of two central dental laboratories (nonstandard units) with mobile clinic and laboratory sections. One was located in London and the other in Cheltenham. The continued concentration of troops, as well as the availability of messenger and courier service for speeding up the transfer of dental packages to and from the laboratories at London and Cheltenham made these places the logical sites for centers of dental service.

Because of the tremendous troop strength of the theater and the overcrowding to which it contributed, the Preventive Medicine Division had to undertake a comprehensive program. Its members made inquiries into conditions accountable for the spread of certain diseases among troops at intervals: the respiratory diseases in 1942 and 1943; the diarrheal diseases in 1943, and a few diseases which did not commonly occur in the British Isles but which were sporadically brought in during the war period by troops from other areas. The chief of these was malaria. Recurrent cases among divisions returning to the United Kingdom from North Africa had to be removed from the ranks before their units embarked upon the continental invasion. Activities in preventive medicine became decentralized, since many preventive tasks, such as the maintenance of sanitary conditions and the control of venereal disease, called for participation by local commands, including air force commands. The assignment of sanitary, venereal disease control, and nutrition officers to the base sections, as well as to Colonel Hawley's office, constituted an effective

[8] The number of casualties evacuated to the United Kingdom from North Africa was relatively small—481 between 1 January and 31 March 1943—when the practice was discontinued, and no more than a handful in 1942. See Annual Report, Surgeon, North African Theater of Operations, U.S. Army, 1943.

network for prevention of disease. No widespread epidemics developed among U.S. Army troops in the theater, with the exception of a mild influenza epidemic of 1942–43. Since many diseases common to tropical areas were not present in western Europe, a large-scale program for control of malaria and other insectborne diseases was unnecessary. On the other hand, more than ordinary effort was needed to check the spread of venereal disease among troops stationed in urban areas in the United Kingdom.

The Professional Services Division, which Colonel Hawley considered the keystone of his office, consisted of the consultants in surgery and medicine and their subspecialties. Under the Director of Professional Services served the chief consultant in surgery and the chief consultant in medicine. Senior consultants were appointed to certain surgical subspecialties—ophthalmology, neurosurgery, anesthesia, orthopedic surgery, and maxillofacial surgery—and to several medical subspecialties—psychiatry, dermatology, and nutrition. By the end of 1942, 10 consultants were on duty; during the following year other consultants were assigned to additional medical subspecialties—cardiology, tuberculosis, and infectious disease—and to further surgical subspecialties—radiology, plastic surgery, otolaryngology, transfusion and shock, orthopedic surgery, and general surgery. Consultants in Europe represented more specialties than did the consultants of any other theater. The title "consultant" was also applied to those in charge of several special phases (rather than specialties) of medical work, including scientific research and medical service for the Women's Army Auxiliary Corps.

During 1942 and 1943, the consultants of Colonel Hawley's office visited fixed hospitals in the base sections; after the invasion they toured Medical Department units and hospitals in the combat zone. They evaluated the quality of work of specialists in the hospitals, offering criticism and advising changes in techniques. They also evaluated the professional complements of all newly arrived medical units, recommending transfers and substitutions in the interest of an equitable distribution of all available talent. They supervised the work of consultants assigned to the headquarters of air forces, armies, and base sections. Particularly qualified specialists in general and station hospitals were used as regional consultants (authorized in May 1943); these served a group of hospitals in a hospital center or hospitals in the vicinity of the one to which they were assigned. Any hospital in the United Kingdom, whether British, American, or Canadian, might employ the services of the appropriate consultant in the treatment of U.S. Army personnel hospitalized therein. Through the medium of a series of circular letters and manuals, the senior consultants in Colonel Hawley's office outlined for medical officers in the hospitals and other medical facilities techniques of treatment found to be of greatest value in the theater. During the long buildup period, the consultants had time to develop a manual of therapy (issued in May 1944), which gave instructions on the management of all types of wounds. Although based in part on data assembled by consultants in the North African theater and British Army doctors, the manual

reflected on every page the specialized knowledge and experience of its authors. Revisions in the original principles and techniques adopted on the basis of combat experience on the European Continent after June 1944 appeared in revised circular letters.[9]

Officers of the Hospitalization Division were occupied throughout 1942 and 1943 with providing hospital beds for troops pouring into the United Kingdom, inspecting hospitals in operation, and planning the design for hospital construction that might have to be undertaken on the Continent. The procurement of buildings for fixed hospitals in the United Kingdom and the establishment of an effective medical supply system, supervised by the Supply Division of General Hawley's office, were large tasks of the theater's medical service which encountered serious administrative difficulties in 1942 and 1943.

Establishing Fixed U.S. Army Hospitals in the United Kingdom

Early requirements for the hospitalization of American troops in the United Kingdom were met through arrangements made for the care of U.S. Army patients in British military hospitals, in hospitals of the Emergency Medical Service, and in two hospitals staffed by American doctors who had volunteered their services to the British Government before the entry of the United States into war. The heavy task was to obtain in crowded Britain buildings to accommodate incoming fixed hospital units and to provide sufficient beds for military patients once the attack on the Continent began. The machinery through which U.S. Army requirements for hospitalization could be established, sites chosen for construction, and satisfactory construction completed, was elaborate. The Chief Surgeon, ETOUSA, served on the Medical Service Sub-Committee of the BOLERO Combined Committee in London which was responsible for planning the buildup of 1 million U.S. Army troops and the necessary facilities and supplies for supporting the assault on the Continent. Medical officers of the British and Canadian armed services and representatives of the British governmental health agencies were fellow members. General Hawley submitted the requirements for hospital facilities for these troops as worked out in his office.

The British turned over to the U.S. Army Medical Department a few hospital plants constructed for the Emergency Medical Service, but large-scale construction was undertaken to meet the requirements for 90,000 hospital beds called for under the BOLERO plan. The British Government assumed re-

[9] (1) See footnote 7 (1) and (3), p. 308. (2) Hawley, P. R.: Advances in War Medicine and Surgery as Demonstrated in the European Theater of Operations. M. Ann. District of Columbia 15: 99–109, March 1946. (3) Report on Schools and Courses of Instruction for Personnel in the European Theater of Operations. Office of the Chief Surgeon, Services of Supply, European Theater of Operations, U.S. Army, 12 Feb. 1944. (4) Memorandum, Brig. Gen. Paul R. Hawley, for G–3, European Theater of Operations, U.S. Army, 13 July 1943, subject: Continuance of the Medical Field Service School at the American School Center. (5) Gordon, John E.: A History of the Preventive Medicine Division in the European Theater of Operations, U.S. Army, 1941–1945, vol. I. [Official record.] (6) Memorandum, Col. H. T. Wickert, for The Surgeon General, 29 Nov. 1943, subject: Report of Visit to U.K. and N. Africa.

sponsibility for constructing the necessary hospitals, largely because shortage of shipping space made it impracticable to bring materials and labor from the United States for the purpose. The British Ministry of Works and Planning directed British civilian contractors in the work. Officers of the Hospitalization Division of General Hawley's office worked closely with the British and the U.S. Army Engineers, who furnished some troop labor for the construction and acted as agents for the medical service with the British War Office. The Royal Engineers placed requests with the War Office, which requested the Ministry of Works and Planning to undertake the construction of buildings approved by the American theater command and the War Office. The Royal Engineer Corps inspected the completed project and accepted it or turned it down on behalf of the War Office. General Hawley could accept the project or defer acceptance until it was modified to meet his requirements.

It was hard to find general hospital sites which possessed all the desired features—adjacency to water, gas, and sewage facilities, and, in anticipation of mass evacuation from the Continent, accessibility to roads and railroads. The British lacked construction materials and suffered from an acute shortage of skilled construction workers. Construction lagged throughout 1942 and the early months of 1943. During 1942 no hospitals were completed on schedule, despite General Hawley's repeated vigorous requests backed by General Lee, to the British representatives on the Medical Service Sub-Committee of the BOLERO Combined Committee that construction be speeded up. His pressure, together with aid in construction given by hospital unit personnel in the later stages of the program, bore fruit. By the close of 1943, 58 fixed U.S. Army hospitals were operating in the United Kingdom—17 general, 34 station, 3 evacuation, and 4 field hospitals. The fixed hospitals in operation by mid-1944 were considered adequate to receive the expected load of evacuees from the continental invasion.[10]

The Medical Supply System

The Supply Division of General Hawley's office established medical sections in five general depots in the United Kingdom during 1942, and in 1943 in six additional general depots, as well as four medical supply depots. Despite this depot system of apparently adequate scope, a number of problems in the handling of medical supply developed at the outset and continued to plague the Chief Surgeon, ETOUSA, until 1944. Some—the early shortages of dental items, for instance—reflected difficulties with procurement in the United States. Others—unsatisfactory packaging and packing, incomplete or late shipments, and the shipment of hospital assemblies on two or more ships (the so-called "split shipments")—were attributable to faulty procedure at depots and shipping points in the United States rather than within the theater. Dif-

[10] (1) See footnote 7 (1) and (3), p. 308. (2) Memorandum, Maj. Gen. Paul R. Hawley, for Commanding General, Services of Supply, European Theater of Operations, U.S. Army, 13 Mar. 1944. (3) Hawley, Maj. Gen. Paul R.: The European Theater of Operations, May 1944. [Official record.]

ficulties connected with shipment from the U.S. ports of embarkation cropped up throughout the buildup period and were straightened out only by the mutual efforts of General Hawley's office and the Transportation Corps and its ports of embarkation in the United States. Faulty packing and split shipments later occurred in the United Kingdom as well, whenever hospital assemblies which had been unpacked for inspection or for use for training within the theater had to be reassembled and forwarded to their destination. Furnishing assemblies for hospital units leaving for the North African invasion placed heavy demands upon the theater's medical supply system at an early date.[11]

In the United Kingdom the Medical Department relied heavily—far more than in any other oversea area—upon the procurement of medical supplies locally. Medical items were bought from the British through a representative of the Chief Surgeon, ETOUSA, on the General Purchasing Board in London, which supervised the purchase of the U.S. Army supply services in the United Kingdom. The policy of making the maximum use of British supplies and services was adopted from the outset because of the critical shipping situation, as well as the opportunity (mutually advantageous to the British and the Americans) to make use of British obligations for furnishing the United States with supplies under the reverse lend-lease procedure. Items requiring a large amount of tonnage and a small amount of labor were procured from the British if possible.[12]

Medical supplies were also obtained from sources other than reverse lend-lease—through spotty local purchases on the open market by officers in the depots, by requisitions from the United States, and by the automatic supply procedure. (Some medical maintenance units and final reserve units went to the theater under the standard procedure.) The variety of sources made it difficult to determine the availability of specific items or to devise an adequate system of stock control. Differences in British and American nomenclature called for the preparation of lists of British items which were equivalent to the standard items of the Medical Department Supply Catalog, as well as lists of acceptable British substitutes. U.S. Army doctors frequently preferred the American-made product to the unfamiliar British item. British shortages of raw materials, packing materials, and especially of skilled workers resulted at times in inferior items, and deliveries were delayed. At the same time the British obtained from the United States through lend-lease procedure some items which they were furnishing U.S. Army doctors in Britain.

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[11] See footnotes 2, p. 304 ; and 7 (3), p. 308.

[12] (1) Annual Report, Medical Procurement Section, Supply Division, Office of the Surgeon, European Theater of Operations, U.S. Army, 1943. (2) See footnote 2, p. 304. (3) Memorandum, Acting Director, International Division, for Commanding General, Services of Supply, 8 May 1944, subject: Procurement of Medical Supplies and Equipment in the U.K. Under Reciprocal Aid. During 1942 approximately 75 percent of all medical supplies, calculated in tonnage, for the U.S. Army were procured in the United Kingdom, either by reverse lend-lease procedure or by local purchase. The percentage dropped to 56 in 1943 and to 24 in 1944.

Throughout 1942 and 1943 the Chief Surgeon, ETOUSA, expressed doubt of the capabilities of the officers sent to take charge of medical supply duties in his office and anxiety over the critical medical supply situation. At the close of 1943, the system of stock control was still inadequate, and the preparations for supporting the invasion with hospital assemblies and medical supplies were far behind schedule. General Hawley then obtained special aid from the Surgeon General's Office in order to establish a system that would furnish adequate support for the impending invasion.[13]

Cooperation With the Allies

The theater surgeon and his staff, as well as Medical Department officers throughout the theater, had extensive dealings with members of the British and Canadian Army medical services—officers of the Royal Army Medical Corps, the Royal Navy Medical Corps, Royal Air Force Medical Corps, and Royal Canadian Army Medical Corps. A British Army medical officer served as liaison officer with General Hawley's medical section to the end of the war in order to facilitate contact between General Hawley's staff and that of the Director-General of the British Army Medical Service. U.S. Army Medical Department officers also had frequent contacts with British Government agencies engaged in medical work, chiefly the Emergency Medical Service and the Ministry of Health, and with the British professional associations of doctors, dentists, and veterinarians. Meetings of U.S. Army Medical Department officers with the British Medical Research Council afforded an exchange of information on recent technical developments in medicine. The British Medical Registry accepted officers of the U.S. Army Medical Corps as members, as did the Royal Society of Medicine. An Inter-Allied Medical Association was sponsored by the British Research Council and the Royal Society of Medicine. During 1943 an exchange of medical officers between British and American hospitals for the period of a month afforded each national group an opportunity to profit from the other's techniques.[14]

During the buildup period, proposals to turn over certain medical resources to the British or to pool U.S. Army medical personnel or installations with those of the British cropped up from time to time. A combined United States-British typhus commission was suggested at intervals. Although Gen-

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[13] (1) Letter, Brig. Gen. Paul R. Hawley, to Maj. Gen. Norman T. Kirk, The Surgeon General, 10 Aug. 1943. (2) Letter, Brig. Gen. Paul R. Hawley, to Maj. Gen. Norman T. Kirk, The Surgeon General, 9 Sept. 1943. (3) Letter, Brig. Gen. Paul R. Hawley, to Maj. Gen. Norman T. Kirk, The Surgeon General, 14 Oct. 1943. There are many similar letters in the Kirk-Hawley file.

[14] (1) Annual Report for 1942 and 1943 of the Hospitalization Division, the Professional Services Division, the Supply Division, and the Operations Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army. (2) See footnote 7 (1) and (3), p. 308. (3) Mason, James B.: Medical Service in the European Theater of Operations, Through 16 January 1944. [Official record.] (4) Circular Letter No. 57, Office of the Chief Surgeon, Headquarters, European Theater of Operations, U.S. Army, 27 Oct. 1942, subject: British Medical Societies. (5) Circular Letter No. 69, Office of the Chief Surgeon, Headquarters, European Theater of Operations, U.S. Army, 9 Nov. 1942, subject: Consulting Service for the American Forces.

eral Hawley favored thoroughgoing exchange of technical medical information and the results of research, he consistently opposed plans for pooling American and British medical resources, holding that any merging of the two medical services would result in lowered standards for the U.S. Army medical service. Pooling of American and British doctors, for instance, would mean that the British, short of doctors, would obtain an increase in the number of doctors per thousand patients while the U.S. Army would suffer a corresponding reduction. Although no merging took place, the agreement made with the Emergency Medical Service for reciprocal care of sick and injured American and British troops prevailed after U.S. Army hospitals had become available, and the British and American army medical services cared for substantial numbers of each other's patients in their respective hospitals.[15]

Liaison between U.S. Army doctors and the medical authorities of most continental countries had to await the invasion, but some contact was established with the Russians in June 1943, when the senior surgical consultant of the theater surgeon's office, Col. Elliott C. Cutler, MC (fig. 72), and Lt. Col. Loyal Davis, MC, consultant in neurosurgery, accompanied a British medical mission to the Soviet Union. The purpose of the mission was to get information on the medicomilitary experience of the Russians in combat with the Germans and to establish good relations with Red Army doctors. They took 2 million units of the then scarce penicillin to the Soviet medical authorities as a gift. The British conferred honorary fellowships on a distinguished Russian surgeon and the chief surgeon of the Red Army, while the American delegation accorded them honorary membership in the leading surgical societies of the United States. Both American medical officers were impressed with the efficient organization of the Red Army medical service.[16]

Base Sections in the United Kingdom: 1942–43

The Services of Supply undertook, beginning in July and August 1942, to establish its area commands, the base sections. To the end of 1943, the logistic organization of the European theater followed fairly closely the principles on which the Services of Supply had been established in the United States. The corps areas (later called service commands) in the United States were taken as models for the base sections in the United Kingdom and like

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[15] Memorandum, Maj. Gen. Paul R. Hawley, for Commanding General, Services of Supply, 13 Mar. 1944.

[16] (1) Report by Col. Elliott Cutler, Supplement to Notes on Staff Conference, 25 Oct. 1943. *In* Annual Report, Professional Services Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1944. (2) Report of Surgical Mission to Russia. [Official record.] (3) Letter, Brig. Gen. Paul R. Hawley, to Lt. Gen. E. I. Smirnov, Chief of Medical Services of the Red Army, 30 June 1943. (4) Letter, Lt. Gen. E. I. Smirnov, to Brig. Gen. Paul R. Hawley, 30 July 1943. (5) Davis, L.: Organization of the Red Army Medical Corps (Editorial). Surg., Gynec. & Obst. vol. 79, September 1944.



FIGURE 72.—Brig. Gen. Elliott C. Cutler, MC.

them were conceived of as smaller replicas of the parent organization designed to perform its functions in a given geographic area.[17]

As was the case with the chiefs of technical services in the United States, the chiefs of service of the European theater had somewhat tighter control over operations within the area commands during the early development of these commands than at a later date. Since the Commanding General, SOS, ETOUSA (General Lee), placed emphasis, as did General Somervell in the United States, upon decentralizing operations to the area commands, during 1943 base section commanders were given control of Services of Supply operations within their areas. By August the duties of chiefs of service with respect to operations in the base sections were confined to technical supervision, maintained through their service representatives on the base section staffs. Hence the base section commander was given command control over the fixed hospitals within the boundaries of his base section and control over the assignments of Medical Department personnel within the base section organization.

[17] (1) Memorandum, Chief of Staff, War Department, for Commanding General, American Forces in the British Isles, 11 May 1942, subject: Organization, Services of Supply. (2) See footnotes 2, p. 304; and 4(3), p. 307.

General Hawley exercised supervision, in his capacity as Services of Supply surgeon, over technical matters in each base section through the surgeon on the staff of the base section commander.

As in the case of the other chiefs of the technical services, General Hawley found that the power given base section commanders interfered at times with his control over medical service afforded by base section installations. In his opinion general hospitals, which served the theater as a whole (in contrast to station hospitals which served merely the local area in which they were located), should be under the command of the chief surgeon. "If we get any sudden influx of casualties here, we have got to play with beds like you play with chessmen on a board, and this ought to be handled by one central agency." [18] His reasoning was similar to that advanced for control of general hospitals in the United States by The Surgeon General, but like the latter he failed to effect a change of jurisdiction.

However, cooperative agreements were usually worked out. When General Lee sent General Hawley to look into conditions in the general hospitals of a base section and General Hawley reminded General Lee that he did not have command of the hospitals, General Lee promised him the base section commander's full support. From then on General Hawley had General Lee's full backing in solving any problems arising from base section control of certain functions. He and his staff made frequent inspections of hospitals, dispensaries, and other medical installations in the base sections, informing commanding officers of the installations, or base section surgeons, of any deficiencies. General Hawley cooperated closely with base section commanders in replacing base section surgeons or hospital commanders who proved inefficient. On the other hand, he noted some decisions of base section commanders which interfered with his ability to render the best possible medical care—for example, the decision to replace with ordinary port laborers crews of Medical Department enlisted men especially trained in loading and unloading evacuees from hospital ships. He also objected to a tendency of base section commanders to burden hospital staffs with military police duties. At such times he reemphasized his conviction that the control of certain functions should not be decentralized to base section commanders.[19]

The relation of the base section surgeons in the European theater to the Chief Surgeon in his Services of Supply capacity in general paralleled the relation of the corps area surgeon in the United States to The Surgeon General, and the duties of base section surgeons broadly resembled those of corps area surgeons. The internal organization of the base section surgeon's office

[18] Notes on Staff Conference, Headquarters, Services of Supply, European Theater of Operations, U.S. Army, no date.

[19] (1) Interview, Maj. Gen. Paul R. Hawley, 18 Apr. 1950. (2) Correspondence between Brig. Gen. Paul R. Hawley, the Director-General of the British Army Medical Service, and the Chief of Operations, Services of Supply, 21 Nov.–7 Dec. 1943. (3) Memorandum, Brig. Gen. Paul R. Hawley, for the Chief of Ordnance Officer, 1 Oct. 1942. (4) Memorandum, Brig. Gen. Paul R. Hawley, for the Chief of Operations, Services of Supply, 26 Nov. 1943. (5) Memorandum, Brig. Gen. Paul R. Hawley, for Maj. Gen. J. C. H. Lee, 8 Apr. 1943.

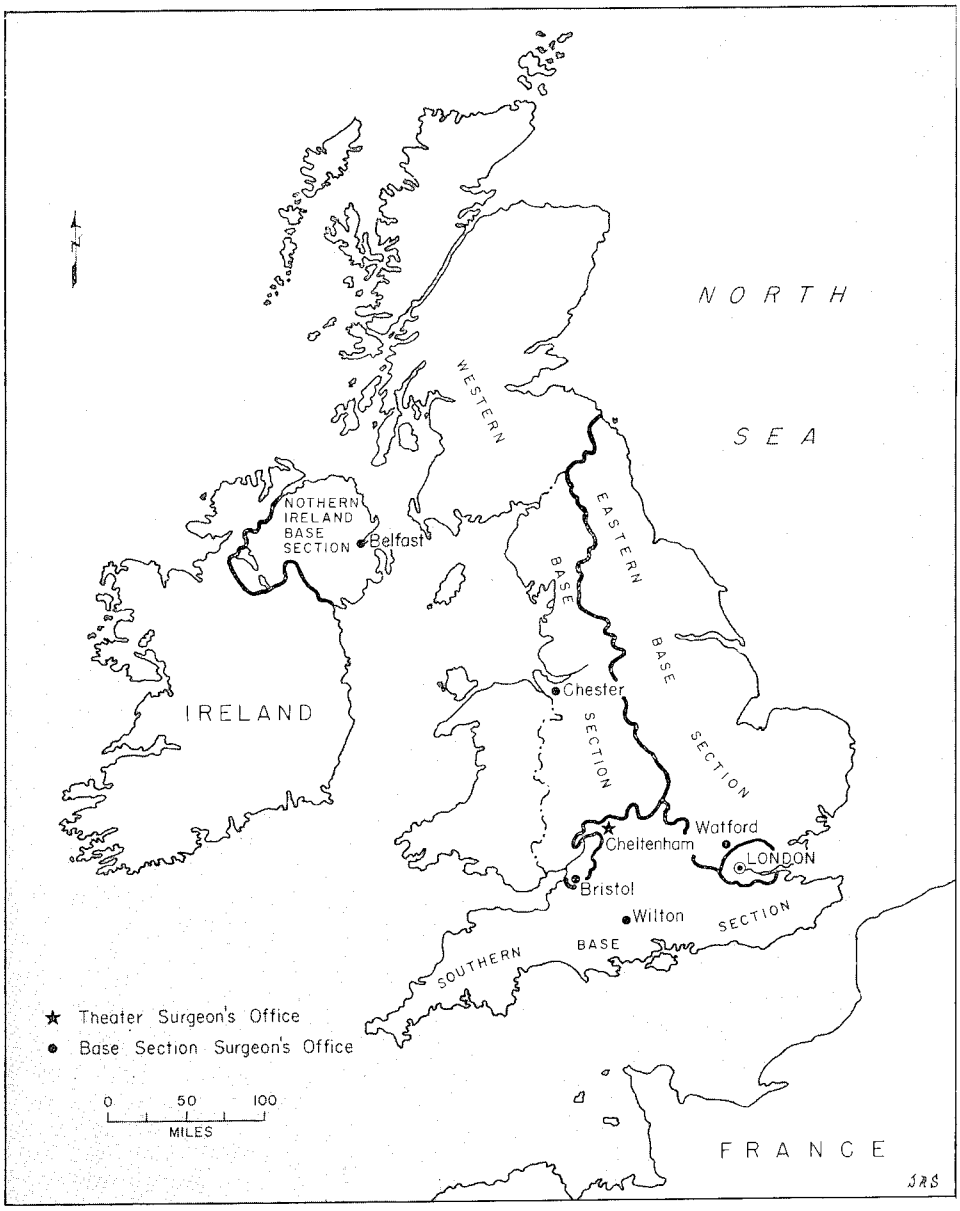
did not differ greatly from that of the theater surgeon's office, although the latter had considerably more personnel.

The base sections in the United Kingdom underwent several changes in name and boundary during 1942 and 1943. Though small in area by comparison with those of some other theaters, they were large in numbers of troops and installations. By the close of 1943 five were in operation, with boundary lines for the most part in correspondence with the existing British territorial commands (map 4). This design facilitated cooperation between staff surgeons of the base sections and their British counterparts. The fixed hospitals, medical supply depots, and other Medical Department facilities operated by each base section served a composite of air, ground, and service troops. Districts—each with a surgeon—were established within each base section, functioning in relation to the base sections as the latter did to the Services of Supply headquarters.[20]

The duties of the base section surgeons and their staffs varied in accordance with the type and number of troops for whose care the base section command was responsible and with the kind of activity—training, staging, supply, and so forth—that burgeoned within the base section's boundaries. The Army's area commands in the United Kingdom diverged greatly as to troop strength, and the troop census of each underwent radical fluctuations. The Northern Ireland Base Section, earliest established, had the task of receiving and processing troops from the United States on their way to the North African invasion. During the early part of 1943 relatively few troops, chiefly of the Eighth Air Force, were stationed there and the area became a district of Western Base Section, but late in 1943, when more troops began pouring in, a full-fledged base section was reestablished in Northern Ireland. In Eastern Base Section the hospitalization, medical supply, and preventive medicine service furnished went largely to the benefit of air force troops concentrated in that area for large-scale bombing of Nazi-held targets on the Continent. Center Base Section (previously known as the London Base Command) operated installations and facilities within about 700 square miles in the London area to serve the thousands of men congregated there, a large proportion of whom belonged to several large headquarters establishments (particularly ETOUSA–SOS). Its dispensaries and subdispensaries and a station hospital in London served American civilians and Navy personnel, as well as resident Army troops and thousands of soldiers on leave.

In 1943, the Western and Southern Base Sections became the chief scenes of Medical Department activity. The great majority of the station and general hospitals which began operating in the United Kingdom in that year were located in these two base sections. Western Base Section contained most of the large ports through which thousands of incoming troops passed. The establishment of many dispensaries in the base section called for decentraliza-

[20] See footnotes 4(3), p. 307; and 14(4), p. 315.



MAP 4.—United Kingdom base sections and surgeons' offices, December 1943.

tion of supply procedures, and small distributing points, strategically placed, took some of the burden from the depots. The medical service provided by Western Base Section became full fledged, comprising strong programs in control of venereal disease, nutrition, rehabilitation, and sanitary engineering, as well as the usual supply, hospitalization, dental, nursing, and veterinary func-

tions. Southern Base Section, which became the great marshaling and training area for the continental invasion dating from the spring of 1943, developed a large-scale medical service comparable to that of Western Base Section.[21]

Effect of the North African Invasion

The long-range buildup in the European theater was subordinated during the late summer and fall of 1942 to plans for the invasion of North Africa. Key personnel were withdrawn from established American and British commands in the United Kingdom to serve on the staff of General Eisenhower's new Allied Force Headquarters, which planned the assault on North Africa and directed the flow of supplies and tactical units from the European theater in support of the invasion.

General Hawley summed up the effect of the plans for the North African invasion upon his office as follows:

> You may be amazed to learn that the general and special staff of the European Theater of Operations has, and has had, no responsibility for the North African show other than to give them all the personnel and all the supplies they asked for. This is an Allied Force, and a special staff was set up for it, which included both British and American officers. The Chief Surgeon is British and Jack Corby is the Deputy Chief Surgeon. They took from me about all the supplies I had, two 1,000-bed general hospitals, one 750-bed station hospital, four 250-bed station hospitals, and the following personnel from my office: Corby, Standlee, Norton, Hutter, and two young regulars, in addition to several reserve officers.
>
> I watched the muddled medical planning until I could stand it no longer and then went to the Chief of Staff, ETO and told him that the stage was all set for the biggest scandal since the Spanish-American War. That jolted them a little, and General Eisenhower told me to step in and straighten things out. I did, but within a week things were right back to where they were—each separate task force doing its own planning without the least coordination. It is for this reason that no consultants have been sent to North Africa although I stand ready to send all of them back and forth as soon as I am brought into the picture.[22]

His picture of the situation reflects the uncertainty that prevailed during the planning period in the late months of 1942 as to whether—and when—the invaded areas of North Africa would become a new theater separate from the European theater. Throughout this period the relationship of the European theater command to the Allied organization directing the North African operation was by no means clear. Definite clarification came only in early February 1943 with the creation of the North African Theater of Operations. During the intervening months the European theater was used as a "zone of interior" for building up army resources in North Africa. Its troop strength was cut

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[21] (1) Annual Reports, Surgeon, Northern Ireland Base Section, 1943, 1944. (2) Annual Report, Surgeon, Center Base Section, 1944. (3) Annual Reports, Surgeon, Eastern Base Section, 1942, 1943. (4) Annual Reports, Surgeon, Western Base Section, 1942, 1943, 1944. (5) Annual Reports, Surgeon, Southern Base Section, 1942, 1943.

[22] Letter, Brig. Gen. Paul R. Hawley, to Col. Charles C. Hillman, Office of The Surgeon General, 11 Dec. 1942.

in half, and its medical strength reduced by a third.[23] Although the loss to the Medical Department was thus relatively low, the removal of key personnel made it necessary for General Hawley to rebuild his office staff, and shifts of Medical Department personnel and installations resulted at all levels of command.

The Reorganization of 1943 and Later Developments

During the months following the North African invasion, the theater and Services of Supply headquarters reviewed their organizational problems, particularly difficulties posed by the location of theater chiefs of technical services at a distance from theater headquarters. Since 20 July 1942, General Hawley and most of his office had been located with the bulk of the Services of Supply staff at its Cheltenham headquarters. General Hawley had had to go to London frequently to consult with the theater general staff on theaterwide medical problems. Only a few Medical Department officers had remained in London in close proximity to the theater staff.

As Colonel Spruit, General Hawley's representative at theater headquarters, was always very loyal to his chief, no such situation had developed in the administration of medical service as in that of some other technical services in the theater, where there was a tendency for the senior representatives at theater headquarters to develop their own organizations and to encroach on the functions of the Services of Supply, but all the chiefs of technical services had found their separation from the theater general staff inconvenient and conducive to delay.[24]

In November 1942, General Hawley proposed that his office be moved back to London and that a subsection be left with Headquarters, Services of Supply, in Cheltenham to handle functions relating to procurement, supply, operation of facilities, and the maintenance of records. He was supported by a representative of G–3, who pointed out that General Hawley was not available to the theater commander for consultation on matters of planning and for coordinating U.S. Army medical service with British agencies. Delegation of these matters to General Hawley's London office was not satisfactory since a good many of them had to be referred to General Hawley in person, in Cheltenham, for final decision.[25]

Although this proposal was not approved for the medical service separately, in March 1943 (soon after the North African theater was divorced from the European theater and Lt. Gen. Frank M. Andrews succeeded General

[23] Between 31 October 1942, just prior to the North African invasion, and the end of February 1943, the troop strength of the European theater dropped from 223,794 to 104,510. Medical Department strength in the same period declined from 15,792 to 10,333. See Medical Department, United States Army. Personnel in World War II. [In press.]

[24] (1) Interview, Brig. Gen. Charles B. Spruit, MC, AUS (Ret.), 20 May 1949. (2) See footnote 2, p. 304.

[25] (1) Memorandum, Chief Surgeon, European Theater of Operations, U.S. Army, for Chief of Staff, European Theater of Operations, U.S. Army, 30 Nov. 1942. (2) Memorandum, Assistant Chief of Staff, G–3, European Theater of Operations, U.S. Army, for Chief of Staff, European Theater of Operations, U.S. Army, 30 Nov. 1942. (3) See footnote 4(3, p. 307.

Eisenhower as European theater commander) a Services of Supply planning echelon was established in London. The chiefs of service placed their basic planning divisions there. After May, when Lt. Gen. Jacob L. Devers became theater commander, the chiefs of service, including General Hawley, served in their Services of Supply capacity, immediately under a Chief of Services (later renamed Chief of Operations) of the Services of Supply. General Hawley's operational staff (the bulk of his office personnel) remained in Cheltenham, while the planning staff was located in London so as to be available to the theater commander and general staff at all times. Representatives of the services at Headquarters, ETOUSA, were removed as they were no longer necessary (chart 18).

General Hawley's Cheltenham office was charged with supervising the Services of Supply medical service and with compiling and evaluating data needed for planning. The London office was responsible for the actual preparation of plans, for formulating policy, and administering and giving technical supervision to the medical service of the theater as a whole. Colonel Spruit, the former special London representative of General Hawley, was made deputy in charge of the Cheltenham office, and Col. Oramel H. Stanley, MC (fig. 73), was brought from Cheltenham to head the planning echelon in London. Under the new scheme General Hawley's own station was London, but he still spent some time in Cheltenham supervising that branch of his office.[26]

During the early months of 1943, the medical section (including both offices) increased in size only slightly, but with the rapid increase in troop strength after the end of May 1943 it expanded markedly. By December officers numbered 115, the enlisted strength came to 234, and the number of civilians reached 120. In November, a year after the invasion of North Africa, the theater's troop strength amounted to 638,112 men (compared with 584,596 in the North African theater) and was to go on increasing until the great concentration of troops for the cross-channel invasion had been assembled. The year 1943 saw Medical Department personnel in the theater increase sixfold, the expansion generally paralleling the growth of theater strength.[27]

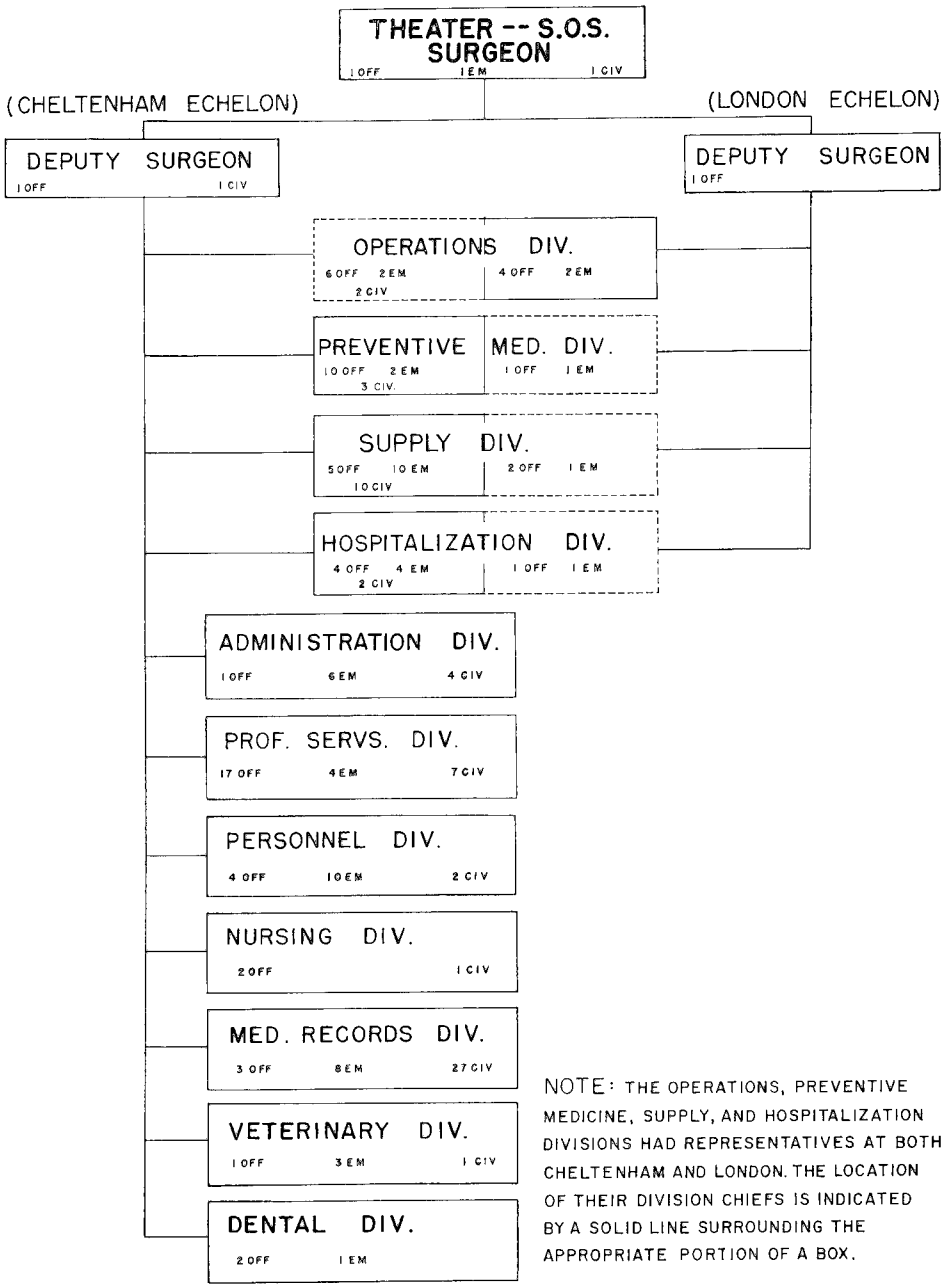
The Ground Forces: 1942–43

Both ground and air force commands building up in the United Kingdom received their technical medical instructions from the office of the Chief Sur-

[26] (1) General Order No. 16, Headquarters, European Theater of Operations, U.S. Army, 21 Mar. 1943. (2) General Order No. 17, Headquarters, European Theater of Operations, U.S. Army, 25 Mar. 1943. (3) Circular No. 63, Headquarters, Services of Supply, European Theater of Operations, U.S. Army, 23 Nov. 1943. (4) Office Order No. 1, corrected, Office of the Chief Surgeon, Services of Supply, European Theater of Operations, U.S. Army, 31 May 1943. (5) General Order No. 25, Headquarters, Services of Supply, European Theater of Operations, U.S. Army, 12 Apr. 1943. (6) Annual Report, Administrative Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1943. (7) See footnotes 4(3), p. 307; and 7(1), p. 308.

[27] (1) See footnotes 7(1), p. 308; and 23, p. 322. (2) Strength of the Army, 1 Nov. 1947, p. 42. Theater strength at the end of December 1943 was 773,753, and Medical Department strength was 65,876.

CHART 18.—*Theater-SOS surgeon's office after reorganization of March 1943*



NOTE: THE OPERATIONS, PREVENTIVE MEDICINE, SUPPLY, AND HOSPITALIZATION DIVISIONS HAD REPRESENTATIVES AT BOTH CHELTENHAM AND LONDON. THE LOCATION OF THEIR DIVISION CHIEFS IS INDICATED BY A SOLID LINE SURROUNDING THE APPROPRIATE PORTION OF A BOX.



FIGURE 73.—Lt. Col. Oramel H. Stanley, MC.

geon, ETOUSA. In 1942 and 1943, the chief ground force command in the theater was V Corps, known interchangeably during the early period as the U.S. Army Northern Ireland Force; the positions of "force" surgeon and corps surgeon were held by the same man. The personnel of the medical section were divided into two groups to meet the needs of both corps and "force," the "force" group carrying the bulk of responsibility. By late June, when administrative functions were completely divorced from tactical duties, the "force" medical personnel (about half of the total) were lost to the newly created Northern Ireland Base Section, the first base section in the theater. The remainder continued as the V Corps Medical Section.

During their stay in Northern Ireland, the American ground forces relied heavily upon British military and civilian authorities for hospital facilities and medical supplies. The V Corps surgeon's office dealt with the chief medical officer of the British troops in Northern Ireland, the civil health officers of the Ministry of Home Affairs for Northern Ireland, the local health officers and Emergency Medical Service representatives, and the leading medical and surgical practitioners of the region. During 1942, members of the surgeon's office participated in a series of command exercises in which both British and American medical units participated.

Near the end of the year, V Corps left Northern Ireland and established its headquarters in Bristol, England. There during 1943 it supplied and

trained incoming units; most of the newly arrived field force units were assigned or attached to its headquarters. The composition of the corps varied from a single infantry division and corps troops in early 1943 to five divisions plus numerous corps units by October. In addition to participating in intensive amphibious exercises during the year, Medical Department personnel in the corps surgeon's office and in medical units of the corps studied reports of the North African, Sicilian, and Italian campaigns and heard talks by officers who had participated in the Mediterranean campaigns. In late October 1943, control of the field forces in the theater was assumed by the newly arrived Headquarters, First U.S. Army, which was established in Bristol, absorbing V Corps.

The introduction of a field army provided a wider basis for planning the invasion of the European Continent. The army surgeon's office was organized after the standard fashion, and the First U.S. Army surgeon, Col. (later Brig. Gen.) John A. Rogers, MC, began a series of conferences with General Hawley to determine what medical units would be allocated to First U.S. Army. As soon as the tentative troop basis had been established, training of units was started, including specialized training at the American School Center at Shrivenham. By early January 1944, the training of Medical Department units was directed at the accomplishment of a landing in Normandy.[28]

The Air Forces: 1942–43

The Eighth Air Force, commanded by Maj. Gen. (later Gen.) Carl Spaatz, built up in the United Kingdom during spring and midsummer of 1942; its headquarters was in London. Until the fall of 1943, this Air Force was the senior U.S. Army air command in the theater and directly subordinate to the theater command. By the end of September 1942 it had, in addition to the office of the air force surgeon—Col. Malcolm C. Grow, MC, formerly Third Air Force surgeon—a medical section headed by a surgeon in each of its five major commands—bomber, fighter, air service, air support, and composite commands. Colonel Grow and his special staff supervised the training of Medical Department personnel in the Eighth Air Force; determined the requirements for medical, dental, and veterinary supplies for the air force and supervised their procurement, storage, and distribution; advised as to the location and operation of the air force's medical establishments; supervised the operation of medical components of the subordinate units; and directed the assignment and reassignment of Medical Department personnel. Colonel Grow, as well as the surgeons of successor air commands, received technical medical instructions from General Hawley's office.

The medical organization and procedures developed during 1942 by the Eighth Air Force, and their modifications as time went on, generally exemplified those later followed by the Ninth Air Force (as well as by the Twelfth,

[28] (1) Annual Reports, Surgeon, V Corps, 1942, 1943. (2) Annual Report, Surgeon, First U.S. Army, 1944.

which was activated for service in the North African theater). The Surgeon, Eighth Air Force Service Command, originally had in his office the Eighth Air Force medical inspector, inspector of animal foods, medical supply officer, dental officer, officer in charge of medical records and statistics, nutritionist, and personnel officer. The medical group in Colonel Grow's office included a few officers in charge of the more technical work; that is, functions directly related to the care of fliers, medical research, and the professional services. Colonel Grow found that this division of responsibility prevented his maintaining centralized control over medical service throughout the air force. He was particularly insistent upon centralized control over assignments and reassignments of Medical Department personnel among the commands, wings, groups, and squadrons, together with recommendations for promotion. Accordingly all functions except those of medical supply were removed to his office. The service command surgeon remained directly responsible to the commanding general of the service command for supervision of medical care given by medical officers throughout all the subelements of the air service command, but retained only one function with respect to the entire air force—the handling of medical supply. This division of responsibility became an accepted pattern of organization of medical service within an air force. In some air forces the supervision of food inspection by veterinarians throughout the air force, as well as the medical supply function, was also handled at the service command level.[29]

Eighth Air Force surgeons continued the efforts, begun by flight surgeons in the United States, to solve special problems connected with maintaining the health of fliers. On account of the rapidity of mobilization, many flying personnel arrived in the European theater with inadequate training in methods of protecting their health and safety during flight. Hence doctors of the Eighth Air Force gave training in the use and care of various pieces of protective equipment, especially the oxygen mask and electrically heated clothing. The European theater became the chief proving ground for testing protective apparatus developed in the United States. The experience of Eighth Air Force fliers with anoxia, frostbite, and aero-otitis—the three chief occupational disorders of fliers—during their long-range bombing missions over Europe at high altitudes in 1942 and 1943 led to many changes in design. Under the personal guidance of the Eighth Air Force surgeon (Colonel Grow), air force technicians in the European theater developed, after extensive research and tests, protective body armor for fliers.

In October 1943 the two numbered air forces in the United Kingdom, the Eighth and the Ninth (the latter transferred from the Middle East to join the Eighth in England), were organized under a single command—the U.S. Army

[29] (1) 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, pp. 528–724. (2) Memorandum, Col. Malcolm C. Grow, for the Air Surgeon, 14 Oct. 1942, subject: Narrative Report of Activities of Medical Service of Eighth Air Force (Through Sept. 1942). (3) Army Air Force Manual 25–0–1, Flight Surgeon's File, 1 Nov. 1945.

Air Forces in the United Kingdom—which served as a theaterwide air command. The new command was responsible for coordinating the administration, including the medical service, of both the strategic Eighth and the Tactical Ninth Air Force, the latter designed to render close support to the ground forces whenever invasion of the Continent should be attempted. Both air forces were several times as large as most of those in other theaters, the Ninth reaching its peak strength of 183,987 in May 1944, while the Eighth was even larger.[30]

The Eighth Air Force surgeon, Colonel Grow, was made surgeon of the U.S. Army Air Forces in the United Kingdom, as well as surgeon of the Eighth Air Force. At the same time his medical section, along with other special staff sections of the Eighth Air Force, was placed, in accordance with the usual scheme for organizing a numbered air force, under the Eighth Air Force's air service command. Thus he had a triple assignment. Detailed technical supervision of medical matters remained the responsibility of small staff medical sections at the headquarters of the other commands (a bomber, a fighter, and a composite command) and of Medical Department personnel assigned to their wings, groups, and squadrons.[31]

In assigning a single officer as staff surgeon of the air force and surgeon of its service command, the Army Air Forces were following, within the restricted structure of the numbered air force, the scheme of the larger theater structure. In a limited sense Colonel Grow's position resembled that of General Hawley; he had the larger staff assignment, but his office was located at the service command headquarters. At the same time Colonel Grow had the task, as surgeon of the U.S. Army Air Forces in the United Kingdom, of coordinating the medical service of the Eighth Air Force with that of the Ninth. This top air command paralleled the top ground command—the Twelfth Army Group—and Colonel Grow's post as Surgeon, U.S. Army Air Forces in the United Kingdom, resembled that of the Surgeon, Twelfth U.S. Army Group.

From the date of its arrival in the United Kingdom to its move to the Continent, the Ninth Air Force medical service underwent a rapid buildup, entailing the accumulation of 40 medical dispensaries (aviation) and 10 medical air evacuation transport squadrons, in addition to the Medical Department officers and men assigned to its increasing numbers of wings, groups, and squadrons. During this period the Ninth Air Force medical section, already experienced with directing the medical service for air force troops under field conditions in the Middle East, made plans for the revamping of its medical units to fit expected combat conditions on the Continent. It made changes, particularly in the medical dispensary (aviation) to achieve greater mobility; the dispensaries, forced to make many moves within the British Isles to accompany the tactical units to which they were assigned, needed even greater mobility for the coming continental operations. The Ninth Air Force surgeon,

[30] Annual Report, Medical Department Activities, Ninth Air Force, 29 Feb. 1945.
[31] Medical History of the Eighth Air Force, 1944.



FIGURE 74.—Brig. Gen. Edward J. Kendricks, MC.

Col. (later Brig. Gen.) Edward J. Kendricks, MC (fig. 74), obtained two field hospitals, each of which he revamped into three smaller hospital units (each staffed by one platoon) to afford medical support to fighter and bomber groups operating from fighter strips after the move to the Continent. Another field hospital, attached to the Ninth Air Force for a few months to serve units of the XIX Tactical Air Command at its airstrips along the south coast of Kent (an area remote from Services of Supply hospitals), afforded three more of these small hospital units which served men of the Ninth Air Force in rapid moves in France and Belgium.[32]

After February 1943, medical service for troops stationed along the eastern end of the air route between England and the United States, as well as for persons being transported over the route, was provided by the newly established European Wing of the Air Transport Command. As in the case of other Air Transport Command wings, its stations were administratively subject to the theater within which they were located although their operations were directed from Headquarters, Air Transport Command, in the United States. After a brief period of reliance upon British medical facilities (including those of the Royal Air Force), as well as facilities of the Services of Supply, the European Wing developed dispensaries of from 10 to 25 beds to care for patients for a maximum period of 72 hours. Any further care neces-

[32] Preliminary Operational Report, Office of the Surgeon, Ninth Air Force. [Maxwell AFB files.]

sary was given at Services of Supply hospitals. By the end of the year, dispensaries were operating at the following stations: Hedon airdrome near London; Prestwick, Scotland; Nutt's Corner, Northern Ireland, St. Mawgans in Cornwall; Valley on the island of Anglesey, Wales; and Stornoway, Isle of Lewis, in the Hebrides. At that date, the wing had assigned to it only 12 medical officers, 4 dental officers, 1 Medical Administrative Corps officer, and 36 Medical Department enlisted men. It was the smallest of all Air Transport Command wings. Its heavy responsibility for evacuating large numbers of patients by air from the theater to the United States began only in June 1944 with the Normandy invasion.[33]

Control of Medical Service for Air Force Troops

During the preinvasion period, medical officers assigned to the Eighth Air Force advocated certain steps which tended to make the air force's medical service independent of the theater command. They made the usual claims as to special needs: medical supplies peculiar to the air forces; medical personnel trained in the special problems of aviation medicine; and special hospital facilities to care for air pilots recuperating from flying fatigue. In addition, they contended that Services of Supply installations, particularly fixed hospitals and medical supply depots in the various base sections, were not always located sufficiently near the air force bases which they served. (Services of Supply installations were concentrated in southern England whereas the majority of the air force bases were in the northeast.) The conflicts that ensued whenever air force surgeons attempted to obtain medical support through their own channels resembled the somewhat more titanic struggle waged over a separate medical service for the Army Air Forces in the United States. They reflected the irresistible trend toward the divorce of air and ground logistics. The interest of air force medical officers in controlling their own medical facilities was especially strong in the early days of the theater's existence when the proportion of air troops to ground and service troops was relatively high and when the Eighth Air Force, engaged in the strategic bombing of targets in Nazi-held territory, was the only element in the theater suffering combat casualties.

As subcommands were created within the Eighth Air Force, officers trained in aviation medicine were needed to staff them. In 1942 many air force units arrived without organic medical personnel, and many medical officers who came lacked training in aviation medicine. Moreover, the Eighth Air Force had to transfer some of its medical officers to the Twelfth Air Force for the North African invasion. Lack of training in the physiologic effects of flight and the proper use of protective equipment was held responsible for some serious plane

[33] (1) History of the Medical Department, Air Transport Command, May 1941–December 1944. [Official record.] (2) See footnotes 4(3), p. 307; and 26(2), p. 323.

accidents in 1942, the salient example being the loss of three 4-motored heavy bombers and 10 airmen within a week or so. Hence the Eighth Air Force surgeon wanted to establish a medical field service school to train officers in aviation medicine. General Hawley, who believed that such training could and should be given at the medical field service school operated at Shrivenham by the Services of Supply, opposed the plan, but the theater command approved it, and the Provisional Medical Field Service School was officially opened by Colonel Grow in August 1942 at Pine Tree, England.[34]

Because of shortages of some items of medical supply in the theater in 1942, the Eighth Air Force was unable to obtain the full quantities of medical supplies which it requested through the regular channels; that is, by requisitions to General Hawley's office. By cabling the Commanding General, Army Air Forces, it was able to get a number of items directly from the United States. General Hawley protested—

> All components of this theater are short of dental laboratories, Chests Nos. 4 and 60. I adhere to the now apparently unique opinion that an aching tooth hurts an infantryman just as badly as it hurts a soldier in the Air Forces; and this office is attempting to make an equitable distribution of all critical medical items so that all components of ETOUSA may be cared for as thoroughly as is possible in the circumstances. If any competition for medical supplies in this theater is tolerated, wastage is certain and chaos probable.

Inability to meet the full demands of the air forces was one of the persistent problems in the handling of medical supplies in the European theater which continued until early in 1944. It furnished the air forces an argument for building up a channel for procuring its medical supplies directly from the Zone of Interior without going through Services of Supply channels.[35]

A third struggle developed with regard to hospitalization for the Eighth Air Force. According to theater policy the air and ground forces were to operate only temporary hospitalization facilities capable of treating cases requiring a hospital stay of not more than 96 hours, but in July 1942 the Eighth Air Force made a request for authority to operate rest homes to treat cases of flying fatigue. General Hawley, stating that the proposed rest homes were, in effect, hospitals, and that fixed hospitals were the responsibility of the Services of Supply, opposed the move. The theater command overruled him and approved the rest home project in August 1942. A later request by the Eighth Air Force for hospital rations for its rest homes substantiated General Hawley's original contention, and, as he stated, much to the chagrin of the theater staff.

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[34] (1) Narrative Report of Activities of Medical Service of the Eighth Air Force up to and including 30 September 1942. (2) Letter, Col. Paul R. Hawley, to Maj. Gen. James C. Magee, The Surgeon General, 11 Sept. 1942, and other letters in Col. Hawley's chronological file. (3) Memorandum, Lt. Col. Lloyd J. Thompson, MC, for Col. J. M. Kimbrough, MC, 24 Sept. 1942, subject: Visit to 8th Air Force. (4) Memorandum, Brig. Gen. Paul R. Hawley, for Col. Malcolm Grow, October 1942.

[35] First wrapper indorsement on incoming cable No. A671, Chief Surgeon, Services of Supply, European Theater of Operations, U.S. Army, to The Surgeon General, 9 Nov. 1942, and numerous similar documents in General Hawley's chronological file for November–December 1942.

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The hospital rations were disapproved on the ground that the rest centers were, by the air force's own statement, not hospitals.[36]

In mid-1943, the Air Surgeon was pressing for air force control of hospitals in the European theater, about the same time that he was attempting to achieve air force control of general hospitals in the United States, but by that date, when the Services of Supply had a substantial number of fixed hospitals operating, he could not obtain very strong backing from air forces medical officers in the theater. General Hawley was able to point out early in the year, when total strength planned for the Eighth Air Force amounted to about 15 percent of that planned for the theater, that 25 percent of the 750-bed station hospitals then under construction were located in the area occupied by the Eighth Air Force. General Hawley recognized the technical aspects of aviation medicine and realized that fliers hospitalized in the general hospitals of the Services of Supply were not always returned to duty as promptly as was desirable. By agreement between General Hawley and Colonel Grow, flight surgeons were stationed in the general hospitals which cared for appreciably large numbers of air force personnel. They advised the disposition boards of the general hospitals as to whether air force patients were fit for return to flying duty and, if not, whether the air force wanted them returned for limited service. Cooperative arrangements for the expeditious handling of air force patients effectively reduced pressure within the theater for air force control of hospitals; by the end of 1943 air force medical officers appear to have become convinced that hospitalization of air force troops in Services of Supply hospitals was satisfactory. The surgeon of the Ninth Air Force, Colonel Kendricks, was disinterested in the theory of separatism and inclined to stress the cooperation which he received from General Hawley's office. As it developed, the air forces in Europe were to remain dependent on the Services of Supply for fixed hospitalization throughout the war despite renewed pressure at intervals by the Air Surgeon's office in Washington.

MEDICAL ORGANIZATION UNDER SHAEF: JANUARY 1944–MAY 1945

From April 1943 to the establishment of the Allied command under General Eisenhower early in 1944, Allied planning for invasion of the European Continent was carried on by a combined British and American staff headed by Lt. Gen. Frederick E. Morgan, the British Chief of Staff to the Supreme Allied Commander (designate). General Morgan's office in London, although a forerunner of SHAEF (Supreme Headquarters, Allied Expeditionary Force), was a planning agency rather than a command. Throughout the life of this planning staff a few Medical Department officers assigned to it from General

[36] (1) Letters, Brig. Gen. Paul R. Hawley, to Maj. Gen. Norman T. Kirk, The Surgeon General, 8 July 1943, 10 Aug. 1943, 17 Sept. 1943, and many similar letters, General Hawley's chronological file, through 1943. (2) See footnote 29(1), p. 327. (3) Letter, Brig. Gen. Paul R. Hawley, to Col. Malcolm Grow, MC, 11 Mar. 1943. (4) Interview, Brig. Gen. Edward J. Kendricks, 23 Feb. 1950.

Hawley's office worked on medical phases of invasion plans, as well as plans for the handling of civilian affairs on the Continent. General Hawley assisted with these plans, which were drawn up in close conjunction with his office.[37]

SHAEF and the Theater Command

The creation of SHAEF, in London in January 1944 in preparation for invading the Continent, together with changes in the responsibilities assigned to various subordinate headquarters and commanders (British as well as American), brought about a different command structure, highly complex, under which the U.S. Army medical service operated until the end of the war. General Eisenhower served in a dual capacity—as Supreme Allied Commander and as a commander of the European Theater of Operations, U.S. Army. Maj. Gen. Albert W. Kenner, who had served as surgeon of the North African theater, and had been Secretary Stimson's first choice to succeed General Magee as The Surgeon General, was made Chief Medical Officer, SHAEF. He acted as adviser to General Eisenhower and dealt with the surgeons of the many commands subordinate to SHAEF.[38]

At the same time, the headquarters of the American theater command and that of its Services of Supply were consolidated into a single headquarters. General Lee retained command of the Services of Supply and was given the additional assignment of deputy theater commander for supply and administration; that is, deputy to General Eisenhower in the latter's capacity as commander of the American theater. The chiefs of technical services, who had formerly served in a dual capacity for both theater and Services of Supply headquarters, continued in these two capacities but were now located at a combined theater and Services of Supply headquarters in London instead of, as formerly, at the Cheltenham headquarters of the Services of Supply. General Hawley (promoted to major general in March 1944) was placed under G–4, along with the other technical service chiefs.[39]

This reorganization seemed to strengthen General Hawley's position. He commented: "All Chiefs of Services, including myself, are Chiefs of Services of the European Theater of Operations, and in addition to their other duties, are Chiefs of Services of the SOS. This is an exact reversal of the previous organization in which the Chiefs of Services were assigned to the SOS and, in addition to their other duties, were Chiefs of Services of the European Theater of Operations. This is, of course, a small point but is proving to be a most important point." [40] By the date of the invasion most of General Hawley's staff

[37] (1) Harrison, Gordon A.: Cross Channel Attack. United States Army in World War II. Washington: U.S. Government Printing Office, 1951, ch. II. (2) Interview, Col. John K. Davis, formerly Deputy Surgeon, SHAEF, 15 Sept. 1945. (3) Letter, Maj. Gen. Paul R. Hawley, USA (Ret.), to Col. John Boyd Coates, Jr., MC, USA, Director, The Historical Unit, U.S. Army Medical Service, 29 Aug. 1955, commenting on preliminary draft of this chapter.

[38] (1) General Order No. 2, Supreme Headquarters, Allied Expeditionary Force, 14 Feb. 1944. (2) Administrative Memorandum No. 3, Supreme Headquarters, Allied Expeditionary Force, 24 Apr. 1944.

[39] See footnotes 2, p. 304; and 14(4), p. 315.

[40] Letter, Brig. Gen. Paul R. Hawley, to Maj. Gen. Norman T. Kirk, 4 Feb. 1944.

was concentrated in London at Headquarters, ETOUSA–SOS, which was soon referred to unofficially as Communications Zone, ETOUSA, in anticipation of the role that it was to fill on the Continent.

At SHAEF, General Kenner headed a medical division made up of two British officers—one of whom, a brigadier, served as his deputy—two American officers, and some British and American enlisted men. The duties of the Chief Medical Officer, SHAEF, were defined in broad terms. He was to advise the Supreme Commander on all matters pertaining to the medical service within the areas under General Eisenhower's command and to coordinate medical policy on an inter-Allied basis. Coordination of the policies of the Army's public health program in the European countries which the Army would occupy with plans of the regular medical service for troops was entrusted to him. He was authorized direct communication on technical matters with the surgeons of the naval forces, air forces, army groups and armies, and other commands—British and American—under the Supreme Commander. He reported to the Chief Administrative Officer, SHAEF, Lt. Gen. Sir Humphrey Gale, a British officer who served as a deputy chief of staff, and his recommendations were also reviewed, as a rule, by G–4, SHAEF.

During his early months at Supreme Headquarters, General Kenner conducted conferences, with representatives of the U.S. Navy and the British armed forces present, to discuss the role of hospital carriers and hospital ships in the forthcoming invasion. Similar conferences with representatives of the Royal Air Force, U.S. Strategic Air Forces, and Allied Expeditionary Air Force were conducted in order to integrate plans of all the Allied air elements with the ground elements for evacuation of casualties by air during the invasion. General Kenner attended First U.S. Army exercises at Portsmouth and prepared a written appraisal of the major problems to be anticipated in evacuating casualties. He conferred with Medical Department officers assigned to G–5, SHAEF, on problems encountered in planning the civil health program, especially the procurement of men trained in public health work. He sent his assistant, Col. J. K. Davis, MC, to Algiers, Naples, and Caserta to get information on the Fifth U.S. Army's experience with medical units and data on Fifth U.S. Army casualties, hospital admissions, and incidence of various types of wounds, during the Italian campaign.[41]

After the invasion, General Kenner spent much of his time traveling up and down evacuation routes on the Continent by car, inspecting the flow of evacuation and the handling of patients. He kept Supreme Headquarters informed on the placement of medical units and hospitals—British, French, and American—in relation to the disposition of combat units and on the flow

[41] (1) Diary, Maj. Gen. Albert W. Kenner. (2) Memorandum, Brig. Gen. Paul R. Hawley, for Maj. Gen. Albert W. Kenner, 25 Feb. 1944, subject: Sea Transport for Casualties. (3) Report of conference, Maj. Gen. Albert W. Kenner and others, 26 Feb. 1944. (4) Reports by Maj. Gen. Albert W. Kenner on exercises in March and April 1944. (5) Memorandum, Maj. Gen. Albert W. Kenner, for Lt. Gen. Sir Humphrey Gale, 29 Feb. 1944. (6) Report of Visit to Allied Force Headquarters by Col. John K. Davis, MC, 1 Apr. 1944.

of medical supplies to forward areas. He made appraisals of combat fatigue among troops, and other matters which would give General Eisenhower and his staff a full picture of the way in which the American and British medical services were supporting the invasion. At times he followed a group of casualties from front to rear, noting any defects in coordination of the movements of evacuees—an overload of patients in the hospitals of a field army or some element of the communications zone, for instance. He reported to General Eisenhower personally about once a week. His action to improve the handling of evacuees usually took the form of personal talks with the surgeons of the commands concerned. When 6th Army Group (comprising the First French Army and the Seventh U.S. Army) entered the theater, his office made recommedations to G–4, SHAEF, for the reallocation of Medical Department units among the tactical components of 12th Army Group and the Allied 6th Army Group to provide balanced support for the two forces.[42]

General Hawley continued as Chief Surgeon, ETOUSA, responsible for technical instructions to the Services of Supply and to the 12th and 6th Army Groups and their subordinate commands. His title and responsibility as Chief Surgeon, ETOUSA, continued to the end of the war. His office remained at General Lee's headquarters, usually known as Communications Zone-ETOUSA after 7 June when the Services of Supply became officially known as Communications Zone. This headquarters continued to be the theater channel for communicating with the War Department on technical matters. To the end of the war General Hawley also informed The Surgeon General (General Kirk) through personal correspondence of his estimates of the medical needs of the Army in Europe.[43]

With time some confusion developed with respect to the mutual responsibilities and spheres of control of Supreme Headquarters and Headquarters, ETOUSA–SOS. General Eisenhower's general staff at Supreme Headquarters directed the tactical operations of the combat forces, whereas in a purely American theater, direction of these forces would normally have been exercised by the general staff of the theater headquarters. After the invasion "there was a tendency for SHAEF to assume more and more the aspect of an American theater headquarters as well as an Allied one." General Lee's activities, correspondingly, tended to contract to those properly belonging to a communications zone. The ambiguity was only deepened by the renaming of General Lee's headquarters as Headquarters, Communications Zone, ETOUSA, in June 1944 and the termination of his position as deputy theater commander

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[42] (1) Letter, General Dwight D. Eisenhower, to General George C. Marshall, 28 Sept. 1944. (2) See footnote 41(1), p. 334.

[43] (1) See footnote 2, p. 304. (2) Letters, Maj. Gen. Paul R. Hawley, to Maj. Gen. Norman T. Kirk, The Surgeon General, from June 1943 to the end of the war. Like the chiefs of other technical services at Headquarters, ETOUSA–SOS and its successor, Communications Zone-ETOUSA, General Hawley was frequently in the position of issuing directives to himself. As theater Chief Surgeon his directives, over the signature of the theater Adjutant General, went to the Services of Supply as well as to the armies and air forces, and so were received by General Hawley in his capacity as SOS surgeon.

in July, although the chiefs of technical services, including General Hawley, continued to exercise the same theaterwide responsibilities as before.[44]

In the circumstances, it is hardly surprising that Medical Department staff officers disagreed as to channels of authority, or that General Kenner and General Hawley were themselves sometimes in doubt as to their respective responsibilities. General Kenner had outlined the command setup for The Surgeon General in March 1944 as follows:

> I am in a rather ambiguous situation as regards my relationship to Hawley, since I am set up as the Chief Medical Officer for this composite force, which, as you know, is made up of Navy, Air, and Ground—British and American. Since I am on this higher staff level, I am concerned only with the coordinated planning and the integration of all things pertinent to the medical service. The operative part of it belongs to Hawley * * *. It's a funny kind of a setup and is without precedent in our medical service.

General Hawley for his part noted the limitations which the command structure imposed upon his activities, specifically in connection with his attempts to get the buildings which he wanted for hospitals in France and Belgium. Because of the involvement of various governments, civilian interests, and a number of Army commands, this problem could not be solved within the communications zone headquarters.

> The organization of this Theater being what it is, it is a practical impossibility for me to bring directly to the attention of the authority who can act, the urgent requirements of the medical service for hospital plant. I must, of course, work through and under General Lee and his general staff. The organization set up demands this—and I cannot, and do not desire to, go over his head.
>
> He and his staff give me all the support that they can: but his appointment as Deputy Theater Commander was terminated after he moved his headquarters to the Continent and practically all authority to act in Theater matters has been taken over by SHAEF. This creates the anomalous situation wherein Theater Chiefs of Services have no approach to the Theater Commander and must depend upon subordinate commander and staff for support. Such an organization works as well as it obviously can.

The matter was resolved, as such conflicts generally were, by conference. Representatives of Headquarters, SOS–ETOUSA, of the Army groups, and of the Armies met on 17 January 1945 at SHAEF headquarters at Versailles, and gave General Hawley the 34 additional hospital sites he wanted.[45]

Many other matters turned out to be involved with Allied interests and to fall within the purview of SHAEF or one of its subordinate Allied commands. Since the Allied Expeditionary Air Force, for example, exercised,

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[44] See footnote 2, p. 304.

[45] (1) Interview, Col. Alvin L. Gorby, MC, 10 Nov. 1949. (2) Recorded remarks of Maj. Gen. Albert W. Kenner at panel discussion of manuscript of this volume, Office of the Chief of Military History, 9 Sept. 1955. (3) Annual Report, Surgeon, First U.S. Army, 1944. (4) Letter, Maj. Gen. Albert W. Kenner, to Maj. Gen. Norman T. Kirk, The Surgeon General, 23 Mar. 1944. (5) Letter, Maj. Gen. Paul R. Hawley, to Maj. Gen. Norman T. Kirk, The Surgeon General, 12 Jan. 1945. (6) Darnall, J. R.: Hospitalization in the European Theater of Operations, U.S. Army, in World War II. Mil. Surgeon 103: 426-439, December 1948. (7) Minutes, Conference on Hospital Sites, G–4, Supreme Headquarters, Allied Expeditionary Force, 17 Jan. 1945. (8) Letter, Brig. Gen. Crawford F. Sams, to Col. Joseph H. McNinch, MC, Chief, Historical Division, Office of The Surgeon General, 5 June 1950, and Colonel McNinch's recorded remarks thereon, 22 June 1950.

through its Combined Air Transport Operations Room, control over the allocation of aircraft to air transport agencies within the theater, any request for plans for air evacuation had to be submitted to CATOR, as this agency was called. General Hawley, who was empowered to act only within theater channels, found it difficult to place his statement of requirements for air evacuation before any commander who had authority to act on it.[46] General Kenner, on the other hand, continued to regard General Hawley's office as the operating agency, and contented himself with an occasional statement to the theater or communications zone command calling attention to medical deficiencies on the purely American side; for example, a rising venereal disease rate in September 1944 and too large a backlog in the number of casualties due, under theater policy, for evacuation from the theater to the Zone of Interior.

Regardless of difficulties encountered by General Hawley on specific matters which came within the compass of SHAEF, he acted as chief of medical service for the American Forces throughout the war, working in close rapport with British Army medical authorities. His office issued under General Eisenhower's signature plans for evacuation which outlined the mutual responsibilities of armies and communications zone elements, as well as those of air forces. The regular medical service for U.S. Army troops which he headed was responsible for care of returned U.S. Army prisoners of war and served many soldiers of the Allied nations as well as many civilians. Consultants in his office visited U.S. Army hospitals in forward areas as well as the communications zone. The series of technical instructions which they issued on procedures and standards for treatment of diseases and injuries of U.S. Army troops were distributed to all Army commands in the European theater. General Hawley and his staff inspected Army hospitals throughout the theater, irrespective of the command to which they were assigned. Many administrative problems were solved by personal discussions and exchange of letters among the surgeons of the commands concerned. Others, calling for compromise among several commands and requiring a command decision, were frequently solved, as in the case of the hospital facilities in France and Belgium, by reaching a formal agreement at a top-level conference. In some instances, when General Hawley found that command channels were lacking for bringing his problems to the attention of a commander with authority to act, he called the matter to the attention of General Kenner, who was able to obtain the backing of SHAEF. General Hawley's and General Kenner's deputies worked in close cooperation.[47]

The Theater-SOS Medical Section

Pursuant to the January 1944 reorganization and in anticipation of the invasion, a number of changes were made in the internal organization of Gen-

[46] Memorandum, Maj. Gen. Paul R. Hawley, for Commanding General, Communications Zone, European Theater of Operations, U.S. Army, 15 Sept. 1944.

[47] (1) Letter, Maj. Gen. Paul R. Hawley, to Maj. Gen. Albert W. Kenner, 21 July 1944. (2) See footnote 46. (3) Memorandum, Maj. Gen. Paul R. Hawley, for Maj. Gen. Albert W. Kenner, 21 Sept. 1944.

eral Hawley's medical section. At the beginning of 1944 the London office at the combined ETOUSA–SOS headquarters was relatively small, consisting of General Hawley, a deputy chief surgeon, the executive officer, and the Planning, Evacuation, and Administrative Division; the bulk of the office was still at Cheltenham. With the consolidation of the theater and Services of Supply headquarters, most of the remaining elements of General Hawley's office were transferred to London, and the total office, particularly its Operations Division, underwent considerable expansion. The Chief of the Operations Division, at Headquarters, ETOUSA–SOS, in London, Col. David E. Liston, MC (fig. 75), was appointed deputy to General Hawley in charge of the London office. During the months before the invasion the office was engaged in preparing the medical annexes of plans for mounting the continental invasion and for administering the communications zone. It developed exclusively medical exercises to test the arrangements for evacuating casualties arriving on the southern coast of England to fixed hospitals. It undertook large-scale reshuffling of Medical Department units to meet the requirements for medical care for troops assembling in the marshaling areas along the south coast of England, for evacuation and care of an anticipated heavy load of casualties from the Continent, for care of troops remaining in the United Kingdom, and for a full-fledged medical service on the Continent in the post-invasion months.[48]

The split of General Hawley's office between London and Cheltenham which had prevailed in 1942 and 1943 was considered by investigators from the Surgeon General's Office a contributory cause of the medical supply crisis that developed by early 1944. When it was evident that the theater's medical supply system would not be able to handle the assembly and distribution of the medical maintenance units and hospital equipment necessary to support the cross-channel invasion, General Hawley requested aid from The Surgeon General. In response, General Kirk sent to the theater a group of officers and some industry experts from the Supply Division, with Col. Tracy S. Voorhees, Director of the Control Division, at their head. Besides arranging for the direct shipment from the United States of sufficient medical maintenance units and hospital assemblies to take the strain off the theater medical supply system, the group proposed overhauling the system itself. The group reported in early February that the fact that General Hawley had had to spend most of his time in London near theater headquarters had prevented his giving close personal supervision to his Supply Division in Cheltenham. Responsibility had been further divided in that procurement of medical supplies from the British had been conducted by a medical supply officer of General Hawley's office who was stationed, along with representatives of the other chiefs of technical services, at the General Purchasing Board in London rather than in General Hawley's office. An insufficient number of officers trained in medi-

[48] (1) See footnote 7(3), p. 308. (2) Annual Report, Surgeon, United Kingdom Base, 1944.



FIGURE 75.—Col. David E. Liston, MC.

cal supply had been sent to staff the Supply Division of General Hawley's office and to man the medical supply depots in the United Kingdom. A lack of coordination between the theater's medical supply network and the Supply Division of the Surgeon General's Office—as to items to be procured from the British, for example—and insufficient coordination between General Hawley's office and the army surgeons as to the medical supply needs of the armies had contributed to the confusion.

In order to remedy defects, the supply mission recommended a reorganization of General Hawley's Supply Division. The changes included increasing personnel from 17 officers and 47 enlisted men to 32 officers and 91 enlisted men, and the removal of certain officers from the division to various more suitable posts in the medical supply system. The mission drew a parallel between the problems which had developed within the European theater and those which had confronted the Supply Service of the Surgeon General's Office in 1942, particularly in the operation of a large depot system. Its report stated: "We must recognize fundamentally that the U.K. supply service and depot problems and functions are not those of a T/O (Theater of Operations) but of a base for a Theater or Theaters and are in essence a replica of the U.S. supply service and depot job with almost exactly the same number of depots." Pursuing this concept, the mission recommended the transfer of certain experienced officers serving in the Supply Service, Surgeon General's Office, and



FIGURE 76.—Col. Silas B. Hays, MC.

in the large medical depots in the United States to the theater; they were to undertake measures found effective at home.

Two officers of the mission remained in the theater as members of the Supply Division; 15 additional officers trained in medical supply were sent from the Surgeon General's Office and the medical supply depots in the United States for 90 days' temporary duty in the theater. In early March, Col. Silas B. Hays, MC (fig. 76), who had served with the mission, became chief of the division. The changes in personnel, together with detailed revisions of policy and method, which Colonel Hays put into effect, brought about a system which General Hawley later declared to have proved highly effective for coping with the problems of the cross-channel invasion.[49]

General Hawley's office reached its full strength soon after the invasion. On 1 July 1944 it consisted of 147 officers, 371 enlisted men, and 125 civilians;

[49] (1) Résumé of Trip to Survey Medical Supplies in ETO, 12 Apr. 1944. [Official record.] (2) Hays, S. B.: Report of Medical Supply Situation, 10 July 1944. [Official record.] (3) Memorandum, Chief, Finance and Supply Division, for Chief Surgeon, Headquarters, Services of Supply, European Theater of Operations, U.S. Army, 21 Dec. 1942. (4) Letters, Maj. Gen. Paul R. Hawley, to Maj. Gen. Norman T. Kirk, 4 Feb., 26 June 1944. (5) Annual Report, Medical Procurement Section, Supply Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1944.

on 1 September the strength amounted to 151 officers, 362 enlisted men, and 125 civilians. It was by far the largest Army medical office overseas and second in size only to the Surgeon General's Office itself. General Hawley had two deputies; Colonel Liston served in this capacity in the Paris office, while the United Kingdom Base Surgeon, Colonel Spruit, was his deputy for activities in the United Kingdom. In March 1945 three deputies were appointed: Colonel Spruit (now brigadier general) who retained his assignment as United Kingdom Base surgeon; Colonel Liston as deputy for operations; and Col. Charles F. Shook, MC (formerly Surgeon, Southern Line of Communications), as deputy for administration.

An important innovation in the office early in 1945 was the creation of a Field Survey Division. Its staff undertook to discover deficiencies of every nature in the medical service and assist commanding officers of Medical Department units in the field to carry out the policies of theater headquarters. Teams of officers from the division visited hospitals, inspecting all activities—wards, laboratories, utilities, and inquiring into patients' complaints. They accompanied patients on hospital ships and trains to check on the care being given evacuees en route.[50]

Other than these developments, the chief changes in General Hawley's office in 1945 resulted from added responsibilities. During the final months of the war the office became increasingly concerned with technical military intelligence activities. In November 1944, Army Service Forces headquarters in Washington had begun taking a strong interest in this area and had sent teams representing each of the services to work with the Combined Intelligence Objectives Subcommittee established in London the previous spring. A medical officer served on the Combined Intelligence Objectives Subcommittee, which determined the fields of German military developments to be investigated. The program for exploring developments in German medicine, research, and production of medical supplies and equipment got under way in mid-May of 1945 after Germany had been overrun by the Allied armies; it was carried out at various levels of theater organization. A few officers and enlisted men served in the Medical Intelligence Branch of General Hawley's Operations Division; others were attached to Advance Section, Communications Zone; another group tested captured enemy supplies and equipment at a U.S. Army general laboratory in Paris; and four medical intelligence teams attached to the First, Third, Seventh, and Ninth U.S. Armies collected information through interrogating prisoners and examining documents and enemy medical installations. German techniques and developments in medicine (including its preventive aspects),

[50] (1) See footnote 7(3), p. 308. (2) Annual Report, Administrative Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1944.

surgery, neurosurgery, dentistry, and veterinary medicine, as well as medical supplies used by the German Army, were thoroughly studied.[51]

The Communications Zone: June 1944–May 1945

During the months before the invasion the Services of Supply, or Communications Zone,[52] as this organization came to be termed in anticipation of its role in logistic support of the invasion, established two new agencies—Forward Echelon, Communications Zone, and Advance Section, Communications Zone. The headquarters of both agencies had medical sections which worked on the medical phases of invasion plans; each maintained liaison with the office of the Surgeon, Communications Zone, General Hawley. The Forward Echelon, Communications Zone, was a nucleus of the main headquarters designed to move quickly to the Continent in advance of the remaining staff (or rear echelon). During the planning period in the United Kingdom, its staff was attached to 21st Army Group, SHAEF's ground force subcommand, which was to have initial top responsibility on the Continent, but it worked more directly with First U.S. Army, the American component of 21st Army Group. It was organized into staff sections fashioned after those at the main headquarters of Communications Zone, in order to facilitate later reintegration of the two staffs. Its medical staff section was headed by Colonel Spruit. By May about 20 officers of General Hawley's medical section had been assigned to the planning undertaken by Colonel Spruit. In the end the work of this group was confined to planning, for the main headquarters of Communications Zone, including General Hawley's office, moved to the Continent a full month ahead of schedule. Hence Forward Echelon never assumed any direction over the territorial commands of the communications zone but was quickly absorbed into the main headquarters at Valognes, France.[53]

Advance Section, Communications Zone, was supervised during the planning period by Forward Echelon. Its medical section was headed by Col. Charles H. Beasley, MC (fig. 77), formerly the surgeon of Iceland Base Command. Before assuming his new duties, Colonel Beasley made a short trip to North Africa and Italy to study the organization of the medical service in the

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[51] (1) Period Report, Medical Intelligence Branch, Operations Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1 Jan.–30 June 1945. (2) Period Report, Medical Intelligence Branch, Operations Division, Office of the Chief Surgeon, Theater Service Forces, European Theater of Operations, U.S. Army, 8 May–30 Sept. 1945. (3) Report of Operations, Office of the Chief Surgeon, Theater Service Forces, European Theater of Operations, U.S. Army, 8 May–30 Sept. 1945.

[52] Officially named Communications Zone, European Theater of Operations, U.S. Army, only on the eve of the invasion. The term "Communications Zone" more aptly applied to the area within which a Services of Supply operated within a theater, was here used to designate the organization itself. The change of name occurred wih the forward push and the expansion of the boundaries of the communications zone. In the early days of the theater, the Services of Supply had base sections as its only area commands. With the move forward, the Services of Supply was in some theaters renamed the Communications Zone. It then had both advance and intermediate sections, as well as base sections, thus fully developing the type of organization shown on chart 12, p. 246.

[53] (1) See footnotes 2, p. 304; 4(3), p. 307; and 7(3), p. 308. (2) Annual Report, Administrative Division, Office of the Chief Surgeon, Headquarters, European Theater of Operations, U.S. Army, 1944.



FIGURE 77.—Col. Charles H. Beasley, MC.

North African theater, particularly that of Peninsular Base Section. His medical section, first set up in London, was transferred to Bristol in March 1944. The plans of the Advance Section were coordinated with those of the First U.S. Army, then training in the Bristol area, for Advance Section was to operate under the direction of First U.S. Army during the initial days of the invasion. In addition to frequent meetings with the First U.S. Army surgeon and his staff, Colonel Beasley held conferences with General Hawley and his representatives, as well as with the medical staff of Headquarters, Third U.S. Army, and the Ninth U.S. Air Force.

A month before the invasion, the surgeon's office of the Advance Section was authorized a strength of 42 officers and 56 enlisted men, to include a nurse and a maximum of 19 Medical Corps officers. Advance Section headquarters reached France on 15 June, 9 days after D-day, when the frontlines were less than 4 miles away. During its period of attachment to First U.S. Army, about a month, its surgeon's office drew up plans for establishing Medical Department installations ashore to serve combat forces as soon as its territorial limits to the rear of First U.S. Army should be defined. When Advance Section was detached from First U.S. Army control on 14 July, the medical section began providing hospital facilities and an evacuation service, administering the procurement and storage of medical supplies, and supervising sanitation in the communications zone on the Continent. By early August, it was operating in France 12 general hospitals, 4 field hospitals, 1 evacuation hospital, and many other types of medical units, supporting both the First and

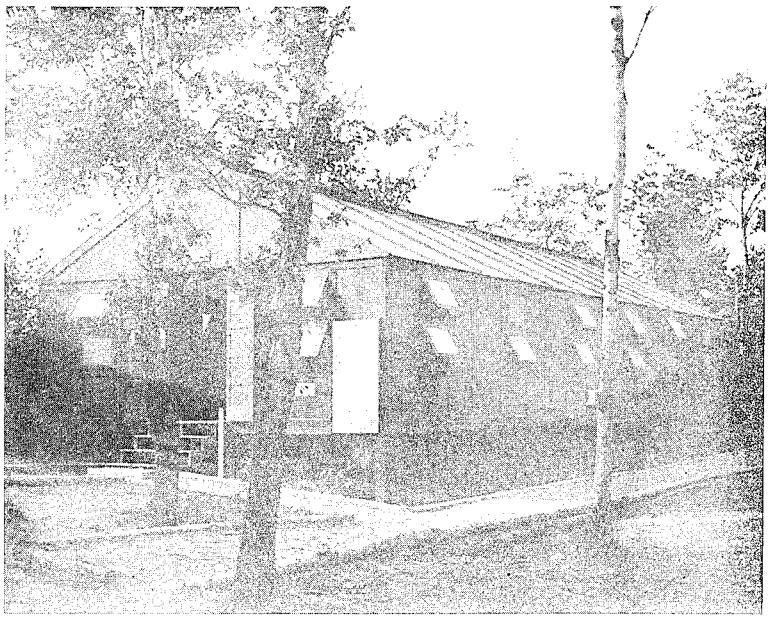


FIGURE 78.—General Hawley's office at Valognes, France, August 1944.

Third U.S. Armies (the latter having begun operations on the Continent on 1 August). Advance Section was now permanently under the control of Headquarters, Communications Zone.[54]

Headquarters, Communications Zone, ETOUSA, moved to Valognes when the rear boundaries of the armies were drawn in early August. By the end of the month most of the surgeon's office had arrived at Valognes and was established in hutments (fig. 78), absorbing the medical staff at the Forward Echelon. At first it appeared that the Communications Zone headquarters would be in Normandy for an indefinite period (planning and construction of the camp at Valognes had been extensive), but it was transferred to its permanent location in Paris in mid-September. The surgeon's office was housed with the offices of the other chiefs of technical services on the Avenue Kleber. Before the end of the year additional officers were requisitioned for the expanding medical section.

With the advance of the armies in France, many changes took place in the organization of the communication zone, but by the middle of October 1944 the structure was near its final form, although boundaries continued to be modified to accord with the changing tactical situation. The communications zone then consisted of an advance section in direct support of the armies and seven base sections: Oise Section, Seine Section, Loire Section, Channel Base Section, Normandy Base Section, Brittany Base Section, and the United

[54] (1) Annual Report, Medical Section, Advance Section, Communications Zone, European Theater of Operations, U.S. Army, 7 Feb.–31 Dec. 1944. (2) See footnotes 4(3), p. 307; and 7(3), p. 308.

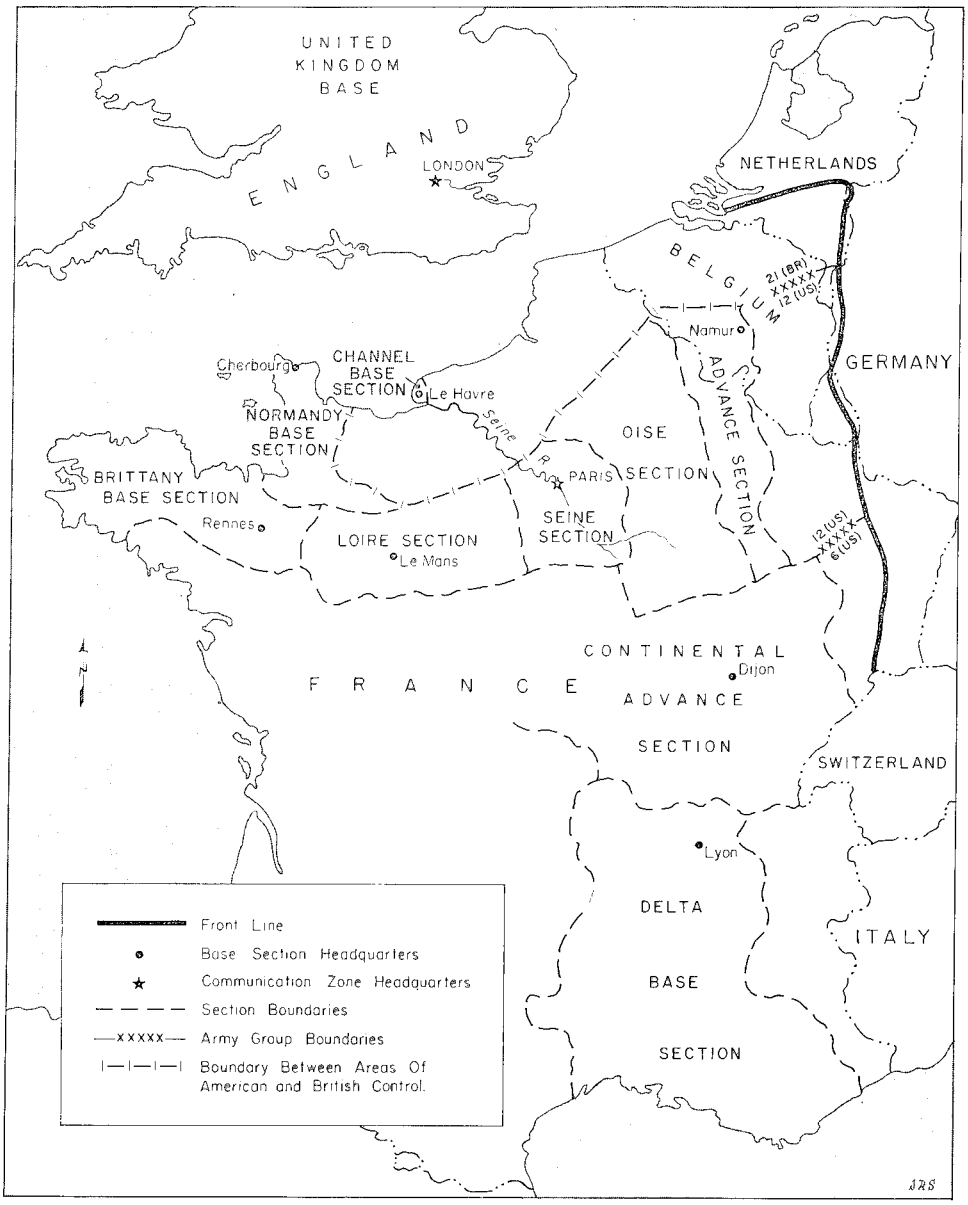
Kingdom Base Section (map 5). The surgeons assigned to the headquarters of continental base sections served on the special staffs of the base section commanders; their offices averaged about 25 officers and 35 enlisted men each. All the continental base sections had substantial numbers of station and general hospitals, medical supply depots, and medical sections of general depots—the full array of units designed to provide the standard medical service of a communications zone.[55]

When the area of southern France invaded from North Africa and Italy was added to the boundaries of the European theater on 1 November 1944, a whole new communications zone was fitted into the vast logistic operation in progress on the Continent. The Communications Zone, MTOUSA, supporting the Seventh U.S. and the First French Armies, had extended its sphere of control to France from Italy. When the invaded area of southern France became a part of the European theater, this command became an additional communications zone command for the European theater, known as the Southern Line of Communications. Its medical section, that of the former Communications Zone, MTOUSA, directed by Colonel Shook, continued performing its duties under a new name in a different theater. With a staff of 19 officers and 39 enlisted men, it directed the medical offices of an advance and a base section supporting the armies in the south. Its work paralleled for some months that done by General Hawley's office in directing the medical sections of the area commands in northern Europe. It supervised the standard medical service of the communications zone—operation of fixed hospitals for Army troops and thousands of prisoners of war, control of disease, and distribution of medical supplies to elements of Southern Line of Communications and the two armies. Its status was of brief duration; before the middle of February 1945 the Southern Line of Communications was disbanded and its troops absorbed by Communications Zone, ETOUSA. Colonel Shook became deputy to the Surgeon, Communications Zone, ETOUSA (General Hawley). The surgeons of the two area commands in the south continued operating with little change, now dealing directly with General Hawley's office.

Both the seven sections in the north (supporting the 12th Army Group) and the two in the south (in support of the 6th Army Group) expanded rapidly toward the German border during late 1944 and early 1945.[56] After the armies and the chief battlefront in northern Europe had shifted eastward, Normandy Base Section's medical service underwent considerable change. It became a rear-area service, hospitalizing prisoners of war, evacuating casualties through the port of Cherbourg, supervising the movements of medical supplies, and furnishing care to troops passing through the staging areas within the base section's territory. When the Brittany Base Section (which had absorbed

[55] (1) See footnotes 2, p. 304; and 4(3), p. 307. (2) Annual Reports, Surgeons, Oise, Seine, Channel, and Normandy Base Sections, 1944.

[56] (1) History, Medical Section, Southern Line of Communications, 20 Nov. 1944–1 Jan. 1945. (2) Interview, Col. Charles F. Shook, MC, USA (Ret.), 31 Mar. 1952. (3) See footnote 4(3), p. 307. (4) Annual Reports, Surgeons, Delta Base Section and Continental Advance Section, 1944.



MAP 5.—European theater communications zone, November 1944.

Loire Section in December 1944) was added to Normandy Base Section early in 1945, the medical service of Normandy Base Section acquired responsibility for additional troops, including those of the Fifteenth U.S. Army who were helping French forces in the coastal sector to contain German units holding out around Lorient and St. Nazaire.

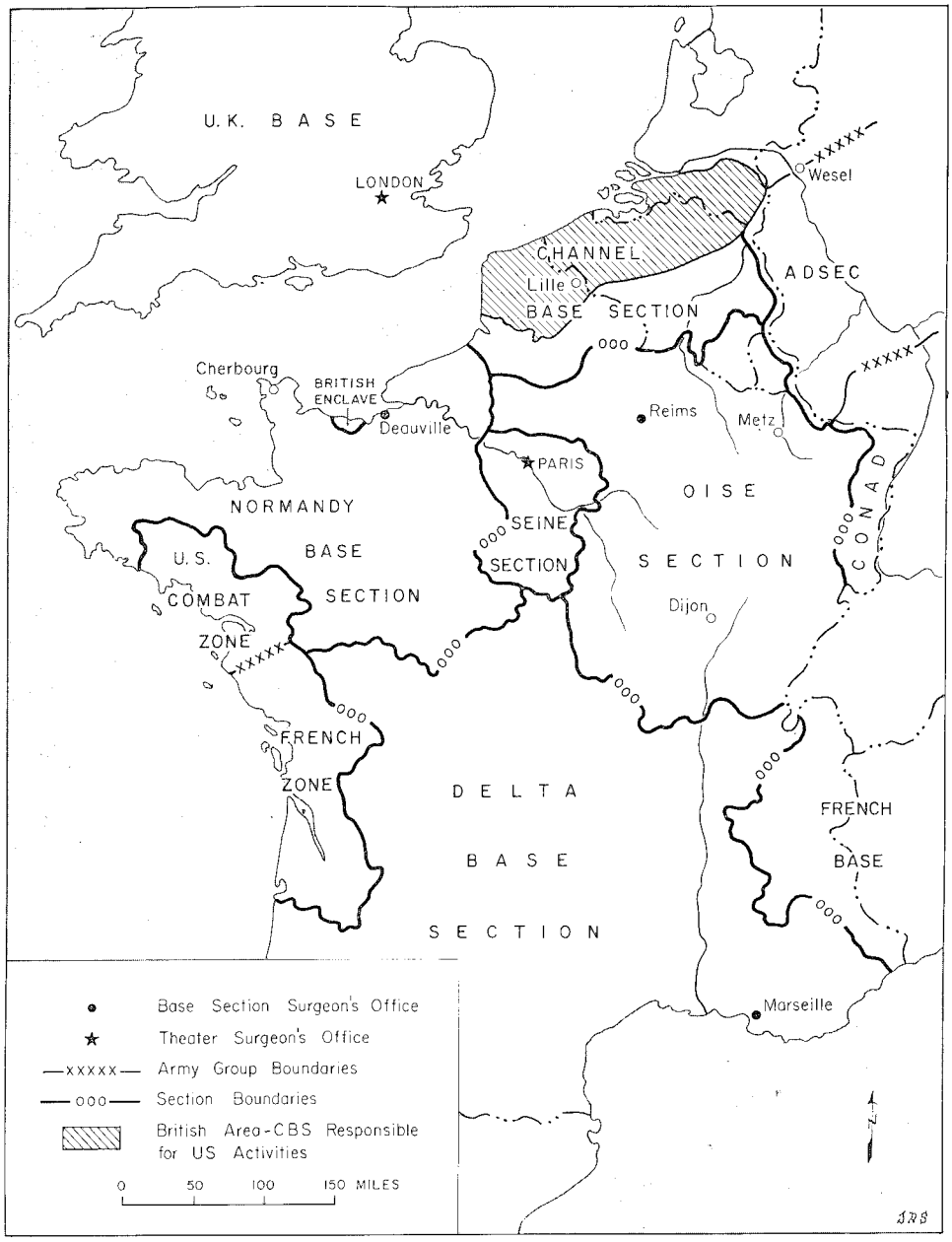
The medical service of Seine Section, situated as it was between the intermediate area and the rear of the communications zone, was largely occupied with receiving patients, distributing them to its hospitals, and evacuating them rearward by air, rail, and motor transport. To the north of Seine Section the larger area known as Channel Base Section reached the peak of its operations in the few months before the end of the war. After turning over to Normandy Base Section an area including Le Havre and Rouen, Channel Base Section acquired that part of Belgium previously within the boundaries of Advance Section. Its surgeon's office was also responsible for U.S. Army medical activities within the area of British jurisdiction along the channel coast (map 6), especially in such ports as Antwerp and Boulogne. At least one-third of Channel Base Section's medical installations were within this area at the close of the war.

During early 1945 the most important area command of the communications zone on the Continent, in terms of Medical Department strength and number of medical installations, was Oise Section (known as Oise Intermediate Section after 2 April). More than half of the fixed hospitals on the Continent (many of which were grouped into large hospital centers) were located within its boundaries by April, after it had absorbed most of the territory of the two advance sections.

Within the communications zone in the south, the most fully developed of the two sections was Continental Advance Section. The mission of its medical section continued to be that of giving immediate support to the Seventh U.S. Army, including fixed hospitalization, evacuation, and medical supply. (After this advance section moved into Germany its support of the French First Army was limited to the furnishing of supplies and equipment.) At the beginning of 1945 medical facilities in this section were fairly well stabilized, but fixed hospitals passed to Oise Intermediate Section early in April with the movement into Germany. The medical mission of Continental Advance Section then became primarily that of evacuation and supply for the Seventh U.S. Army and the continuation of medical supply for the French First Army, along with provision of medical care for its own troops, displaced persons, and prisoners of war. The other major element of the communications zone in the south was Delta Base Section, which was comparable to Normandy Base Section in the north in that it included considerable coastline—the Mediterranean coast of France. Most of its medical installations were concentrated around Marseille. Continental Advance Section maintained the larger number of general hospitals since it provided close support for the 6th Army Group; Delta Base Section needed only enough beds for static troops and long-term patients.[57]

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[57] (1) See footnote 4(3), p. 307. (2) First Semiannual Report, Office of the Surgeon, Continental Advance Section, 1 July 1945. (3) Final Report, Medical Section, Delta Base Section, 25 Jan. 1946. (4) First Semiannual Report, Office of the Surgeon, Normandy Base Section, 1 Jan.–30 June 1945. (5) First Semiannual Report, Office of the Surgeon, Seine Section, 1945. (6) Semiannual Report, Medical Section, Channel Base Section, 1 Jan.–1 July 1945. (7) First Semiannual Report, Medical Section, Oise Intermediate Section, 1 Jan.–30 June 1945.



MAP 6.—European theater communications zone, 15 April 1945.

The medical service provided in the rearmost area of the communications zone, the United Kingdom, underwent considerable change during the months that troops were being readied for the cross-channel assault. Upon the surgeons of Southern and Western Base Sections fell the burden of providing medical service for the thousands of troops assembling in the marshalling areas of the southern coast. Many camp dispensaries and first aid stations were set up to care for incoming troops. The base section surgeons had to provide them initial equipment and replacement supplies. Many fixed hospitals in Southern Base Section were designated "transit" hospitals as links in the chain of evacuation from the invaded areas, and mass evacuation of patients already being treated in these hospitals to the hospitals of Western Base Section was undertaken by the Southern Base Section medical service in order to make room for invasion casualties.

After the invasion and concurrently with the establishment of base sections on the Continent, all the base sections in the United Kingdom were consolidated under a single United Kingdom Base, the former base sections becoming districts of the new base. Colonel Spruit became United Kingdom Base surgeon; his office, briefly in Cheltenham, was located in London near the end of October 1944. His staff was larger than equivalent components in the continental base sections and larger than that of the theater surgeon's office in all theaters except the European and Mediterranean. At the end of 1944 it consisted of 81 officers, 1 warrant officer, 124 enlisted men, 45 members of the Women's Army Corps, and 83 civilians; its internal organization was identical with that of General Hawley's office as of May 1945 (appendix B, p. 562) except that it lacked a Field Survey Division and a Historical Division. It was made up of some personnel left at Communications Zone-ETOUSA headquarters when General Hawley's office moved to the Continent, as well as personnel of the medical section of the former Southern Base Section. At the outset it assumed technical supervision of 64 general hospitals, 43 station hospitals, 5 field hospitals, 19 hospital trains, and several medical depot companies which were operating 3 medical depots and medical sections in 13 general depots. Its numerous medical installations and units probably constituted the greatest concentration of U.S. Army medical facilities in history. From D-day to 7 May 1945, the hospitals assigned to the United Kingdom Base cared for nearly 428,000 sick and wounded soldiers (including prisoners of war) returned from the Continent, and nearly 160,000 patients from troops stationed in the United Kingdom.[58]

An important feature of base section administration after the invasion was the hospital center—a group of fixed hospitals (general, station, and convalescent) operating under a single headquarters. Early in 1944 three groups of hospitals at Cirencester, Malvern, and Whitchurch in western England had

[58] (1) Annual Reports, Medical Section, United Kingdom Base, 1944 and 1945. (2) See footnotes 4(3), p. 307; and 7(3), p. 308. (3) Annual Report, Supply Division, Office of the Surgeon, United Kingdom Base, 1 Sept.–31 Dec. 1944.

been put under hospital center headquarters for the sake of more efficient operation. With the consolidation of the base sections of the United Kingdom into a single base, responsible for administering over 100 hospitals (at the close of 1944, 66 general hospitals, 32 station hospitals, and 5 convalescent facilities), it became even more useful to employ an intermediate administrative headquarters between the individual hospital and the United Kingdom Base surgeon's office.

With the onset of mass evacuation from the Continent to the United Kingdom, the grouping of hospitals into a hospital center brought added advantages. A hospital center would furnish enough vacant beds for the reception and care of the 200–300 evacuees from the Continent which a hospital train would carry. Thus discharge at a single railhead, instead of at the separate localities of several hospitals (or instead of maintaining sufficient vacant beds at a single hospital, thus losing bed capacity), would be possible. Moreover, a single hospital could be chosen to render all service provided in the entire group in a given specialty such as thoracic surgery, with all the thoracic surgeons from the various hospital staffs concentrated in the one hospital. In one of the largest centers, the 12th at Great Malvern, French patients were cared for as a group, and within a single hospital at some centers were concentrated personnel skilled in chemical warfare medicine as well as the necessary supplies, in readiness for a possible large-scale influx of gas casualties.

After the invasion, additional hospital centers were established in the United Kingdom. Seven operated there, mostly in southern and western England and all under United Kingdom Base organization; they were located at Taunton (Somersetshire), Blandford (Dorsetshire), Devizes (Wiltshire), Cirencester (Gloucestershire), Great Malvern (Worcestershire), Whitchurch (Flintshire), and New Market (Cambridgeshire). By the close of December 1944, 45 general hospitals, 11 station hospitals, and 2 convalescent facilities were in operation in the continental base sections, and the grouping of hospitals became practicable there as well. After January 1945, nine hospital centers were developed in the continental base sections: seven were in northern and eastern France—Cherbourg, Paris (two centers), Nancy, Le Mans (later at Vittel), Var-le-Duc, and Mourmelon—one in Liége, and one in Aachen. The commanding general of a hospital center commanded the hospitals and other units and served as the communicating agent on technical, administrative, and professional matters with the office of the base section (or base) surgeon. Hospital centers proved more practicable in the European theater than elsewhere, for their usefulness depended in large measure upon their employment in connection with the mass evacuation of large numbers of casualties.[59]

[59] (1) General Order No. 15, United Kingdom Base, 2 Oct. 1944. (2) See footnotes 7(3), p. 308; and 58(1), p. 349. (3) Annual Reports, 12th, 15th, 801st, and 802d Hospital Centers, 1944 and 1945. (4) Letters, Maj. Gen. Paul R. Hawley, MC, USA (Ret.), to Col. John Boyd Coates, Jr., MC, USA, Director, The Historical Unit, U.S. Army Medical Service, 29 Aug. and 7 Sept. 1955, commenting on preliminary draft of this volume. (5) Report of the General Board, U.S. Forces, European Theater, on Medical Service in the Communications Zone, European Theater of Operations, Medical Section Study No. 95. [Official record.]

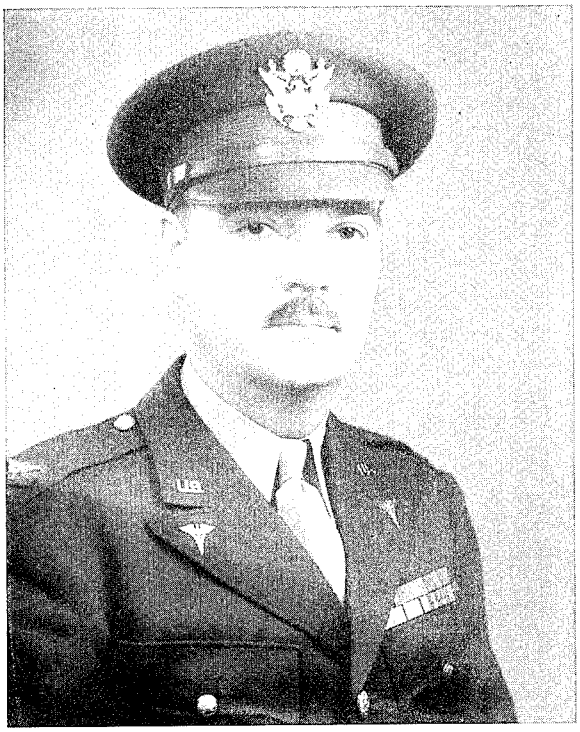


FIGURE 79.—Col. Thomas J. Hartford, M.C.

The Ground Forces: 1944–45

The bulk of U.S. Army ground troops arrived in the European theater after January 1944. Until the fall of 1943, the major ground force element in the theater had been V Corps; in October the First U.S. Army had assumed the position of top ground force command. The Third, Ninth, and Fifteenth U.S. Armies followed, building up in 1944 in that order. All were eventually in operation on the Continent under the command of 12th U.S. Army Group. The First U.S. Army surgeon was Col. John A. Rogers, MC. The Third U.S. Army surgeon, Col. (later Brig. Gen.) Thomas D. Hurley, MC, was succeeded by Col. Thomas J. Hartford, MC (fig. 79). The Ninth U.S. Army surgeon was Col. William E. Shambora, MC, and the surgeon of Fifteenth U.S. Army was Col. L. Holmes Ginn, MC (fig. 80). From the Mediterranean theater came another American combat force, the Seventh U.S. Army—Col. Myron P. Rudolph, MC, surgeon—which landed in southern France 10 weeks after the Normandy invasion. It and the First French Army were under the control of the 6th Army Group. The First Allied Airborne Army, organized in August 1944 without any headquarters medical section, was under the direct control of Supreme Headquarters, Allied Expeditionary Force.

In this theater, which contained the overwhelming majority of U.S. Army ground troops overseas, the army group became the highest ground force



FIGURE 80.—Col. L. Holmes Ginn, MC.

command. After September 1944, both the 12th U.S. Army Group and the Allied 6th Army Group were under the tactical control of SHAEF. The headquarters of the 12th, which controlled the bulk of the American ground troops, became in a sense the U.S. Army ground force headquarters in the theater organization.

The army group headquarters confined its activities for the most part to tactical and policy matters, being designed primarily, like the corps headquarters, for the purpose of coordinating the activities of subordinate elements. Hence the 12th Army Group surgeon—Col. Alvin L. Gorby, MC (fig. 81), who had served as Armored Force surgeon in the United States—was not concerned with the direct supervision of medical service for troops; this was the province of the field armies and their subordinate elements. No table of organization existed for the army group surgeon's office, as the army group was a new organization; Colonel Gorby kept his medical section, one of 19 special staff sections, small and its organization simple. It included no dental or veterinary officers or consultants, as the offices of army surgeons commonly did; its two chief elements were a Plans and Operations Division and Preventive Medicine Division. The peak strength of personnel assigned to it was 14 officers and 10 enlisted men, although a few additional officers assigned to the offices of army surgeons served as liaison officers between their respective medical sections and Colonel Gorby's office.

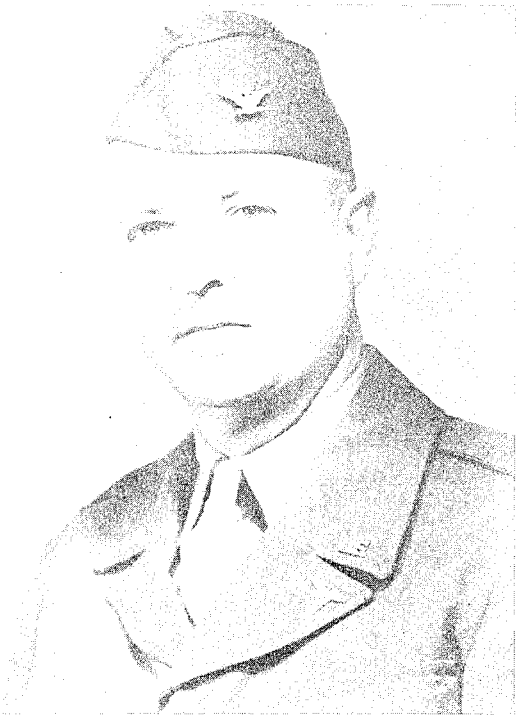


FIGURE 81.—Col. Alvin L. Gorby, MC.

During the months of planning for the invasion, Colonel Gorby's medical section (originally created as the medical section for 1st U.S. Army Group, the progenitor of the 12th) was occupied with working out, in cooperation with the Chief Surgeon, ETOUSA, and the Chief Medical Officer, SHAEF, the respective responsibilities of the armies, air forces, and naval forces for medical supply and evacuation. Evacuation problems to which it devoted special attention were the methods of recording casualties, evacuation of casualties by water, and a system of property exchange whereby litters, blankets, and similar items transferred with evacuees would be replaced. For a brief period, from 16 May to 6 July 1944, it acted as the medical section for the American staff attached to rear headquarters of the British 21st Army Group, the higher headquarters which directed the field armies during the initial stages of the invasion. From 7 July to the end of the month, a period during which the medical section moved to France, it returned to control of 1st U.S. Army Group but functioned once more under 21st Army Group during its first month of activity on the Continent, the month of August. After 1 September, it became the medical section for General Bradley's 12th Army Group which from then on functioned directly under SHAEF.

After September, when the Ninth U.S. Army launched the attack on the Brittany Peninsula, Colonel Gorby's medical section had the task of allocating

medical units among three armies—the First, the Third, and the Ninth U.S. Armies. The shifting of units reached a peak at critical periods; some had to be loaned to 6th Army Group coming up from the south, and many had to be transferred after the German breakthrough in the middle of December 1944. The office kept the tables of organization and equipment of Medical Department units assigned to the army group under continuous review and recommended changes. It kept in close touch with the medical office of Advance Section and other elements of Communications Zone for mutual arrangements concerning medical supply, evacuation, and hospitalization. It allocated Medical Department units and critical items of medical supply, such as whole blood, among the field armies and coordinated policies and techniques designed to prevent trenchfoot, combat exhaustion, and neuropsychiatric cases—problems encountered by all the field armies in combat in Europe during the winter of 1944–45.

The 6th Army Group, composed of the Seventh U.S. and First French Armies, and commanded by Lt. Gen. Jacob L. Devers had, unlike the 12th, no special staff medical section, but a few Medical Department officers and enlisted men were assigned to G–4. Their work, limited by the size of the group and its subordination to G–4, was confined to inspecting medical units of the two armies under 6th Army Group, the coordination of successive stages of evacuation, and the development of a workable system of property exchange between air and ground forces in air evacuation.[60]

The Surgeon, 6th Army Group, Col. Oscar S. Reeder, MC (fig. 82), pointed out the excessive staff work which his medical section had to undertake because of its incorporation in G–4:

> Under normal staff procedure the Surgeon deals with all general and special staff sections of a headquarters. Matters that require processing through Command Channels are forwarded through the appropriate general staff section, while technical subjects are coordinated directly with the special staff section interested. Technical matters comprise approximately 90% of the work of the Surgeon. Under the initial organization of this headquarters, all such correspondence was routed through the A.C. of S., G–4. This procedure forced considerable unnecessary detail to the attention of this general staff officer, whereas, normally only the completely coordinated studies would have been presented. Furthermore, all incoming papers and messages of interest to the Surgeon only were routed through the G–4 section instead of being transmitted directly from the message center. This made the G–4 section responsible for the action regardless of the subject.[61]

This direct subordination of the staff surgeon to G–4 occurred in other commands at intervals and sometimes evoked similar protests. In such cases, the surgeon frequently felt handicapped by lack of direct access to his commanding general. In May 1945, Colonel Reeder's medical section was placed

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[60] (1) See footnotes 4(3), p. 307; and 45(1), p. 336. (2) Report of Operations, 12th Army Group, vol. XIII: Medical Section. (3) Interview, Brig. Gen. Alvin L. Gorby, 23 Jan. 1953. (4) History, Medical Section, 12th Army Group, 1 Jan.–30 June 1945. [Official record.] (5) Annual Report, Surgeon, 6th Army Group, 1945.

[61] Annual Report, Surgeon, 6th Army Group, 1944.

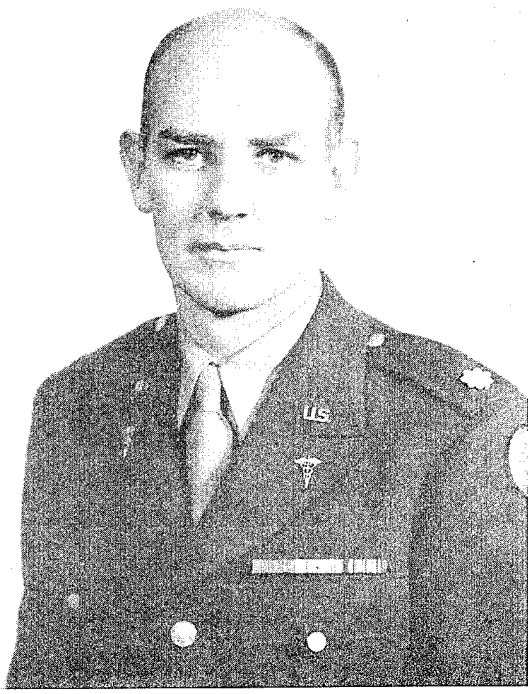


FIGURE 82.—Lt. Col. Oscar S. Reeder, MC.

on the special staff of 6th Army Group, and he noted that the Medical Department had then been placed "in its rightful position in this Army Group." [62]

All field armies had similar medical sections (in general conformity to a table of organization) at headquarters; they consisted of about 24 officers and 30 enlisted men. The army surgeon was a colonel or a brigadier general of the Medical Corps. Army medical sections usually included, besides the surgeon and his executive officer, the following subsections: Administration, personnel, operations, training, preventive medicine, supply, dental service, veterinary service, nursing, and consultants. Since the field armies had hospitals (field, evacuation, and convalescent) assigned to them, representatives of the professional services were needed at army headquarters; the staff nurse of Third U.S. Army, for example, supervised the work of an average 600 nurses in the army's hospitals. Officers of the staff medical section of the field army were frequently put on liaison duty with the headquarters of the various corps under the army, and additional officers were sometimes attached to the army medical section for special purposes; for example, a medical liaison officer of the air forces for arranging evacuation of patients by air from the army area to the communications zone.

[62] Letter, Col. Oscar S. Reeder, to Maj. Gen. Albert W. Kenner, 5 May 1945.

The offices of army surgeons operated as a unit at a single headquarters only rarely. During the period of preinvasion planning in the United Kingdom, for instance, the First U.S. Army surgeon and part of his staff spent some months in London in order to work in conjunction with SHAEF and other planning headquarters in completing the invasion plans; the remainder of the staff was at the army's command post in Bristol. During periods of combat on the Continent, army surgeons' staffs were usually split, along with the rest of the army headquarters, into forward and rear echelons. Army surgeons were usually concerned with the proper division of their staffs between the two echelons. It was difficult to coordinate the work of the divided medical section, especially since Medical Department units assigned to the field army also operated at times in two echelons. The Third U.S. Army surgeon favored placing himself, his executive officer, the surgical consultant, his operations and training subsection, and his medical supply subsection at forward echelon, leaving the rest of his staff—the dental, veterinary, and preventive medicine personnel, the remaining consultants, and staff engaged in personnel and administrative matters—at the rear echelon.

The field army had a large number of Medical Department units assigned; these were mostly concerned with the evacuation of patients from the division and corps areas and their treatment in army hospitals. Units assigned to the field army in the European theater consisted chiefly of the following: Medical groups; medical battalions; separate collecting, clearing, and ambulance companies; field, evacuation, and convalescent hospitals; medical depot companies, auxiliary surgical groups, a medical laboratory, and an occasional medical gas treatment battalion. The army surgeon was responsible (subject to coordination with the army staff) for training these units in the precombat period, for planning their movement into combat areas at the proper time and in the proper proportion (the so-called "phasing in"), and for their utilization during combat. Coordination of the evacuation process from forward areas called for close liaison by the army surgeon's office with each division and corps surgeon and his staff, and with the medical staff at Communications Zone headquarters, and frequently led to a temporary redistribution of personnel or units. In December 1944, for example, the First U.S. Army surgeon had to supply from its units many Medical Department enlisted men, as well as some officers, to divisions under the army; as a result it had to borrow in turn more than 300 Medical Department personnel from Communications Zone units.[63]

During the European campaigns 15 corps were used among the 5 American field armies on the Continent. Most were shifted from one army to another in the way that the many divisions in the theater were reassigned among the various corps. The medical service functioning under the corps was geared to the standard concept of the corps as a tactical unit rather than as a self-

[63] (1) Annual Reports, Medical Sections, First, Third, Seventh, and Ninth U.S. Armies, 1944. (2) Annual Report, Medical Section, Fifteenth U.S. Army, 1945.

sufficient organization like the field army or the division. Hence the corps surgeon had no Medical Department units under his control with the exception of a medical battalion which administered medical service to corps troops (as distinct from divisions under the corps) and handled medical supplies for them. Occasionally other field army medical units (such as medical groups, flexible organizations to which various types of technical units might be attached) served with the corps. Each corps headquarters had a small medical section composed typically of two Medical Corps officers, two Medical Administrative Corps officers, a warrant officer, and four enlisted men. As in the case of the medical section at army group headquarters, Dental, Veterinary, and Nurse Corps personnel were not normally assigned.[64]

The Air Forces: 1944–45

Early in March 1944, USSTAF (U.S. Strategic Air Forces in Europe) replaced the U.S. Army Air Forces in the United Kingdom. The new top American air command had control of the administration, including the medical service, of the Strategic Eighth and the tactical Ninth Air Forces. An air service command of the U.S. Strategic Air Forces was also organized; it was analogous to the Air Service Command, Army Air Forces, in the United States.

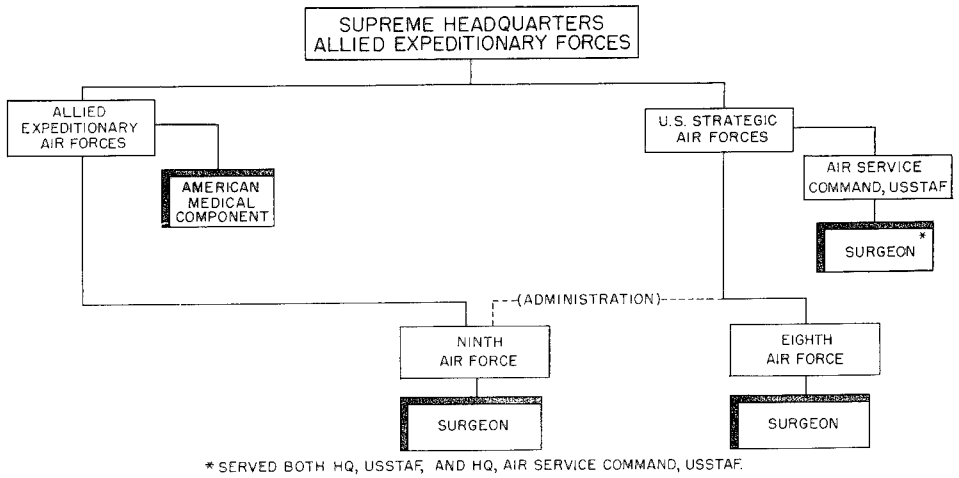
General Grow, the surgeon of the Eighth Air Force, the Eighth Air Service Command, and U.S. Army Air Forces in the United Kingdom, became the chief medical officer in U.S. Strategic Air Forces, serving under the Commanding General, Air Service Command, USSTAF, who was also the Deputy Commanding General for Administration, USSTAF. Although his office was placed at the service command level, General Grow had ready access to the Commanding General, USSTAF, Lt. Gen. Carl Spaatz, through the deputy commander under whom he served. His medical staff included a deputy surgeon, executive officer, professional services officer, special projects officer, medical statistics officer, care-of-fliers officers, personnel officer, administrative officer, and later a nutritionist, a veterinarian, and a sanitary officer.[65]

Thus, from spring 1944 to the close of the war, the following air commands of the European theater had medical sections at their headquarters: U.S. Strategic Air Forces and Air Service Command, USSTAF, which had the combined medical section headed by General Grow; the Eighth Air Force; and the Ninth Air Force (chart 19). Both headquarters, USSTAF, and Headquarters, Air Service Command, USSTAF, were located just outside London in Bushy Park until September 1944 when they moved to the outskirts of Paris where they could maintain close liaison with SHAEF in Versailles. The headquarters of Eighth Air Force remained in Britain, but that of the tactical

[64] See periodic reports of the surgeons of V, VII, XII, XVI, and XX Corps, 1944 and 1945.

[65] (1) Report of Medical Activities, U.S. Strategic Air Forces, 1 Jan.–1 Aug. 1944. (2) See footnote 29(1), p. 327.

CHART 19.—*Medical sections at major U.S. Army Air Force commands in the European theater, March 1944*



Ninth Air Force which supported the armies in combat in Europe moved to France soon after the invasion of the Continent.

An Allied air command with a British-American medical office existed briefly in the European theater. The Allied Expeditionary Air Force was created in November 1943 to direct the operations of British and American tactical air forces committed to the invasion of the Continent. Since it controlled only the operations of the American tactical air force, the Ninth (administrative matters in the Ninth being directed by the highest American air force headquarters, U.S. Strategic Air Forces), the American component of the medical office at its headquarters, was never of great importance. It was headed by Lt. Col. James Jewell, MC, whose rather limited duties consisted chiefly of giving information to the commander of the Allied air command on the health of troops of the Ninth Air Force, cooperating with his British colleague, and keeping in touch with the Medical Division, Supreme Allied Headquarters. The Combined Air Transport Operations Room maintained by Allied Expeditionary Air Force allocated the requests it received for aircraft from various ground and air force commands among British and American air transport agencies and thus exercised functions with respect to medical supply and evacuation through controlling the means for furnishing these by air. With the invasion of Europe, Allied Expeditionary Air Force exercised considerably less authority than originally planned, and by mid-October 1944 it was disbanded, thus ending what has been called "the least successful venture of the entire war with a combined Anglo-American command." [66]

[66] (1) Craven, W. F., and Cate, J. L., editors: The Army Air Forces in World War II. Chicago: University of Chicago Press, 1951, vol. II, pp. 561–562, 620. (2) Preliminary Operational Report, Surgeon, Ninth Air Force, 18 July 1944.

After the main branch of Headquarters, USSTAF, moved to Paris in September, General Grow's office maintained a small medical section at Headquarters, USSTAF (Rear), in London to direct medical service for air troops, chiefly of the Eighth Air Force, left behind in the United Kingdom. This office acted as a link between the parent medical section in Paris and medical officers at headquarters of the Eighth Air Force. It dealt with the office of the United Kingdom Base surgeon in arranging for hospitalization of air force personnel stationed in the United Kingdom and supervised the industrial hygiene program for civilian employees at large air force depots in the United Kingdom. One of its officers was attached in a liaison capacity to the Rehabilitation Division of General Hawley's office in order to give special supervision to the rehabilitation and training of air force troops convalescing in the general hospitals of the Services of Supply.

As medical section of the Air Service Command, USSTAF, General Grow's office advised the Director of Supply of that command on procurement, receipt, storage, distribution, and issue of medical, dental, and veterinary equipment and supplies for the air forces and commands under the administrative control of the Commanding General, USSTAF. As medical section at staff level, it coordinated intra- and extra-theater air evacuation, research in aviation medicine, and activities of the air forces and commands concerned with the care of fliers and the rehabilitation of air force personnel convalescing at communications zone hospitals. Other duties included the examination of medical equipment and protective clothing and safety equipment captured from German planes and aircrews. General Grow's office also undertook measures to reduce industrial hazards in air force installations. It coordinated with other branches of USSTAF headquarters the medical planning for special projects and for postwar medical activities.

Supervision of technical work concerned with protecting the health of fliers was centered in the Care-of-Fliers' Section of the surgeon's office in the Eighth and Ninth Air Forces. The Care-of-Fliers' Section in General Grow's office had the task of coordinating their work. It planned and operated rest homes for fliers, since these were used by both the Eighth and Ninth Air Forces, and it allocated beds in the rest homes between them. Seventeen rest homes were in operation late in 1944; they served members of combat crews suffering from fatigue or tension induced by participation in a number of combat missions. The Care-of-Fliers' Sections in the surgeons' offices of the Eighth and Ninth Air Forces had the more immediate responsibility for protecting flying personnel of these commands against stresses, diseases, and injuries of an occupational nature. Their work was a special phase of preventive medicine. They carried out their program largely by means of the so-called "central medical establishment" developed in each air force.

In the last 2 years of the war the central medical establishment was in the process of evolution; the Air Surgeon's Office in Washington advocated the

creation of one for each numbered air force and toward the close of the war succeeded in establishing an official table of organization for this unit. The First Central Medical Establishment, which served the Eighth Air Force, was created in November 1943 by reorganizing the Medical Field Service School (Provisional) which the air force had been operating at Pine Tree, England, since mid-1942. In 1942 the school had largely confined its work to giving an indoctrination course in aviation medicine to newly arriving medical officers who had not had this training in the United States. As most medical officers arriving for service with the air forces in 1943 and later had had the course, the First Central Medical Establishment shifted its emphasis to special problems being encountered by fliers in the European theater. It also continued the training, which it had begun late in 1942, of special "oxygen and equipment officers," in the effort (later considered successful) to reduce casualties due to failures, defects, or misuse of safety equipment. Trained officers gave in their turn continuous instruction to combat crewmen in the elementary principles of aviation medicine and the use of protective equipment. The First Central Medical Establishment also engaged in some research, with the aid of an Engineer officer, on possible defects in personal flying equipment, suggesting modifications and devising several new items. A central medical board of the establishment determined the qualifications or disqualifications for flying of borderline cases referred to it, primarily from combat units. In March 1944 a similar unit, termed the Third Central Medical Establishment, was organized in the Ninth Air Force.[67]

Army Air Forces pressure for control of its own hospitals in the European theater increased early in 1944. Although neither General Grow nor the surgeon of the Ninth Air Force, Colonel Kendricks, shared the enthusiasm of the Air Surgeon for putting fixed hospitals under Army Air Forces control in the European theater, General Grant had kept up the fight in Europe, as well as in other oversea areas. The matter was brought to the attention of President Roosevelt, who appointed a board to survey the situation in the European theater. The three members of the board—The Surgeon General, the Air Surgeon, and Dr. Edward A. Strecker, consultant in psychiatry to the Secretary of War—went to Europe in the spring of 1944, visiting hospitals in which patients were preponderantly of the air forces and conferring with air force commanders. The board decided in favor of the existing system of hospitalization, which, it found, was operating satisfactorily, and recommended that no changes be made on the eve of invasion of the Continent. During the remainder of the war General Hawley, strongly supported by The

[67] (1) Annual Reports, Medical Department Activities, Eighth Air Force, 1943 and 1944. (2) General Order No. 51, Headquarters, Ninth Air Force, 17 Mar. 1944. (3) Special Order No. 186, Headquarters, Ninth Air Force, 26 Mar. 1944. (4) Annual Report, 3d Central Medical Establishment, Ninth Air Force, 1944. (5) Report, Medical Department Activities, U.S. Strategic Air Force, Aug.–Dec. 1944. (6) See footnote 29(1), p. 327.

Surgeon General, maintained control of fixed hospitals in the European theater.[68]

Medical Department officers of the air forces in Europe took part in two special missions auxiliary to operations in the European theater but outside its boundaries. In the summer of 1944 the Surgeon, USSTAF, aided in planning medical service for the Eastern Command, USSTAF, established in Soviet Russia to facilitate the shuttle bombing of Germany. A command surgeon was assigned, and a 75-bed dispensary, in effect a small hospital, was set up at each of the 3 airbases established east of Kiev. During their stay in Russia, the command's medical officers found the Soviet medical authorities generally cooperative and intensely interested in methods used by the U.S. Army Air Forces. Under the close supervision of the Russians, American medical officers visited Soviet hospitals and bases. Their work was of relatively brief duration. A crippling blow to the main base at Poltava, delivered by the German Air Force 3 weeks after the first shuttle flight, reduced their effectiveness, while the westward advance of the Red Army soon left them far behind the lines.[69]

The Eighth Air Force also gave some medical aid to American airmen interned in Sweden, amounting by the end of July to the men of 94 aircrews. The medical officer who headed the program was assigned to the office of the U.S. Military Air Attaché of the American Legation in Stockholm. During the fall of 1944, officers sent to Sweden surveyed the health of internees at the eight camps maintained for them, determined immediate medical needs, and arranged payment for the services of Swedish physicians. In addition to their basic assignment, they assisted the Office of Strategic Services with the medical care of American personnel secretly dropped by air in Norway, advising Norwegian doctors who cared for the Americans and aiding them in obtaining medical supplies from the United States.[70]

As the invasion of Germany got under way, Medical Department officers of the air forces made increasingly active inquiry into developments in aviation medicine within the German air forces; this work became a special phase of the investigation of all aspects of German military medicine being undertaken by the Combined Intelligence Objectives Subcommittee. In the spring of 1945, flight surgeons of the Eighth and Ninth Air Forces were sent to Germany to work with the medical intelligence teams which accompanied the

[68] (1) Letters, Col. Edward J. Kendricks, MC, to Maj. Gen. David N. W. Grant, 18 July, 20 Aug. 1944. (2) Memorandum, Maj. Gen. Norman T. Kirk, The Surgeon General, Maj. Gen. David N. W. Grant, and Dr. Edward A. Strecker, for the Chief of Staff, through the Deputy Theater Commander, European Theater of Operations, U.S. Army, 20 Mar. 1944. (3) Letter, Maj. Gen. Paul R. Hawley, to Maj. Gen. Malcolm C. Grow, 27 Mar. 1944. (4) Annex 4 to Ninth Air Force Plan for Operation OVERLORD, pt. II, Medical Plan, 24 Mar. 1944. ((5) Interview, Brig. Gen. Edward J. Kendricks, MC, 23 Feb. 1950.

[69] (1) Craven, W. F., and Cate, J. L., editors: The Army Air Forces in World War II. Chicago: University of Chicago Press, 1951, vol. III, ch. IX. (2) Quarterly Report, Medical Department Activities, Eastern Command, U.S. Strategic Air Forces in Europe, January–March 1945. (3) Special Medical Report, Eastern Command, U.S. Strategic Air Forces in Europe, 12 June 1944.

[70] Potter, F. A.: History, Legation of the United States of America, Stockholm, Sweden, 27 September 1944–9 July 1945. [Official record.]

advancing armies and investigated German medical installations. The Director of Medical Services, USSTAF, maintained at his rear office in London an aeromedical research section which acquired information, documents, and materiel pertaining to the medical service of the *Luftwaffe*. This office interrogated doctors and pilots of the *Luftwaffe* and forwarded documents and captured materiel of significance to aviation medicine sent them by field investigators to the Aero-Medical Research Laboratory at Wright Field, Ohio. Later an aeromedical museum established in London at the request of the Director of Medical Services, USSTAF, served as a depository for the examination of medical items, flying equipment, air-sea rescue equipment, protective chemical warfare equipment, and emergency rations used by the *Luftwaffe*.[71]

Medical Care for Civilians in Liberated Countries

The organization which handled the public health programs among the populations of Europe liberated by the advancing Allied armies eventually became an elaborate network functioning at higher levels of command under a general staff section termed G–5. This chain of control, separate from the office of staff surgeons with responsibility for the health of troops, was more completely established after the orthodox concept in the European theater than in any other area during the war. However, a number of factors—chiefly post-invasion developments on the Continent—tended to disturb the standard organization in the later months of the war and to thrust more and more responsibility for the medical program for civilians upon the offices of command surgeons whose primary responsibility was for troops.

A Medical Department officer was assigned to the Civil Affairs Section, a special staff unit of Headquarters, ETOUSA, in July 1943.[72] Only two or three Medical Department officers worked in this Public Health Department, as it was called, of the Civilian Relief Branch of the Civil Affairs Section. During this early period the specialized functions of various War Department corps were not closely adhered to in the organization for civil affairs. An Engineer Corps officer, for example, headed the Public Health Department at one period, while the Medical Department officer who headed the Public Health Department for a time was later put in charge of the entire Civilian Relief Branch. The work of Public Health Department officers in the fall of 1943 was largely a job of planning the desirable organization, maintaining liaison with General Hawley's office, furnishing information to visiting officers from the War Department's Civil Affairs Division, and planning for medical supplies for civilian use. A small Public Health Department (absorbing most of the medical personnel of Civil Affairs Section, ETOUSA) was established in

[71] (1) See footnotes 29(1), p. 327; and 69(2), p. 361. (2) Medical History, U.S. Air Forces in Europe, 1945. [Official record.] (3) Quarterly Report, Medical Department Activities, Eastern Command, U.S. Strategic Air Forces in Europe, Aug.–Dec. 1944.

[72] A civil affairs officer had been assigned to the theater headquarters staff as early as August 1942 (General Order No. 26, Headquarters, European Theater of Operations, U.S. Army, 1942), but no medical subelement had been developed in his office.

the Office of COSSAC (Chief of Staff to the Supreme Allied Commander), the Allied military office for planning which preceded the establishment of the full Allied command. Here, too, the Public Health Department was placed under the Civilian Relief Branch. The group of Medical Department officers which constituted it had the job of coordinating the plans for a civilian medical program being made by the Americans with those being drawn up by the British.

One medical officer, Lt. Col. Carl R. Darnall, MC, who held a number of posts in the European civil affairs program, both medical and nonmedical, and at various command levels, noted several defects in the organization from an early date. He found the subordination of the public health branch to a "civilian relief branch" at various levels disadvantageous to the planning of health programs for occupied territories; nonmedical officers were insufficiently interested in the public health aspects of civilian relief and were inclined to discourage any communication by members of the public health branch with Medical Department officers responsible for the health of troops, including General Hawley. Colonel Darnall worked closely with Medical Department officers assigned to the normal military medical service for troops, including General Hawley and his staff at London and Cheltenham. He proposed the complete removal of public health matters from the civil affairs organization to the control of the theater surgeon and the other usual special staff medical sections of subordinate headquarters, but his ideas gained no headway during the planning period. His criticisms were echoed by other Medical Department officers in 1944 and 1945 when the public health program got under way.[73]

By the end of 1943, a few Medical Department officers had been assigned to the civil affairs element of theater headquarters; to that of the Office of COSSAC; and to that of 1st Army Group, as 12th Army Group was initially called. The next step in the development of the organization to handle civilian affairs was the creation of the European Civil Affairs Division, which trained both American and British personnel, including U.S. Army Medical Department officers, for field work in civil affairs.

The European Civil Affairs Division was a subordinate agency of the Civil Affairs Division (or G–5) of Supreme Headquarters, Allied Expeditionary Force. Although it was organized, like the regular tactical division, into regiments, companies, and so forth, its primary function was to train personnel in all aspects of civil affairs and hold them until the field armies should need them. American medical personnel for the division were selected by the Office of The Surgeon General and arrived in England from January 1944 on. They were trained, along with officers assigned to other aspects of the civil affairs program, at the American School Center at Shrivenham. Of the approximately 175 American officers assigned to the division to work on one aspect or

[73] (1) Darnall, C. R.: Report of Medical Civil Affairs Planning and Organization, 31 Oct. 1944. [Official record.] (2) Study No. 32, Civil Affairs and Military Government, Organization and Operations, by General Board [established 17 June 1945], U.S. Forces, European Theater, no date.

another of public health, about 60 were physicians, the remainder being dentists, sanitary engineers, nutritionists, entomologists, biologists, veterinarians, agriculturists, bacteriologists, research workers, public welfare officers, and administrative officers. A few served with the Public Health Branch, SHAEF, either on the permanent staff or as consultants, some on the staffs of army groups and armies. A good many worked eventually with the advancing armies or with the reestablished national governments.[74]

The civil affairs detachments (called "military government detachments" in Germany) and the country missions were the two main types of field units created out of the European Civil Affairs Division. The detachments served at the division, corps, or army level; as army rear boundaries advanced, the detachments theoretically passed to the control of the Communications Zone (that is, to its area commands) to be returned later to the European Civil Affairs Division for reassignment to forward elements of the armies. Few, however, seem ever to have been reassigned under this plan. They were so scarce that they were either husbanded by the armies for immediate reuse, intercepted by some other organization en route, or left by the armies at larger towns where local authorities were unable to cope with civil problems.[75]

Country missions, so-called, were organized in England within the framework of the European Civil Affairs Division in the early months of 1944 to serve as liaison agencies between the national governments of the liberated countries and Allied military authorities. Missions served in Norway, Denmark, Holland, Belgium, Germany, and France. In general, the mission for each country was provided with one or two medical officers and a Sanitary Corps officer, specialists in various fields being added according to the needs of the country in which they operated. The mission estimated the kinds and quantities of medical, sanitary, and food supplies which the national governments would have to obtain from Allied military sources. It investigated sanitary conditions, outbreaks of disease, and the status of nutrition in the civil population and aided in establishing measures to control venereal disease and to report communicable diseases. Both the Allied military authority and national governments could get from the country mission information on medical matters affecting the mutual welfare of the population and of Allied troops, and each could use the mission as a medium for representing its interest to the other.[76]

Shortly before the invasion of Europe, the organization for administering the Army's public health program became stabilized within the G–5 chain of control. The chief development was the establishment of a public health

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[74] (1) Report, Public Health Branch, G–5, Supreme Headquarters, Allied Expeditionary Force, Observations and Comments Upon Its Organization, Operations, and Relationships, by Dr. W. F. Draper, no date. (2) See footnote 73(2), p. 363. (3) Williams, Ralph C.: The United States Public Health Service, 1798–1950. Washington: Commissioned Officers Association of the U.S. Public Health Service, 1951, p. 698ff.

[75] See footnote 73(2), p. 363.

[76] See footnote 74(1).

branch at Supreme Headquarters, Allied Expeditionary Force, in May. Lt. Col. Leonard A. Scheele of the U.S. Public Health Service, who had served in the public health program in North Africa and Italy, had been assigned to G–5, SHAEF, soon after the command was created, but no fully developed medical group had existed there. The establishment of the fully developed branch took place only pursuant to a visit of Col. Thomas B. Turner, MC, Director of the Civil Affairs Division of the Surgeon General's Office to the European theater early in the year. Colonel Turner noted the same lack of centralized control over the public health program at staff level in SHAEF that he had marked in Allied Force Headquarters during a previous trip to the North African theater. He recommended that a public health element be established within every level of the civil affairs organization in the European theater, with the chief public health officer directly responsible to the chief civil affairs officer.[77]

The Public Health Branch, G–5, SHAEF, became the top medical office directing the medical program for civilians, existing from May 1944 until the dissolution of the Allied command in July 1945. Brig. Gen. (later Maj. Gen.) Warren F. Draper, Deputy Surgeon General of the U.S. Public Health Service (fig. 83), assumed charge of the branch at the request of the Secretary of War and on recommendation by The Surgeon General (General Kirk). A British officer served as deputy chief. A few other officers and enlisted personnel were engaged in preventive medicine and medical supply activities and administrative work. Consultants in the following medical specialties or special fields were attached to the branch: Nutrition, sanitary engineering, venereal disease, veterinary disease, narcotics control, public health nursing, and general field inspection. Members of the United States of America Typhus Commission who worked on the antityphus program among civilians in western Europe were considered for administrative purposes as staff members of the branch.

Public health policies formulated by this group were conditioned, of course, by military policies and practices and tactical considerations. The Public Health Branch advocated, for instance, that the Allied command adopt, as a measure for control of venereal disease among troops, a policy of placing brothels out of bounds throughout the theater. However, existing military policy placed responsibility for control of venereal disease among troops upon the individual field commander; hence some variation occurred in the policies and procedures adopted by the field commanders after the invasion.[78]

[77] (1) Memorandum, Director, Civil Public Health Division, Office of The Surgeon General, for The Surgeon General, no date (covers visit to ETOUSA, 24 Feb.–8 Mar. 1944), subject: Report on Plans for Civil Public Health in the European Theater of Operations. (2) Memorandum, Col. Thomas B. Turner, MC, for The Surgeon General, no date, subject: Activities in the North African Theater of Operations. (3) See Medical Department, United States Army. Preventive Medicine in World War II. Vol. VIII. Civil Public Health Activities. [In preparation.]

[78] (1) See footnote 74(1), p. 364. (2) Letter, Chief, Preventive Medicine Service, Office of The Surgeon General, to Field Director, United States of America Typhus Commission, 26 Apr. 1944. (3) Letter, Supreme Headquarters, Allied Expeditionary Force, to All Branches, G–5, 27 July 1944, subject: Organization and Missions of Public Health Branch, G–5. (4) Memorandum, Supreme Headquarters, Allied Expeditionary Force, for Commander in Chief, 21st Army Group, and Commanding General, 12th Army Group, 25 Aug. 1944, subject: Revised Directive for Civil Affairs Operations in France.



FIGURE 83.—Maj. Gen. Warren F. Draper, USPHS.

Additional developments in May 1944 tended to fix the public health program within the G–5 chain of control. At that date, the civil affairs section at the combined Headquarters and Communications Zone, ETOUSA, and one at 12th Army Group headquarters, both previously elements of the special staff, were shifted to the general staff level and termed G–5. A G–5, or civil affairs division, with a small medical section or subsection, was also established at each army group and each army headquarters. Although a G–5 element was established at corps headquarters and a special staff section at division headquarters to handle civil affairs at these levels, as a rule no public health element was created on the staff of the corps or division.[79]

Control over the public health program was maintained for some months after May 1944 under G–5 direction at both Allied headquarters and the headquarters of army groups and armies. Within the combined theater and communications zone organization, on the other hand, a tendency toward shifting responsibility for the public health program to the regular medical service appeared almost as soon as the program was well established under G–5 control. The major responsibility of General Hawley's office—to provide medical service for the military forces—increased with the establishment of large base sections

[79] (1) Operations Memorandum No. 19, Third U.S. Army, 21 June 1944. (2) See footnotes 73(2), p. 363; and 78(4), p. 365. (3) Monthly Public Health Reports, 12th Army Group, 1944 and 1945. (4) Annual Report, Division of Preventive Medicine, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1944.

on the Continent. Originally the large number of medically trained personnel in his office had naturally weighed against any idea of a buildup of the public health group in G–5 of the theater headquarters; consequently only one or two officers were assigned to G–5 at that level. A similar situation existed in the base sections. After May 1944, a theater-communications zone headquarters tended to place an increasing share of the responsibility upon General Hawley's office and the offices of base section surgeons.

About the same time that the Civil Affairs Division of the theater-communications zone headquarters was shifted from special staff level to G–5 (23 May 1944), a theater directive made General Hawley's office responsible for certain duties in the civil medical program. It was to requisition, procure, store, and issue medical supplies for civilian use, to supervise activities in public health and sanitation, and to rehabilitate civil hospitals; in July, a Civil Affairs Branch was established in the Operations Division of his office to handle these responsibilities. A directive of September also added to his office the responsibility for furnishing technical advice and aid to personnel directly assigned to the civil affairs program. Although these directives conflicted with similar outlines of the responsibilities for the public health program issued by Allied headquarters, the tendency to place upon General Hawley's office additional responsibilities for civilians continued. Clearer duties for the Civil Affairs Branch of his office emerged with the advance of the armies into western Europe late in 1944. It was the obvious choice for two medical jobs, left in the wake of the advance, requiring coordination among the base sections, which could best be handled through the normal technical channels of the Communications Zone. One was the assembly of medical supplies captured from the enemy and their allocation and distribution to the various base sections for civilian use. The other was the procurement of medically trained personnel to supervise medical service for thousands of displaced persons en route to their homes by train.[80]

The 23 May 1944 directive was not interpreted in the same way at all echelons, and for a time there was a general confusion as to the channels of control over the public health program. At many levels, however, the staff surgeons and medical officers assigned to the G–5 sections cooperated closely with each other despite their conflicting theories and interests. At none of the army groups and army headquarters were there more than one or two Medical Department officers assigned to G–5, and many of these were inclined

[80] (1) Memorandum, Headquarters, European Theater of Operations, U.S. Army, for Chiefs of General and Special Staff Sections, European Theater of Operations, U.S. Army, 23 May 1944, subject: Staff Duties and Responsibilities for Civil Affairs. (2) Memorandum, Headquarters, European Theater of Operations, U.S. Army, for Chiefs of General and Special Staff Sections, European Theater of Operations, U.S. Army, 25 Sept. 1944, subject: Staff Duties and Responsibilities for Civil Affairs. (3) Annual Report, Civil Affairs Branch, Operations Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1944. (4) Annex 7 to Period Report, Civil Affairs Branch, Operations Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1 Jan.–30 June 1945. (5) Civil Affairs Administrative Memorandums Nos. 8 and 9, Communications Zone, European Theater of Operations, U.S. Army, 8 Aug. 1944.

to work closely with the staff surgeons of their respective commands for two main reasons. The first was the conviction, fairly widespread among medical officers, that the staff surgeon should control all medical programs, whether for military personnel or for civilians, in which the command engaged. The second, a very practical reason, was the fact that the staff surgeon controlled the so-called "medical means" of the command; that is, the medical supplies, personnel, transport, and other facilities on which those assigned to the public health program with the field armies had to depend whenever their own means became scarce. The Chief Medical Officer, SHAEF (General Kenner), had declared, when Colonel Turner's plan had been proposed early in 1944, that public health officers assigned to G–5 would not be able to function properly in a combat area and had recommended that they not be so assigned at the corps and division level. He had also warned of possible difficulty if the command surgeons were called on to divert to civilian use medical supplies needed for troops and noted that medical units lacked the personnel and the means of transport to handle extra medical supplies earmarked for civilians.[81]

As it turned out, over the long run the staff surgeons of armies and army groups, as well as the theater surgeon and base section surgeons, had to assume more and more responsibility for handling public health problems encountered during the eastward sweep of the armies into France. By November 1944, the Third U.S. Army had had to set up a half dozen assembly centers, or camps, for displaced persons and staff them with medically trained personnel. More and more cases of diphtheria and other communicable disease were found among civilians, and rapid immunization of the population against them on a large scale had to be undertaken. Immunization of animals against foot-and-mouth disease was necessary, as well as the burial of thousands of dead animals as a protection against water contamination. The crisis came with the advance of the armies from the east and south into Germany.

The thousands of displaced persons freed by the advance into Germany added to the U.S. Army's responsibilities in sanitation and medical care for civilians; in the late spring of 1945 many had to be taken into hospitals intended for troops. The Third U.S. Army reported, for instance, more than 13,000 civilians admitted to its hospitals in May. The increasing numbers of cases of typhus encountered, particularly among displaced persons and the inmates of concentration camps, made necessary the dusting of thousands of civilians with DDT. In April the Fifteenth U.S. Army established a cordon sanitaire along the east bank of the Rhine to prevent the transfer of louse-borne typhus west of the river by displaced persons returning to their homes. Delousing stations were established at each port of entry; it was estimated that by the end of June 1945 well over a million people had been dusted with

[81] (1) See footnotes 73(1), p. 363; and 77(3), p. 365. (2) Letter, Brig. Gen. John A. Rogers, USA (Ret.), to Editor in Chief, Medical Department, United States Army in World War II, 5 Sept. 1950. (3) Memorandum, Maj. Gen. Albert W. Kenner, for Assistant Chief of Staff G–5, 2 Mar. 1944, subject: Directive on Public Health.

DDT. Facilities, medical supplies, and medical personnel intended for troops, and hence controlled by the staff surgeons of the armies, had to be used in the civilian public health program. Twelfth Army Group estimated that the forces under its control eventually uncovered more than 4 million displaced persons; responsibility for their care stretched available personnel to the utmost.[82]

A trip of inspection which General Kenner made in the latter part of March convinced him that the G–5 organization, lacking personnel and facilities, would not be able to meet its commitments. After a conference with General Draper and other G–5 medical representatives, as well as the 12th Army Group surgeon (Colonel Gorby), he prepared a SHAEF directive on 14 April which turned over the total responsibility within the army groups and armies in enemy-occupied territory to the commanding officers of all commands and their staff medical officers. Under the directive (applicable to the British and French forces, as well as the American), officers formerly assigned to public health work in G–5 of the armies and army groups were reassigned to the army or army group surgeons, who established a "public health section" in their offices.[83]

A few other factors, besides necessity, were instrumental in bringing about this shift of control. A significant one, of long-range importance, was the tendency of many Medical Department officers (doctors from civilian life as well as those of the Regular Army) to believe that the regular medical service was the most efficient agent for handling the Army's responsibilities for civil health. Staff surgeons pointed out that they needed control over the program for civilians in occupied territories because of the close rapport between health conditions among civilian populations and the health of troops. Some Medical Department officers assigned to G–5 did not like the subordination of the civilian medical program to "relief" or "welfare," in the standard setup; others did not like their immediate subordination to a nonmedical officer. The affinity of medically trained men for each other led some of those assigned to G–5 to work more closely with the staff surgeons of their commands than with nonmedical personnel in their own G–5 divisions.[84]

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[82] (1) Monthly Public Health Reports, Third U.S. Army, 1944–1945. (2) Memorandum, Field Director, United States of America Typhus Commission, for Chief, Public Health Branch, G–5, Supreme Headquarters, Allied Expeditionary Force, 27 Mar. 1945, subject: Confirmation of Verbal Report on Visit to Ninth and First Armies to Investigate Typhus Control in Those Areas. (3) Letter, Headquarters, European Theater of Operations, U.S. Army, to Commanding Generals, U.S. Strategic Air Forces in Europe, each Army Group, Communications Zone, each Army, and others, 12 April 1945, subject: Establishment of a "Cordon Sanitaire." (4) Monthly Public Health Report, G–5, 12th Army Group, June 1945. (5) Report of Operations, 12th Army Group, vol. I.

[83] (1) See footnote 82(1). (2) Monthly Public Health Reports, 6th Army Group, 1944 and 1945. (3) Cable FWD SHAEF, to Commanding Generals, 12th and 6th Army Groups, 21 Army Group, and Communications Zone, 28 Mar. 1945. (4) Memorandum, Chief, Public Health Branch, G–5, Supreme Headquarters, Allied Expeditionary Force, for Chief Medical Officer, Supreme Headquarters, Allied Expeditionary Force, 16 Mar. 1945, subject: Future Organization for Public Health Branch, SHAEF. (5) Letter, Supreme Headquarters, Allied Expeditionary Force, to Headquarters, 21 Army Group, Commanding Generals, 6th and 12th Army Groups, and Commanding General, Communications Zone, European Theater of Operations, U.S. Army, 14 Apr. 1945, subject: Public Health Functions in Occupied Territory. (6) Diary, Maj. Gen. Albert W. Kenner, entries for March–April 1945.

[84] See footnote 73(1), p. 363.

In retrospect, the chief of the Public Health Branch, G–5, SHAEF, General Draper, pointed to the lack of sufficient trained personnel as the major stumbling block in the way of the medical program for civilians. The work had called particularly for men trained in control of communicable diseases, especially the venereal diseases, in medical supply work, sanitary engineering, nutrition, veterinary work, public health nursing, and control of narcotic drugs. It had been necessary to use specialists in other fields, unversed in public health work, in positions for which public health training was desirable. An acute shortage of British health officers in 21 Army Group had made it necessary to loan 20 American officers for a time to the British for public health work. As soon as the armies had thoroughly penetrated Germany, personnel assigned to public health duties at the G–5 level within the armies had been scarce in relation to the numbers needed to work among the thousands of displaced persons and the internees of the large concentration camps and to maintain a far-reaching typhus control program. Medical Department officers thus had had to assume complete responsibility in many public health operations. In the interest of proper assignment and use of Medical Department personnel, command surgeons responsible for the health of troops had naturally insisted that they should administer the public health program and that the personnel formerly assigned to the G–5 level should be taken over by them. Nevertheless, General Draper maintained, administration of the program through G–5 channels was organizationally sound and logical despite its partial breakdown when unusual problems confronted it.[85]

CLOSEOUT IN THE EUROPEAN THEATER

During the spring of 1945, when the surrender of Germany appeared certain, plans were made for dissolving the Allied command and reestablishing the usual U.S. Army theater organization. When chiefs of staff sections were announced on 12 May, General Kenner became Chief Surgeon, ETOUSA, relieving General Hawley, who had served in that capacity for almost 3 years. General Hawley soon returned to the United States as Medical Director of the Veterans' Administration. On 19 July, General Kenner became Chief Surgeon, U.S. Forces, European theater, as the postwar theater command in Europe was termed, and on 3 August, Chief Surgeon, Theater Service Forces, ETOUSA. The offices of the chiefs of technical services were located at Theater Service Forces headquarters; General Kenner's medical section was so located. For a time it was split between the main office of theater Service Forces headquarters in Frankfurt and its rear office in Versailles, the center of redeployment and supply activities, but concentration of his staff in the main office in Frankfurt was effected by the autumn of 1945.[86]

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[85] See footnote 74 (1), p. 364.

[86] (1) General Order No. 90, Headquarters, European Theater of Operations, U.S. Army, 12 May 1945. (2) General Order No. 161, Headquarters, U.S. Forces, European Theater, 19 July 1945. (3) General Order No. 159, Headquarters, Theater Service Forces, European Theater, 3 Aug. 1945.

A letter issued by Headquarters, U.S. Forces, European Theater, on 21 August defined General Kenner's responsibilities. His position became exceptional among the chiefs of technical services in that he was to serve as a special staff officer of the theater commander when acting in the capacity of Chief Medical Inspector of all troops and installations in the theater. In supervising the furnishing of the normal medical service and supplies to U.S. Army troops and to civilians attached to the Army, he was responsible to the Commanding General, Theater Service Forces. In general this situation marked a return to the setup which had prevailed before the creation of SHAEF. In order to make sure of his control over medical administration on a theaterwide basis, General Kenner had made special effort to obtain a specific statement of his authority to make medical inspections of all troops and units in the theater. He held the tenet that this authority would assure him theaterwide control in spite of his location at the service force headquarters. With the dissolution of SHAEF, a simpler command structure had come into existence and control over the medical service for the U.S. Army during its occupation of Europe became centralized.[87]

[87] (1) Report of Operations, Headquarters, Theater Service Forces, European Theater, 8 May–30 Sept. 1945. (2) Statement of General Kenner to the author, 26 Mar. 1956.

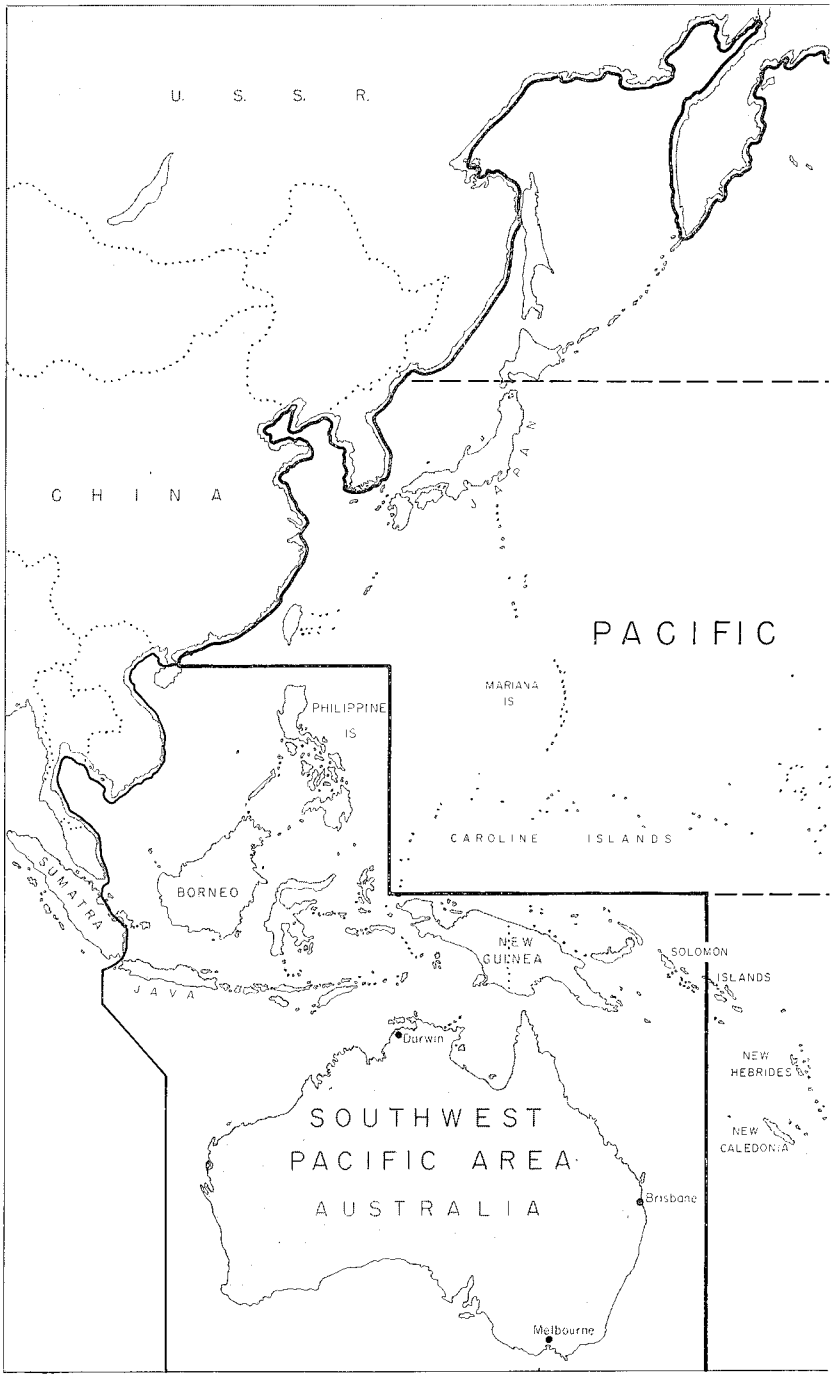
CHAPTER IX

The Pacific Ocean Areas

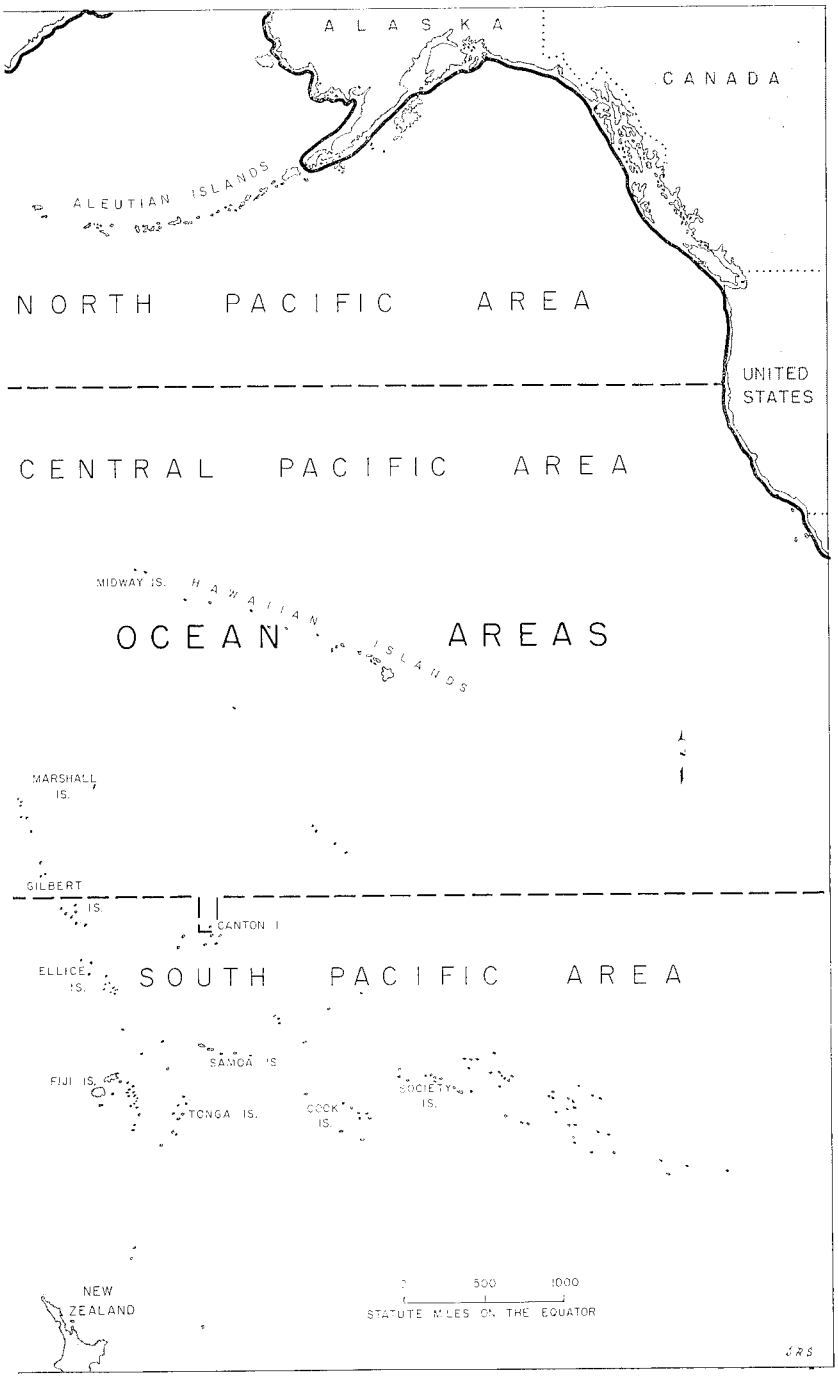
Although Army troops in the Pacific were eventually organized within a single Pacific theater, from 1942 to August 1944 separate theater organizational structures prevailed in three main areas: the Central, South, and Southwest Pacific Areas (map 7).[1] In these three regions the land areas, small in proportion to the ocean surface, were strung out over great distances, with long stretches of water between. This feature had far-reaching effects upon command structure, as well as military tactics. In the absence of continuous land masses, the communications zones developed for the three areas did not follow the orthodox pattern laid down for theaters of operations. The fact that land masses were small, with poor facilities for overland transport, and separated by long stretches of water, led to the burgeoning of many small commands with staff medical sections and to considerable decentralization in the supervision of medical service. The Pacific islands varied greatly in climate, types of endemic disease, and sanitary conditions. They presented Army doctors with many problems of local scope.

The strategic Pacific areas that were to prevail throughout most of the war were established in March 1942. In the Southwest Pacific Area, Gen. Douglas MacArthur was in supreme command. In the other two major Pacific regions, the Central and South Pacific Areas, Army forces were subordinate to a higher Navy command headed by Adm. Chester W. Nimitz. In addition to his Navy assignment as Commander-in-Chief, U.S. Pacific Fleet, Admiral Nimitz was made Commander-in-Chief, Pacific Ocean Areas. The Commanding General, Hawaiian Department (and his successor, the Commanding General, U.S. Army Forces, Central Pacific Area) was made directly subordinate to Admiral Nimitz. Over the Commanding General, U.S. Army Forces, South Pacific Area, Admiral Nimitz exercised command through a deputy naval commander. Through the extension of the principle of single control and responsibility downward, the Navy controlled various subordinate Army headquarters and units in the Central and South Pacific Areas (Pacific Ocean Areas, as these two were jointly termed), while the Army exercised highest jurisdiction over Navy headquarters and units in the Southwest Pacific Area. Although Army medical service was fully organized within the various Army commands in the three areas, the fact of final naval authority in the Central and South Pacific Area indirectly affected medical planning for combat, as well as the actual operations of field medical service in these areas.

[1] The North Pacific Area is omitted from this discussion. Except for air units in the Aleutians assigned to the Navy-controlled North Pacific Force, Army units in that area belonged to the Alaskan Defense Command, which in terms of its organization and administration resembles a Zone of Interior rather than an oversea command.



MAP 7.—U.S. Army commands in the



Pacific Ocean Areas, February 1943.



FIGURE 84.—Brig. Gen. Edgar King, MC.

CENTRAL PACIFIC AREA

Hawaiian Department

When Pearl Harbor was attacked on 7 December 1941, the surgeon's office of the Hawaiian Department, located at Fort Shafter on the island of Oahu, was composed of 10 officers (including 4 of the Regular Army), 8 enlisted men, and 15 civilians. In addition, certain medical, dental, and veterinary officers assigned to hospitals on Oahu were considered part of the department surgeon's staff. On the day of the attack, the office of the department surgeon, Col. (later Brig. Gen.) Edgar King, MC (fig. 84), was divided, together with the other technical services, into forward and rear echelons. Colonel King was made directly responsible to the commanding general of the department (Lt. Gen. Delos C. Emmons, after 17 December), who maintained his forward echelon headquarters underground in Aliamanu Crater. Forward echelon performed the functions of a theater of operations headquarters; rear echelon of those of a communications zone. The Hawaiian Department was placed under martial law, and as the commanding general held the additional responsibility of military governor (with headquarters

at Iolani Palace, Honolulu), Colonel King became responsible for the health of civilians, as well as for that of Army troops, in Hawaii.

During the early days of confusion after the Pearl Harbor attack, Medical Department units of the 24th and 25th Infantry Divisions and Army and civilian doctors and dentists pitched in to perform whatever service was most needed. As on the mainland of the United States, but under even greater compulsion, Army Medical Department officers and governmental and private agencies handling medical work cooperated closely. The Japanese attack had made clear this community of civilian and military interest. The uncertainty as to the wisest allocation of medical personnel, supplies, and facilities as between military and civilian agencies and other questions of jurisdiction which repeatedly cropped up on the mainland in 1942 made little appearance in Hawaii. The stringencies of martial law, the longer working hours of the population, the threatened shortages of supplies, and the frequent movements of the military and of civilian workers in and out of the outlying islands as well as Oahu called for all medical assets that the Army could muster in Hawaii. The Army was given leading responsibility for civilian health.

Throughout 1941, Medical Department officers had made plans for immediate medical care of civilians in the event of an assault on the islands. During 1941, emergency aid stations had been set up in Honolulu, civilians trained in first aid, and surgical teams of civilian doctors and ambulance corps organized. Schools had been selected for conversion to hospitals, military and civilian, should the need arise. As Japanese planes struck at Oahu, all these units—aid stations, surgical teams, and converted hospitals—went into action, some of them within minutes after the attack.

Medical Department officers had also made long-range plans, with the support of local agencies, for coping with preventive medicine problems in the event of an attack. During the prewar period the health record of Army troops stationed in the islands, where few tropical diseases were endemic, had been excellent. Plans centered around preparations to cope with the possible need for emergency hospitalization on a large scale, the increase of health hazards under wartime living conditions, and the threat of introduction of diseases from other areas.

One of the most important measures taken had been the establishment of a blood plasma bank for the protection of civilians. Originally set up at the instance of the department surgeon, it became the first to operate under the jurisdiction of the United States under wartime conditions. The Honolulu Chamber of Commerce, the American Red Cross, the University of Hawaii, certain commercial organizations, and a few local hospitals had contributed technical equipment, trained personnel, or moral support. Although the supply of plasma, built up since June 1941, was exhausted within some hours after the Pearl Harbor attack, it was promptly replenished through already established channels.

The Army's prewar industrial medical program in Hawaii was derived from studies made by the Territorial Board of Health (counterpart of a State health department on the mainland) with the aid of U.S. Public Health Service funds, to detect industrial poisons and determine conditions of heat, ventilation, and lighting in industrial plants. In September 1942, the Medical Department assumed joint responsibility with the Territorial Board of Health for industrial hygiene in the islands.

With the Pearl Harbor attack the destruction of insects on planes flown into the islands became a responsibility of the Medical Department. During 1941 the U.S. Public Health Service, then responsible for putting quarantine regulations into effect, had obtained the cooperation of the Army in enforcing the regulations on Army planes. By October it had become clear that the increasing number of flights and the exigencies of military secrecy might interfere with notifying civil authorities of the arrival of military planes. The Hawaiian Sugar Planters' Association, concerned over the possible introduction of crop-destroying or disease-bearing insects, had contributed the services of its entomologists stationed on Canton and Midway Islands in identifying insects on planes landing there en route to Hawaii. After the Territory was put under martial law, the Army assumed full responsibility for disinfestation of its incoming aircraft, and the Surgeon, Hickam Field, was designated Air Quarantine Officer to make inspections. In May 1942, the department surgeon assigned a medical officer on his staff to supervise the program, and in June the senior medical officer of each airfield in the department was made quarantine officer for the inspection of aircraft.[2]

Plans had been made in the prewar period to cope with a contingency which never developed—the deliberate contamination of food or water supplies by Japanese living in the islands. Fear had developed that the Japanese would undertake some form of chemical or bacteriological warfare in the event of an outbreak of hostilities. Nearly all dairies, food processing plants, and water supply systems employed people of Japanese descent. On the day of the Pearl Harbor attack the commanding general of the department made the department surgeon his adviser on all problems connected with the possible contamination, deliberate or accidental, of food and water. In his capacity as staff surgeon for the military governor, he issued a series of general orders designed to control the sale of poisons, medicinal spirits, narcotics, and incendiary chemicals. An officer in his medical section obtained inventories of medical

[2] (1) Office of the Surgeon, Headquarters, U.S. Army Forces in the Middle Pacific: History of Preventive Medicine. [Official record.] (2) Whitehill, Buell: Administrative History of Medical Activities in the Middle Pacific. [Official record.] (3) Office of the Surgeon, Headquarters, U.S. Army Forces in the Middle Pacific: History of Surgery, Section III, Clinical Subjects. [Official record.] (4) History of U.S. Army Forces, Middle Pacific and Predecessor Commands, During World War II, 7 December 1941–2 September 1945. [Official record, Office of the Chief of Military History.] (5) Annual Report, Surgeon, Hawaiian Department, 1942. (6) Annual Report, Surgeon, 24th Infantry Division, 1941. (7) Annual Report, Surgeon, 25th Infantry Division, 1941. (8) Memorandum, Brig. Gen. Edgar King, for Col. Joseph H. McNinch, MC, 31 May 1950, subject: Supplemental Data in Reply to Letter of 2 May 1950.

stocks from dealers and passed upon the sale of all drugs under special restriction. The sanitary inspection of military installations, water systems, and local plants engaged in processing foods or bottling drinks was intensified.

In June 1942, Secretary Stimson became alarmed over the possible use of bacteriological warfare by the Japanese in the Hawaiian Islands when he received a letter of warning from a doctor in Honolulu. The writer declared that large numbers of Japanese in the islands were loyal to the Japanese Empire. He advocated adoption of the following measures to prevent spread of bacterial disease: The registration of bacteriological laboratories and bacteriologists and the internment of all laboratory workers of known Axis sympathies; the eradication of mosquitoes and, more especially, of rats because of the danger of plague; and the immunization of all inhabitants against yellow fever and cholera.

At Secretary Stimson's request for recommendations, Surgeon General Magee advised the appointment of an officer to tackle the problem. He advocated supervision and inspection of civilian bacteriologists and laboratories, cooperation with health authorities in protecting the civilian population of the islands against infectious disease through vaccination, and finally, cooperation with authorities engaged in the protection of agriculture and animal husbandry. The officer in charge, in General Magee's opinion, should have an assistant trained in laboratory science and preventive medicine. He should be on the staff of the Chemical Warfare Officer, Hawaiian Department, and should report to the Secretary of War, through the commanding general of the department, on any biological warfare undertaken by the enemy and on measures taken to counteract it.[3]

The reaction of the Secretary of War and The Surgeon General to the Honolulu letter revealed the ignorance of current operations which sometimes prevailed at high levels as a result of the necessity for keeping certain programs secret to all but a few people. It also reflects the fear, then prevalent in all quarters, of subversive action by Hawaiian inhabitants of Japanese descent. Although The Surgeon General seems to have been aware of a general prewar program for counteracting biological warfare in Hawaii and the Secretary had taken the initiative in establishing this program on the homefront, neither seems to have been informed of the latest development in Hawaii. The Hawaiian Department Surgeon had been put in charge of antibiological warfare activities at the outbreak of hostilities. Later an Army medical officer was designated antibiological warfare officer for each of the task forces which invaded the westward islands, and officers of the Veterinary and Sanitary Corps were given similar assignments on the various islands. All worked closely

[3] (1) Memorandum, W. B. Herter, M.D., Honolulu, T.H., for the Secretary of War, 12 June 1942, subject: The Next Attack Upon Oahu—Bullets or Bacteria. (2) Memorandum, Harvey Bundy, Special Assistant to Secretary of War, for The Surgeon General, 26 June 1942; and reply by Brig. Gen. Larry B. McAfee and Col. James S. Simmons, MC, same date. (3) See footnote 2(2), p. 378.

with the medical inspector of the department surgeon's office, with the chemical warfare officer, and with the Territorial Health Department.[4]

With the expansion of military camps throughout the Territory of Hawaii and of camps for civilian employees of the Army, the work of the medical inspector of the department surgeon's office increased. The large preventive medicine program of the Territory, for which responsibilities were somewhat scattered in 1942, finally centered in his hands. Work which had formerly been limited to the inspection of fixed Army installations gradually grew into a large program of many phases: Determination of the adequacy of food and water supplies, waste disposal, mosquito and rat control, venereal disease control, immunization of Army troops and of civilians in the Territory against a variety of diseases, the three programs mentioned above (occupational health, foreign quarantine measures, and the antibiological warfare program), and many general sanitary measures.

Before December 1941, the department surgeon had had no dental officer assigned directly to his office. In accordance with the prewar custom of assigning responsibilities to the chief of dental service at the major installation in a corps area or department, the chief of dental service at Tripler General Hospital had acted as dental adviser to the department surgeon. In early 1942, he was formally assigned to the position in the department surgeon's office. The commanding officer of the veterinary general hospital at Fort Armstrong, Oahu, served in a similar capacity in veterinary matters. Besides supervising the usual inspection of meat and dairy food and the quarantine and treatment of animals and work in antibiological warfare, he gave technical aid to the military governor on the storage and handling of foods for civilian consumption. Not until March 1943 was a staff nurse appointed to the department surgeon's office.

The Pearl Harbor attack also led to the development of the standard laboratory planned by the Surgeon General's Office for corps areas and departments. Creation of a departmental laboratory in Hawaii had been long delayed because of some uncertainty in the Surgeon General's Office as to its necessity, possibly because the prewar health status of Army troops in Hawaii had always been high. With the outbreak of war, the role it could play in the prevention of epidemic disease was acknowledged; the Hawaiian Department Laboratory was established in January 1942.[5]

In spite of the advent of war and the inclusion of the Hawaiian Islands in one of the strategic Pacific areas—the Central Pacific Area—in March 1942, the Army command in the islands was not organized after the fashion of a theater of operations; throughout 1942 it continued to be known as the Hawaiian Department. Early in 1942 some nearby island groups—the so-called Line Islands, Midway, Christmas, Baker, and Canton Islands—and a few others

[4] [Whitehill, B. (?)]: Rough copy of History of Anti-Bacteriological Warfare, 7 December 1941–2 September 1945.

[5] See footnote 2(2), p. 378.

occupied by American troops or jointly by British and American troops were added to the territory included in the department; station hospitals and branch medical depots were located on these islands. Additional veterinary and sanitary service also became necessary when Christmas and Canton Islands were stocked with chickens and cattle to supply food for troops.

When service commands were organized in March 1942 for the islands of the Hawaiian group—the Hawaii, Maui, Molokai-Lanai, and Kauai Service Commands—a surgeon was assigned to each. The surgeons' offices of the service commands and the station hospitals on the islands served a variety of components: the service command itself; divisional and air force elements; elements of the Territorial Guard, the Women's Air Raid Defense Service, and the Air Raid Warning Service; U.S. Engineering Department employees; and some Coast Guard personnel.

The introduction of a Services of Supply into the Hawaiian Department in October 1952 did not greatly change the situation. Although it was a distinct command, it was staffed by members of Headquarters, Hawaiian Department. Colonel King, who had held since the attack on Pearl Harbor a dual position as surgeon of the Hawaiian Department and as the responsible medical official for the military government, was made additionally Surgeon, Services of Supply. The Services of Supply (renamed Hawaiian Department Service Forces in April 1943) was merely an intermediate command between the already established area commands—here called "service commands" in Zone of Interior terminology rather than base sections—and the departmental setup. Within the Services of Supply command, Colonel King's office was made subordinate to a Supply Service Division headed by the Assistant Chief of Staff, G–4, Hawaiian Department.[6]

Before 7 December 1941, the Hawaiian Air Force, which suffered several hundred casualties when the Japanese attacked Oahu, had had several dispensaries for the use of its troops, including one of 60 beds which was actually the station hospital for Hickam Field. Lt. Col. (later Col.) A. W. Smith, MC (fig 85), the senior flight surgeon, became surgeon of the Seventh Air Force, as the Hawaiian Air Force was renamed in March 1942. Flight surgeons were needed to staff the nine airbases in the islands (including Midway, Christmas, and Canton) which the air force opened during the succeeding year; the air force surgeon obtained permission from the Commanding General, Army Air Forces, to train locally medical officers obtained through the cooperation of the Surgeon, Hawaiian Department. The Seventh Air Force surgeon's office also conducted the training of medical officers as aviation medical examiners who would administer physical examinations for Hawaiian applicants seeking aviation training on the mainland.[7]

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[6] See footnote 2(4), p. 378.

[7] Consolidated Medical History of the Seventh Air Force from its Activation to 1 June 1946. [Official record.]



FIGURE 85.—Col. A. W. Smith, MC.

At the end of 1942, the Army Medical Department in Hawaii was engaged in caring for the health of Army troops on the Hawaiian Islands (Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai) and on Christmas, Fanning, and Canton Islands. It was also carrying out policies which the Office of the Military Governor had established for the protection of civilian health—quarantine regulations and other measures for control of communicable diseases, regulatory measures for control of laboratories engaged in bacteriological work, and regulations concerning the sale and use of civilian medical supplies. During the year of martial law, civilian hospitals had been under Army control, and some Army doctors and nurses had been assigned to them. The fixed hospitals of prewar days on Oahu—Tripler General near Fort Shafter in Honolulu and the station hospitals at Schofield Barracks and Hickam Field—had been augmented by several station hospitals. Many aid stations had been built, some partially or completely underground. Dental clinics had been set up in areas not served by other fixed medical installations, and dental trailers served troops in still more remote areas. A main supply depot located at Fort Shafter and a number of branch depots furnished medical supplies for Army troops in the Central Pacific Area.[8]

During 1943, as the fear of further enemy attack on Hawaii lessened, the responsibilities of the Office of the Military Governor for civilian health were

[8] (1) See footnote 2 (4) and (5), p. 378. (2) Memorandum, Brig. Gen. Edgar King, for Editor, History of the Medical Department, 22 Mar. 1950.

gradually returned to the public health authorities which had handled them before the war. Beginning about March 1943, the control of communicable diseases and the regulation of sale of medical supplies and poisons were returned to civil authorities. Army supervision of laboratories was relinquished a few months later. Colonel King's office continued to cooperate closely with such civil authorities as the Territorial Board of Health and the Office of Civilian Defense in efforts to maintain civilian health. A few epidemics, including a poliomyelitis outbreak and an epidemic of dengue fever in 1943, were brought under control through the combined efforts of military and civilian authorities.[9]

Central Pacific Area Command: August 1943–Mid-1944

A major reorganization took place in August 1943 when the U.S. Army Forces in the Central Pacific Area was established, with headquarters at Fort Shafter, under the command of Lt. Gen. Robert C. Richardson, Jr. This change marked the revamping of Army organization for the offensive warfare in the Central Pacific Area which resulted in the taking of the Gilbert, Marshall, and Marianas Islands. The Army's Hawaiian Department had been subordinate to Admiral Nimitz' Pacific Ocean Areas command since the spring of 1942, but the concept of the Central Pacific as an important area of combat operations had applied primarily to Navy activities there. Although he continued to hold the nominal post of Hawaiian Department Surgeon, General King became surgeon on the special staff of General Richardson. His medical section operated until mid-1944 as the chief medical office of U.S. Army Forces in the Central Pacific—that is, in the role of a theater medical section. Headquarters, U.S. Army Forces in the Central Pacific Area, now had the chief responsibility as a training agency for Army forces mounting from the Hawaiian Islands, as the logistic agency for supporting forward operations and as the administrative agency for all Army forces in the Central Pacific Area.[10]

The Hawaiian Department Service Forces (as the Hawaiian Services of Supply had been renamed) was abolished at the time of this reorganization, but an Army Port and Service Command, set up on Sand Island, took over certain of its functions applicable to the ports and subports of the Hawaiian Department. The port of Honolulu underwent intensive development in preparation for the capture of the westward bases. The Army Port and Service Command enforced quarantine regulations applicable to personnel entering or leaving ports and furnished medical service on transports and harbor craft operated by the command. Up to the end of 1944, medical responsibilities increased as the command received several important additional tasks: The training and use of port companies, operation of the Waimanalo Amphibious

[9] (1) See footnote 2 (1), (2), (4), and (5), p. 378.

[10] (1) See footnote 2(4), p. 378. (2) Memorandum, Brig. Gen. Edgar King, for Col. J. H. McNinch, MC, 9 Aug. 1950, subject: Additional Data for History.

Training Area and the Central Pacific Casual Depot, and the command of the prisoner-of-war camps.

At the end of 1944—a date by which the war had moved far away from Hawaii—Medical Department personnel assigned to the Army Port and Service Command included 38 medical officers, 14 dental officers, 4 Medical Administrative Corps officers, 1 Veterinary Corps officer, 243 enlisted men, and 1 civilian. Its Medical Division at headquarters contained, besides the surgeon, an assistant surgeon and medical inspector, a port surgeon, and a port veterinarian and administrative officer. Veterinary personnel of the division supervised the loading and discharge of the Army's perishable foods aboard ships and inspected ship refrigeration. The division provided medical attention at dispensaries maintained at the various posts for Army and civilian personnel and those at prisoner-of-war compounds. Individuals served by the dispensaries totaled about 37,000 by the end of 1944; about 7,000 were prisoners of war, largely Italians. The division also received and evacuated casualties by transports, provided quarantine information, made medical and sanitary inspection of Army transports, supervised medical service on ships assigned to the port of Honolulu, and provided medical supplies to Army transports stopping at the port.[11]

Soon after Army reorganization under the Central Pacific Area command, Medical Department officers were given some responsibility in coordinating medical plans for support of Army combat units with those of Navy medical officers for support of their forces during the amphibious operations westward. Admiral Nimitz, who as Commander in Chief, Pacific Ocean Areas, had had a joint Army-Navy command (in addition to his naval command of the U.S. Pacific Fleet) since early 1942, was now to conduct joint combat operations. A staff of Navy and Army officers was established for him in his capacity as Commander in Chief, Pacific Ocean Areas, in September 1943; it drew up the plans for Army-Navy assaults on the Gilberts, Marshalls, and Marianas. Within its Logistics Division was created in October a medical section, initially composed of a Navy medical officer (the former Fleet Medical Officer) and an Army medical officer who had previously worked in General King's office. A number of Navy medical officers were added, but the section never contained more than two Army medical officers, a second one being assigned in January 1944. When first established, the joint medical section was mainly concerned with the campaign of November 1943 in the Gilbert Islands (Tarawa and Makin atolls), making plans for evacuation, hospitalization, preventive measures, and the care of civilians. Later it drew up medical plans for the campaign of January–March 1944 in the Marshall Islands (Kwajalein and Eniwetok atolls) and that of June–August 1944 in the Marianas (Guam, Tinian, and Saipan). Continuing duties were the preparation of directives on medical and sanitary problems and the allocation of Army and Navy facili-

[11] Annual Report of Medical Activities, Army Port and Service Command, Hawaiian Department, 1944.

ties for hospitalizing patients on the captured islands and for evacuating patients to fixed hospitals at the rear bases. Medical officers on the joint staff also had duties with the Joint Intelligence Center, Pacific Ocean Areas; their work in medical intelligence was of a type normally performed by an Army medical officer assigned to G–2 of a general staff.[12]

The Office of the Surgeon, Central Pacific Area, worked in close liaison with the two Army medical officers participating in the high-level planning on Admiral Nimitz' staff; it prepared in its turn the more detailed medical phases of plans for the Army combat units participating in the westward offensive. The Operations and Training Section of General King's office took on increased importance; it conducted several training programs aimed at support of the island campaigns. Basic medical training was given to men of the divisions staging on Oahu; technical training was given to medical technicians in the hospitals on Oahu; medical officers and nurses were instructed in work under field conditions. At a Medical Department training camp established in January 1944 at Koko Head, intensive training was given to Medical Department units and special instruction to tactical units in the best methods of survival in tropical jungle. Some of the surgeon's staff observed rehearsals and maneuvers in amphibious and jungle warfare. The movement of troops from the salubrious Hawaiian Islands into areas of endemic tropical disease called for additional immunizations of troops and special equipment and trained personnel to combat insect vectors of disease.

General King's medical section had to provide medical support for the six divisions (the 6th, 7th, 24th, 40th, 77th, and 96th) which were sent to other islands during 1943 and 1944 after staging in the Central Pacific Area; all but the 24th received medical units and equipment especially designed to support amphibious operations. The office worked out plans for the Medical Department units which came to be standard support for the reinforced division (about 20,000 men) typically used in the island assaults in the Central Pacific Area: a field hospital, two portable surgical hospitals, and a malaria control and a malaria survey unit. Another standard development which emerged from its planning was the addition of equipment to the divisional clearing company which enabled it to operate as a 250–400-bed hospital on small islands where mobility was not so imperative as on large land masses.

Staff medical sections and fixed hospital units (station and general) were furnished to the Army garrison forces which accompanied task forces and became the Army administrative organizations on the westward islands after combat had ceased. Supply officers in General King's medical section worked out special procedures for providing medical supplies to the remoter islands

[12] See footnote 2(2), p. 378. Since this medical section was under control of the Navy and naval medical officers assigned to it greatly outnumbered Army Medical Department personnel, an appraisal of its work is not in order here. However, an opinion expressed in the document cited, to the effect that the medical section on Admiral Nimitz' joint staff could have been more efficient "had Naval Medical Officers been trained or experienced in staff and logistics principles and procedures to the extent that those of the Army had been" is of some significance in this connection.

directly from the mainland; the ordinary lines of communications did not prevail in this area and the bypassing of islands produced more rapid delivery.[13]

In addition to General King and his deputy, Col. Kermit H. Gates, MC (fig. 86), former surgeon of the 24th Infantry Division, the theater medical section at the end of 1943 included 27 Medical Department officers, 3 warrant officers, and 121 enlisted men. Before mid-1944 specialists in medicine, surgery, orthopedic surgery, and laboratory work in several general hospitals had been given the additional assignment of consultants in those fields in General King's office. At that date, General King's medical section served as the highest medical office in the Central Pacific Area, supervising directly (without the interposition of a Services of Supply) the work of the surgeons' offices of the following commands: XXIV Corps and various divisions, the service commands on the outlying Hawaiian Islands, the army garrison forces on the westward islands, the Army Port and Service Command in Hawaii, and the Seventh Air Force. In June 1944, the total Army strength in the Central Pacific Area was approximately 296,000 men.[14]

Late in 1943, when the westward offensive began, units of the Seventh Air Force, which until that time had been chiefly occupied with defense and training, were scattered over a number of islands; total air force strength in November 1943 was about 25,000. The Seventh Air Force maintained dispensaries at airfields, but as a result of close cooperation between the Surgeon, U.S. Army Forces in the Central Pacific Area, and medical officers of the air force, these dispensaries did not tend to develop into hospitals as did those operated by the air forces in some other areas. The Seventh Air Force surgeon, Colonel Smith, although favorably disposed in theory to the operation of separate hospitals by the air forces overseas, pointed out several factors which argued against it so far as the Central Pacific Area was concerned: the small proportion of air force patients in the total number of hospitalized troops, the convenient location of the fixed hospitals maintained by the Hawaiian Department Service Forces, and the sympathetic consideration given by the Pacific Area surgeon to air force medical problems.

The general and station hospitals run by the Hawaiian Department Service Forces on the islands of Oahu and Hawaii took care of air force, as well as ground force, patients, although the station hospital at Hickam Field was operated by the air force with Medical Department personnel assigned by the theater surgeon. As in other air forces, a few veterinarians inspected foods when they were received at airbases from the theater command and when they were issued to air force units. One medical supply platoon (aviation) drew

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[13] (1) See footnotes 2(2) and 2(8), p. 378. (2) Interview, Col. Kermit H. Gates, MC, 17 July 1945. (3) History of the Medical Service, Central Pacific Base Command, vol. VIII. [Official record, Office of the Chief of Military History.] (4) Annual Report, Medical Section, Headquarters, U.S. Army Forces, Pacific Ocean Areas, 1944. (5) Quarterly Reports, Medical Department Activities, XXIV Corps, 2d, 3d, 4th Quarters, 1944.

[14] See footnotes 2(2) and 2(4), p. 378.



FIGURE 86.—Col. Kermit H. Gates, MC.

medical supplies from the Fifth Medical Supply Depot and furnished them to the units of the Seventh Air Force by truck or to outlying bases by air. For its laboratory service the Seventh Air Force depended upon the regular theater laboratory service.[15]

Until the summer of 1943 only two or three divisions were stationed in the Central Pacific Area at any one time; as divisions arrived from the United States, others moved westward to participate in the island campaigns directed by the Navy. In April 1944, XXIV Corps was activated, and a corps surgeon's office coordinated the medical work of the divisions assigned to it. During the summer several additional Medical Department officers and enlisted men were temporarily assigned to the office to aid with intensive planning for Medical Department personnel and supplies to support the invasion of Yap Island in the Palaus by XXIV Corps, then scheduled for the fall.[16]

The Pacific Wing of the Air Transport Command had its headquarters in the Central Pacific Area—at Hickam Field, Honolulu—and for many months, in advance of the organization of all Army forces in the Pacific into a

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[15] (1) See footnote 7, p. 381. (2) Medical Report, Seventh Air Force, 26 Nov. 1943. (3) Interview, Maj. Everett B. Miller, VC, 27 June 1951. (4) Letter, Col. A. W. Smith, to Acting Air Surgeon, 5 Apr. 1944.

[16] Annual Report, Medical Department Activities, XXIV Corps, 1944.

single theater of operations, it conducted Pacific-wide air evacuation. The wing surgeon and nine other medical officers arrived in Honolulu soon after the wing was established early in 1943. By April, they had established dispensaries at several locations along the Pacific routes of the Air Transport Command: Hickam Field, Amberley Field near Brisbane, Christmas Island in the Line Islands, Canton Island in the Phoenix Islands, Nandi Airport on Viti Levu in the Fijis, and Plaines des Gaiacs in New Caledonia. These installations served, as did other Air Transport Command dispensaries, personnel en route by air. During 1943 the Pacific Wing evacuated thousands of patients from forward areas to fixed hospitals in rearward Pacific bases, especially Hawaii, and to the United States. Because of the great distances, a relatively large proportion of evacuees in the Pacific were transported by plane.[17]

SOUTH PACIFIC AREA

The creation of the Army command which administered medical service for Army troops throughout the South Pacific Area (map 7) took place in mid-1942. During the early months of the year, Army troops, as well as Marine and Navy units, had moved into the islands of the southern Pacific; the chief Army elements were the Americal Division in New Caledonia and the 37th Division in the Fijis, smaller troop elements being scattered over a number of other islands and atolls. Until the end of the year, with the exception of the work of a few station and general hospitals, medical service was largely furnished by the units that had come in with troops. At times during the early island campaigns a single unit, such as an evacuation hospital, had rendered the medical care commonly afforded by hospital units of both the combat and the communications zones, performing the standard functions of a collecting company, clearing company, general hospital, and so forth, since it was the only Medical Department unit within hundreds of miles.[18]

Areawide Direction of Medical Service

The U.S. Army Forces in the South Pacific Area was established in July 1942, with headquarters in Auckland, New Zealand, until November when they were moved to Nouméa, New Caledonia. Commanded by Maj. Gen. (later Lt. Gen.) Millard F. Harmon, it was directly subordinate to the Commander of the South Pacific Area (Vice Adm. Robert L. Ghormley, later Vice Adm. William F. Halsey), who was in turn responsible to the Commander in Chief, Pacific Ocean Areas, Admiral Nimitz. Col. (later Brig. Gen.) Earl Maxwell, MC (fig. 87), became staff surgeon of the U.S. Army Forces in the South Pacific Area, and when the Services of Supply, South Pacific Area, was created

[17] (1) History of the Medical Department, Air Transport Command, May 1941–December 1944. [Official record.] (2) See footnote 2(2), p. 378.

[18] Letter, Col. Earl Maxwell, MC, Surgeon, U.S. Army Forces in South Pacific Area, to The Surgeon General, 7 Dec. 1942.



FIGURE 87.—Brig. Gen. Earl Maxwell, MC.

late in the year he was additionally made surgeon of that command. In his staff position with General Harmon, an air force officer, at Headquarters, U.S. Army Forces in the South Pacific Area, Colonel Maxwell was termed Air Surgeon, as he was the senior flight surgeon in the area. At the same time he served as assistant surgeon on Admiral Halsey's staff, second only to the Navy staff surgeon.

Colonel Maxwell's office prepared plans for medical units and supplies to support Army combat troops invading the South Pacific islands. Although the Navy surgeon on Admiral Halsey's staff had the higher responsibility for making medical plans for forward movements and the Navy the final authority in the South Pacific campaigns, in some cases—plans for medical support of the Bougainville operation, for example—Colonel Maxwell was given the major responsibility, for he had a larger staff than the Navy surgeon. As in the Central Pacific Area, many changes were made in the composition of units and equipment to fit the needs of medical service in jungle and amphibious warfare on small islands.

When Colonel Maxwell became surgeon of the newly formed Services of Supply in November 1942, his office personnel were transferred to the head-

quarters of that organization, but after late March 1943 some were assigned to theater and some to Services of Supply headquarters. Officers who worked in the fields of operations and planning were assigned to the U.S. Army Forces in the South Pacific Area, while those handling medical supply, personnel, hospitalization, food inspection, and statistics were Services of Supply personnel. Assignments were essentially nominal, however, for the two groups occupied the same quarters in Nouméa. Often an officer performed the same work after a theoretical transfer to the other headquarters. The medical section remained under this dual arrangement throughout the life of the South Pacific Area command—that is, until August 1944; it never moved with General Harmon's headquarters to forward areas. The use of one surgeon and of complementary rather than duplicate assignments for two static headquarters effected a substantial savings in medical personnel. Colonel Maxwell favored a small, simple organization at this top level, believing that too large an organization would be unwieldy. He recognized the need for a good deal of decentralization in a region in which the land areas were so widely dispersed as in the South Pacific.

Not until the closing days of the New Georgia campaign were vacancies for a surgical consultant and a medical consultant allotted to the medical section of U.S. Army Forces in the South Pacific Area. In mid-1943, Colonel Maxwell obtained the release of a medical officer from the 39th General Hospital, an affiliated unit from Yale University stationed in New Zealand, and of another from the 19th General Hospital, an affiliated unit from The Johns Hopkins University stationed in the Fijis, for duty with his office as surgical consultant and medical consultant, respectively. Later in the year a neuropsychiatric consultant and an orthopedic consultant were added to his staff.[39]

Since it became standard policy to decentralize responsibility to local commands, each island tended to become medically independent. Because of the absence of sizable metropolitan areas on some islands and the inaccessibility of the larger towns to troops on others, venereal disease was a minor problem on many islands. Wherever preventive measures were necessary, the medical officers of the Army area command handled the problem in conjunction with local authorities. The work of the theater surgeon's office was thus greatly restricted.

Problems of general sanitation were also tackled on a local basis. In New Caledonia, when several thousand American troops crowded the island, sanitary problems increased; the dumping of additional garbage and the opening of new bistros and restaurants called for additional sanitary inspections.

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[39] (1) See footnotes 2(2), p. 378, and 18, p. 388. (2) Memorandum, Brig. Gen. Fred W. Rankin, for The Surgeon General, 2 Nov. 1943, subject: Remarks on Recent Trip Accompanying Senatorial Party. (3) Report of Observations of Medical Service in SWPA and SPA, 12 July 1943, by Brig. Gen. C. C. Hillman. (4) Annual Report, Medical Department Activities, South Pacific Area, 1943. (5) Interviews, Brig. Gen. Earl Maxwell, 11 and 12 May 1950. (6) Memorandum, Lt. Gen. M. F. Harmon, for Assistant Chief of Staff, Operations Division, War Department, 6 June 1944, subject: The Army in the South Pacific. (7) Letter, Brig. Gen. Earl Maxwell, to Col. J. H. McNinch, MC, 8 Mar. 1950.

These tasks could be handled only through liaison with the local French Government. Army and Navy medical officers and French medical officials therefore established a Joint Sanitation Board. This organization—a coordinating rather than an operating one—served to prevent duplication of effort and disagreement on Army, Navy, and French policies with respect to maintaining a satisfactory water supply, standards of sanitation in barbershops, restaurants, and other establishments frequented by troops, as well as on prevention of venereal disease.[20]

The isolation of units and installations on the scattered islands hampered the pooling of their resources. The central dental clinic, effectively used in some areas to pool the specialized training of dental officers and special dental supplies and equipment that separate installations had in insufficient quantity, could not be effectively established in the South Pacific Area. Here the distances between camps on separate islands were too great. The hospitals had to furnish prosthetic equipment, which was not provided to tactical units; and small units without dental personnel were attached to specific hospitals for dental care. By the spring of 1944, when enough trained enlisted personnel became available, prosthetic teams were formed; they were attached to the various hospital and division dental clinics to furnish dentures to troops receiving rehabilitation after periods of combat.[21]

One of the most difficult problems encountered by Colonel Maxwell's office was the establishment and supervision of a satisfactory system of inspecting foods for Army troops. The usual system prevailed among local commands on the various islands, where foods were inspected when they were received at island ports and at various stages of distribution and preparation for troop consumption. At these stages the task was complicated chiefly by the necessity for many transshipments from island to island (making further inspections necessary) to adjust to changing troop strength. A more serious problem arose in connection with inspection of foods at the point of origin, mainly New Zealand. From mid-1942 to the close of 1945, millions of pounds of dairy products and fresh vegetables and fruits, as well as canned foods, were bought monthly in New Zealand by the Joint Purchasing Board in Wellington (established June 1942 and immediately responsible to the Commander, Service Squadron, South Pacific Force) for consumption by Army, Navy, and Marine Corps troops on the scattered islands. In the early period, the Board maintained a policy not in accord with the thinking of U.S. Army veterinarians assigned to Colonel Maxwell's office in New Caledonia. Partly out of reliance upon the sound reputation of New Zealand food exports in prewar years and the country's strong protective legislation, the Purchasing Board in Wellington was inclined to rely upon the New Zealand Government's

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[20] (1) Annual Report, Headquarters, Service Command, New Caledonia, 1943. (2) King, Arthur G.: Medical History of New Caledonia Service Command. [Official record.] (3) Letter, Col. Arthur G. King, to Director, Historical Unit, Office of The Surgeon General, 21 Aug. 1955.

[21] (1) See footnote 2(2), p. 378. (2) Dental History, South Pacific Area. [Official record.]

standards and its system of inspection. Army veterinarians of the U.S. Army Forces in the South Pacific, on the other hand, noted the lack of enforcement under wartime conditions, of New Zealand legislation relating to food products, partly as a result of the shortage of qualified New Zealand inspectors; they warned of the danger that persons interested in the sale of food products would bring pressure to lower standards. They insisted upon the need for a sound system of food inspection by Army veterinarians at slaughterhouses and processing and packing plants.

Some struggle between the two points of view continued throughout the war. In July 1943, an Army veterinarian was assigned to the Joint Purchasing Board. This agency created a Food Inspection Division to supervise the inspection of food and food processing plants to insure that products bought were processed from suitable raw materials and packed under sanitary conditions. By dint of continued pressure, bolstered by an inspection of the situation in New Zealand by General Maxwell's veterinarian, the Army succeeded early in 1944 in assigning 13 veterinarians to the Board. They were placed in charge of food inspection in the various areas of New Zealand and supervised the inspection of foods processed at plants and items in storage; they checked also on the sanitary conditions of ships loading foods for shipment at the New Zealand ports. Two laboratories maintained in New Zealand by the Food Inspection Division made examinations of canned, frozen, and dehydrated products and tested dairy and water supplies from processing plants and ships.

As in the case of other protective measures involving relations with local governments—as well as with the Navy command—large-scale inspection of local food products by Army veterinarians was difficult to achieve to the satisfaction of all concerned. Nevertheless, in spite of some dissatisfaction with the amount of support afforded to the program by the Navy command in control of the Joint Purchasing Board, as well as with the number of Army veterinarians assigned to the Board, the special system had been founded. During the last year of the war the scope of its work and the results were considered generally satisfactory by the Army veterinarians of the South Pacific Area command, as well as by those assigned to the work with the Joint Purchasing Board.[22]

Control of Malaria and Other Insectborne Diseases

The prevention of tropical diseases, chiefly malaria, was the challenge that demanded, and received, centralized control in the South Pacific Area. The most serious diseases in the islands were insectborne—mainly malaria, dengue fever, filariasis, and scrub typhus. In 1942 malaria rates rose to epidemic proportions on Efate in the New Hebrides Islands and on Guadalcanal in the

[22] (1) Annual Report, Veterinary Service, Headquarters, U.S. Joint Purchasing Board, 1945, and inclosures. (2) History of the South Pacific Base Command. [Official record, Office of the Chief of Military History.] (3) See footnote 2(2), p. 378. (4) Annual Report, Veterinary Service, Headquarters, U.S. Army Forces, Mid-Pacific, 1945.

Solomons, where American troops with insufficient antimalaria supplies (chiefly the Americal Division and the 1st and 2d Marine Divisions) were in close proximity to infected enemy troops, as well as malarious natives. Colonel Maxwell noted in November 1942 that malaria was "the most serious disease present." The exigencies of the military situation and the typical belief of commanding officers that malaria control was of secondary importance, or that it was not possible to cope with the disease during the combat period, made a purely local system of control unsatisfactory. The statement of one officer that "we are out here to fight Japs and to hell with mosquitoes" succinctly expressed the attitude of many line officers.[23]

An organization at a high level appeared to be the solution for control of a disease prevalent in most of the islands and responsible for the loss of many hours of work and combat. The South Pacific Malaria and Insect Control Organization [24] was set up in November 1942, almost concurrently with the establishment of the Headquarters, U.S. Army Forces in the South Pacific Area. Its primary task was the control of malaria among Army troops (including the Thirteenth Air Force), the Navy (including Marine Corps personnel), and the New Zealand forces. The organization developed by the Surgeon General's Office for control of malaria overseas was somewhat modified to fit the complex command structure, but most of its features prevailed, although the resources of the Army and Navy were pooled and the Navy had final authority. A Navy medical officer, attached to the staff of the Commander, South Pacific Area, headed the organization; Lt. Col. Paul A. Harper, MC, acted as Army liaison officer and held the highest Army position in it. Army Medical Department officers and Army malaria control and survey units were added from January 1943 on; since the Army had more personnel available than the Navy, it performed the greater portion of the work.

By the end of 1943, 49 Army Medical Department officers, including malariologists, sanitary engineers, entomologists, and parasitologists, and 264 enlisted men were working on malaria control. The headquarters of the organization was first located at Efate, then at Espíritu Santo after April 1943, and finally moved to the headquarters of the Commander, South Pacific Area, on New Caledonia in February 1944. With the addition of about a dozen malarious islands to the command, the South Pacific Malaria and Insect Control Organization eventually directed a large network of Navy, Army, Marine, and Allied personnel in antimalaria work among a troop population of more than 200,000. Later, it had responsibilities for control of other epidemic diseases as well, including two other mosquitoborne diseases—

[23] (1) Memorandum, Surgeon, U.S. Forces in the South Pacific Area, for The Surgeon General, 4 Nov. 1942, subject: Preliminary Sanitary Survey of CACTUS (Guadalcanal). (2) Harper, Lt. Col. Paul A., Butler, Comdr. Fred A., Lisausky, Capt. Ephraim T., and Speck, Maj. Carlos D.: Malaria and Epidemic Control in the South Pacific Area, 1942–44. [Official record.]

[24] This title appears to have been used loosely to apply sometimes to the total network of personnel engaged in control and sometimes to the top directing personnel only. Other titles used were "South Pacific Malaria and Epidemic Control Organization" and "Malaria Control Board."

filariasis, which appeared in epidemic form on several of the eastern bases in 1943, and dengue fever which reached epidemic proportions on New Caledonia early in 1943—as well as the miteborne scrub typhus. The mosquito was unquestionably the outstanding disease vector in the South Pacific islands; by about the middle of 1944, more than 750 personnel trained in entomology, engineering, and malariology and about 4,000 laborers were engaged in mosquito control.

Army malariologists went to the South Pacific Area as casual officers, were originally assigned to the Services of Supply and then reassigned to the various bases and to divisions. Six malariologists became senior base malariologists at headquarters; six more became division malariologists. A malariologist was also appointed for General Maxwell's office. As in other malarious areas, Army survey units and control units performed the field-work. As of 1 June 1944, 17 malaria survey units and 20 malaria control units were in the South Pacific Area.

An organization was set up at each island base; the area entomologist, engineer, and others of the staff at headquarters kept in touch with the work on each island through frequent visits. A senior base malariologist (either an Army or a Navy officer) was responsible on each island, originally through a commanding officer of the island service command, to the island commander, and later directly to the island commander, for developing a program applicable to all forces (Army, Navy, Marine, and Allied) on the island. The senior base (or island) malariologist estimated the assistant malariologists and survey and control units needed and requisitioned them from the area malariologist. Theoretically, the island malariologist, one survey unit, and one control unit formed the organization for malaria control at a base, but a larger island, such as Guadalcanal, had an assistant island malariologist and one or more survey and control units for each of several districts. On most islands a mixed Army and Navy organization was used.

The responsibilities of the island malariologist were of broad scope: The initiation of malaria surveys, the preparation of directives for protective measures to be enforced by unit commanders among troops, and measures taken in collaboration with colonial authorities or native chiefs to reduce the threats of transmission of malaria from natives to troops. In order to prevent transmission from infected natives, camps were located at some distance from native villages, or if necessary, the villages were moved. Another task of the island malariologist was the inspection of departing ships and planes for the presence of mosquitoes; some areas—New Zealand, New Caledonia, Fiji, and Samoa—were nonmalarious, and disinfestation of ships and planes was undertaken to prevent transmission of malaria vectors to uninfested islands. The island malariologist—as well as the island entomologist, the parasitologist, and the engineer—also had the job of training troop personnel assigned to malaria control work.

The malaria survey unit made geographic surveys of areas within the base for actual and potential breeding grounds of mosquitoes, maintained records on the mosquito population, and surveyed malaria parasites among troops, natives, white civilians, and Japanese prisoners. The control unit eliminated mosquitoes by draining and applying larvicides and insecticides to areas designated by the survey unit. Army Engineer troop units and Navy construction battalions provided additional skilled or semiskilled labor. To perform the unskilled, and some semiskilled, work, troop antimalaria details and Army medical sanitary companies (consisting of two platoons, each made up of two drainage teams, two oiling teams, and two spraying teams), as well as natives, were used.

The malaria control carried out in Army tactical units was done exclusively by personnel of the Army Medical Department; that is, the programs of the Army and Navy were separate at this level. Unit commanders had direct responsibility for initiating and enforcing the antimalaria measures in Army units. An antimalaria detail, consisting of a noncommissioned officer and enlisted men in numbers proportionate to the size of the unit (company, battery, squadron, or other unit), maintained mosquito control by oiling, spraying, and draining on campsites and in the surrounding area for a distance of 1 mile. Battalion and regimental surgeons were designated malaria control officers for their respective units and given responsibility for training the antimalaria details. For the Army division the control group consisted of a malariologist, responsible to the division surgeon, and one malaria survey and one malaria control unit. Whenever the division went into a new combat area, its antimalaria group carried out control work until the base organization was in working order; thereafter the antimalaria work of the division was closely integrated with that of the base. Antimalaria personnel assigned to a base usually had the more stable duties, of course, while the division malariologist sometimes had to create temporary teams for spraying and to shift them about as the tactical situation changed.[25]

Obviously no set pattern prevailed either for the various bases or for Army units. The number of units and their assignments varied with the terrain and climate of the island bases and were modified within the base or the Army unit in accordance with change of season, shifts in the tactical situation, and so forth. During periods of combat or movements of units, emphasis shifted from environmental control of malaria to the mass taking of Atabrine (quinacrine hydrochloride), then the drug of choice for suppression of malaria. But the establishment of broad uniform policies, standard assignments of per-

[25] (1) See footnotes 2(2), p. 378; 19(3), 19(4), and 19(5), p. 390; 20(2), p. 391; and 23(2), p. 393. (2) Report No. 35, Air Evaluation Board, Southwest Pacific Area: Medical Support of Air Warfare in the South and Southwest Pacific, 7 December 1941–15 August 1945. (3) Memorandum, Chief, Professional Services, to Chief Surgeon, USAFIA, 6 Oct. 1943, subject: Malaria Control. (4) Annual Report, Malaria and Epidemic Control, Guadalcanal Island Command, 1944. (5) Annual Report, Medical Department Activities, South Pacific Base Command, 1944. (6) See also Medical Department, United States Army. Preventive Medicine in World War II. Volume VI, Communicable Diseases: Malaria. [In press.]

sonnel, and routine procedures helped to prevent interruptions in control whenever troops moved from one island to another.

A steady decline in malaria rates took place in the South Pacific Area, beginning in mid-1943 and continuing in 1944 and 1945, interrupted only by sporadic rises whenever troops went on maneuvers or entered uncontrolled areas. The low rates on Bougainville, potentially an area of high malaria incidence, and on other islands occupied in 1943 and 1944, proved the value of control work begun on the day of occupation. The draining, leveling, or filling in of extensive mosquito breeding areas, clearing of underbrush, spraying water surfaces and buildings with DDT, better identification of malaria-carrying mosquitoes through improved laboratory work, more thorough training of troops and wider publicity of the need for control—all these undertakings of the organization for malaria control contributed to the decline of malaria. The regular dosage of troops with Atabrine in order to build up immunity in advance was relied on to prevent the incidence of the disease in mosquito-infested areas during the early days of combat before the mosquito population could be destroyed. Commanding officers, impressed by the loss of man-days resulting from the incidence of malaria on Efate and Guadalcanal, enforced more strictly the Atabrine regimen on the eve of later campaigns.[26]

One noteworthy feature of the South Pacific Malaria and Insect Control Organization was that from its inception its head, a Navy doctor, was placed at the highest level of command in the South Pacific Area; a similar position for the island or base malariologist was early established. The principle of centralized control over malariologists and control and survey units was steadfastly maintained. Most observers found that the organization in the South Pacific worked more smoothly than that in the Southwest Pacific Area, where the question of the proper structure and placement of the malaria control organization was bandied about for some time and where control over the effective employment of units was lost through their assignment to various commands. While some problems arose in the South Pacific Area wherever local command relationships were not well defined, Army and Navy forces attained a high degree of cooperation in their joint program in the South Pacific. Ready exchange of supplies, facilities, and technical knowledge seems to have taken place. Administrators made the following appraisal: "The efficiency and economy of this joint use of personnel and equipment is a stimulating chapter in combined service organization." Colonel Harper stated: "It is worthy of emphasis that the South Pacific Malaria and Insect Control Organization was based on a combination of centralized control over assignment of personnel and over matters of policy which could reasonably be areawide in application and of decentralized responsibility for day to day operations at each base." [27]

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[26] See footnotes 19(4), p. 390; and 22(2), p. 392.

[27] (1) See footnote 23(2), p. 393. (2) Letter, Paul Harper, M.D., to Col. John Boyd Coates, Jr., MC, USA, Director, The Historical Unit, U.S. Army Medical Service, 25 July 1955.

The Ground Combat Forces and the South Pacific Islands

U.S. Army tactical troops sent to the South Pacific Area from early 1942 to the spring of 1944 (when plans were made for redeployment of troops in the South Pacific to the Southwest Pacific) consisted of six divisions (the 25th, 37th, 40th, 43d, 93d, and Americal Divisions) and the Thirteenth Air Force. During combat, the divisions usually functioned under XIV Corps. The latter's headquarters on Guadalcanal included a medical section which by March 1943 was acting as the medical section for a provisional island command for Guadalcanal as well as the medical section of the corps. From July to about November 1943, it functioned in the same dual capacity on New Georgia. In the winter of 1943–44, the office of XIV Corps surgeon, then consisting of three Medical Department officers, was on Bougainville. In June 1944, when XIV Corps took over control of New Georgia, Treasury, and Green Islands in the northern Solomons, as well as Bougainville, and of Emirau in the Bismarck Archipelago, four more officers were added to the medical section. As in most corps medical sections, officers were of the Medical or Medical Administrative Corps, the task of the corps medical section being largely that of coordinating the medical work of the divisions operating under the corps. On 15 June 1944, XIV Corps was transferred to the Southwest Pacific Area command, having entered islands within the latter's boundary lines.[28]

With the progress of combat, "island commands" were established on islands of strategic importance on which troops were concentrated in considerable strength; each was composed of all tactical troops on the island—Army, Army Air Forces, Navy, and Marines. Island commands were finally established on the seven following South Pacific islands or island groups: New Caledonia, Fiji, Efate, and Espíritu Santo in the New Hebrides; Guadalcanal and New Georgia in the Solomons; and the Russell Islands. In addition, the Army maintained for varying periods of time garrison forces at the following locations: Auckland, New Zealand; Upola and Wallis Island in the Samoan Islands; Tongatabu in the Tonga Islands; Bora Bora in the Society Islands; Aitutaki and Tongareva in the Cook Islands; Treasury Islands, Bougainville, and Green Islands in the Solomons; and Emirau Island in the Bismarck Archipelago. While troop strength varied greatly, most of these forces, except on Bougainville, were small. In January 1944 nearly 36,000 Army troops were on Bougainville, approximately the same number as were on Guadalcanal and on New Caledonia. By early August 1944 (when the South Pacific Area command was abolished), only four island commands still existed—New Caledonia,

[28] (1) Annual Report, Medical Department Activities, Headquarters, XIV Corps, 1943. (2) Quarterly Reports, Medical Department Activities, Headquarters, XIV Corps, 1st, 2d, and 3d quarters, 1944. (3) Letter, Col. Maurice C. Pincoffs, MC, to Brig. Gen. Guy B. Denit, 10 July 1944. (4) Annual Report, Surgeon, Service Command, Guadalcanal, 1943. (5) History of U.S. Army Forces in the South Pacific Area During World War II, 30 March 1942–1 August 1944. [Official record, Office of the Chief of Military History.]

Fiji, Espíritu Santo, and Guadalcanal Island Commands—the remaining three having been made subbases.[29]

On 10 islands or island groups a service command (corresponding to a base section in other theaters of operations) was set up to serve all Army troops on the island. (A naval advanced base filled this role for Navy troops.) Between November 1942 and April 1944, the following 10 service commands were established in the order named: New Caledonia, New Zealand, Fiji, Guadalcanal, Espíritu Santo, Efate, Russell Islands, Green Islands, Emirau, and Bougainville. Whereas the island commander—who might be either an Army, a Navy, or a Marine Corps officer—was responsible to the Commanding General, U.S. Army Forces, South Pacific Area (General Harmon), the service commander was responsible (through the Commander, Services of Supply, Forward Area [30]) to the Commanding General, Services of Supply, South Pacific Area. On some islands there existed, for a limited time after tactical troops moved into an island, both an island command surgeon and a service command surgeon, who operated within the channels of their respective commands. Their respective functions roughly resembled those of the surgeon of an army and those of a service command surgeon in the United States, or of an army surgeon and the usual base section surgeon in an oversea theater. Later the position of island command surgeon was discontinued, and the service command surgeon was then the Army medical officer of chief responsibility on the island. Although he served within the service command setup, he was usually assigned additional duty as island command surgeon or given unofficial recognition in that capacity. A provisional service command which arrived on Guadalcanal early in 1943, for example, had a medical section by May 1943. This section took over the responsibility for the Army's medical program on Guadalcanal from the medical section of the provisional island command (XIV Corps) mentioned above, when the latter left Guadalcanal in mid-1943.

Channels of command were somewhat involved for the service command surgeon. He was responsible to the service commander of the island, who, although on the next echelon below the Commanding General, Services of Supply, South Pacific Area, was responsible to the island commander for local operations. However, both channels for the service command surgeon led back to the individual with single responsibility for the health of Army troops, Colonel Maxwell, for he was not only Surgeon, Services of Supply, South Pacific Area, and surgeon at the next higher, or theater, level, but also assistant surgeon on the staff of the Commander, South Pacific. Thus, Army medical responsibilities were clearly centralized at the top level. Certain complications that arose in medical administration on the South Pacific islands were not due to lack of centralized responsibility within the command structure but to

[29] (1) Annual Report, Medical Department Activities, South Pacific Area, 1942. (2) See footnote 22(2), p. 392. (3) General Order No. 1175, Headquarters, South Pacific Base Command, 3 Aug. 1944. (4) General Order No. 1184, Headquarters, South Pacific Base Command, 19 Aug. 1944.

[30] Under the Navy organization of the South Pacific Area the island commands lay within the forward area, intermediate between combat and rear areas.

the great distance between islands which prevented effective control from the top level and thrust responsibility downward to the island level where several channels of command, including Navy commands, prevailed.[31]

The medical administration on the largest of the New Hebrides islands, Espíritu Santo, governed under French-British condominium, illustrates the situation that prevailed on the island bases and the problems that arose. Espíritu Santo was used as a base by air units for attacks on Guadalcanal; by early 1943 the Thirteenth Air Force was based there, as well as some Army ground force, Navy, and Marine Corps elements—the medley of troops characteristic of the South Pacific bases. During 1942 Army medical officers on Espíritu Santo were those assigned to tactical units. A Navy hospital received Army sick, and a French colonial hospital cared for sick or injured natives employed by the U.S. Army. The organization of Army medical service was not of islandwide scope until March 1943, when Lt. Col. Arthur G. King, who had pioneered as surgeon for the service command of the very large base of New Caledonia, organized the medical section for the newly formed Espíritu Santo Service Command. An evacuation, a station, and a general hospital opened on the island in 1943, and Colonel King's office established a fairly elaborate system of dispensaries for the 17,000 widely scattered Army troops there.

The IV Island Command had tactical control of all Army troops on Espíritu Santo and was responsible to the Commanding General, South Pacific Area. The Espíritu Santo Service Command, though locally responsible to IV Island Command, took orders from the Commanding General, Services of Supply, South Pacific Area, in turn responsible to the Commanding General, South Pacific Area. As no rival surgeon existed at IV Island Command headquarters, Colonel King appears to have been recognized as island command surgeon, as well as service command surgeon. On the other hand, he encountered difficulty in coordinating his work with that of surgeons of various commands on Espíritu Santo. The Surgeon, Thirteenth Air Force, reported directly to the theater surgeon at Headquarters, U.S. Army Forces, South Pacific Area, in spite of the fact that Colonel King, as service command surgeon, had responsibility for hospitalizing Thirteenth Air Force personnel in hospitals on Espíritu Santo and, as island command surgeon, was responsible for issuing sanitation orders to which the Thirteenth Air Force units, along with other military units, were subject. Until the fall of 1943, when a naval advanced base surgeon was appointed, with duties comparable to his own as service command surgeon, Colonel King was obliged to handle problems of sanitation on an individual basis with the various Navy medical officers concerned. Colonel King still had to deal separately with Marine Corps units, and with the two large naval hospitals, as only the service elements of the

[31] (1) See footnotes 2(2), p. 378; 19(5), p. 390; 20(2), p. 391; and 28(3) and (4), p. 397. (2) Scattered quarterly reports of Medical Department activities from various South Pacific islands, including Aitutaki, Tongareva, Upolu, Green Islands, and Viti Levu.

Navy were under the Naval Advanced Base, while the Marine Corps elements were semi-independent of the Navy.

As might be expected, he experienced his major difficulties in preventive measures which called for consistent policies among troops throughout Espíritu Santo, such as garbage disposal and other general sanitary measures, quarantine regulations, and malaria control. The island commander instructed him to emphasize sanitary measures, which, before the establishment of a service command, had failed signally because of the plurality of tactical units and chains of command. An order of the commander in March 1943 that each unit clean up its own accumulation of garbage, tin cans, and cocoanut waste had led to the threat of armed clashes when units tried to dump garbage on each other's territory. A system of fixed sanitary sectors had also proved ineffective. Colonel King established a central sanitary detail, composed of personnel from Army, Air Force, Navy, and Marine Corps elements on the island, to clean up the entire occupied portion of the island, as well as a central garbage and trash dump. Centralized control by the Medical Department with the backing of the island commander proved to be the answer.

Problems arose with respect to the jurisdiction and responsibility of the port surgeon in Colonel King's office over quarantine and disinfestation measures for incoming ships and planes. Apparently considering Colonel King only an Army service command surgeon, the naval advanced base command was averse to recognizing his port surgeon's authority to inspect Navy-controlled ships and to issue the necessary certificate of health for disembarking personnel, as well as his authority to disinfest Navy-controlled ships and planes. An epidemic of hog cholera among swine on a plantation on an island near Espíritu Santo, supposedly caused by garbage dumped overboard by Navy ships, gave further trouble. In this case not even the naval advanced base command could control the situation effectively, as ships of the Fleet were not responsible to it but directly to the Commander, South Pacific. Not only did the epidemic endanger the supply of meat for troops, but his problem, like some others encountered on Espíritu Santo, could have affected relations of the U.S. Army with the French plantation owners, since the latter paid their native Melanesian workers in hogs. These conflicts with the Navy were eventually solved by various compromises after considerable effort by the service command surgeon to establish specific responsibilities and reconcile conflicting claims.

Although the organization for malaria control seemed a satisfactory one to the malariologists, Colonel King found some defects in the workings of an unorthodox system that singled out a single phase of medical service, albeit an important one, for control through special channels. An early requirement that the malaria control officer (Navy) approve the location of any troop unit was ignored by many Army units. Various directives for malaria control measures, issued by the South Pacific Area command, its Services of Supply, and The Surgeon General sometimes conflicted with the policies of the local

command. In the spring of 1943, the responsibility for directing the program on Espíritu Santo rested with the Navy malaria control officer. Colonel King considered himself responsible, in his capacity as island command surgeon, for carrying out the program, while the Services of Supply, South Pacific Area, provided the necessary supplies. In late May 1943, however, a Navy order put all malaria control work under the authority of the island malaria control officer, who was responsible to the Commander, South Pacific. This order short circuited the Army chain of command, that is, the Espíritu Santo island command, the U.S. Army Forces in the South Pacific Area, and the Services of Supply, South Pacific Area. Thus the island commander received only information copies of monthly reports, sometimes strongly critical, of work in malaria control among his own troops after the original report had gone to higher headquarters. A directive requiring submission of malaria control reports to the commanding general of the island through the commanding general of the service command straightened out the matter temporarily. However, in August a directive issued by the Navy Bureau of Medicine and Surgery placed the control of all epidemic disease under the malaria control officer; hence reports on control of not only malaria but all epidemic diseases were once more sent through Navy channels, the island commanding general and his surgeon receiving only information copies at a later date. The appearance of a War Department circular placing all insect control of any island under the commanding general of the island led to further confusion, but the Army command apparently avoided duplication of Navy work in malaria control. In October 1943, a directive requiring all communications of the malaria control officer to be routed through service command channels brought an end to the controversy.

A proposal to prevent contact of troops with the malaria-ridden Tonkinese laborers working for French planters on Espíritu Santo was also bandied about in various commands. After failure to move the Tonkinese or to get French doctors to treat them early in 1943, the malaria control officer proposed in August their forcible removal to a central village from which they could be transported daily to the plantations. The island commander approved this move without consulting the surgeon, but when the commanding general of the service command protested, the scheme was dropped. In October the Commander, South Pacific, ordered the removal of all Tonkinese and other natives from the military area on Espíritu Santo without any consultation with a newly appointed island commander. The following day the order was rescinded. A few days later the island commander directed the surgeon to treat the Tonkinese on the plantations, and treatment was given with the cooperation of the French planters. Colonel King noted that this satisfactory solution was brought about only through centralizing authority in the new island commander who was able to deal realistically and tactfully with the sensitive French.

Colonel King found his lack of control over the assignments of medical personnel another stumbling block to efficient medical service. Like many

another island command surgeon (and many base section and theater surgeons), he noted his need of a pool of medically trained personnel to replace officers to be sent home for rest and recuperation and to fill certain medical jobs which had developed in the areas outside official allotments and tables of organization. When he tried to use the personnel of hospital ship platoons, stranded for lengthy periods in the theater, for this purpose, he found that command channels interfered with transfer of medical personnel from one command to another. He developed a plan to effect more efficient use of medical personnel on the island by transferring them to the positions for which they were best fitted after classifying them according to specialized training, experience, and proficiency. This undertaking bogged down because of the unwillingness of commands to surrender personnel and the many paper transactions necessary to effect reassignments. His efforts to transfer a pathologist, then surgeon of an antiaircraft battalion, and a highly qualified orthopedic surgeon, who was a ship's hospital platoon officer, to hospitals where their specialized skills were urgently needed, were defeated in spite of complicated paper transactions.

In summing up his experiences, Colonel King made a plea for a medical service with more direct control by medical officers and less hampered by chains of command. In his opinion "the complex and cumbersome" command relationships on Espíritu Santo and throughout the South Pacific Area had put difficulties in the way of administering medical service there. His insistence in his report that "optimal cooperation between the Army, Navy, and Air Force, even to the point of loss of identity, was sorely needed" is significant in view of the trend towards unification of the three military arms that took place in the postwar period.[32]

Thirteenth Air Force

The Thirteenth Air Force built up in the South Pacific from and after early 1942. Its nucleus was air units dispatched to South Pacific islands from Hawaii, which were temporarily supplied by their remote parent organization, the Seventh Air Force. An island air command, with a flight surgeon on its special staff, was created on each of several islands, and in December administrative control of all air units on the South Pacific islands became the responsibility of Headquarters, U.S. Army Forces in the South Pacific Area. In January 1943 Headquarters, Thirteenth Air Force, was called into being, with Lt. Col. (later Col.) Frederick J. Frese, MC (fig. 88), as its surgeon, based on Espíritu Santo; Colonel Frese had previously been assistant to Colonel Maxwell, who was serving in the dual capacity of Surgeon and Air Surgeon, U.S. Army Forces in the South Pacific Area. Like Colonel Maxwell himself, Colonel Frese had been trained as a flight surgeon.

[32] (1) King, Arthur G.: Medical History of Espíritu Santo (New Hebrides) Service Command, 12 March 1943–15 May 1944. [Official record.] (2) Annual Report of Medical Activities on Espíritu Santo, 1944. (3) Diary, Lt. Col. Arthur G. King, MC, 12 Mar. 1943–21 Nov. 1944.

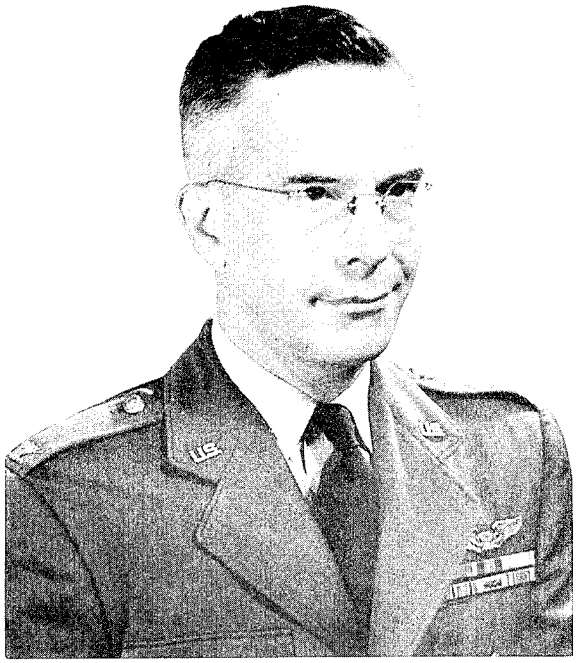


FIGURE 88.—Col. Frederick J. Frese, MC.

As units of the Thirteenth Air Force were scattered over the South Pacific islands and were operating against the Solomons in close conjunction with air elements of the Navy, Marines, and the New Zealand forces, centralized direction of medical service throughout the air force from headquarters was out of the question. Late in 1943, duties of staff surgeons were unorthodox. One officer of the headquarters medical section was on detached service with the combined Army-Navy-Marine headquarters for all aircraft on the Solomon Islands, and another was acting as flight surgeon in the rest area at Auckland. The Surgeon of XIII Air Service Command was also serving at Auckland, while his assistant was handling the neuropsychiatric duties for the whole air force. At that date the bomber command was the only one of the air commands which had a well-developed medical section functioning as planned.

The geographic and tactical situation weakened arguments for control of separate hospitals by the air force, as well as efforts at centralized supervision of medical service for air force troops. The Thirteenth Air Force surgeon agreed with the Air Surgeon's Office in Washington that oversea air forces should operate separate hospitals for their personnel, but Colonel Maxwell noted that the short stay of the air force units on small islands made control of hospitals by the Thirteenth Air Force in that area impracticable. Hospitals assigned to the air force would have been subject to frequent moves to conform to the rapid changes of station of air force units; they would have had to be

put under tentage and would have lacked various facilities. Sending in one hospital, under the Services of Supply, for both ground and air troops to a relatively permanent location had resulted in better construction, running water, screening, and other advantages. In the Thirteenth Air Force the majority of tactical as well as service groups established small infirmaries, many as well equipped as small station hospitals except for such specialized items as operating equipment. These treated many cases of malaria and dengue. After the transfer of Thirteenth Air Force to the Southwest Pacific Area command, a few 25-bed portable surgical hospitals were attached to it; the group infirmaries were then abandoned. An informal agreement by Colonel Frese and Colonel King on Espíritu Santo to ignore the rules for distribution of patients on an area basis and concentrate all Thirteenth Air Force patients in only one of the three hospitals on the island, with free participation by flight surgeons in their treatment, solved the problem in that area to the satisfaction of the Thirteenth Air Force surgeon.[33]

The organization which directed air evacuation within the South Pacific Area—the area where large-scale evacuation by air occurred earliest in World War II—was an interservice command, which reflected both the advantages and the problems inherent in joint Army-Navy direction of a medical activity. From the fall of 1942 to the spring of 1943, no special organization existed to evacuate casualties by air from the overcrowded facilities on Guadalcanal to base hospitals on New Caledonia. During the late months of 1942, unarmed and unescorted planes of the Marines and troop carrier planes of the Thirteenth Air Force which carried supplies to troops on Guadalcanal evacuated patients on their return flights to their bases, with Marine Corps hospital corpsmen assigned to each plane to care for patients en route. Late in November, the South Pacific Combat Air Transport Command was formally organized, under direction of the Marine Corps, to carry supplies; its returning planes took care of intratheater air evacuation. Planes and medical personnel of the Thirteenth Air Force were used, along with those of the Navy and Marine Corps, by the combined command. After the 801st Medical Air Evacuation Transport Squadron arrived early in 1943 and was assigned for duty with the medical section of the combined command at Tontouta on New Caledonia, Army Air Forces medical personnel constituted three-fourths of the personnel available to accompany patients in flight.

Personnel of the squadron (later based on Espíritu Santo) were individually assigned and reassigned by the South Pacific Combat Air Transport Command (directly by the Navy flight surgeon who headed its medical section) rather than by an Army Air Forces command as in other areas. In a report on the effectiveness of medical support given air force elements in the Pacific theater, the Air Evacuation Board criticized the tendency of the Navy and Marine Corps to establish policies on air evacuation without consultation with

[33] Letter, Col. Arthur G. King, MC, USA (Ret.), to Col. John Boyd Coates, Jr., MC, USA, Director, The Historical Unit, U.S. Army Medical Service, 21 Aug. 1955.

the Thirteenth Air Force and a tendency to assign patients to the care of Navy corpsmen during flight in preference to putting them in the hands of the more highly trained flight nurses of the Army Air Forces. Nevertheless the operations of the Army evacuation unit under this system were highly successful. By the close of 1943, 62 members had flown more than 18,700 hours, nearly all in combat zones, evacuating thousands of Army, Air Force, and Navy patients over the lengthy routes from the Solomons.[34]

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[34] (1) Medical Report, Thirteenth Air Force, 11 December 1943. (2) See footnotes 19(5), p. 390; 25(5), p. 395; and 28(5), p. 397. (3) War Critique Study, XIII Air Force Service Command. (4) Special Order No. 1, Headquarters, Island Air Command, 17 Oct. 1942. (5) General Order No. 407, Headquarters, U.S. Army Forces in the South Pacific Area, 19 March 1944. (6) Annual Report, 801st Medical Air Evacuation Transport Squadron, 1943. (7) 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, pp. 773–774.

CHAPTER X

The Southwest Pacific Area

The Army medical service which took shape in Australia under Gen. Douglas MacArthur in the spring of 1942 succeeded that which had existed in the Philippine Department in the prewar period. While the Army was losing out in the Philippines it was building up in Australia. Before the close of 1942, a thoroughgoing medical service characteristic of a theater of operations had been founded in the Southwest Pacific Area.

DECLINE OF MEDICAL SERVICE IN THE PHILIPPINES

The life of Army medical service in the Philippines after the United States entered the war was brief but dramatic. When the Japanese bombed Clark Field on the day after their attack on Pearl Harbor, the department surgeon, Col. Wibb E. Cooper, MC (fig. 89), and his staff had to switch rapidly from the normal medical activities of an Army oversea department to those of a theater of operations. From that date on, the story was one of medical service rendered under extreme difficulty. Although the withdrawal to Bataan and Corregidor accorded with long-established plans, the administration of medical service in this time of retreat conformed to the exigencies of rapidly shifting circumstances rather than to any repeatable pattern.

When the move out of Manila began in the latter part of December 1941, Colonel Cooper's office moved to Corregidor with Headquarters, U.S. Army Forces in the Far East, and was ultimately established in the Malinta Tunnel (fig. 90). An advance echelon of the surgeon's office was simultaneously set up on Bataan, initially sited with General Hospital No. 1 at Limay and later with Services of Supply headquarters. Colonel Cooper served in the dual capacity of Philippine Department Surgeon and Acting Surgeon, U.S. Army Forces in the Far East, until 21 March 1942 when the latter command was superseded by U.S. Forces in the Philippines. Colonel Cooper was named surgeon of the new command by Lt. Gen. Jonathan M. Wainwright.[1]

In December 1941, Lt. Col. (later Col.) William J. Kennard, MC (fig. 91), the senior flight surgeon in the Philippines, who was wounded by bomb fragments during the attack on Clark Field, was surgeon of the Far East Air Force and of its service command. The departmental medical service furnished medical supplies and hospitalization to the air troops. Excellent relations, due in some measure to the proximity of Army and Air Forces in-

[1] (1) Cooper, Col. Wibb E.: Medical Department Activities in the Philippines from 1941 to 6 May 1942, and Including Medical Activities in Japanese Prisoner of War Camps. [Official record.] (2) See also Medical Department, United States Army. Medical Service in the Asiatic-Pacific Theater in World War II, ch. I. [In preparation.]



FIGURE 89.—Col. Wibb E. Cooper, MC.

stallations, existed between the department surgeon and Colonel Kennard. Medical Department officers were stationed at Clark and Nichols Fields to serve the air force squadrons which had arrived in 1940 and 1941, while just before the attack a few medical officers had moved out of Luzon with air force units to other islands as part of a dispersion program. After the move to Bataan a number of the air force squadrons were transformed into two regiments with regimental surgeons. The latter and the various group and squadron surgeons were scattered over Bataan and Mindanao. From about Christmas Day of 1941 to early April 1942, Colonel Kennard traveled several thousand miles from camp to camp, making sanitary inspections and aiding in hospitalization and evacuation.[2]

At the outbreak of war, Sternberg General Hospital in Manila and five station hospitals were the total assets of the Philippines in fixed Army hospitals. The commander of the station hospital at Fort Mills, Corregidor, was also the Surgeon, Harbor Defenses, and had jurisdiction over all Medical Department officers stationed at the fortified islands, including Corregidor,

[2] Kennard, Lt. Col. William J.: Report on Philippine and Australian Activities, 1942. [Official record.]

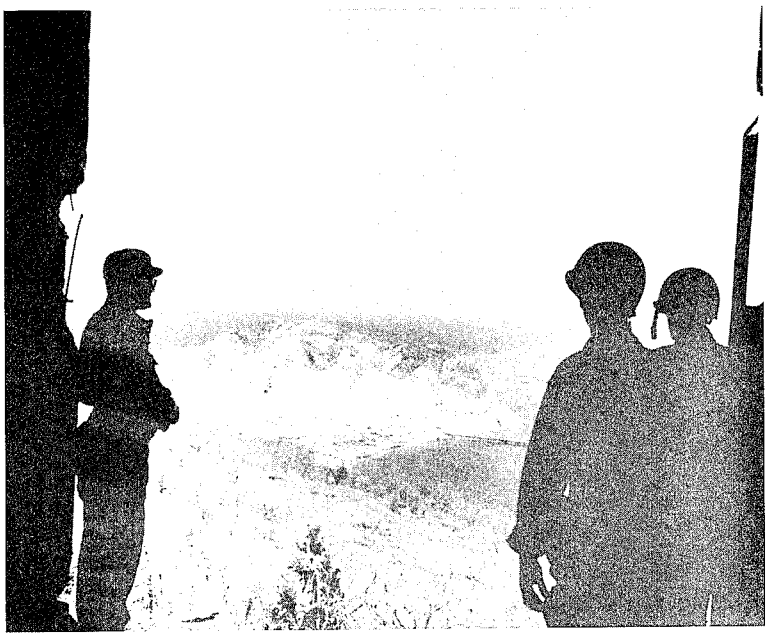


FIGURE 90.—Malinta Tunnel, Corregidor, which housed both a hospital and the office of the Surgeon, U.S. Army Forces in the Far East.

which protected Manila Bay. On 8 December, in accordance with a previous plan, the Manila Hospital Center was established by adding several annexes, some in college and university buildings, to Sternberg General Hospital. The care of the incoming wounded lasted only a month, as the move to Bataan began in the latter part of December. On Bataan were set up General Hospital No. 1 at Camp Limay (later at Little Baguio), General Hospital No. 2 near Cabcaben Airfield, and the Philippine Army General Hospital near the Philippine Army headquarters in the rear of Bataan.

The Philippine Medical Depot in Manila, which housed the equipment for a number of tactical hospitals at the outbreak of war, furnished medical supplies by trucks and barges to both ground forces and air forces. Late in December 1941, it was transferred to a location near General Hospital No. 2 on Bataan. In April shellfire destroyed it.

In the first bombing of Corregidor in late December 1941, the Fort Mills Station Hospital sustained several direct hits and was immediately moved to Malinta Tunnel. By 9 April, as the evacuation from Bataan to Corregidor took place, fixed medical service in the Philippines—care of the many cases of malaria, malnutrition, and dysentery—was concentrated in the tunnel, with Colonel Cooper in charge. Colonel Cooper remained in Malinta Tunnel with his hospital staff and patients after the surrender of Corregidor on 6 May until 25 June, when the Japanese allowed them to move to the renovated Fort Mills Hospital. In early July all were transferred to Manila, the nurses



FIGURE 91.—Col. William J. Kennard, MC.

finally to Santo Tomas University, converted to a prison, and Colonel Cooper and the patients to separate quarters in Bilibid Prison. Any semblance of medical organization of the U.S. Forces in the Philippines may be said to have ended at that date. Colonel Cooper was shortly transferred to Tarlac, where he rejoined General Wainwright and his group and learned of the Death March. In August, with other top-ranking officers, he was sent to a prison camp on Formosa.[3]

THE EARLY MONTHS IN AUSTRALIA

While medical officers in the Philippines were retreating with the Army to Bataan and Corregidor, medical service in the Southwest Pacific was taking shape in Australia. Its birth may be dated from the hasty formation of a headquarters staff, including a surgeon, for the provisional Task Force, South Pacific, under command of Brig. Gen. Julian F. Barnes. En route from Hawaii to the Philippines, the force was diverted to Australia and arrived at Brisbane on 22 December. Medical Department personnel aboard were those

[3] (1) See footnote 1 (1), p. 407. (2) Noell, Maj. Livingston P., MC: Report of Personal Experiences in the Japanese Prison Camps of the Philippine Islands, 8 April 1942–15 February 1945. [Official record.] (3) Interview, Marie Adams, Field Director, American Red Cross, 7 June 1945, subject: Conditions at Santo Tomas.

attached to a few tactical units, plus about a dozen casual medical officers. Most of the convoy's troops, including most of the casual medical officers, went northward with the convoy toward the Philippines. Since they were unable to put in at any port in the archipelago, they landed at Darwin, in northern Australia, with the exception of a field artillery battalion, which went on to Java.

The U.S. Army Forces in Australia,[4] under command of Maj. Gen. (later Lt. Gen.) George H. Brett, had its headquarters in Melbourne. The theater organization began to take shape in January 1942. Four base sections were set up extending inland from the northern and eastern coasts of Australia, with headquarters respectively at Darwin, Townsville, Brisbane, and Melbourne (map 8).[5] No permanent surgeon was assigned to U.S. Army Forces in Australia until February, when The Surgeon General sent Lt. Col. (later Brig. Gen.) George W. Rice, MC (fig. 92), to be theater surgeon. Col. (later Brig. Gen.) Percy J. Carroll, MC (fig. 93), had meanwhile arrived in Australia on the hospital ship *Mactan* carrying patients out of the Philippines. Since Colonel Carroll was Colonel Rice's senior, the post went to him on 7 February.[6]

During the spring and summer of 1942, Colonel Carroll requested additional medical personnel from the War Department. About 230 nurses arrived in February, as well as the staff of the first complete hospital, the 4th General. He also urged the War Department to send hospitals, airplane ambulances, dental laboratories, and various medical supplies, particularly dental. He had to meet urgent requests for anesthetics, blood plasma, quinine, and other medical items for General MacArthur's hard-pressed forces in the Philippines. Some further drainage of his supplies, and personnel as well, occurred when the task force for New Caledonia in the South Pacific Area sailed from Melbourne in March; nearly half the nurses accompanied the task force to New Caledonia.[7]

During the early months of 1942, the medical organization of the four base sections initially established, of two additional ones to the south and southwest—Base Section 5 with headquarters at Adelaide and Base Section 6 with headquarters at Perth—and finally Base Section 7, established in April with headquarters at Sydney, was taking shape (map 8). The early tasks of staff surgeons sent to organize the medical service for the base sections were to set

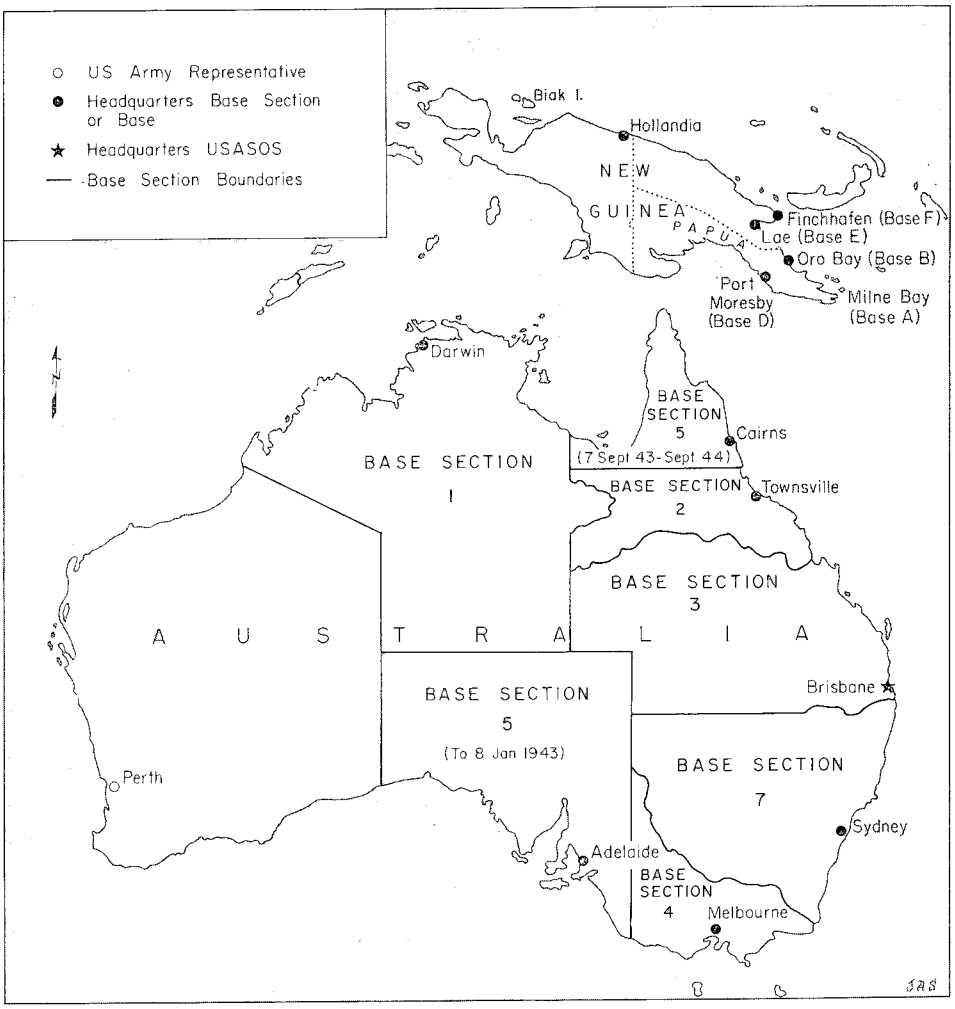
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[4] For 2 weeks, from 22 December 1941 to 5 January 1942, the designation was simply USFIA (U.S. Forces in Australia).

[5] The operational base section established in the Netherlands East Indies, with headquarters at Soerabaja, Java, had some medical officers assigned, but with the collapse of the short-lived American-British-Dutch-Australian command under Field Marshal Sir Archibald Wavell in Java, Army medical service there underwent no further developments.

[6] (1) Dairy, Col. Percy J. Carroll, December 1941–30 June 1942. (2) Annual Report, Chief Surgeon, Southwest Pacific Area, 1942. (3) Barnes, Maj. Gen. Julian F.: Report of Organization and Activities of U.S. Army Forces in Australia, 7 December 1941–30 June 1942 (6 Nov. 1942). [Official record.] (4) Military History of U.S. Army Services of Supply in the Southwest Pacific Area. [Official record.] (5) General Order No. 1, U.S. Army Forces in Australia, 5 Jan. 1942. (6) Letter, Lt. Col. George W. Rice to Col. John Rogers, 20 Apr. 1942.

[7] See footnote 6(2).



MAP 8.—Services of Supply in the Southwest Pacific Area, January 1944.

up the surgeon's office in some building furnished by the Australians, to establish and operate a dispensary, and to plan for hospital construction and a permanent system of U.S. Army hospitals. Meanwhile, they obtained medical supplies from the Australians and arranged for hospitalization of U.S. Army personnel in Australian hospitals. The number of U.S. Army patients in these hospitals reached a peak of approximately 16,500 in May and June of 1942. Eventually the duties of the Australian base section surgeons were to become the standard ones, but circumstances conspired to make their tasks rather unorthodox in the early months of 1942. They had to get acquainted with the Commonwealth and State medical agencies in Australia, as well as with the Australian military medical organization, and local sources of medical

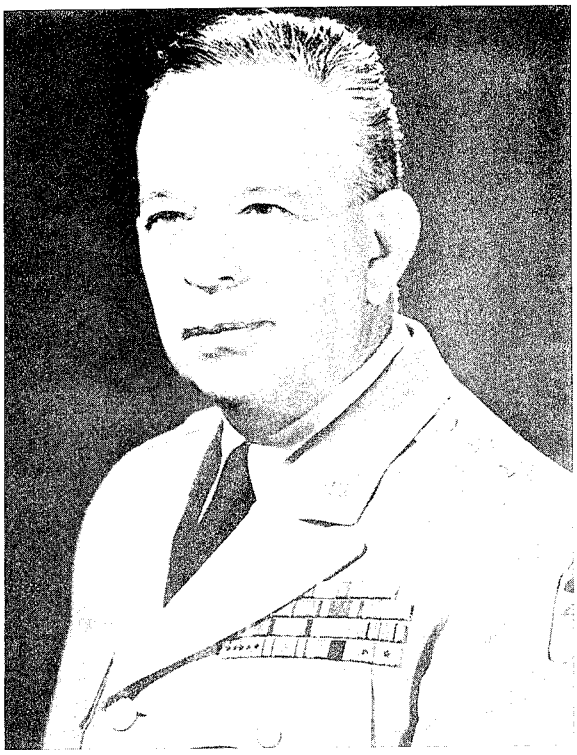


FIGURE 92.—Maj. Gen. George W. Rice, MC.

supplies and facilities. The base section surgeon in Australia needed talent for diplomacy in borrowing, for improvisation when supplies and facilities were not to be had, and for adjustment to existing shortages— skills not mentioned in Army field manuals.

Moreover, the circumstances under which base section medical service developed varied markedly from one region to another. During the severe Japanese air raid on Darwin, where the headquarters of Base Section 1 was located, on 19 February 1942 several U.S. Army hospitals, as well as an Australian hospital ship, were fired upon. U.S. Army troops evacuated Darwin and went southward. For some months all medical supplies and hospitalization were furnished by the Australians, and the base section surgeon's office became a leaky tent in the bush. U.S. Army troop areas in Base Section 1 were well within the Tropics, and roads and railroads were scarce.

At the large southeastern ports of Brisbane and Melbourne, on the other hand, it was possible to get off to an earlier start. The Australian population was concentrated in the southeastern cities, and communications and facilities there were superior to those in the north. In Brisbane, medical supplies brought in by the convoy which had arrived in December were available, and a medical supply depot was set up. The 153d Station Hospital arrived, was

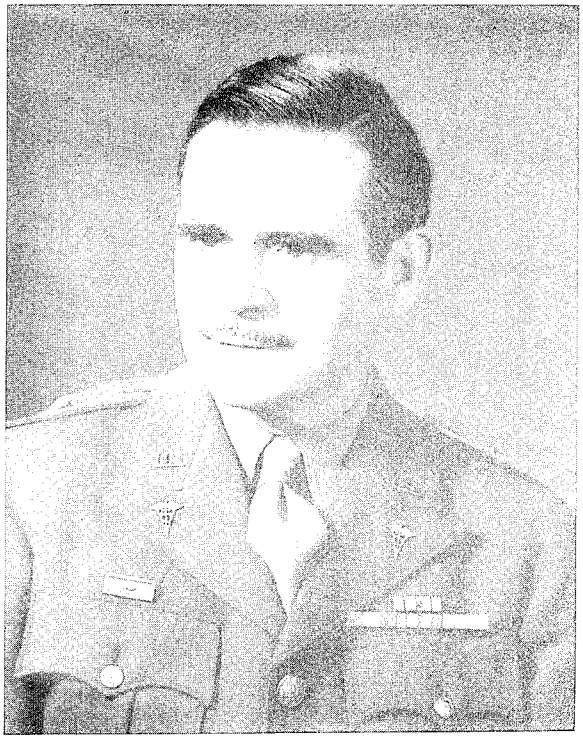


FIGURE 93.—Brig. Gen. Percy J. Carroll, MC.

assigned headquarters at Queensland Agricultural College, and opened in March. In Melbourne, the surgeon of Base Section No. 4 soon had enough personnel to make such orthodox assignments as dental officer and medical supply officer, and was able to set up a dispensary, an X-ray service, and an ambulance service for troops in the area. In addition to the base section surgeon's office, the offices of the Surgeon, U.S. Army Forces in Australia, and the surgeon of the U.S. Air Forces in Australia, as well as the 4th General Hospital, were in Melbourne. For some months, Army medical service was concentrated in that area. Base Section 2 in Queensland and Base Section 6 in western Australia each had a station hospital in operation by the end of March.[8]

In April, when the Allies had lost the Netherlands East Indies and were bottled up in the Philippines, U.S. Army elements in the Southwest Pacific were reorganized. On the 18th, General MacArthur, who had arrived from the Philippines, assumed command of all forces of the United States, the United Kingdom, Australia, and the Netherlands in the Southwest Pacific

[8] (1) See footnote 6(3), p. 411. (2) Periodic Reports for 1942 of Base Sections 1–7, variously dated. (3) General Order No. 38, U.S. Army Forces in Australia, 15 Apr. 1942. (4) Memorandum, Col. Percy J. Carroll, MC, for Civil Control Level of Information, Office of The Surgeon General, 15 Dec. 1942, subject: Medical Service in Australia.

Area. Colonel Carroll continued as surgeon of the U.S. Army Forces in Australia, the highest U.S. Army command in the Southwest Pacific Area. With the creation of General MacArthur's Allied command, the U.S. Army Forces in Australia became primarily a service command and was superseded by the U.S. Army Services of Supply in July.

With the arrival of a group of medical officers and enlisted men from the States for duty in the surgeon's office in Melbourne in early April, Colonel Carroll was able to construct a medical staff in general accordance with the table of organization prescribed for the medical section of a communications zone (T/O 8–500–1, 1 Nov. 1940). Besides his deputy, he had a colonel of the Dental Corps, a lieutenant colonel of the Veterinary Corps, and a captain of the Army Nurse Corps to put in charge of the Dental, Veterinary, and Nursing Sections. The remaining sections of the office, each headed by a major of the Medical Corps, were: Hospitalization, Supply and Fiscal, Personnel, Evacuation, and Sanitation and Vital Statistics. Most members of Colonel Carroll's staff were reserve officers. At this early period his office was more completely staffed than that of Maj. Gen. Paul R. Hawley in the United Kingdom. On 24 April 1942 it included 27 officers. This situation resulted in part from the fact that some personnel already in the area—escapees from the Philippines—were available to fill certain positions in the surgeon's office.[9]

By May, the roster of surgeons for the seven base sections was complete. A dental consultant was assigned to the staff of each, and base section dental laboratories were set up to fabricate prosthetic appliances for all units within the base section. In June, a Venereal Disease Control Section was added to the office of the Surgeon, U.S. Army Forces in Australia, at Melbourne, and shortly afterward a venereal disease control officer was appointed for each base section headquarters. Thus, by mid-1942 the base sections were developing fairly full fledged medical offices at headquarters.[10]

Medical service within the air forces in Australia was also taking shape in the early months of 1942. Air force troops who had left Java and the Philippines were reorganized in Australia with headquarters at Melbourne. A medical office was placed under the newly created Army Air Services in April. The major territorial elements established by the air forces in Australia, corresponding to base sections for the ground troops, were the Northeastern Area and the Northwestern Area; each had a surgeon. In September, when air troops in Australia and New Guinea were amalgamated into the Fifth Air Force, medical service for air troops began shaping up accordingly.[11]

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[9] (1) See footnotes 6(2), 6(3), and 6(4), p. 411. (2) General Order No. 1, General Headquarters, Southwest Pacific Area, 18 Apr. 1942. (3) General Order No. 43, U.S. Army Forces in Australia, 20 Apr. 1942. (4) Office Order No. 5, U.S. Army Forces in Australia, 24 Apr. 1942.

[10] See footnote 8(2), p. 414.

[11] (1) Annual Report, Surgeon, Fifth Air Force, 1942. (2) Memorandum, Maj. W. C. Shamblin, Acting Assistant Adjutant General, Headquarters, U.S. Army Air Services, for Commanding General, Army Air Force, 7 July 1942, subject: Record of U.S. Army Air Services.

The first 6 months' experience of Army medical officers in Australia brought to light a problem which was to plague the Medical Department and higher officers of the War Department, including the Chief of Staff, throughout the war, particularly in the last half of 1942 and the first 6 months of 1943—a high incidence of malaria in the early stages of the Southwest Pacific Area campaigns. Malaria was rare in Australia itself, even in the northern tropical regions where dengue fever was endemic, but by June 1942 about 50 percent of the Australian forces around Port Moresby, New Guinea, had been infected with malaria. Australian medical authorities were perturbed over the loss of the Netherlands East Indies as a source of quinine and their failure to get a quantity out of Java. At meetings, attended by U.S. Army medical officers, which Australian medical authorities held in Melbourne in mid-1942, several aspects of the problem were discussed: the menace posed by the entry of Allied troops infected with malaria into Australia, measures taken to conserve quinine, and the threat of mosquitoborne diseases in general to Australia.[12]

MEDICAL OFFICES AT HEADQUARTERS OF THE THREE MAJOR COMMANDS

Theater organization in the Southwest Pacific Area underwent rapid changes in command structure. It is perhaps impossible to pick any period after Advance Base was established in New Guinea in August 1942 during which the Army's many commands in the Southwest Pacific Area remained static in name, location, and principal mission longer than a month. Many Medical Department officers in the area noted the lack of a stable and centralized control of medical service as contemplated in Army manuals and pointed to its detrimental effect upon efficient operations. The nature of the conflict—amphibious operations against small islands, and hacking out of small bases in jungles, with enemy troops still at bases in the rear—together with the extended nature of the combat and communications zones in the area, militated against any concentration of medical administration. Responsibility was thrown upon local commands.

The presence of a staff surgeon at General MacArthur's Allied headquarters, with undefined duties, caused considerable confusion in 1942 and 1943. Two further developments, uncommon in other theaters of operations, hampered centralized control of medical service. One was the lack of any U.S. Army command with theaterwide responsibilities, and hence the absence of a true "theater surgeon" from July 1942, when the Services of Supply was estab-

[12] (1) Letter, Gen. George C. Marshall, Chief of Staff, to Lt. Gen. Dwight D. Eisenhower, Allied Force Headquarters, Algiers, 13 July 1943. (2) Bass, Maj. James W.: Report of Meeting Held at Royal College of Surgeons, 7 May 1942. [Official record.] (3) Fairley, N. H.: Malaria in South-West Pacific, With Special Reference to its Chemotherapeutic Control. M.J. Australia 2: 145–162, 3 Aug 1946.

lished, to February 1943. The other was the absence of a surgeon at the headquarters of the command with theaterwide responsibilities (the reestablished U.S. Army Forces in the Far East) from September 1943 to January 1944, as the result of a shift of all the theater chiefs of services to Services of Supply headquarters. In other theaters a chief surgeon was consistently assigned to the headquarters of the theater command.

One feature that gave some continuity to administration was the fact that from February 1942 to December 1943, Colonel Carroll headed the medical office which may be termed the theater medical office, since it was consistently located at the highest level of U.S. Army command in the area. However, the shift of this office from Headquarters, U.S. Army Forces in Australia, to the Services of Supply headquarters in July 1942, then to Headquarters, USAFFE (U.S. Army Forces in the Far East), when it was reestablished in February 1943, and once more to Services of Supply headquarters in September 1943, led to uncertainty as to the responsibilities and authority of Colonel Carroll and his staff. These shifts in medical organization contrast with the situation in other theaters where the top command structure remained relatively stable for long periods and the same surgeon continued as head of the medical service for a top U.S. Army command headquarters long enough to acquire status.

Army doctors in this area encountered two essential difficulties in the face of the periodic absence of any surgeon and medical section at a headquarters with theaterwide authority. One was in the allocation of medical personnel, supplies, and facilities—in a region which demanded quantities out of proportion to troop strength—to the areas and commands where they were most needed. The other was the problem of effecting measures to prevent environmental disease throughout all the U.S. Army commands in the theater.

An official history produced under General MacArthur's auspices accurately sums up the environmental threats to the health of troops in New Guinea:

> The penetrating, energy-sapping heat was accompanied by intense humidity and frequent torrential rains that defy description. Health conditions were among the worst in the world. The incidence of malaria could only be reduced by the most rigid and irksome discipline and even then the dreadful disease took a heavy toll. Dengue fever was common while the deadly blackwater fever, though not so prevalent, was no less an adversary. Bacillary and amoebic dysentery were both forbidding possibilities, and tropical ulcers, easily formed from the slightest scratch, were difficult to cure. Scrub typhus, ringworm, hookworm, and yaws all awaited the careless soldier. Millions of insects abounded everywhere. * * * Disease was an unrelenting foe.[13]

The climate and terrain of New Guinea called for strict application of preventive measures on a theaterwide scale to prevent high incidence of disease among troops. The effort to prevent tropical disease, the greatest single menace

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[13] Historical Report, Allied Operations in Southwest Pacific Area. Vol. I (Supplement), MacArthur in Japan, The Occupation. [Official record, Office of the Chief of Military History.]

to maintaining an effective fighting force in the Southwest Pacific, almost constitutes a unifying theme for the entire history of Army medical service in that region during World War II. Surgeons at many levels of command laid heavy emphasis on the urgent need for control of insectborne diseases; they frequently commented upon the lack of centralized direction of efforts at control during 1942 and 1943.

A chronological account of developments will throw light on the effect of the changing command structure upon medical administration. From December 1941 to July 1942, U.S. Forces in Australia and its successor, U.S. Army Forces in Australia, acted as a combined theater and Services of Supply command. In July 1942, when USASOS (U.S. Army Services of Supply) was established on the eve of the Papuan Campaign, Colonel Carroll was transferred to the Melbourne headquarters of the new command, along with the rest of the staff of the now defunct Headquarters, U.S. Army Forces in Australia. From July 1942 to February 1943, no U.S. Army headquarters with administrative authority over all U.S. Army elements in the area—ground, air, and service—existed. The functions normally assigned to a theater command were split between General MacArthur's Allied command—General Headquarters, Southwest Pacific Area—and USASOS. Since General Headquarters at Brisbane at first had no surgeon assigned to it, Colonel Carroll was the surgeon of highest position in the theater, but USASOS headquarters could not issue medical directives to the Army's tactical ground and air force elements, since tactical operations were the responsibilities of GHQ, Southwest Pacific Area (exercised through Allied Land Forces, Allied Air Forces, and Allied Naval Forces). Its directives went only to its area commands—the Australian Base Sections and the developing New Guinea bases.

In September, Colonel Rice was made Surgeon, General Headquarters, possibly in recognition of the distance of General Headquarters from Services of Supply headquarters (GHQ had moved to Brisbane, while USASOS remained behind in Melbourne) and continued in that position until the fall of 1944. He accompanied a forward echelon of General Headquarters which moved to Port Moresby for the New Guinea campaign and to sites further forward as the offensive progressed. As surgeon for the Allied command, his duties seem to have been primarily those of coordinating the medical activities of the American Army with those of the Australian Army and other elements of the Allied forces and of drawing up medical plans for forward moves of Allied task forces, which the medical sections of USAFFE and USASOS refined and elaborated. Apparently GHQ never issued any written delineation of his duties or authority. In accordance with General MacArthur's insistence that his general and special staff sections remain small in order to keep his headquarters mobile, Colonel Rice never had any

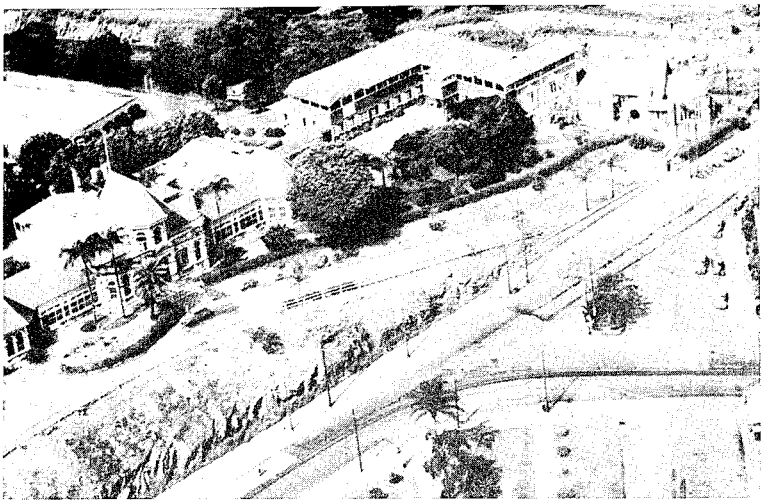


FIGURE 94.—Office of the Surgeon, U.S. Army Forces in the Far East, Brisbane, Australia.

staff of medical officers, but only one or two enlisted men as assistants. He operated largely through G–4.[14]

In February 1943, shortly after the New Guinea campaign had got under way, USAFFE was established in Australia. General MacArthur was in command of it as well as of the Allied command, General Headquarters, Southwest Pacific Area, to which it was subordinate; the headquarters of both commands were in Brisbane (fig. 94). While General Headquarters continued to direct the operations of combat forces, USAFFE served as the higher administrative headquarters above USASOS, the Sixth U.S. Army, and the Fifth Air Force. It supervised the administrative organization of troops, the training conducted in the theater, the provision and adoption of equipment, and the movement of troops in other than the combat zone. Thus the responsibilities normally assigned to a theater command were divided between GHQ and USASOS. The U.S. Army Services of Supply, with headquarters at Sydney since September 1942, became the typical Services of Supply in a theater of operations, with its responsibility for administration of medical service limited to that within its own area commands. As the chiefs of technical services hitherto assigned to the Services of Supply were at this date transferred to the Brisbane headquarters of the new command, Colonel Carroll

[14] (1) Rice, Maj. Gen. George W.: Account of Activities in the Southwest Pacific Area, attached to 1st indorsement, 9 Mar. 1950, to letter, Editor, Historical Division, Office of The Surgeon General, to General Rice, 2 Feb. 1950. (2) General Order No. 36, General Headquarters, Southwest Pacific Area, 26 Sept. 1942. (3) Memorandum, Col. W. L. Wilson, for The Surgeon General, 20 Oct. 1943, subject: Visit to Southwest Pacific Area. (4) Letter, Col. John F. Bohlender, MC, to the Editor, Historical Division, Office of The Surgeon General, 26 Feb. 1951. (5) Interview, Col. Gottlieb Orth, MC, 5 Mar. 1952. (6) Letter, Maj. Gen. George W. Rice, to the Editor, Historical Division, Office of The Surgeon General, 19 June 1951. (7) Personal notebook, Col. Maurice C. Pincoffs, MC. (8) Compare appendix B, p. 562.

became Chief Surgeon, USAFFE, and a few of his staff were shifted with him. Col. Frederick J. Petters, MC, became Surgeon, Services of Supply, at this date. Most officers of the former Services of Supply medical section remained at USASOS headquarters under the new chief.

General Headquarters continued to exercise control over strategic and tactical operations of elements of the Allied armies, which still included United States, Australian, British, and Dutch units. This command made the requests to the U.S. War Department (and to the Allied Governments) for major combat and service units necessary for Allied operations, established priorities for supplies for strategic and tactical operations, and formulated policies governing the command's relations with the various Allied forces and Allied governmental agencies. Colonel Rice continued as the medical representative at General Headquarters.[15]

During the period from February to September 1943, the presence of a surgeon and a medical section at U.S. Army Forces in the Far East, which could issue medical directives to the Sixth U.S. Army and Fifth Air Force, resulted in more thoroughgoing centralized control of medical service than had prevailed since July of the previous year. Nevertheless, some difficulty resulted from the continued assignment to the Services of Supply of certain functions, which needed to be exercised on a theaterwide basis. For a few months after the theater command and its medical section were set up, the statistical section in the office of the Surgeon, USASOS (Colonel Petters), experienced difficulty in obtaining statistics from the Sixth U.S. Army and Fifth Air Force, and later from the 14th Antiaircraft Command. In order to establish the authority of the Surgeon, USASOS, to obtain statistical reports from all Army elements in the Southwest Pacific Area, General MacArthur had to issue a special directive to the Commanding General, USASOS, establishing it as the Central Medical Records Office. With this special authorization, the Central Medical Records Office, USASOS, was able thereafter to obtain and consolidate medical reports from all Army elements in the Southwest Pacific Area.[16]

During the period from February to September 1943, the Chief Surgeon, USAFFE, had a small medical office, including a chief of professional services, Col. Maurice C. Pincoffs, MC (fig. 95), formerly commanding officer of the

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[15] Staff Memorandum No. 3, General Headquarters, U.S. Army Forces in the Far East, 19 Feb. 1943, subject: Allocation of Administrative Functions in USAFFE. (2) USAFFE Letter, 26 Feb. 1943, subject: Allocation of Administrative Functions within USAFFE. (3) Memorandum, the Adjutant General, Headquarters, U.S. Army Forces in the Far East, for Commanding Generals, Sixth U.S. Army, Fifth Air Force, and U.S. Army Services of Supply, 26 Feb. 1943. (4) See footnotes 6(4), p. 411; and 14(3), p. 419. (5) Order of Battle, U.S. Army in World War II, The War Against Japan, Command, Administration, and Supply Organization. [Official record, Office of the Chief of Military History.] (6) Letter, Chief Surgeon, U.S. Army Forces in The Far East, to The Surgeon General, 11 Mar. 1943. (7) General Order No. 1, U.S. Army Forces in the Far East, 26 Feb. 1943. (8) General Order No. 11, U.S. Army Services of Supply, 23 Feb. 1943.

[16] Memorandum, Preventive Medicine Division, U.S. Army Services of Supply, to Historian, U.S. Army Services of Supply, 10 Jan. 1944, subject: Relationships Between the Preventive Medicine Division, Surgeon's Office, USASOS, Sections, SOS, and Other Commands in the Southwest Pacific Area.



FIGURE 95.—Lt. Col. Maurice C. Pincoffs, MC.

42d General Hospital; the theater malariologist; a lieutenant colonel of the Veterinary Corps; a Medical Corps major in charge of hospitalization and evacuation; and a captain of the Medical Administrative Corps in charge of administrative matters. The rest of the members of the usual staff medical section, including the chief consultants in surgery, neuropsychiatry, and orthopedic surgery, were in the medical section of the Services of Supply in Sydney. Various observers emphasized the lack of a preventive medicine division, and of a consultants division, at the higher headquarters as serious defects in medical organization. Even in the medical section of the Services of Supply, where several officers were assigned to various functions in the field of preventive medicine (for example, venereal disease control), these functions were not coordinated under a single chief of preventive medicine until late in 1943. This internal organizational defect was responsible, according to Lt. Col. G. L. Orth, MC (fig. 96), assistant theater malariologist, for the deficiencies in unit equipment for the chlorination of water supply. No group with a comprehensive program for enlisting the cooperation of the Engineers in ordering the proper equipment existed in the office of the USASOS surgeon.

The Chief Surgeon, USAFFE, noted problems posed by the position of consultants in the theater setup. A consultants section developed in Colonel Carroll's office after July 1942, when a specialist in surgery and one in neuropsychiatry were sent to the area by the Surgeon General's Office. Most full-

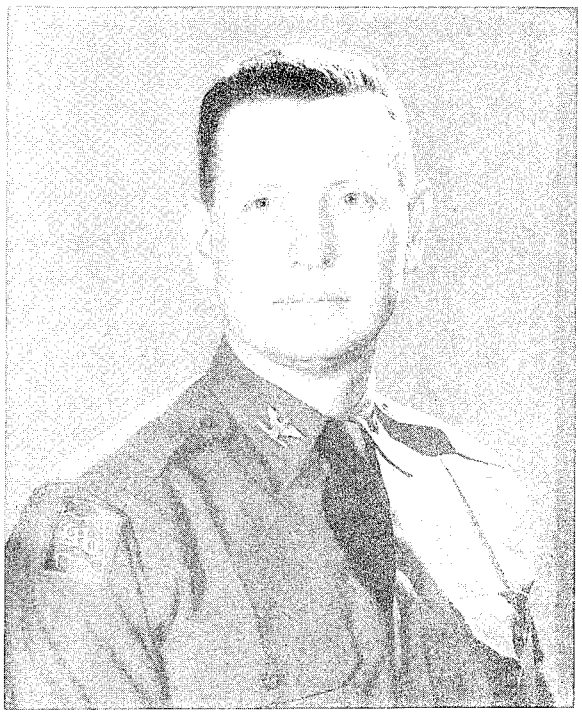


FIGURE 96.—Col. Gottlieb L. Orth, MC.

time consultants (that is, those who were not assigned to hospitals with additional duties as consultants) were consistently assigned to USASOS headquarters; hence they lacked authority to inspect hospitals of the Sixth U.S. Army and the Fifth Air Force. Efforts which Colonel Carroll made to transfer the consultants to Headquarters, USAFFE, apparently met with a refusal to increase the number of Medical Department officers assigned to the higher headquarters. A duplicate assignment of consultants to both USAFFE and USASOS was considered undesirable, since it would have wasted scarce, highly specialized personnel. The Chief Surgeon, USAFFE, therefore advocated that consultants be placed on temporary duty with Headquarters, USAFFE, whenever it was desired that they inspect elements of the Sixth U.S. Army and the Fifth Air Force. On the other hand, he sometimes placed consultants assigned to Headquarters, USAFFE, on temporary duty with Headquarters, USASOS; the latter operated most of the large fixed hospitals needing consultants' advice, and consultants found that they could work more effectively when they were in close proximity.[17]

[17] (1) Check Sheet, Monthly Report, Chief Surgeon, U.S. Army Forces in the Far East, March 1943. (2) Memorandum, Chief Surgeon, USAFFE, for Deputy Chief of Staff, 31 May 1943. (3) See footnote 14(7), p. 419. (4) Interview, Lt. Col. G. L. Orth, MC, 12 June 1947. (5) Annual Report, Chief Surgeon, Southwest Pacific Area, 1942, and supplement (1 Jan.–28 Feb. 1943).

In the Southwest Pacific Area divergent views were voiced as to the true functions of consultants: for example, whether or not they should be used farther forward and whether or not they should make inspections or restrict themselves to a consultative function. References by Colonel Carroll to "my veterinary consultant," to the chief of the Dental Division, USASOS, as "chief dental consultant," and to officers in similar positions at the bases as "base dental consultants" show a loose use of the term "consultant" in the Southwest Pacific Area in 1943 and 1944 that apparently resulted from lack of contact with the Surgeon General's Office.

In addition to the uncertainty as to the real purpose of the consultant system, several other factors militated against the establishment of a full-fledged consultant system comparable to that in the European theater, where as early as the end of 1942, 10 consultants representing a number of subspecialities were on full-time duty in the theater surgeon's office. Lack of a sufficient officer allotment in the office of the Surgeon, Services of Supply, Southwest Pacific Area, limited its roster to consultants in the three major specialities of surgery, neuropsychiatry, and medicine (assigned in late 1943), and a consultant in orthopedic surgery. Only the chief surgical, medical, and neuropsychiatric consultants were sent to the Southwest Pacific Area by the Surgeon General's Office. A number of officers on duty with the general hospitals at the New Guinea bases were "attached" to the office of the Surgeon, SOS, as consultants but remained on duty at hospitals in the bases. Although senior consultants of the office of the Surgeon, USASOS, spent weeks at a stretch visiting hospital after hospital in the field, the distances of the New Guinea bases from the office (located at Sydney throughout 1943), together with the difficulties of travel, precluded complete coverage of units scattered widely throughout Australia and New Guinea. Some observers considered line commanders in the Southwest Pacific insufficiently receptive to the services of consultants, while others found the chief surgeons of USASOS and USAFFE not fully informed as to their most effective use. Inadequacy in numbers, assignment at the Services of Supply level, lack of a clear concept as to their most effective employment, and the difficulties of travel over great distances, all combined to limit the effective use of consultants in the Southwest Pacific Area.[18]

In September 1943 the special staff sections, including the medical section of the U.S. Army Forces in the Far East, were returned to the Services of

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[18] (1) Hillman, Brig. Gen. C. C.: Report of Observations of Medical Service in the Southwest Pacific Area and the South Pacific Area, 12 July 1943. (2) Morgan, Brig. Gen. Hugh J.: Comments and Recommendations, Medical Departments, U.S. Army Forces in the Far East, 12 Aug. 1943. (3) Letter, Surgeon, General Headquarters, Southwest Pacific Area, to Col. Maurice C. Pincoffs, MC, 16 Sept. 1943. (4) Memorandum, Brig. Gen. Fred W. Rankin, for The Surgeon General, 2 Nov. 1943, subject: Remarks on Recent Trip Accompanying Senatorial Party. (5) See footnote 14(3), p. 419. (6) Memorandum, Col. W. L. Wilson, MC, for Executive Officer, Office of The Surgeon General, 1 Nov. 1943, subject: Visit to the Southwest Pacific Area. (7) Memorandum, Lt. Col. G. S. Littell, MC, for Col. Arthur B. Welsh, MC, 31 Dec. 1943, subject: Report on Medical Department Activities in the Southwest Pacific Area. (8) Memorandum, Surgeon, Services of Supply, for Chief Surgeon, U.S. Army Forces in the Far East, 10 Sept. 1943. (9) Annual Report, Chief Surgeon, U.S. Army Services of Supply, 1943.

Supply. Colonel Carroll, once more Chief Surgeon, USASOS, headed what was still the top medical office in the Southwest Pacific Area, although it was under the Services of Supply. Thus from September 1943 to the end of the year, there was no surgeon or medical office at Headquarters, USAFFE, although a lieutenant colonel of the Medical Corps was assigned to G–4, USAFFE, for liaison with the Services of Supply. Colonel Carroll was again at the headquarters which could not issue medical directives to the Sixth U.S. Army and Fifth Air Force.[19]

During 1942 and 1943, confusion arose as to the responsibilities of General Headquarters versus those of the U.S. Army Forces in the Far East with respect to Medical Department tactical units. Requisitions for units from the United States could originate with the Surgeon, GHQ, SWPA, or the surgeon at theater headquarters. If they originated with the latter, they had to go through G–4, USAFFE, to G–4, GHQ, and thence through the surgeon at General Headquarters before they were forwarded to the War Department. The existence of a surgeon at the higher headquarters, General Headquarters, above the level of the medical office which had the major responsibility for planning, led to some confusion in case of disagreement as to the types or numbers of units needed. In this area, a good many changes were made in the composition of the standard Medical Department units to fit the needs of task forces created for taking small coastal areas and islands. The character of combat in the Southwest Pacific Area—amphibious landing operations and jungle fighting with limited objectives rather than the open land warfare stressed in the Army schools in the prewar period—called for specially designed task forces. It led likewise to changes in the composition of some Medical Department units and to the use of units at different echelons in the chain of evacuation than those for which they had been designed. Before the close of 1942, Colonel Carroll had developed 27 small portable hospitals for use by the combat forces along the New Guinea trails during the initial stages of invasion. Their personnel were taken from the staffs of general, station, evacuation, and other hospital units. Colonel Carroll not only developed some new mobile units, including laboratory and pharmacy units, but broke up some standard units and directed some to uses other than those for which they were designed. Mobile hospitals were commonly substituted for fixed installations.

The exercise of authority over the movements of Medical Department units, as well as their composition, by General Headquarters put special difficulty in the way of centralized control of medical service in 1943. At intervals, General Headquarters issued orders to theater or Services of Supply headquarters to assign specific medical units to task forces. In the fall of 1943, for instance, it ordered, without consultation with the theater malariologist, the assignment of certain malaria control and survey units to the Alamo Force, in addition to ones already allotted by the malariologist. Colonel

[19] (1) Staff Memorandum No. 74, U.S. Army Forces in the Middle East, 27 Sept. 1943. (2) Staff Memorandum No. 155, U.S. Army Services of Supply, 27 Sept. 1943.

Carroll pointed out that decision as to the proper assignment of units to areas where they were most needed should be made only by the theater malariologist, who maintained a file of information on the current location of the units and on rates of malaria incidence in the various regions and islands. About the same date, the Surgeon, USASOS (Colonel Petters), noted cases of arbitrary diversion by General Headquarters of hospital units to various task forces in New Guinea without reference to the Services of Supply. All hospital units, mobile as well as fixed, in the theater were under the aegis of the Services of Supply while they were being trained and equipped. Colonel Petters noted that other factors besides the immediate needs of the task force should be taken into consideration whenever units were assigned in order to have an effective distribution of hospitals in accord with needs: the percentage of bed capacity available to the Services of Supply, the areas of greater patient load, and similar factors.[20]

During 1942 and 1943, reports on difficulties with medical administration in the Southwest Pacific Area reached the Surgeon General's Office from a number of sources, both officers serving in the area and those sent there on special missions. They emphasized several theaterwide administrative problems: insufficient number of consultants, nutritionists, and malaria control and survey units; inadequate training in malaria control of troops sent from the United States; insufficient beds in fixed hospitals in proportion to troop strength; and the poor quality and small number of Medical Department personnel trained in sanitation and tropical disease who were qualified for administrative posts—for example, base section surgeons. Colonel Carroll noted the lack of men qualified to fill key positions. The chief target of criticism was the organizational scheme. The multiplicity of commands had resulted in delay on decisions, in increase in the number of nonmedical officers through whose hands proposed directives must pass, and some medical directives at variance with those of Colonel Carroll based on divergent views of surgeons of many commands. Some observers thought that the posts of Surgeon, GHQ, and Surgeon, USAFFE, should be held by the same man. Critics agreed that no unified control over medical service existed and that a single highly placed Medical Department officer in full control was of vital importance.[21]

In January 1944, Brig. Gen. (later Maj. Gen.) Guy B. Denit, MC (fig. 97), formerly surgeon of the Atlantic Base Section in North Africa, became simultaneously Chief Surgeon, U.S. Army Forces in the Far East, and Chief Sur-

[20] (1) Letters, Col. George W. Rice, MC, to Col. Percy J. Carroll, MC, 13 Nov. 1942, 6 Jan. 1943, 12 Jan. 1943. (2) Letter, Col. George W. Rice, MC, to Col. John A. Rogers, MC, Office of The Surgeon General, 31 Jan. 1943. (3) Letter, Col. George W. Rice, MC, to Col. Maurice C. Pincoffs, MC, 16 Sept. 1943. (4) Letter, Col. George W. Rice, MC, to The Surgeon General, 14 July 1943. (5) Memorandum, Chief Surgeon, U.S. Army Services of Supply, for Deputy Chief of Staff, 22 Sept. 1943. (6) Memorandum, Surgeon, U.S. Army Services of Supply, for G–3, 24 Sept. 1943. (7) Interview, Brig. Gen. George W. Rice, 13 July 1951.

[21] (1) Letters, The Surgeon General, to the Chief Surgeon, U.S. Army Services of Supply, 22 Jan. and 12 Feb. 1944, and replies, 16 and 26 Feb. 1944. (2) Letter, Chief Surgeon, U.S. Army Forces in the Far East, to The Surgeon General, 11 Mar. 1943. (3) For reflections of confusion in medical administration, see documents cited in footnote 14, p. 419.

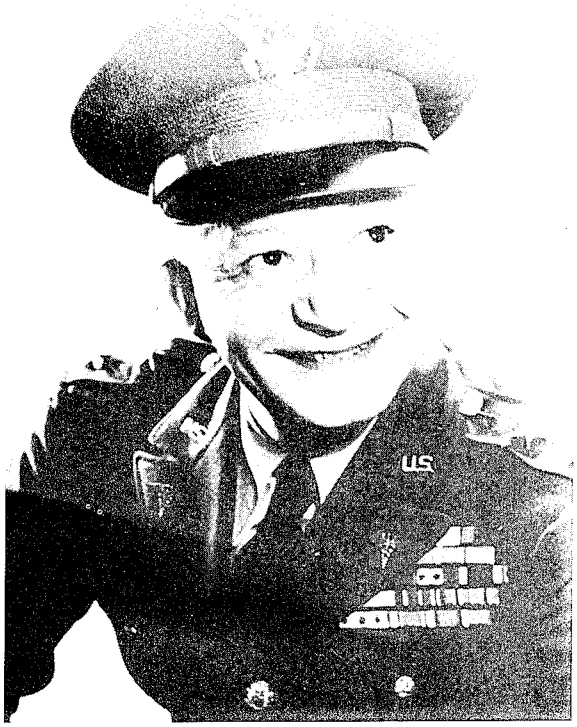


FIGURE 97.—Maj. Gen. Guy B. Denit, MC.

geon, U.S. Army Services of Supply. From then on, control over medical service was somewhat more centralized, although continuation of the theater's policy of placing most of General Denit's staff (as well as the staffs of other chiefs of technical services) at Services of Supply headquarters hampered centralized control to some extent. The role of the Surgeon, GHQ, continued to be a somewhat ambiguous one.[22]

General Denit and The Surgeon General (General Kirk) made a concerted effort in 1944 and 1945 to build up a stronger medical section for administering the medical affairs of the Southwest Pacific Area, an effort that resulted in exercise of somewhat more influence by the Surgeon General's Office in the selection of General Denit's staff. Efforts to raise rank and increase numbers, on the other hand, ran into a good deal of opposition. When General Kirk attempted to elevate the rank of General Denit's staff dental officer (as well as that of his counterpart in each of the major theaters) to brigadier general, General Denit found himself unable to have the dental officer assigned to theater headquarters. He noted that any recommendation for promoting the dental surgeon at USASOS headquarters to brigadier general would arouse resent-

[22] (1) General Order No. 4, U.S. Army Forces in the Far East, 17 Jan. 1944. (2) General Order No. 18, U.S. Army Services of Supply, 30 Jan. 1944.

ment among some of the chiefs of technical services who were only colonels, as well as among the surgeons (also only colonels) of such commands as the Sixth U.S. Army and Fifth Air Force. When General Kirk wanted to assign his chief consultant in medicine, a brigadier general, who had requested oversea duty, to General Denit's office, the latter objected on the ground that the senior officer at each headquarters in the Southwest Pacific Area automatically became the chief of his technical service; that is, he would have supplanted General Denit. General Denit stated that he could not "sell" the command on another general officer for any of the headquarters there.[23]

Throughout the period under discussion (mid-1942 to August 1944), the number of Medical Department officers in the medical sections of Services of Supply and of theater headquarters did not vary greatly in spite of a steady increase in troop strength, with concomitant increases in Medical Department strength, and in combat activity. The total (including officers of the Army Nurse Corps) in the Services of Supply medical section, the larger of the two, apparently never amounted to more than 35. The size of this medical section, plus that of the medical section at Headquarters, USAFFE (during the time when such a section existed), may justifiably be compared with the office of "theater surgeon" in other theaters. Apparently no more than 9 or 10 Medical Department officers were ever assigned to Headquarters, USAFFE. Thus despite an increase in troop strength (from 105,295 in September 1942 to 664,508 at the end of July 1944), the top medical office in the Southwest Pacific Area never underwent the steady growth in officer personnel that the theater medical section of the North African and European theaters experienced. The rank of officers heading major organizational elements in the Services of Supply medical section also remained low compared with that of some other theaters. In July 1944, for instance, only five colonels were assigned to that office, most branches of the medical section being headed by lower ranking officers.[24]

SERVICES OF SUPPLY IN AUSTRALIA AND NEW GUINEA

In September 1942, Headquarters, U.S. Army Services of Supply, moved from Melbourne to Sydney, following General MacArthur's move of General Headquarters from Melbourne northward to Brisbane. From its Sydney headquarters, where it remained for a year, the Services of Supply operated the base sections in Australia and bases newly established with the advance of troops westward through New Guinea. Some additional Medical Department units arrived in the theater during that year; hospital trains were obtained from the

[23] (1) Letter, The Surgeon General, to Surgeon, U.S. Army Forces in the Far East, 1 Apr. 1944, and reply, 17 Apr. 1944. (2) Letter, The Surgeon General, to Surgeon, United States Army Forces in the Far East, 26 Apr. 1944, and reply, 25 May 1944.

[24] (1) Lists of personnel in the Office of the Chief Surgeon, U.S. Army Services of Supply, 14 Nov. 1942 and 6 Oct. 1943. (2) Office Memorandum No. 3, Chief Surgeon, Headquarters, U.S. Army Services of Supply, 5 Mar. 1943. (3) Office Memorandum No. 1, Chief Surgeon, Headquarters, U.S. Army Services of Supply, 3 Mar. 1944. (4) See footnote 17(1), p. 422. (5) Letter, The Surgeon General, to Surgeon, General Headquarters, Southwest Pacific Area, 2 Nov. 1943. (6) Memorandum, Assistant Chief, Personnel Section, for Surgeon, United States Army Services of Supply, 8 Oct. 1943.

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Australians to take care of evacuation among the base sections in Australia, and ships were prepared to receive patients to be transferred from one New Guinea base to another.

By the end of July 1943, USASOS still had only four general hospitals (two of 1,000 beds and two of 500 beds), all in Australia, but 26 station hospitals (ranging from 50 to 500 beds each) were serving in the Australian base sections and at the New Guinea bases. The platoons of two medical supply depots were also distributed among the base sections and bases, while detachments of two medical laboratories served in several.[25]

The medical section at Services of Supply headquarters faced the difficulty of maintaining control over medical installations and units dispersed along a single line—from southeastern Australia along the northern coast of New Guinea and later to the Philippines—rather than a true zone of communications. It had to modify the standard composition and equipment of units to fit jungle, mountain, and amphibious warfare. Far removed from the San Francisco Port of Embarkation (about twice as far as its counterparts in the European and Mediterranean theaters were from New York), it was beset with difficulties of communication and transport. Because of shortages of manpower and materials, USASOS made but slow progress in 1943 in constructing buildings for hospitals.

Shortly before the transfer of the Surgeon, USAFFE, to the Services of Supply in September 1943, USASOS headquarters was moved again, this time from Sydney to Brisbane, where Headquarters, USAFFE, was already located (map 8). A rear echelon of USASOS, including a medical office, remained behind in Sydney for about a month to handle local procurement of equipment and supplies in Australia and Tasmania. Headquarters, USASOS, stayed at Brisbane until near the close of the New Guinea campaign (31 December 1944). Its advance headquarters kept in close proximity to the advance echelons of General Headquarters; of Headquarters, USAFFE; and of the Sixth U.S. Army, Fifth Air Force, and 14th Antiaircraft Command. In November 1944 it shifted from Brisbane to Hollandia (Base G), New Guinea; in February 1945 to Tacloban, Leyte (Base K); and in April 1945 to Manila. Its frequent moves and concomitant splits into an advance and a rear echelon led to segmentation of its headquarters medical office. The Chief Surgeon, USASOS (who after January 1944 was also Chief Surgeon, USAFFE), seems usually to have headed the small group of Medical Department officers familiar with problems of hospitalization, evacuation, and medical supply who went forward with the advance echelon. As the advance echelon had charge of the so-called "ADSOS Fleet," consisting of ships operating interport service at the forward bases, medical personnel assigned to the advance echelon, as well as those at the forward bases in New Guinea, had a good deal of work to do in inspecting vessels to assure that sanitary conditions were satisfactory and that

[25] Civil Control Level of Information Report for 16–31 July 1943, Headquarters, U.S. Army Services of Supply.

their safety equipment was in good order. The Deputy Chief Surgeon, USASOS, was in charge of the medical section at the main, or rear, headquarters of the Services of Supply during the periods when the advance echelon was split off from it. The frequent moves created a special problem in the administration of medical records. The large Central Medical Records Office at Services of Supply headquarters relied heavily upon civilian employees as a means of releasing soldiers for duty on the New Guinea front. With each move, numbers of civilian personnel had to be replaced and new employees trained.[26]

Australian Base Sections

Until late in 1943, the principal areas of U.S. Army medical work in Australia continued to be Base Sections 1, 2, 3, 4, and 7 (map 8). The original Base Sections 5 and 6, in southwestern Australia, were disbanded about the end of 1942, because few U.S. Army troops had ever been stationed in that area. In September 1943, however, the northward movement of troops towards New Guinea and the concentration of medical units and installations around Cairns, led to the establishment of a new Base Section 5, by dividing Base Section 2. By August 1944, the decline in Australian base sections had set in, and Base Sections 1 and 4 had been disbanded.

The headquarters of the Australian base sections contained at the peak of their development in 1943 about 10 or 12 Medical Department officers each, including a dental officer, a veterinary officer, a venereal disease control officer, and a chief nurse. Officers assigned to other functions (medical supply, hospitalization, evacuation, and so forth) were often formally assigned to Medical Department installations in the vicinity—most commonly general hospitals. About mid-1943, Base Sections 2, 3, and 7 were each assigned a newly arrived food and nutrition officer. These men investigated the conditions under which food supply was procured in the base section, as well as the methods of handling it and issuing it to troops, analyzed menus, and inspected messes. Both the veterinary and venereal disease control officers worked in close cooperation with the appropriate Australian civil and military authorities. Dental clinics and laboratories and medical supply depots were established for each base section. Very few base or base section surgeons appear to have appointed a preventive medicine officer to coordinate the several activities in this field (sanitation, venereal disease control, medical inspection, malaria control, and so forth) under a single head, officers being assigned to these functions individually. One observer attributed the lack of coordination of preventive medicine.

[26] (1) Interview, 2nd Lt. C. W. Wilson, MAC, 5 Dec. 1945. (2) Letter, Headquarters, U.S. Army Services of Supply, to Commanding General, Advance Echelon, Services of Supply; Commanders of Sections, Bases, and so forth, 5 Feb. 1944, subject: Water Transportation, Control, and Responsibilities. (3) Annual Report, Chief Surgeon, U.S. Army Services of Supply, 1943. (4) Memorandum, Surgeon, U.S. Army Services of Supply, for Deputy Chief of Staff, 31 May 1943, subject: Movement of Medical Records Section.

functions of the surgeons' offices of subordinate commands of the Services of Supply to a similar lack in the office of the Surgeon, USASOS.[27]

After October 1943, some of the Australian base sections (as well as later-established bases in New Guinea and the Philippines) were organized in accordance with a scheme advocated by Headquarters, Services of Supply, SWPA. Three commands were established at a base section or base: A service command, a port command, and an area command. Theoretically, a surgeon was assigned to each, but in a number of instances one man held two of these assignments. In some cases, the commanding officer of a hospital acted as port surgeon or area surgeon in addition to his hospital duties; or one officer might act as port surgeon and at the same time have charge of the work in sanitation and vital statistics for the base section. These dual assignments were frequently assigned to lack of personnel, but presumably the duties of a surgeon in such a restricted command were often insufficient to warrant an officer's full-time duty.

The surgeon of the base service command (which had under it the base chemical service, ordnance service, and so forth, as well as the base medical service), had the usual base surgeon's duties with respect to medical supply, hospitalization, and evacuation, and the usual base medical personnel were assigned to his office. The port surgeon inspected Army-controlled vessels for sanitary conditions and operated a port dispensary. At the port of Brisbane, for instance, where many ships moved in and out during 1943, 60 ships carrying troops to the advanced base in New Guinea were inspected by the port surgeon's office in the last 3 months of the year. The area command controlled all personnel not assigned to the service command or to the port command. These were chiefly personnel temporarily assigned to the base while staging or in transit. The area command surgeon worked out an areawide system of garbage removal, inspected kitchens and drainage, and cooperated with unit commanders of ground and air forces in the common effort.[28]

Some common features and problems, as well as some significant variations in medical administration, in the Australian base sections may be noted. Malaria was indigenous only in the tropical regions of northern Australia (Base Sections 1, 2, and 5), but in late 1942 and early 1943, medical officers in Base Sections 3 and 4 were confronted with the problem of preventing the introduction of malaria into the southeast. During that period the malaria-ridden troops of the 1st U.S. Marine Division arrived from Guadalcanal and those of the 32d Division from New Guinea for hospitalization and convalescence, presenting the possibility of spread of the disease to nonmalarious areas. Malaria control at Brisbane and Melbourne was, like the control of venereal disease,

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[27] (1) Memorandum, Col. Percy J. Carroll, MC, for The Surgeon General, 29 Aug. 1942, subject: Medical Services in Australia. (2) Annual Report, Chief Surgeon, Southwest Pacific Area, 1942. (3) Regulation No. 1–10, U.S. Army Services of Supply, 13 Nov. 1942, subject: The Mission, Organization, and Methods of Operation of Base Sections. (4) See footnotes 15(4), p. 420; 16, p. 420; and 17(4), p. 422.

[28] See quarterly reports of the various Southwest Pacific Area base sections for 1943.

a problem common to the large ports; it called for close liaison between U.S. Army doctors and Australian authorities, as well as close cooperation of base section medical officers with surgeons of the divisional units. In April 1943, a malaria control school was organized in Brisbane for medical officers of the 32d Division. The course, given to line officers as well as medical officers, consisted of lectures at the 42d General Hospital, work at the 3d Medical Laboratory, and practical field exercises in malaria survey and control work at an Army camp. Nearly a thousand officers, and many nurses and enlisted men, received training at the school before it was discontinued in July 1944.

Melbourne, Sydney, and Brisbane were the sites of the four general hospitals (two were in the Brisbane area) which served evacuees from New Guinea during 1943. The large eastern ports of Australia had responsibility for the initial reception of many Medical Department units, including dispensaries, various types of hospitals, medical supply depots, and medical laboratories arriving from the United States. Throughout 1943, the port of Brisbane (Base Section 3) received the bulk of medical supplies and was the chief distribution point for all parts of the Southwest Pacific Area. The base section surgeon had a relatively large office of 35 officers, 35 enlisted men, and 25 civilians. Its work included supervision of an industrial health program for Australians employed by the U.S. Army in the base section. Closely resembling similar work in service commands in the United States, this program covered about 10,000 employees by the end of 1943. Medical examinations were given to prospective employees, industrial health inspections were made of plants operated by the U.S. Army, and Australian employees were treated in Army dispensaries and hospitals.

The medical situation in the tropical, undeveloped Northern Territory (Base Section 1) differed greatly from that in eastern Australia. Here the base section surgeon was located under tentage in "the bush" south of Darwin after the Japanese bombed Darwin early in 1942 until April 1943. He supervised the medical service at five troop locations scattered along the thousand-mile stretch between Darwin in the north and Alice Springs in the south.[29]

The New Guinea Bases

The establishment of U.S. Advance Base at Port Moresby, New Guinea, in August 1942 was the first move in the extension of the Services of Supply organization to New Guinea; during the succeeding 2 years, seven bases, preceded by a number of subbases, were developed. By June of 1943, four so-

[29] (1) Quarterly Reports, all Australian Base Sections, through 3d Quarter, 1944. (2) See footnotes 14(6), p. 419; and 16, p. 420. (3) Memorandum, Surgeon, Base Section 3, for The Surgeon General, 7 July 1944, subject: History of Base Section 3 Malaria Control School. (4) Letter, Col. C. R. Mitchell, to Dr. Maurice Pincoffs, 9 Dec. 1946. (5) Memorandum, Commanding General, U.S. Army Services of Supply, for Chiefs of General and Special Staff Sections, no date, subject: Plan for Organization of Base Section, USASOS and Reduction of Headquarters, USASOS. (6) Minutes, Conference of General and Special Staff Sections, Headquarters, U.S. Army Services of Supply, 2 May 1944. (7) Monthly Historical Summary, Medical Section, Base Section, U.S. Army Services of Supply, June 1944. (8) Medical History, 32d Infantry Division, 1 Jan.–30 June 1943.



FIGURE 98.—Col. J. M. Blank, MC.

called "advance subbases," three of which were forerunners of three New Guinea bases, Bases A, B, and D[30] (map 8), had been established under the control of U.S. Advance Base. Col. J. M. Blank, MC (fig. 98), with three other Medical Corps officers, one Medical Administrative Corps officer, and eight enlisted men undertook the task of setting up the office of the Surgeon, Advance Base, at Port Moresby in September 1942. Small U.S. Army tactical hospitals were already serving troops close to the front, but Colonel Blank's office was the first element of the Services of Supply medical organization to be established there. As a result of Japanese bombing around Port Moresby, buildings were ramshackled, and the office used furniture improvised from empty ammunition cases and packing crates. The surgeon's staff faced many difficult tasks during the early months: inspection of canned food in ration dumps, investigation of water supply, arranging storage for medical supplies shipped from Brisbane and Townsville, and delivery of medical supplies and hospital units and their equipment to forward areas by ship, plane, and parachute during the Owen Stanley-Buna campaign. Medical Department officers of Advance Base, surgeons of the 32d Division and Fifth Air Force, and medical

[30] Advance Subbase C on Goodenough Island lasted only from April to July 1943 and never developed into a base.

officers of the Australian forces cooperated in planning measures to prevent insectborne diseases and dysentery and in adopting uniform standards of sanitation for Australian and American troops. In February, a malaria control committee of representatives of the American and Australian forces was organized, and in the following month the Australian Army medical service started a school in malaria control for men from each force in the U.S. Advance Base. The Advance Base Surgeon alluded to the usual complexity of coordinating efforts at sanitary control among air forces, ground forces, and troops of different nationalities when he stated that he was fighting simultaneously the American Air Force, the Royal Australian Air Force, the Australian Imperial Force, and the Japanese.[31]

The establishment of the first three bases in New Guinea, Bases A, B, and D,[32] at Milne Bay, Oro Bay, and Port Moresby, respectively, largely set the pattern for all the New Guinea bases, the last of which was established on Biak Island as Base H in August 1944. Medical officers accompanied the task forces to some bases, while in other cases the nucleus of the surgeon's office went to the new base from an Australian base section, from U.S. Advance Base at Port Moresby, or from an already established base in New Guinea. A number of Medical Department officers who were consistently assigned to the New Guinea bases, and later to the Philippine bases, were frequently shifted, often remaining only a month or so at one place.

Initial tasks of the medical group at a New Guinea base were to establish the base surgeon's office, a headquarters dispensary, and a medical supply depot, all usually under tentage, and to select sites for hospitals. In the New Guinea bases, malaria was a serious problem from the outset. At Milne Bay the rates were terrific in late 1942, at times amounting to 4,000 cases per 1,000 men per year. Some control work was undertaken in the early months. An Australian antimalaria control unit, for example, arrived at Oro Bay in January 1943 and began work with the aid of native labor, but the U.S. Army Medical Department's formal campaign against the disease began only in March with the arrival of control and survey units sent by the Surgeon General's Office.

Base organization in New Guinea was continually shifting in 1943 and 1944. As the Allies moved northwestward through New Guinea, forward bases were in various stages of building up, those to the southeast were in full operation, perhaps at their peak, while rear bases were in the process of

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[31] (1) Memorandum, Acting Surgeon, U.S. Advance Base, for The Surgeon General, 11 Apr. 1943. (2) Letter, Surgeon, U.S. Advance Base, to Col. Percy J. Carroll, MC, 19 Sept. 1942. (3) Memorandum, Surgeon, Advance Base, for the Commanding General, Advance Base, 15 Oct. 1942, subject: Conference on Sanitation and Hygiene. (4) Letter, Surgeon, Advance Base, to Surgeon, U.S. Army Services of Supply, 20 Oct. 1942. (5) Day by Day Account of Inspection Trip to Advance Base, New Guinea, and Base Sections 2 and 3, 6 November–25 November 1942, no signature.

[32] There were various changes of designation from the date of the first establishment at Milne Bay in November 1942 to November 1943, when the terminology became "Base A," "Base B," and so forth. Down to August 1943, they were consistently referred to as "subbases." The final designation "base" is used throughout the text.

"rolling up," as the Army's popular usage puts it. Changes in functions assigned and units and installations controlled were rapid. In August 1943, Advance Section, USASOS (replacing Advance Base, which was disbanded), was set up, with headquarters first at Milne Bay (Base A) and shortly afterward at Port Moresby (Base D), to exercise direct control over the three New Guinea bases in existence (Bases A, B, and D). In November, Intermediate Section, with headquarters briefly at Port Moresby and then at Oro Bay (Base B), exercised control over the same bases. A new Advance Section established in November had headquarters at Lae (by January 1944 at Finschhafen) and controlled two newly established forward bases, Base E at Lae and Base F at Finschhafen (map 8). The job of the offices of the surgeons of both Advance and Intermediate Sections was largely that of supervising and coordinating the medical activities of the bases under the control of their respective sections.[33] By March 1944, both Base E and Base F had passed to the control of Intermediate Section, and Advance Section was disbanded. Bases A, B, and D continued active throughout the war. A full story of the medical work at Base A would include an account of its struggle to reduce malaria rates, handling of casualties from the Milne Bay air raids in 1943, and the great expansion of hospital beds there in 1943 and 1944. It was the site of the Second Medical Concentration Center, a pool for Medical Department units held in reserve, which by early 1944 was being expanded to a troop capacity of 5,000.

Bases E and F at Lae and Finschhafen were both established in November 1943 after these towns had been taken from the Japanese in September and October, respectively. The medical section of Binocular Force, which established a base at Lae for supplying the Fifth Air Force base at Nadzab, landed at Lae on 18 September. As a result of previous experience at the New Guinea bases, strict measures for the control of insectborne diseases, including the burning of kunai grass which harbors the mite vectors of scrub typhus, were instituted from the start. Medical units began arriving by 1 October. By the end of March 1944, personnel handling base medical duties included, in addition to the base surgeon, a medical inspector, a dental officer, a veterinary officer, an evacuation officer, a plans and operations officer, and a chief nurse. In early April, a nutrition officer and a venereal disease and statistics officer were assigned.

Medical personnel went from Base E to the future location of Base F in late October to make sanitary surveys and choose hospital sites. A surgeon's office was set up in early November and began operating a dispensary. Hospitals began arriving at Finschhafen at about the same time. By the end of

[33] (1) General Order No. 75, U.S. Army Services of Supply, 15 Nov. 1943. (2) General Order No. 73, U.S. Army Services of Supply, 14 Nov. 1943. The Advance and Intermediate Sections in New Guinea differed in concept from commands of the same name in other theaters. They did not include a geographic area but were merely headquarters established to supervise and coordinate the activities of two or more bases. Each was usually located at the same town as one of the bases which it controlled, and part of the personnel staffing the base also staffed the section. Decentralization of responsibility to the individual bases was the guiding principle in the administration of Services of Supply in New Guinea.

April 1944, medical installations at Base F included a general hospital, four station hospitals, two field hospitals, seven dispensaries, a medical laboratory, and medical supply depots. Eight malaria survey and control units and a sanitary company were functioning.[34]

Base G was established at Hollandia, Dutch New Guinea, in June 1944, to operate as an advance base directly under the control of Headquarters, USASOS, but in about 2 weeks it became an intermediate base under the control of Intermediate Section. In the Hollandia area the major headquarters—General Headquarters of the Southwest Pacific Area, and the headquarters of U.S. Army Forces in the Far East, Allied Land Forces, Allied Air Forces, Fifth Air Force, and the Sixth and Eighth U.S. Armies, as well as of the U.S. Seventh Fleet—settled down during the months before the launching of the campaign for the Philippines. The last established of the New Guinea bases, Base H on Biak Island, was developed in August 1944 after the hard summer campaign for the island.

Most medical problems encountered at the New Guinea bases, especially those which called for early solution on an area basis, were intensified in New Guinea by conditions of climate and terrain and the fact that combat preceded the establishment of the base. The undeveloped character of the country made it difficult to select satisfactory hospital sites and locate good water sources. Surgeons' offices, as well as medical installations, were usually under canvas or housed in temporary construction. Hospital personnel frequently had to clear hospital sites of trees and brush, make roads, and build their own hospitals, all the while caring for the sick and the wounded. The larger hospitals proved of less value at the New Guinea bases; to the end of 1943, no general hospitals served there, and patients needing general hospital treatment were evacuated to the large eastern ports of Australia where the general hospitals were located. As for insectborne diseases—malaria, dengue, and scrub typhus—and other tropical maladies, these were much more prevalent in New Guinea than in the tropical regions of Australia; their control was rendered difficult by the fact that some cases occurred during combat before the base section organization could put areawide environmental control measures into effect.

Assignments and duties of officers in the medical sections of New Guinea bases differed little from their counterparts in the Australian base sections except for the employment of more venereal disease control officers in the Australian base sections; less emphasis on control of venereal disease was necessary in New Guinea where troops had relatively little contact with native women. The surgeons' offices of New Guinea bases seem to have suffered a more rapid turnover of personnel than those of Australian base sections,

[34] (1) Quarterly Reports, Surgeons, Bases A–H, 4th quarter 1942 through 3d quarter 1944. (2) Quarterly Reports, Surgeons, Advance and Intermediate Sections, U.S. Army Services of Supply, 4th quarter 1943 through 3d quarter 1944. (3) History of USASOS and AFWESPAC Base at Lae Until March 1944. [Official record, Office of the Chief of Military History.] (4) History of USASOS and AFWESPAC, Finschhafen, New Guinea, Since Activation 1943 Until April 1944. [Official record, Office of the Chief of Military History.]

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building up to a greater strength and declining rapidly as troops and units were moved forward or the lines of evacuation shifted, bypassing the hospitals of the base.

THE TACTICAL FORCES

For some months, the highest tactical command of the U.S. Army ground forces in the Southwest Pacific Area was I Corps. Its staff medical section and that of the 32d and 41st Divisions in Australia and New Guinea were the principal offices supervising medical service for the U.S. Army ground forces in the area. Not until early in 1943 did a field army—the Sixth U.S. Army—build up in the Southwest Pacific Area.

Air force units were originally stationed in northern Australia around Darwin and Townsville, but as early as May 1942 some moved up to New Guinea. The Fifth Air Force was established to comprise these units in September 1942.

Air Forces

The Fifth Air Force was constituted on 3 September 1942 with headquarters at Brisbane. By the end of the year it had been organized into the three major commands typical of a numbered air force—a service, a bomber, and a fighter command—each with a staff surgeon. Col. Bascom L. Wilson, MC, was made Surgeon, Fifth Air Force. In order to conserve medical officers (venereal disease control officers and dental officers especially were needed in tactical units), the office of the air force surgeon and of the air service command surgeon, which had the larger staff, were combined. When the advance echelon of the Fifth Air Force was established in New Guinea, Maj. Dan B. Searcy, MC, became its surgeon; after his death on a bomber mission in January 1943, Lt. Col. Alonzo Beavers, MC, took his place. From the fall of 1942 to February 1944, the advance echelon was at Port Moresby; then it moved to the Nadzab Air Base (near Lae, headquarters of Base E) and remained there until June 1944, when it went to Owi Island in the Schouten group off northwestern New Guinea.

In March 1943, both the Fifth Air Force surgeon and the advance echelon surgeon had small staffs of two Medical Corps officers, a veterinarian, and a few enlisted men and civilian clerks. In succeeding months the three main task forces of the Fifth Air Force, later made bombardment wings, were organized with flight surgeons assigned to each. By the end of 1943, about four-fifths of the approximately 75,000 troops of the Fifth Air Force had moved northward to the Darwin area of Australia or to New Guinea—the majority beyond the Owen Stanley Mountains.[35]

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[35] (1) See footnote 11(1), p. 415. (2) Annual Report, Medical Department Activities, Fifth Air Force, 1943. (3) Annual Report, Surgeon Advance Echelon, Fifth Air Force, 1942. (4) Memorandum, Surgeon Fifth Air Force for The Air Surgeon, 1 Mar. 1943, subject: Report of Medical Activities.

During 1942 and part of 1943, the lift of thousands of patients over the Owen Stanley Range to Port Moresby was accomplished by Australian and American transport planes without benefit of medical personnel. Although various official reports noted the lack of an effective system of air evacuation from New Guinea, no basic change took place until the arrival of the 804th Medical Air Evacuation Transport Squadron in June 1943. This unit was originally assigned to the Services of Supply, but the Fifth Air Force soon succeeded in getting all personnel of the squadron except the nurses transferred to the jurisdiction of its 54th Troop Carrier Wing. By the end of the year it had gained control of the nurses as well. Nevertheless, air evacuation continued to be hampered by difficulties in coordinating the efforts of General Headquarters, Services of Supply, and the air force elements. Problems continued under discussion throughout 1943.[36]

Like other air forces, the Fifth Air Force possessed a number of dispensaries equipped with beds. By the end of 1943, it had 12 with from 3 to 40 beds each in northeastern Australia and eastern New Guinea. Five of the 25-bed portable surgical hospitals (with capacity for expansion to 50 beds each), which the Services of Supply had designed for use by task forces far forward, were assigned to the Fifth Air Force and were operating at Finschhafen and in the Markham Valley of New Guinea. The Fifth Air Force surgeon voiced the common complaint of some oversea air force surgeons that the hospitalization of patients in fixed hospitals of the Services of Supply was unsatisfactory in some respects. Officers no longer fit for flying were returned to duty in New Guinea, he averred, by hospital boards unversed in the factors which should be considered in determining fitness for flying. Fifth Air Force patients discharged by general hospitals in Australia (no general hospitals were operating in New Guinea in 1943) were not returned promptly to their units in New Guinea. In order to maintain more effective control over air troops in general hospitals in Australia, the Fifth Air Force stationed a medical officer in Brisbane and one in Sydney. These men kept the air force units informed on the status and disposition of their troops hospitalized in Australia. They served as effective links for the air force elements in New Guinea with base section surgeons in Australia, as well as with Australian medical authorities.[37]

In June 1944, the Far East Air Forces and its service command were established with headquarters at Brisbane including not only the Fifth Air Force but also the Thirteenth Air Force, which was being transferred from the South Pacific. Col. R. K. Simpson, MC, who had served briefly as Fifth Air Force surgeon, became Surgeon, Far East Forces, when the headquarters of the Fifth

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[36] Air Evaluation Board, Report No. 35, The Medical Support of Air Warfare in the South and Southwest Pacific, 7 December 1941–15 August 1945.

[37] (1) See footnotes 6(4), p. 411; 18(9), p. 423; 27(1), p. 430; 35(2), p. 436; and 36. (2) Report of Inspections, 4 to 24 Oct. 1943, by Chief, Operations Division, Office of the Air Surgeon. (3) Letter, Headquarters Advance Echelon, Fifth Air Force, to Commanding General, Fifth Air Force, 20 Apr. 1944, subject: Request for Assignment of Hospitals.

Air Force became headquarters for the new top air force command. He headed a small coordinating medical office. The Advance Echelon, Fifth Air Force, then at Owi Island in the Schouten group off northwestern New Guinea, was made Headquarters, Fifth Air Force, and Lt. Col. Alonzo Beavers thus became surgeon for the entire Fifth Air Force. Towards the close of 1944, personnel of the Far East Air Forces totaled about 135,000.

During the stay of the Thirteenth Air Force in the South Pacific Area, the medical sections of its headquarters and its service command headquarters had functioned jointly at a single office. In June, the office of the air force surgeon moved from Guadalcanal to Los Negros in the Admiralty Islands. Col. Kenneth J. Gould, MC (fig. 99), succeeded Colonel Frese as surgeon in September 1944. The service command surgeon's staff remained at Guadalcanal, performing medical tasks connected with the shift of air force units to the Southwest Pacific Area. In January 1945, it moved to Morotai, where it undertook medical planning for the move of Thirteenth Air Force units into the Philippines. The frequent moves of commands and subordinate elements to scattered islands led to the same demand for large numbers of Medical Department officers for administrative positions which was evident in theater organization and which the Thirteenth Air Force had experienced since its early days in the South Pacific.

Intratheater air evacuation was handled by three medical air evacuation transport squadrons assigned to the 54th Troop Carrier Wing of the Fifth Air Force. Besides the unit already assigned to the Fifth Air Force, a second air evacuation transport squadron (the one which had performed a large share of the evacuation by air which the South Pacific Combat Air Transport Command had accomplished) became available when it accompanied the Thirteenth Air Force to the Southwest Pacific Area. A third squadron arrived from the United States in mid-1944. The wing level from which the squadrons were controlled was too low a level from which to effect coordination of air evacuation with General Headquarters and U.S. Army Services of Supply. The problem of theaterwide coordination was not solved until mid-1945.

As of August 1944, when personnel of the air forces comprised about 17 percent of the theater's troop strength, of the 32 malaria survey units in the theater, 5 were assigned to the Fifth Air Force and 3 to the Thirteenth Air Force. Of the 55 control units, 10 were assigned to the Fifth and 5 to the Thirteenth Air Force. The Thirteenth had had no malaria control or survey units under its control until it moved to the Southwest Pacific Area, as the Malaria and Epidemic Control Board had exercised full direction over the operations of all such units in the South Pacific Area. In the Southwest Pacific, air elements were located on islands where no Services of Supply bases existed (Morotai, for example), and the air forces needed such units for a preventive program among its own troops.



FIGURE 99.—Col. Kenneth J. Gould, MC.

One unusual development occurred in medical administration for the air forces when the theater command took over, late in 1943, several medical supply platoons (aviation) originally requested by the Fifth and Thirteenth Air Forces, as well as the single medical air evacuation transport squadron (the 804th) then in the area. Only one of the supply units was assigned to the Fifth Air Force and none to the Thirteenth. Instead, the Southwest Pacific Area command, finding the units which the air forces had designed more suited for handling medical supply during the early stages of amphibious operations than were the larger medical supply units, assigned them to the Services of Supply and to Sixth U.S. Army. After repeated requests the Fifth Air Force received a second medical supply platoon (aviation), and when the Far East Air Forces was created in June 1944 the two units assigned to the Fifth Air Force were transferred to the Far East Air Service Command. Other such units arrived in the theater but were assigned to the armies and to the Services of Supply. The Air Evaluation Board, which was sent by the War Department to the Southwest Pacific Area in 1944 and 1945 to appraise the effectiveness of air operations there, sustained the claims of the Far East Air Forces that the number of medical supply platoons (aviation) assigned to it was insufficient. In the case of these units, as with the first medical air evacuation

transport squadron sent to the Southwest Pacific Area, the air forces actually lost control of their own specially developed units to the Services of Supply.[38]

Sixth U.S. Army

The man originally chosen for the position of Sixth U.S. Army surgeon, Col. John Dibble, MC, was killed en route to the Southwest Pacific Area in a plane crash off Canton Island. Col. (later Brig. Gen.) William A. Hagins, MC (fig. 100), who arrived in Australia in early March 1943, took his place. During the early months in Australia, Colonel Hagins and his staff were located at the army's headquarters at Camp Columbia near Brisbane. His medical office included an executive officer, operations and training officer, officers to head supply and statistics, and a Dental Corps officer and a Veterinary Corps officer to head their respective branches. In May, a venereal disease control officer was added at the instance of the theater command.

With the exception of special features for malaria control, the Sixth U.S. Army's medical organization at army, corps, and division level differed little from that of armies in the Mediterranean and European theaters. Below the office of the army surgeon were the staff of the Surgeon, I Corps, at Rockhampton, Queensland, and the surgeons' offices of several divisions in eastern New Guinea and northeastern Australia. In the middle of 1943, the 24th, 32d, and 41st Infantry Divisions, and the 1st Cavalry Division were assigned to Sixth U.S. Army, which also had operational control of the 1st Marine Division at this date.

At intervals, the medical staff of Headquarters, I Corps, or of the various divisional headquarters, as well as those of Sixth U.S. Army headquarters, were split between a forward and a rear echelon. The division surgeon's office typically included a division medical inspector, a division dental surgeon, a veterinarian, and perhaps an executive and a medical supply officer.

Malaria, and at times scrub typhus, was a serious problem to medical officers serving with Sixth U.S. Army. Prevention of malaria in forward areas called for tremendous efforts in spraying ponds and other breeding places in New Guinea, filling holes, and clearing out undergrowth and brush in camp areas, as well as training divisional troops in methods of control. In 1943, the menace of malaria hung like a pall over divisional elements recalled to Australia from combat in New Guinea. Convalescent areas and rest camps were set up in Queensland to care for men recovering from the disease. Many chronic, debilitated, relapsing cases of malaria of the 32d and 41st Divisions were reconditioned in the Sixth U.S. Army Training Center at Rockhampton.

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[38] (1) General Order No. 5, Headquarters, Far East Air Forces, 15 June 1944. (2) General Order No. 53, Headquarters, U.S. Army Forces in the Far East, 14 June 1944. (3) Annual Report, Medical Department Activities, Fifth Air Force, 1944. (4) Monthly Reports, Thirteenth Air Force Service Command, May 1944–April 1945. (5) See footnotes 14(3), p. 419; and 36, p. 437. (6) Quarterly Report, Medical Department Activities, Far East Air Forces, 2d quarter 1944. (7) Quarterly Report, Surgeon, Thirteenth Air Force, 3d quarter 1944.



FIGURE 100.—Col. William A. Hagins, MC.

In June 1943, Colonel Hagins and a few of his staff joined the forward echelon (known as the Alamo Force) Sixth U.S. Army in New Guinea near Milne Bay. Thereafter Colonel Hagins' staff, usually split into two and sometimes three echelons, moved to many locations in the course of the war. The forward echelon remained at Milne Bay until October 1943, moving then to Goodenough Island and early in 1944 to Cape Cretin on the Huon Peninsula of New Guinea. Throughout all this period, a rear echelon remained behind at Camp Columbia, joining the forward echelon at Cape Cretin in February 1944. The reunited surgeon's office moved to the vicinity of Hollandia (Base G) in June. There it remained until fall when the move into the Philippines began.

By 1 July 1944, when the entire medical section of Sixth U.S. Army was near Hollandia, it had enlarged to 16 Medical Department officers and 1 warrant officer. These included, besides the surgeon and his executive, two supply officers, a personnel officer, a statistical officer and his assistant, a hospitalization and evacuation officer and his assistant, a dental surgeon and his assistant, a combined veterinary officer and medical inspector and his assistant, a malariologist, an operations officer, a task force surgeon, and a surgeon for the Alamo Scouts. The two last named were special assignments of Medical Department

officers in an army on the move. The Eighth U.S. Army surgeon also served temporarily with the office. Throughout 1944 many gains and losses occurred in Sixth U.S. Army's medical staff, several malariologists being added.

To the task forces (typically a reinforced division) which operated in New Guinea and the small outlying islands, units over and above the organic medical service, including many mobile units devised by Colonel Carroll and his staff, had to be added. Whenever a task force was set up for a specific operation, a surgeon, sometimes the commanding officer of a medical unit, was chosen, and a member of the medical section at Sixth U.S. Army's forward echelon acted as liaison officer with the task force surgeon.[39]

CONTROL OF MALARIA AND OTHER TROPICAL DISEASES

The program for malaria control in the Southwest Pacific Area got off to a late start. No malaria control or survey units arrived until March 1943 after high malaria rates had occurred in New Guinea. At the close of 1942, a rate of over 1,000 cases per 1,000 men per year occurred among troops at Milne Bay. About 30.3 percent of the hospitalized cases among U.S. Army troops between 3 October 1942 and 3 April 1943 were due to malaria; battle casualties accounted for only 2.75 percent.[40] Rates were lowered at a later date, but the antimalaria program in the Southwest Pacific Area was characterized by considerable administrative confusion during 1943 and was never under strongly centralized control until late in the war.

A number of factors influenced the effectiveness of antimalaria efforts: the degree of familiarity of individual Army doctors with malaria, the support given the program by line officers, the numbers of trained personnel and quantities of antimalaria supplies and equipment available, and the advance planning done by the Surgeon General's Office. In July 1943, the War Department Chief of Staff (General Marshall) made the following appraisal: "Apparently the trouble in the past has been that priorities for munitions overrode those for the necessary screening and other materiel to provide protection at the bases, also there has not been sufficiently rigid sanitary discipline as to the individual soldier." Medical Department officers who had a major share in administering the program also pointed to low priorities for antimalaria supplies and to inadequate support of the program by some line officers. Many, including Colonel Carroll and the Chief of the Tropical Disease and Malaria

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[39] (1) Periodic Reports, Medical Department Activities, Sixth U.S. Army, 1943, 1944. (2) Report of Medical Department Activities, Alamo Force, June–December 1943. (3) Quarterly Reports, Medical Department Activities, Headquarters, I Corps, 1943. (4) Annual Report, Surgeon, 24th Infantry Division, 1943. (5) Annual Report, Surgeon, 32d Infantry Division, 1943. (6) Annual Report, Surgeon, 41st Infantry Division, 1943. (7) Annual Report, Surgeon, 1st Cavalry Division, 1943. (8) History, U.S. Army Forces in the Far East, 1943–1945. [Official record, Office of the Chief of Military History.] (9) Letter, Maurice C. Pincoffs, M.D., to Col. John Boyd Coates, Jr., MC, USA, Director, The Historical Unit, U.S. Army Medical Service, 1 Sept. 1955, and inclosure.

[40] Memorandum, Lt. Col. Paul F. Russell, MC, for The Surgeon General, 1 July 1943, subject: Malaria in South and Southwest Pacific Area.

Control Section of the Surgeon General's Office, ascribed a good deal of the difficulty to the lack of centralized control over the program.[41]

The high command in the Southwest Pacific Area adopted several measures, beginning in September 1942, designed to cope with the malaria threat. In an interview with Colonel Rice, who had just been appointed Surgeon, GHQ, General MacArthur stressed the part which malaria had played in his defeat in the Philippines and urged intensive effort to prevent high malaria rates in New Guinea. In the same month, Gen. Sir Thomas Blamey, Commander, Allied Land Forces, sent Col. N. Hamilton Fairley, Director of Medicine, Australian Army Medical Corps, and an Australian chemist to London and Washington to convince British and American authorities of the gravity of the malaria threat to Allied forces in the Southwest Pacific Area; in the United States they pressed for large-scale manufacture of antimalaria supplies, especially Atabrine. This drug became the chief substitute for quinine as a suppressant of malaria among U.S. Army troops in malarious areas, but was still in short supply during the early months of 1943.[42]

Early in 1943, General MacArthur took a further step to deal with the malaria problem. The arrival of the 1st Marine Division, with high malaria rates, from the South Pacific Area and the high incidence of malaria in troops of the 32d Division in New Guinea made it clear that a control program should be directed from General Headquarters, whence control over the operations of tactical forces was exercised. General Blamey and General MacArthur agreed that cooperation between Australian and American forces fighting in close proximity in New Guinea was essential. In March, General MacArthur appointed the Combined Advisory Committee on Tropical Medicine, Hygiene, and Sanitation, made up of specialists from the military forces of both countries. The committee's function was to advise him on measures for the prevention and treatment of tropical diseases in the Allied forces, on "medical implications in any present or future theaters of operations," and on means of preventing the introduction and spread of tropical diseases into Australia by troops returning from malarious regions. In recognition of the strong interest

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[41] (1) See footnotes 12(1), p. 416; and 40, p. 442. (2) Lt. Col. Paul F. Russell, MC, Chief, Tropical Disease and Malaria Control Section, Office of The Surgeon General: Abstract of Report and Recommendations Regarding Malaria and Its Control Among American Forces in the Southwest Pacific Area, 25 May 1943. (3) Letter, Col. Percy J. Carroll, MC, to Lt. Col. Paul F. Russell, MC, 18 June 1943. (4) Memorandum, Chief Surgeon, U.S. Army Services of Supply, for Commanding General, U.S. Army Services of Supply, 7 Oct. 1943, subject: Organization for Malaria Control, Southwest Pacific Area. (5) Parrish, Susan F.: Summary, Preventive Medicine at USAFFE Level, Organization for Malaria Control, no date. [Official record.] (6) For greater detail, see Medical Department, U.S. Army, Preventive Medicine in World War II. Volume VI. Communicable Diseases: Malaria. Washington: U.S. Government Printing Office. [In press.]

[42] (1) Letter, Maj. Gen. George W. Rice, to Editor, Historical Division, Office of The Surgeon General, 19 June 1951, and inclosure. (2) Fairley, Col. N. Hamilton: Results of Mission to USA and UK regarding Malaria, Anti-Malarial Drugs, and Other Essential Supplies for the Control of Malaria, no date. [Official record.] (3) Combined Advisory Committee on Tropical Medicine, Hygiene, and Sanitation: Review of Activities From the Inception of the Committee to 30 June 1944. [Official record.] (4) See footnotes 12(3), p. 416; and 41(6). (5) Walker, Allen S.: Australia in the War of 1939–1945. Clinical Problems of War. Canberra: Australian War Memorial, 1952, p. 84.

of the Australians in keeping tropical disease out of the continent, Colonel Fairley was made chairman. Col. Maurice C. Pincoffs, MC, Chief of Professional Services, Headquarters, USAFFE, served as secretary to the end of the war. He and Colonel Fairley were the committee's most active members; they worked in close cooperation. The theater malariologist and the Fifth Air Force surgeon also served on the committee.

The Combined Advisory Committee devoted itself to the consideration of the total problem of control of tropical diseases, giving attention to cholera and other diseases, including some which are not solely tropical, such as smallpox. It was concerned with control by environmental means, suppressives, vaccines, or other methods. It issued broad directives applicable to the ground, naval, and air forces of all the Allies. By virtue of its location at General Headquarters, it was able to press for priorities for shipment of antimalaria supplies to the Southwest Pacific Area. A serious handicap to the committee's work, on the other hand, was its lack of a regular source of information on the incidence of tropical diseases among troops. Since the separate commands were not required to furnish statistical reports to it on disease incidence, it had to depend upon committee members to make available whatever information they gleaned in the course of their other official duties. Nor was it regularly informed of impending operations. Hence whatever knowledge it possessed of tropical diseases to be expected by Allied troops invading enemy-held areas could not be put to effective use for planning preventive measures during specific campaigns. The committee encountered no major difficulties in getting its general recommendations accepted, since it was located at General Headquarters and since members of the committee served the subordinate commands in other capacities. In the opinion of its secretary, the committee filled in some measure the gap in the medical section at theater headquarters resulting from the lack of a preventive medicine division. However, the committee's functions were advisory; it never had control over the actual operations of the men and units engaged in malaria control—the malariologists and the malaria control and survey units. After General Headquarters had moved to Hollandia in 1944 and was poised to go on to Leyte, it became difficult for the committee to hold effective meetings, since some of its members had primary duties with headquarters of commands located elsewhere.[43]

The malariologists and control and survey units came into the theater in early 1943. In answer to the request of the Surgeon General's Office for the number of these needed in Southwest Pacific Area, General Headquarters asked the War Department on 1 December 1942, on the recommendation of Colonel Carroll (then at U.S. Army Services of Supply headquarters), for 1 malariolo-

[43] (1) Suggested Combined Advisory Committee on Tropical Medicine and Hygiene, 19 Feb. 1943, by Gen. T. A. Blamey. [Official record.] (2) See footnotes 14(1) and 14(7), p. 419; and 42(3), p. 443. (3) Letter, Adjutant General, General Headquarters, Southwest Pacific Area, to Commander Allied Land Forces, Commander Allied Air Forces, and Commanding General, U.S. Army Forces in the Far East, 2 Mar. 1943, subject: Combined Advisory Committee on Tropical Medicine, Hygiene, and Sanitation. (4) Minutes, Meetings of Combined Advisory Committee, 13 Mar. 1943–31 Aug. 1944.

gist, 6 assistants, 3 survey units, and 12 control units. At this date none of the units were ready, but after War Department approval of the proposed organization late in the year, some of the malariologists and parts of units were sent to Australia by air. By February 1943, three full survey units had arrived at Brisbane, but more than a month's delay ensued before they reached New Guinea on 22 March. Control units did not arrive in New Guinea until June. Meanwhile, in February, Col. Howard F. Smith of the U.S. Public Health Service, who had worked on quarantine problems in the Philippines and was General MacArthur's family physician, was made theater malariologist at Headquarters, U.S. Army Forces in the Far East.[44]

As a result of shifting top commands, the organization for malaria control in the Southwest Pacific Area was less stable than that in the South Pacific. Originally, the theater malariologist appointed in February 1943 was assigned to the office of the Surgeon, U.S. Army Forces in the Far East. He remained there until the following September, when the special staff, USAFFE, was discontinued. From September to the end of the year, he was in the office of the Services of Supply surgeon. Malaria records and reports were handled all this time by the office of the Surgeon, USASOS; thus from February to September 1943, the theater malariologist was at a headquarters other than that where statistics on malaria incidence among troops were maintained.[45]

The Chief of the Tropical Disease and Malaria Control Section of the Surgeon General's Office, Lt. Col. Paul F. Russell, MC, was sent to the Southwest Pacific Area (as well as the South Pacific) by The Surgeon General in mid-1943, shortly after the malaria control organization there got under way, to investigate control measures. By then, the 32d U.S. Division had been incapacitated for some months by high malaria rates (including high relapse rates) after being evacuated from combat in New Guinea, and a similar fate threatened the 41st Division in the Buna-Gona area. Malaria had also forced the evacuation of the 6th and 7th Australian Divisions from New Guinea, and of the Americal Division and the 1st and 2d Marine Divisions from Guadalcanal, in all six Allied divisions in the Southwest and South Pacific Areas. At this date, the organization for malaria control consisted of 1 malariologist, 7 assistant malariologists, 3 malaria survey units, and 12 malaria control units, with additional trained personnel and units requested. The buildup of the malaria control organization was slow because antimalaria units could not be activated and sent from the United States until the theater organization had become convinced of their value and had requested them.[46]

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[44] (1) Memorandum, Capt. Harold M. Jesurun, Assistant Malariologist, for Division Surgeon, 41st Infantry Division, 29 Apr. 1943, subject: Medical History, Malaria Survey Units in New Guinea. (2) See footnote 14(5), p. 419. (3) Letter, Col. George W. Rice, MC, to Col. Percy J. Carroll, MC, 13 Nov. 1942, and attachment. (4) Interview, Thomas A. Hart, M.D., formerly of 6th Malaria Control Unit, June 1951. (5) Staff Memorandum No. 3, U.S. Army Forces in the Far East, 27 Feb. 1943.

[45] See footnote 41(5), p. 443.

[46] McCoy, Lt. Col. Oliver R.: The Tropical Disease Control Division, 1 July 1946. [Official record.

Colonel Russell noted that the Surgeon General's Office had designed the network for malaria control in the expectation that it would function as a single entity under a theater surgeon, with authority stemming from the theater commander through the theater surgeon; it was meant to undertake control measures in the ground, service, and air forces alike. He noted some past failures of commanding officers to carry out the official directives for malaria control. In his opinion malaria control personnel in the Southwest Pacific Area could not function effectively, for they were split between two headquarters. The chief malariologist, who was also medical inspector, and his assistant were at this time assigned to the Chief Surgeon, USAFFE, while the other assistant malariologists and the control and survey units were assigned to the Chief Surgeon, USASOS. Although the chief malariologist and his assistant had technical control over the assistant malariologists, the latter group had no authority to deal with the air forces or the armies on malaria control problems. Colonel Russell remarked that the anopheles did not respect command channels and that it infected men within specific areas regardless of the command to which they were assigned.

Colonel Russell advised separating the position of chief medical inspector for the theater from the job of chief malariologist and making the latter responsible solely for malaria control. He advocated making the theater malariologist, Colonel Smith, "chief medical inspector" and his first assistant malariologist, Colonel Orth, "medical inspector (special) malariologist." Both were to remain at USAFFE headquarters in their new assignments, but the theater malariologist, who should have direct operational control over antimalaria personnel, could best function from the Advance Base, New Guinea. The theater malariologist and the Surgeon, USAFFE, concurred in the main with Colonel Russell's recommendations. They believed that the Services of Supply should furnish malaria control personnel and units with rations, quarters, and supplies but that the U.S. Army Forces in the Far East should retain full control over the assignments and operations of all elements of the malaria control organization.[47]

In June 1943, Colonel Russell's recommendations were largely put into effect, although no such separation of the duties of medical inspector and theater malariologist as he suggested appears to have been carried out. Colonel Smith—sometimes termed "medical inspector special (malariologist)" and sometimes "theater malariologist"—and Colonel Orth—variously termed "chief malariologist" and "assistant theater malariologist"—and the other malariologists, called "assistant medical inspectors special (malariologist),"

[47] (1) See footnote 41(2), p. 443. (2) Check Sheet, Theater Malariologist, for Chief Surgeon, U.S. Army Forces in the Far East, 31 May 1943, subject: Comments in Reports by Lt. Col. Russell Relative to Malaria Control. (3) Memorandum, Chief Surgeon, U.S. Army Forces in the Far East, for Assistant Deputy Chief of Staff, United States Army Forces in the Far East, 31 May 1943. (4) Memorandum, Adjutant General, United States Army Forces in the Far East, for Commanding General, U.S. Army Services of Supply, Southwest Pacific Area, 28 Feb. 1943, subject: Assignment of Malariologists and Malaria Survey Units.

were all assigned to the office of the Surgeon, USAFFE. Any of the malariologists (except the theater malariologist and his assistant) might be attached to the staff of a commander to advise him on control measures and to supervise the control work undertaken within his command. Although the control and survey units were assigned to the Services of Supply for administrative purposes, jurisdiction over their operations and movements was vested in USAFFE headquarters. Normally they would be assigned to area commands of the Services of Supply (that is, base sections or bases), but they might be attached to various other commands. Movements of antimalaria units within a base were to be effected by the base commander on request of the senior malariologist, USAFFE, on duty in the base. USAFFE headquarters would direct the movements of the units from one base to another. Regardless of the command to which they were attached or assigned, both malariologists and antimalaria units were to remain under the direct supervision of the theater malariologist.

These arrangements satisfied Medical Department officers immediately concerned with the malaria control program, but difficulties persisted. The Fifth Air Force surgeon, for instance, wanted all antimalaria units operating with the air force assigned to it, and General Headquarters at times demanded the assignment of these units to task forces. Tactical commands showed unwillingness to recognize the desirability of distributing antimalaria units on the basis of theaterwide needs.[48]

In any case, the scheme mapped out in June was short lived. When the segments of the offices of the chiefs of technical services assigned to Headquarters, U.S. Army Forces in the Far East, were transferred in the fall of 1943 to Services of Supply headquarters, the malariologists were transferred with Colonel Carroll. The latter pointed out the division of authority that the transfer produced: responsibility for malaria control was now vested in the headquarters of three mutually independent commands, the Services of Supply, the Sixth U.S. Army, and the Fifth Air Force, each of which had charge of the program within its own command. In the combat areas of New Guinea, Colonel Carroll noted, troops of the Sixth U.S. Army, the Fifth Air Force, and the Services of Supply were commonly stationed close to each other; mosquitoes bit all impartially. Colonel Carroll emphasized the need for uniformity in discipline and education with regard to malaria and for standardization of treatment of the disease. He recommended that theater headquarters give authority, by formal statement, to the organizational elements for malaria control, now entirely under the Services of Supply, to operate throughout all areas of the theater occupied by American troops, regardless of command. Headquarters, U.S. Army Forces in the Far East, issued such a statement in November 1943. The Commanding General, USASOS, was to have control of

[48] (1) Memorandum, Adjutant General, U.S. Army Forces in the Far East, for Commanding Generals, Sixth U.S. Army, Fifth Air Force, U.S. Army Services of Supply, 15 June 1943, subject: Organization for Malaria Control. (2) See footnote 41(3), p. 443. (3) Letter, Lt. Col. G. L. Orth, MC, to Lt. Col. D. A. Chambers, MC, 21 July 1943, and reply, 9 Aug. 1943. (4) Letter, Lt. Col. D. A. Chambers, to Lt. Col. G. L. Orth, MC, 22 Sept. 1943.

the movements of personnel and units of the organization for malaria control, not only those assigned to the Services of Supply which he could move about freely within and among bases but also of those attached to the Sixth U.S. Army and the Fifth Air Force. In the case of the latter two commands, the concurrence of the respective commanding general had to be obtained in order to move a unit. The Commanding General, USASOS, was to publish the official instructions on malaria control, discipline, standards of suppressive and curative treatment, and on investigations of malaria among Army troops; he was to receive all formal reports on malaria from other commands.

Some difficulty continued, however, as long as the heads of the malaria control organization were under the Services of Supply—that is, throughout the last 3 months of 1943—in spite of additional official utterances asserting the independence of the malaria control organization and reemphasizing the obligations of commanders for carrying out malaria control measures. The Sixth U.S. Army wanted the assistant theater malariologist, Colonel Orth, then located at Advanced Section headquarters in New Guinea, assigned to that army. Late in the year, the assistant malariologists were unable to visit tactical units of the Sixth U.S. Army or Fifth Air Force until they obtained permission for each trip from those commands. At that date, all assistant malariologists were assigned to the 8th Medical Laboratory because of the desire of the Commanding General, USASOS, that they not be carried as part of the overhead of his headquarters. Their commanding officer was too low in the hierarchy to permit effective appeal whenever the assistant malariologists encountered stumbling blocks.[49]

In January 1944, when General Denit was made both theater surgeon and Services of Supply surgeon, Colonel Smith was made "chief malariologist and medical inspector," U.S. Army Forces in the Far East. Direction of the antimalaria program continued to be exercised from the USAFFE level throughout the life of that command. During 1944, an adequate number of skilled personnel and units arrived in the theater; some were transferred from the Central and South Pacific Areas. Near the close of August 1944, the Southwest Pacific Area had 18 malariologists and 32 survey and 55 control units, a considerably higher number than were sent to any other theater of operations during the course of the war. Ten more units were en route to Hollandia at that date. As the Services of Supply received additional units, it became more amenable to releasing them to the tactical forces.

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[49] (1) See footnote 41(4), p. 443. (2) Memorandum, Chief Surgeon, U.S. Army Services of Supply, for Chief of Staff, 22 Oct. 1943. (3) Memorandum, Assistant Adjutant General, U.S. Army Forces in the Far East, for Commanding Generals, Sixth U.S. Army, Fifth Air Force, U.S. Army Services of Supply, 24 Oct. 1943, subject: Organization for Malaria Control and Amendment of 1 Nov. 1943. (4) Memorandum, Assistant Theater Malariologist for Chief of Professional Service, Office of the Chief Surgeon, U.S. Army Services of Supply, 17 Nov. 1943. (5) Letter, Chief Surgeon, U.S. Army Services of Supply, to Assistant Theater Malariologist, 1 Dec. 1943. (6) Memorandum, Assistant Adjutant General, U.S. Army Forces in the Far East, for Commanding Generals, Sixth U.S. Army, Fifth Air Force, U.S. Army Services of Supply, 14 Anti-aircraft Command, 22 Dec. 1943, subject: Operation of Malaria Control. (7) Letter, Director, Tropical Disease Control Division, Office of The Surgeon General, to Chief Surgeon, U.S. Army Forces in the Far East, 26 Jan. 1944.

The assistant theater malariologist—Colonel Orth, until late 1944, when he relieved Colonel Smith—functioned under the Services of Supply, which employed the bulk of the antimalaria personnel at the New Guinea bases. With the aid of a few enlisted men and an occasional officer, he directed malaria control operations in New Guinea from Headquarters, Intermediate Section, located at Oro Bay, and later from other bases in New Guinea and the Philippines. His office issued a monthly bulletin, *Malaria*, which kept antimalaria personnel informed of the latest measures being taken in New Guinea, of the location of personnel and units engaged in the prevention program, and of new developments in the control of mosquitoborne diseases in other oversea theaters. Its chief task was to move antimalaria personnel and units to the areas where they were most needed—the New Guinea bases, intermediate towns along the northern coast of New Guinea, and to Goodenough Island, New Britain Island, and Manus Island in the Admiralties. During 1944, many were concentrated around Oro Bay (Base B), Lae (Base E), at the important base of the Fifth Air Force at nearby Nadzab, and at Finschhafen (Base F).[50]

Additional campaigns to control dengue, scrub typhus, and other endemic diseases were undertaken by the malaria control organization. Since dengue is mosquitoborne, antimosquito efforts contributed to the prevention of dengue fever as well as malaria. Army experience with miteborne typhus, or so-called "scrub typhus," in New Guinea was more serious than that with louseborne epidemic typhus in the Mediterranean and European theaters, for both the sick rates and the mortality rates for scrub typhus in New Guinea were higher than for louseborne typhus in these other theaters. Scrub typhus assumed more of a threat temporarily than even malaria, when relatively high mortality rates occurred during a few of the New Guinea operations. Cases appeared during the early days of combat before destruction of the mite vector throughout an invaded area could be undertaken. During 1942–43, 957 cases of scrub typhus, with a case fatality rate of 5.9 percent, occurred among troops in bases north of Australia. On Goodenough Island, a small epidemic of 75 cases occurring during the period 1 November 1943–15 January 1944 resulted in 19 deaths. Small outbreaks continued with the advance along the northern coast of New Guinea, two of the more serious developing during the Owi-Biak and Sansapor landings in the period May–August 1944.

Army doctors lacked a thorough acquaintance with scrub typhus and with various fevers of undetermined origin, as many fever cases were diagnosed.

[50] (1) Memorandum, Chief Surgeon, U.S. Army Forces in the Far East, for The Surgeon General, 23 Sept. 1943, subject: Medical Department Units. (2) See footnotes 44(4), p. 445; and 49(2), p. 448. (3) Memorandum, Lt. Col. G. L. Orth, MC, for Surgeons, Sixth U.S. Army, Fifth Air Force, and others, 22 Nov. 1943, subject: Movement of Organization for Malaria Control. (4) Assistant Theater Malariologist for Surgeon, Advance Echelon, General Headquarters [Southwest Pacific], 1 Jan. 1944. (5) Memorandum, Maj. Donald S. Patterson, Malariologist, U.S. Army Services of Supply, for U.S. Army Services of Supply Malaria Control Components, 28 June 1944, subject: Standard Operating Procedure. (6) News Letter: Malaria? Headquarters, Malaria Control, Southwest Pacific Area, monthly from 15 Dec. 1943 through July 1945. (7) Circular No. 34, U.S. Army Forces in the Far East, 19 Apr. 1944, subject: Malaria Control.

A special group of investigators, headed by the president of the Army Epidemiological Board, was sent to New Guinea by the Surgeon General's Office in conjunction with the U.S.A. Typhus Commission. It began investigations of scrub typhus near Buna and Oro Bay in the fall of 1943 and continued with the advance along the New Guinea coast and neighboring islands to the Philippines and Japan. An intensive control program was instituted; the use of clothing impregnated with dimethyl phthalate and the burning of the kunai grass which harbors the mite carrier, at as early a stage during the combat phase as possible, became the chief means of preventing the disease. The malaria control and survey units carried it out with the aid of the Engineer Corps, unit commanders, and others. The rates of incidence for scrub typhus among U.S. Army troops in the area never became as high as those for malaria.[51]

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[51] (1) Maxey, Kenneth F.: Scrub Typhus (Tsutsugamushi Disease) in the U.S. Army During World War II. *In* Rickettsial Diseases of Man. Washington: American Association for the Advancement of Science, 1948, pp. 36–46. (2) Report on Activities of the Army Epidemiological Board for 1943. (3) Memorandum, Director, U.S.A. Typhus Commission, for the Secretary of War, 26 Nov. 1945, subject: Termination of the U.S.A. Typhus Commission. (4) See also Medical Department, United States Army. Preventive Medicine in World War II. Volume VII. Communicable Diseases: Arthropodborne Diseases Other Than Malaria. [In preparation.]

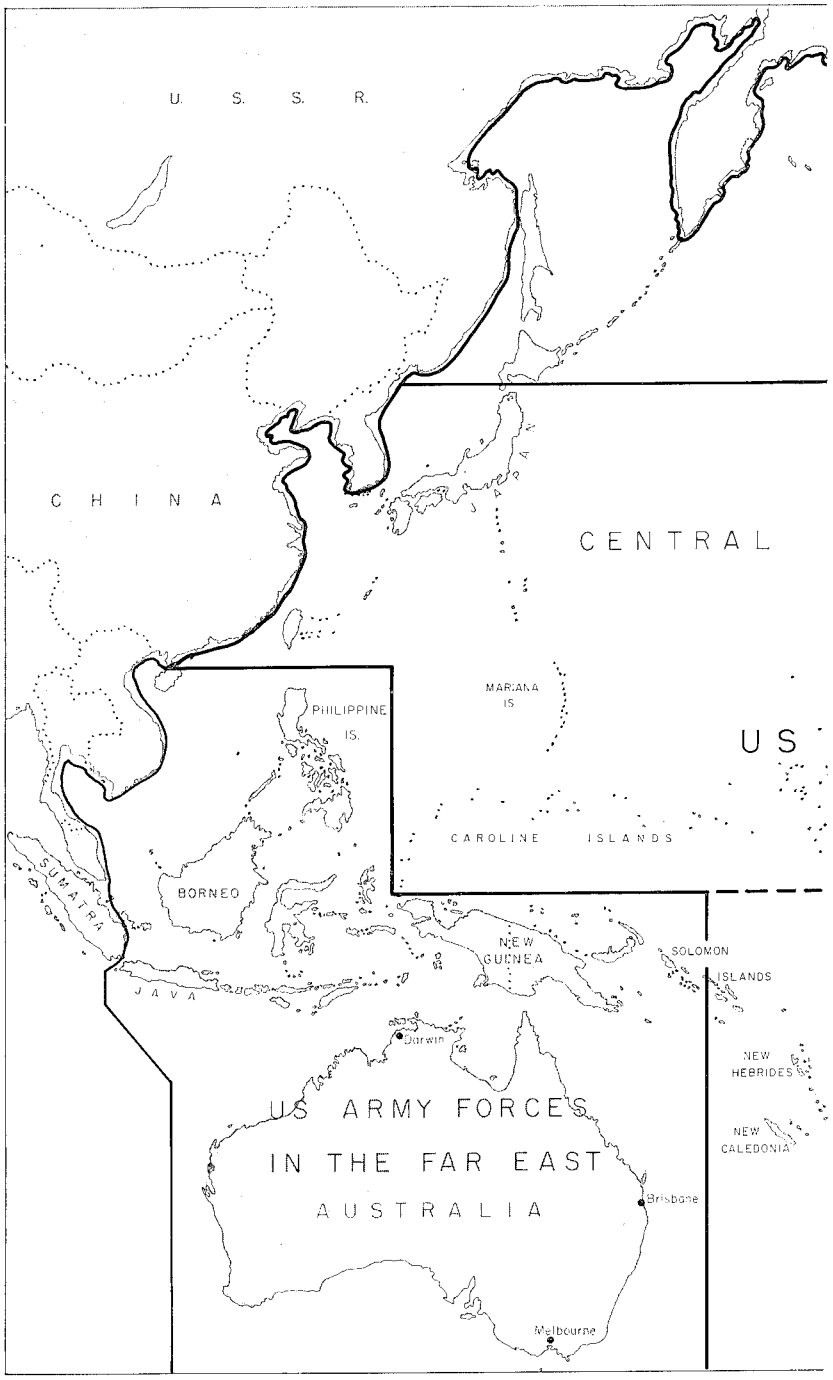
CHAPTER XI

The Pacific: August 1944 Through 1946

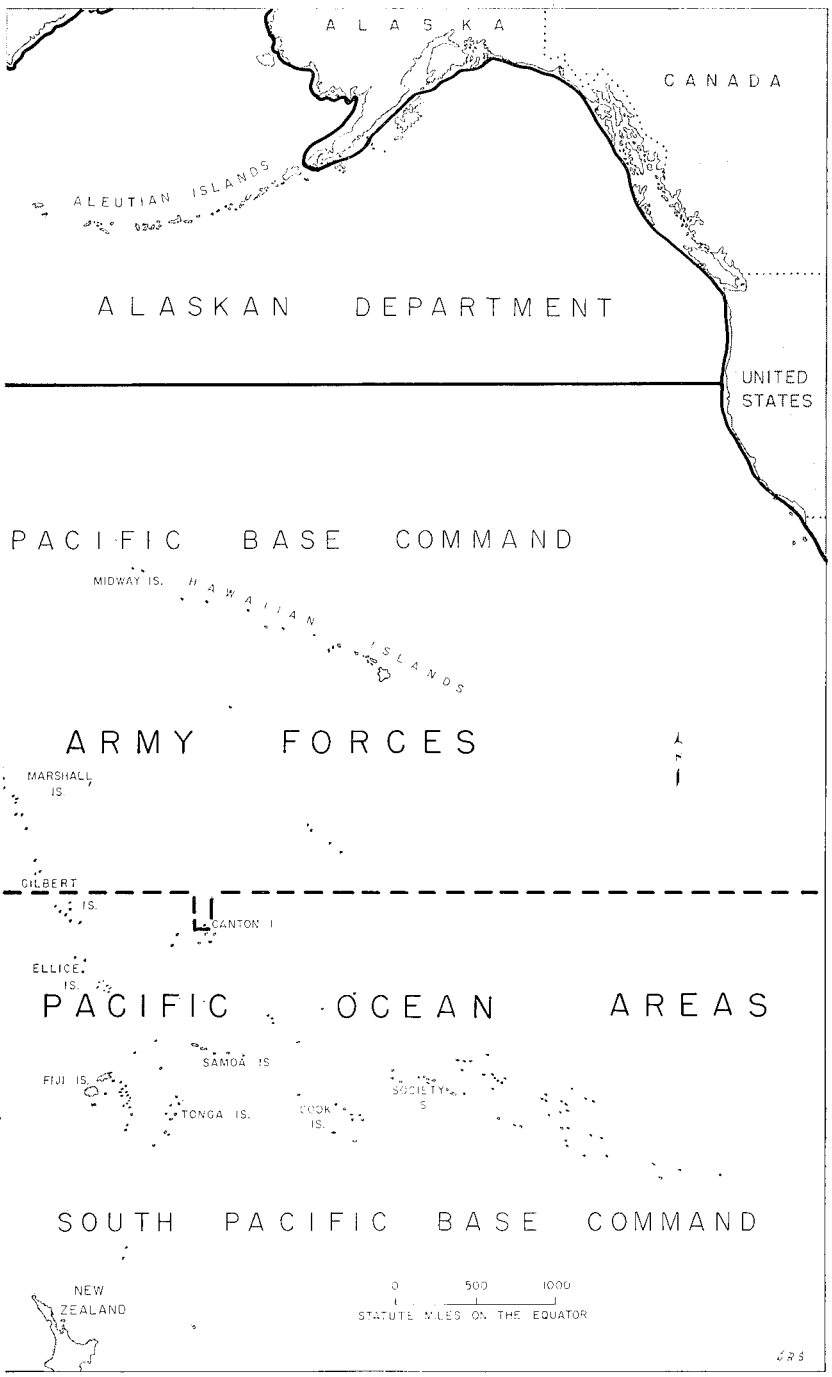
In the summer of 1944, shortly before the invasion of the Philippines, a major reorganization of U.S. Army forces in the Pacific Ocean Areas (Central and South Pacific Areas) took place (map 9). It marked an attempt to make the Army parallel with the Navy in the command structure there, as well as a shift of troops to the west. Army forces in the Central and South Pacific Areas were newly organized into U.S. Army Forces, Pacific Ocean Areas, under Lt. Gen. Robert C. Richardson, with headquarters at Fort Shafter, Hawaii. The Central and South Pacific Base Commands were its major area commands. Tactical elements formerly subject to Army commands in the South Pacific Area, including the half dozen divisions and the Thirteenth Air Force which had comprised the bulk of its combat forces, had been moving into the boundaries of the Southwest Pacific Area command since the New Georgia campaign of mid-1943. The newly created South Pacific Base Command remained responsible for some months for the logistic support, including medical supply, evacuation, and rehabilitation, of some of its former troops, now in the northern Solomons. Army organization in the Southwest Pacific Area remained unchanged at this date except for the acquisition of the tactical elements from the South Pacific.

The Air Transport Command continued to function throughout the Pacific. After 1 August 1944, its Pacific Division consisted of three wings, the West Coast Wing with headquarters in California, the Central Pacific Wing with headquarters at Hickam Field, Hawaii, and the Southwest Pacific Wing, which had headquarters first at Brisbane, then at Hollandia, and in 1945 in the Philippines. The routes of the two last named cut across the territory of the Pacific Ocean Areas and the Southwest Pacific Area. During 1944 additional Air Transport Command bases were established in the Southwest Pacific Area—at Nadzab (New Guinea), Kwajalein, Saipan, Hollandia, and Biak. The three medical air evacuation squadrons which served the Pacific Wing transported patients thousands of miles by air eastward to fixed hospitals at rearward bases and in western United States. During the period July 1944–June 1945, air evacuees from the Southwest Pacific Area and the Pacific Ocean Areas totaled over 24,000, approximately a third of the evacuees from all oversea areas to the United States during that year.

A wing surgeon for the Central Pacific Wing and one for the Southwest Pacific Wing supervised medical and sanitary work at the bases of the routes. The medical staffs at the bases were responsible for sanitation, mosquito control, sick call, minor complaints, and care of all cases not requiring hospitaliza-



MAP 9.—U.S. Army Commands



in the Pacific, August 1944.

tion. As in other areas, Army or Navy hospitals near the bases afforded hospitalization to Air Transport Command personnel.[1]

Although a single command with jurisdiction over all U.S. Army forces in the Pacific was not established until April 1945, in 1944 the War Department and the Surgeon General's Office tended increasingly to consider the Pacific as a whole when reviewing and reappraising medical problems. They attempted to coordinate several phases of medical service for Army troops in the three areas, amounting by the close of June 1944 to over 1 million. Late in 1944, The Surgeon General expressed concern over the lack of qualified consultants in the Pacific and made efforts to have them sent to the theater. He also dispatched a medical supply mission, headed by Col. Tracy S. Voorhees, JAGD, to the Pacific to attempt some integration of the procedures for handling medical supplies throughout the three areas.

The mission noted the adverse effect which the complex Army command setup in the Pacific had had on the distribution of medical supplies throughout the region. Three separate Army area commands had prevailed, and no well-coordinated system for redistributing any excess stocks on an equitable basis throughout the three had been developed. Surplus medical stocks had accumulated in the Central and South Pacific Base Commands; the 6 to 10 divisions which had trained in those areas during 1941–44 had left large stocks of medical supplies behind, being furnished new combat supplies for their advance into forward islands. The critical shortage of water transportation had contributed to the failure to ship these supplies forward.

The mission reported that the lack of unified command in the Pacific thwarted its efforts to transfer excess medical stocks from the Pacific Ocean Areas to the Southwest Pacific Area, as well as its efforts to transfer excess personnel handling medical supplies to areas where they were needed. Hence it failed to establish, as it had succeeded in doing in the European theater, a coordinated system of medical supply for future operations in the Pacific.[2] The conclusions of the mission were corroborated by The Surgeon General and his Deputy Chief of Plans and Operations (Col. Arthur B. Welsh, MC) when they visited the theater early in 1945. General Kirk reemphasized at that time the lack of coordination in the logistic plans of the South and Southwest Pacific Areas and the need for conceiving of the Pacific areas as a single theater of operations.

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[1] (1) Quarterly Report, Medical Department Activities, Pacific Division, Air Transport Command, 3d quarter, 1944. (2) History of the Medical Department, Air Transport Command, May 1941–December 1944. [Official record.] (3) Correspondence between Col. Walter S. Jensen, MC, Headquarters, Army Air Forces, Pacific Ocean Areas, and the Air Surgeon, August-September 1944. (4) Annual Report of the Air Surgeon, Fiscal year, 1945.

[2] (1) Letter, The Surgeon General, to Chief Surgeon, U.S. Army Forces in the Far East, 25 Oct. 1944. (2) Report No. 35, Air Evaluation Board: Medical Support of Air Warfare, Southwest Pacific Area. (3) Memorandum, Col. T. S. Voorhees, for The Surgeon General, 18 Jan. 1945, subject: Confidential Notes on Pacific Trip. (4) Voorhees, Tracy S.: Story of Pacific Trip, Oct.–Dec. 1944. In Colonel Voorhees' personal file. (5) Radio messages, War Department, to Commanding General, Central Pacific Area, and Commander in Chief, Southwest Pacific Area, and replies, May 1944.

PACIFIC OCEAN AREAS

At the time of its organization in August 1944, USAFPOA (U.S. Army Forces, Pacific Ocean Areas) comprised, in addition to its two area commands (Central and South Pacific Base Commands), the Tenth U.S. Army and the Army Air Forces, POA. The latter was created as a top air command when the general reorganization took place. In April 1945, the Western Pacific Base Command (the Marianas, Iwo Jima, and the Palau Islands) was added as a major element. The combined Army-Navy command under Adm. Chester W. Nimitz, Commander in Chief, Pacific Ocean Areas, continued to direct the operation of ground and air, as well as naval units. Two Army Medical Department officers remained as liaison officers with his staff at Pearl Harbor, participating in the joint Army-Navy planning. Late in 1944, they aided in formulating medical phases of the plans for taking Iwo Jima and Okinawa. When Admiral Nimitz established an advance headquarters on Guam in January 1945, one of these officers went there with the advance element of its medical section.[3]

Brig. Gen. John M. Willis, MC (fig. 101), became Surgeon, U.S. Army Forces, Pacific Ocean Areas, in November 1944, relieving Brig. Gen. Edgar King, who had been assigned to that position for a few months after holding the top Army medical assignment in the Central Pacific for about 5 years. General Willis served on the special staff of Lt. Gen. Robert C. Richardson, Jr., Commanding General, U.S. Army Forces, Pacific Ocean Areas, and Commanding General, Hawaiian Department, at the latter's headquarters at Fort Shafter (fig. 102).

Most of the staff of the former surgeon, Central Pacific Area—those officers who had had typical base medical duties—were transferred to the office of the Surgeon, Central Pacific Base Command, Col. Paul H. Streit, MC (fig. 103). That portion of General King's staff which had been engaged in operational planning—in estimating the medical troop and supply requirements for movement into the Marshall Islands, the Marianas, and the Western Carolines—was transferred with him to the office of the Surgeon, U.S. Army Forces, Pacific Ocean Areas. During the late months of 1944, several Medical Department officers from the Central Pacific Base Command served on the staff of the Surgeon, U.S. Army Forces, Pacific Ocean Areas, in various capacities—as dental surgeon, veterinarian, laboratory consultant, and director of nursing. Other posts—those of surgical consultant and neuropsychiatry consultant, for example—were filled by attachment from the South Pacific Base Command. The staff of the Surgeon, Pacific Ocean Areas, at this period was thus unorthodox, being made up in large measure of officers actually assigned to other commands. At the same time the number of occupied islands for which General

[3] (1) Whitehill, Buell: Administrative History of Medical Activities in the Middle Pacific. [Official record.] (2) History of U.S. Army Forces, Middle Pacific, and Predecessor Commands During World War II, 7 December 1941–2 September 1945. [Official record, Office of the Chief of Military History.] (3) See footnote 2(3), p. 454.



FIGURE 101.—Brig. Gen. John M. Willis, MC.

Willis was responsible was increasing, and full-time consultants were needed to advise him.

In the course of his investigation of the status of medical supply in the Pacific late in 1944, Colonel Voorhees obtained certain data on medical organization in the Pacific Ocean Areas for The Surgeon General, who was on the eve of a trip to the Pacific. Colonel Voorhees noted that only 18 of the 34 officers requested for General Willis' office had been tentatively approved and that the 18 included several division malariologists charged to the office because the table of organization for the Army division had no place for them. Thus, a number of the 25 officers actually on duty were not included in the official allotment. Colonel Voorhees considered General Willis' allotment too small and the office of the Surgeon, Central Pacific Base Command, also at Fort Shafter, overstaffed for the reduced scope of work facing it at the beginning of 1945. Although Colonel Voorhees called attention to the similarity of the situation in the Pacific Ocean Areas to that which he had noted in the China-Burma-India theater, no such amalgamation as he achieved in the latter took place in the Pacific Ocean Areas. On the other hand, Col. Arthur B. Welsh, MC, who visited the Pacific Ocean Areas command with The Surgeon General early in 1945, favored a larger office at Central Pacific Base Command headquarters.

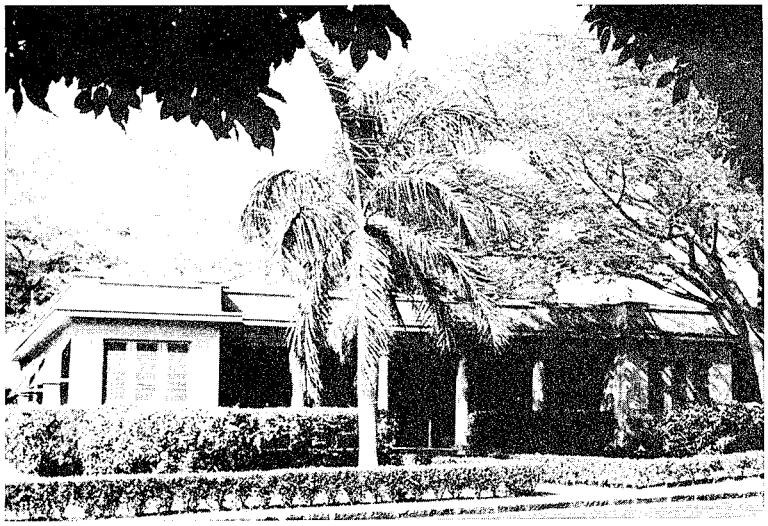


FIGURE 102.—Headquarters, U.S. Army Forces, Pacific Ocean Areas, Fort Shafter, T.H., where the command surgeon was located.

He did not consider an amalgamation of the two medical offices feasible, probably because a separate medical section handling details of administration for medical units and installations on the Hawaiian Islands freed the Surgeon, USAFPOA, for the large task of medical planning for forward areas.

What General Willis considered an adequate allotment for his office was obtained only in the middle of 1945, when the War Department approved 45 officers and 64 enlisted men for the office. Until that time the surgical consultant, the orthopedic consultant, and the neuropsychiatric consultant served in General Willis' office on detached service from the Central and South Pacific Base Commands—the office had only the medical consultant actually assigned to it—while a sanitary engineer sent by the Surgeon General's Office was attached to the medical section in the status of "attachment of officer for training." [4]

Central Pacific Base Command

The Central Pacific Base Command encompassed the islands of Hawaii and later the so-called "Marshall-Gilberts Army Area." The office of its surgeon, Colonel Streit, had a number of sections performing the orthodox duties of a base surgeon's office; his staff also included eight part-time consultants whose primary assignments were as staff officers in hospitals. Medical Department officers in Hawaii were now little concerned with problems of de-

[4] (1) See footnotes 2(1) and (3), p. 454; and 3(1) and (2), p. 455. (2) Annual Report, Medical Section, Pacific Ocean Areas, 1944. (3) Memorandum, Acting Chief, Preventive Medicine Service, Office of The Surgeon General, for Chief, Operations Service, Office of The Surgeon General, 3 Nov. 1944, subject: Medical Officers for Assignment to Pacific Ocean Areas. (4) Report, Col. Arthur B. Welsh, MC, 7 Mar. 1945, and inclosures thereto, subject: Visit to Pacific Theater.



FIGURE 103.—Col. Paul H. Streit, MC.

fense; they were chiefly occupied with training and giving logistic support to the tactical units invading the Marianas and Ryukyus and to the army garrison forces which settled on those islands. They provided fixed hospitalization for patients returned from the westward islands and directed a reconditioning program in the larger hospitals in Hawaii. As in the case of the base sections and bases in the Southwest Pacific Area, it was found feasible, in a static situation, to give Medical Department officers more direct authority over local installations. In August 1944, Colonel Streit was made Commanding Officer, Medical Service, Central Pacific Base Command, and in this capacity had command control of all Medical Department units and installations on Oahu and of their movements within its boundaries. Types of units and installations which he controlled included: General, station, field, and portable surgical hospitals; medical groups; medical battalions; collecting companies; clearing companies; veterinary detachments and hospitals; dental clinics; medical laboratories; medical supply depots; malaria control and survey units; sanitary companies; ambulance battalions and companies; two Medical Department concentration centers; and a convalescent and reconditioning center. Numerous units which belonged to divisions staging or training on Hawaii were placed under Colonel Streit's command. Officers on Colonel

Streit's staff functioned, as he did, in a dual capacity. For the purposes of administering the Medical Service, Central Pacific Base Command, Colonel Streit's office was organized in accordance with the usual staff pattern, with an S–1, S–2, S–3, and S–4.[5]

South Pacific Base Command

After August 1944, when the Services of Supply, South Pacific Area, was abolished and the U.S. Army Forces, South Pacific Area, was reorganized into the South Pacific Base Command, the area declined steadily in importance. However, the new South Pacific Base Command was still responsible for logistic support of the three Army divisions (the 37th, 93d, and Americal Divisions) under XIV Corps which had moved to the Solomon Islands and for support of the 25th Division at New Caledonia until it left for the Philippines in December 1944. It continued to afford hospitalization to these troops for some months. With the abolition of the Services of Supply, South Pacific Area, the service commands on the various islands were absorbed by the island commands, and some of the island commands were reduced to subbases. The Thirteenth Air Force had started moving to the Southwest Pacific Area.

As of August 1944, only a little over 110,000 troops (including those of the 25th Division which had a strength of 14,500) were in the South Pacific Area. The great majority of this force was concentrated on New Caledonia, Fiji, Espíritu Santo, Guadalcanal, Efate, and the Russell Islands. Of these, the first four had island commands with surgeon's offices, while the last two were organized as subbases. The transfer of the former service command surgeon (who had usually acted as an island surgeon on the staff of the commander of the island command as well) to the staff of the island commander had little effect on the responsibilities of the service command surgeon except that it gave him definite responsibility for supervising the dispensaries of ground force and air force units located at the base. On Guadalcanal, for instance, a dispensary officer in the island surgeon's office supervised the work of about 60 dispensaries in the fall of 1944.

Brig. Gen. Earl Maxwell remained as Surgeon, South Pacific Base Command, until November 1944, when Col. Laurent L. LaRoche, MC (fig. 104), succeeded him. Except for relief of the four original consultants and their partial replacement by Medical Department officers already in the area, personnel of the office underwent little change until May 1945. At that date the surgeon's section of the South Pacific Base Command (including the consultants) was made the surgeon's section for Army Service Command O, intended for logistic support of the invasion of Japan and transferred to the Philippines to await its mission. The office of the Surgeon, New Caledonia

[5] (1) Annual Report, Medical Department Activities, Central Pacific Base Command, 1944. (2) See footnotes 3(1) and 3.2, p. 455. (3) Interview, Col. Paul H. Streit, MC, 21 May 1945. (4) History of the Central Pacific Base Command During World War II. [Official record, Office of the Chief of Military History.]



FIGURE 104.—Col. Laurent L. LaRoche, MC.

Island Command, took over the duties of the base command's medical section in addition to those for New Caledonia.[6]

In late 1944, scenes of U.S. Army activity in the South Pacific Base Command had shrunk to three main locales at Nouméa and nearby areas on New Caledonia, and on Espíritu Santo and Guadalcanal; troop strength had dropped below 100,000. Despite the decline, the South Pacific Base Command and the naval command in the area were continuing an aggressive program of construction and were exhibiting a tendency to hang on to units and supplies which could be better used in the Southwest Pacific Area. Consequently hospitals in the South Pacific islands were only half full and enormous surplus stocks of medical supplies were still there. On 1 January 1945, a general hospital (1,500 beds), 5 station hospitals (totaling 1,550 beds), and a field hospital were idle in the South Pacific islands. The Southwest Pacific Area had an option on

[6] (1) See footnote 3(2), p. 455. (2) History of the South Pacific Base Command During World War II. [Official record, Office of the Chief of Military History.] (3) Annual Report, Medical Department Activities, South Pacific Base Command, 1944. (4) Quarterly Reports, Medical Department Activities, Headquarters, XIV Corps, 1st and 2d quarters, 1944. (5) Annual Report, Surgeon, Headquarters, Island Command (Russell Islands), 1944.

surplus units and stocks, but the South Pacific Base Command was slow in declaring them surplus. The Pacific still did not constitute a single theater in terms of Army command, and as late as February 1945 the Southwest Pacific Area command was uninformed as to what medical units it could obtain from the South Pacific Base Command.[7]

Another late-date problem in the coordination of higher command policy was noted by The Surgeon General's inspection party which visited the base command early in 1945: the Navy was still failing to give adequate command support to the program for inspection of food conducted by Army veterinary officers assigned to the Joint Purchasing Board in Wellington, New Zealand. This situation straightened out a few months later when arrangements were made for assigning additional Army veterinarians to the Board to inspect the foods bought in New Zealand, as well as for forwarding the veterinarians' reports direct to the office of the Surgeon, South Pacific Command.[8]

Tenth U.S. Army and Okinawa Island Command

Throughout 1944 several divisions, mostly attached to XXIV Corps, were trained in Hawaii. Some, temporarily attached to various amphibious corps, took part in joint Army-Navy assaults on Saipan and Guam in the Marianas, as well as the Palau Islands in the Western Carolines. The XXIV Corps (the 7th and 96th Divisions), originally scheduled for the Yap operation, was sent to Leyte and from the fall of 1944 to February 1945 came under the control of the Southwest Pacific Area Command.

From September 1944 on, the major ground combat command under the Commanding General, Pacific Ocean Areas, was the Tenth U.S. Army, which had headquarters at Schofield Barracks on Oahu and invaded the Ryukyus in the spring of 1945. All Army divisions in Hawaii not charged with defense of the islands, as well as three Marine divisions, were assigned to the Tenth U.S. Army. Col. Frederic B. Westervelt, MC (fig. 105), who had been on the medical planning staff of Admiral Nimitz, became Surgeon, Tenth U.S. Army; by the end of August 1944 a surgical consultant, a medical consultant, a dental surgeon, a veterinarian, and a neuropsychiatrist had been assigned to his staff. An orthopedic consultant was assigned in February 1945.

The XXIV Corps, now in Leyte, was placed under the Tenth U.S. Army for the invasion of the Ryukyus and thus came under control of the Commanding General, Pacific Ocean Areas. From the middle of February to April 1945, the small office of the Surgeon, XXIV Corps, on eastern Leyte was busy with readying troops medically for the invasion. It drew up a medical plan, and under its supervision vitamin tablets were distributed; troops were immunized for tetanus, smallpox, cholera, typhoid, and typhus; and troop units

[7] (1) See footnotes 2(3) and 2(4), p. 454. (2) Annual Report Medical Department Activities, South Pacific Area, 1945.

[8] (1) Memorandum, The Surgeon General, for Commanding General, Army Service Forces, 10 Mar. 1945, subject: Report of Inspection. (2) See footnote 4(4), p. 457. (3) [History], Surgeon's Section, U.S. Army Forces in the South Pacific Area and South Pacific Base Command.

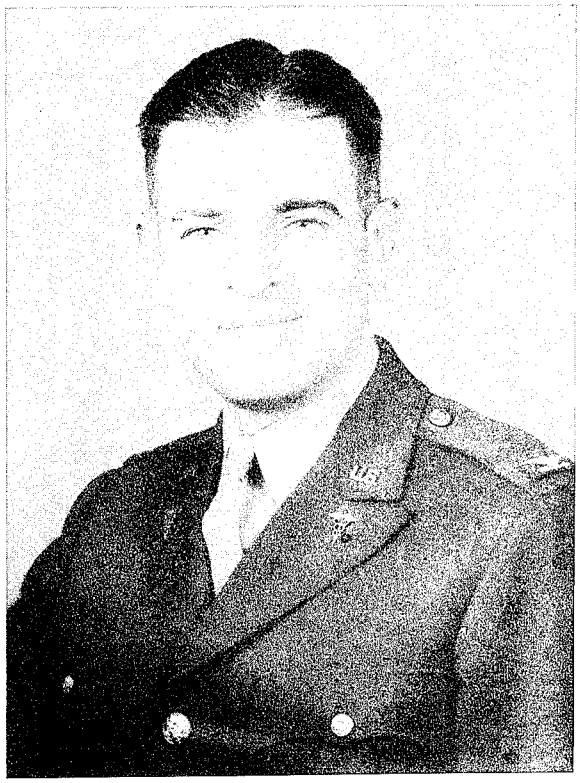


FIGURE 105.—Col. Frederic B. Westervelt, MC.

were up to their full strength in medical officers. Malaria control and survey units were assigned to XXIV Corps during the planning period.

Several divisions of Tenth U.S. Army (in addition to XXIV Corps) trained throughout the winter of 1944–45 in Hawaii. During the planning period the Tenth U.S. Army Surgeon was aided by the surgeons of several other major commands with headquarters on Oahu: the U.S. Army Forces, Pacific Ocean Areas; the Army Air Forces, Pacific Ocean Areas; and various Navy commands. The joint planning of these headquarters for malaria control measures to be adopted during combat, based on the experience of the South Pacific Area, was a notable feature of the medical plans for the Okinawa campaign. Troops were given Atabrine during the preinvasion period and the use of larviciding teams in division areas during combat materially reduced the mosquito population.

The medical consultant of the army was attached to III Amphibious Corps (consisting of three Marine divisions), which had been added as a second corps to the Tenth U.S. Army, and aided in coordinating medical policies of the two corps. An island command was established for Okinawa on Oahu early in January, and its medical section was provided with a nucleus staff. In addi-

tion, 12 officers and 22 enlisted men of the Tenth U.S. Army medical section were placed on special duty with the island command medical section.

An "operational group" of the Tenth U.S. Army's medical section left Oahu for Okinawa on 5 March 1945; a corresponding group of the island command medical section left on the same day. Practically all personnel of both medical sections were on Okinawa by the middle of April. All medical units landing during the early days of April were under control of the two corps of the Tenth U.S. Army. Then ensued a period during which additional units landing were controlled by the island command. In the early days of May, the Tenth U.S. Army assumed control of a majority of medical units ashore and was responsible for hospitalization and evacuation from divisions, through hospitals, to surface and air holding stations, while the island command retained control of air and surface evacuation from the island. On 7 May, Headquarters, Medical Service, Tenth U.S. Army, was established under the command of the Surgeon, Tenth U.S. Army, and to it were assigned all the combat medical units except those under XXIV Corps and those concerned with supply and sanitation, which remained under island command control. Island Command, Tenth U.S. Army, had full responsibility for all evacuation from Okinawa and established an evacuation center made up of divisional medical units.

By the close of the Okinawa campaign at the end of June 1945, Island Command, Okinawa, was operating 35 Medical Department units, including 10 field, station, and portable surgical hospitals, and 15 Army and Navy malaria and epidemic disease control units which were directed by a malaria and insect control headquarters in the field. The reception of more than 1,000 sick and wounded Japanese prisoners of war had placed a heavy burden on the hospitals. Plans had been formulated for the establishment of 14 additional station and general hospitals. A total of about 400 officers of the Medical, Dental, Veterinary, and Sanitary Corps and about the same number of nurses were serving in subordinate units within Okinawa Island Command.[9]

Army Air Forces, Pacific Ocean Areas

As a phase of the reorganization in the Pacific in August 1944, AAFPOA (Army Air Forces, Pacific Ocean Areas) was created, with headquarters at Hickam Field, under the command of Lt. Gen. Millard F. Harmon. It consisted of Army Air Forces units in the Central and South Pacific Areas. Major components in the fall of 1944 were the Seventh Air Force (the direct descendant of the old Hawaiian Air Force), which was made a tactical air

[9] (1) Annual Report, Medical Department Activities, Tenth U.S. Army, 1944. (2) See footnote 3 (1) and (2), p. 455. (3) Report of Operations in the Ryukyus Campaign, 26 Mar.–30 June, 1945, Tenth U.S. Army, ch. 11, sec. XV: Medical. (4) Report of Surgical, Medical, and Orthopedic Consultants for Operational Reports of Okinawa Campaign, 30 June 1945. [Official record.] (5) History, Medical Section, Headquarters, Tenth U.S. Army, 1 Jan.–15 Oct. 1945. (6) Quarterly Reports, Surgeon, XXIV Corps, 1st and 2d quarters, 1945. (7) See also Medical Department, United States Army. Preventive Medicine in World War II. Volume VI. Communicable Diseases: Malaria. [In press.]

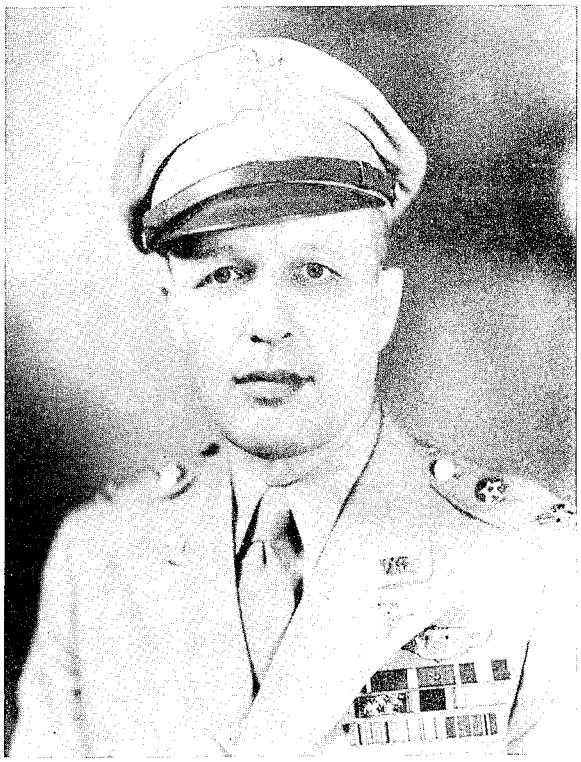


FIGURE 106.—Col. Walter S. Jensen, MC.

force, and XXI Bomber Command, which had begun moving into the Pacific Ocean Areas from the United States. Col. Walter S. Jensen, MC (fig. 106), became Surgeon, AAFPOA, while Col. Ralph Stevenson, MC (fig. 107), was Surgeon, Seventh Air Force (based on Saipan from December 1944 to mid-1945 and afterward on Okinawa), and Col. H. H. Twitchell, MC (fig. 108), was Surgeon of XXI Bomber Command.

The XXI Bomber Command became a major element of the strategic Twentieth Air Force which carried out long-range bombing missions in both the China-Burma-India theater and Pacific Ocean Areas in an airstrike against Japanese industry. Although its operations were to be aimed at a single enemy—Japan—its bombardment wings were based in two areas under separate commands. Hence direction of the operations of elements of the far-flung Twentieth Air Force was vested in the Joint Chiefs of Staff in Washington, where the Force was served directly in the staff of Army Air Forces headquarters. Under this system of remote control from Washington, Gen. Henry H. Arnold, Commanding General, AAF, served as commander of the Twentieth Air Force, and the Air Surgeon, Maj. Gen. David N. W. Grant, as its surgeon.

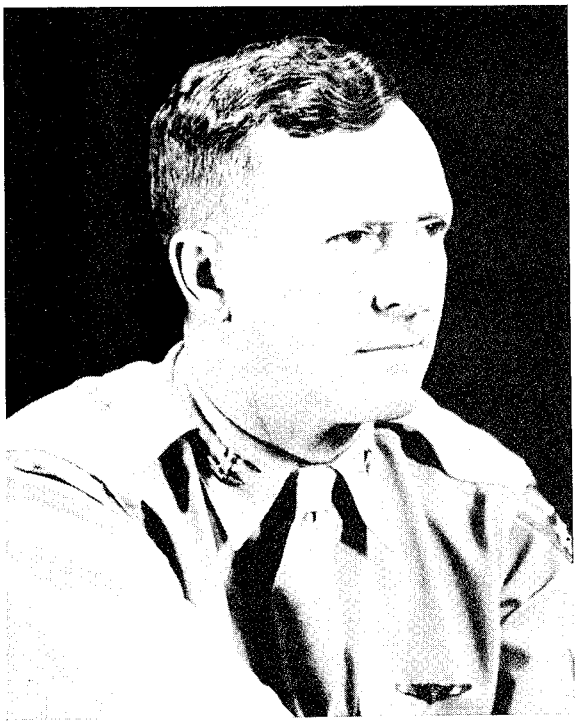


FIGURE 107.—Col. Ralph Stevenson, MC.

In order to coordinate the operations of XXI Bomber Command—based in Hawaii for some months after it began moving into the theater—with those of the Seventh Air Force, the Commanding General, AAFPOA (General Harmon), was made Deputy Commanding General, Twentieth Air Force; his surgeon, Colonel Jensen, became deputy surgeon for the air force as well as Surgeon, AAFPOA. The bombardment wings of XXI Bomber Command moved into the Marianas between October 1944 and mid-1945, making the command's first raid on Tokyo in November 1944. They were based at airfields on Saipan, Guam, Tinian, and Iwo Jima. Other elements of the command settled on Okinawa and Ie Shima after June 1945. The surgeon of XXI Bomber Command and Surgeon, AAFPOA (Deputy Surgeon, Twentieth Air Force), were both located at their respective headquarters on Guam after early 1945.

Besides the usual dispensaries maintained by the bombardment and air service groups of XXI Bomber Command, 100-bed dispensaries, in reality small hospitals, were operated by the bombardment wings, whenever elements of the wing were not too dispersed to make a small hospital practicable. The command found that these installations served to decrease the loss of man-days resulting from hospitalization of air force personnel in hospitals not under air force control. Air force surgeons were particularly loath to lose the flying



FIGURE 108.—Brig. Gen. H. H. Twitchell, MC, USAF.

time of the highly specialized men who manned the long-range B–29's. Moreover, the wing dispensaries proved of value in relieving the regular fixed hospitals of some of their burden during periods of heavy evacuation from invasions. More serious cases among air force patients were sent to hospitals maintained by the Army Garrison Forces on Saipan or returned to hospitals in the Hawaiian Islands. Medical supplies were furnished XXI Bomber Command elements through the usual Army Garrison Force channels on the various islands.[10]

Colonel Jensen, who had recently been executive officer for the Air Surgeon in Washington, worked in close cooperation with the Air Surgeon's Office to build up, in accord with the latter's policy for all oversea air forces, special medical components and practices removed from the control of the local Army command. Besides a drive to have station and general hospitals assigned to

[10] (1) Army Air Forces Letter 20–3, 8 Apr. 1944, to Chief of Air Staff, and others. (2) Narrative of Experiences of the Medical Section, Headquarters, XXI Bomber Command, for 1 March–31 December 1944. [Official record.] (3) Quarterly Reports, Medical Section, Twentieth Air Force, 1st, 2d, and 3d quarters, 1945. (4) Memorandum, Col. Walter F. Jensen, MC, for the Air Surgeon, 10 Apr. 1944, subject: Administrative Responsibilities, Twentieth Air Force, Management Control.

XXI Bomber Command, the Air Surgeon's Office and the Surgeon, AAFPOA, made efforts throughout 1944 and early 1945 to set up a central medical establishment in both the Seventh Air Force and the XXI Bomber Command—larger than the Seventh Air Force. This was the same type of unit that had been established shortly before in the Eighth and Ninth Air Forces in the European theater and in the Thirteenth Air Force in the South Pacific Area. The Air Surgeon's Office made strenuous efforts to get approval for a table of organization for a combined central medical establishment and convalescent center, but by June 1945 this proposal had been definitely turned down. However, during late 1944 and 1945 Headquarters, AAFPOA, took over a number of rest and recreation camps and formed the Army Air Forces Pacific Ocean Areas Rest and Recreation Center. These camps had been established for Seventh Air Force personnel by a committee of Honolulu civilians soon after the beginning of the war at the request of the Seventh Air Force surgeon (Col. A. W. Smith). Located at Hawaiian beaches, ranches, and mountain resorts, they were used by thousands of combat crewmen of the Seventh and Twentieth Air Forces.

The Surgeon, AAFPOA, did not appear greatly interested, on the other hand, in the efforts of the Air Surgeon's Office to develop another unit which the latter office favored, the "Air Force Insect Control Unit." No particular problem had arisen in his area with respect to Army Air Forces' responsibility for airplane spraying of DDT; the work had been successfully handled informally. After a Navy malaria and epidemic disease control unit (attached to Naval Construction Battalions) did the initial job of spraying, the island surgeon (who might be an air, ground, or naval officer) took charge, and the Army Air Forces simply furnished the planes which he asked for. Apparently, Colonel Jensen did not feel that the prestige of Army Air Forces would be materially enhanced by the recognition of a special "air force insect control unit."

SOUTHWEST PACIFIC AREA

From August 1944 to April 1945, the top structure of theater organization in the Southwest Pacific Area underwent no major changes except for the establishment of a top air force headquarters, the Far East Air Forces, to coordinate the activities of the Fifth and the newly arriving Thirteenth Air Forces. Several important subordinate commands were added as additional Army elements formerly in the Central Pacific and South Pacific Areas moved into the Southwest Pacific Area. The Eighth U.S. Army built up in the theater after September 1944 on the eve of the Leyte invasion. With the progress of the Luzon campaign, the headquarters of practically all the major commands, including their medical sections, moved from New Guinea to Luzon.

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Allied Headquarters, U.S. Army Forces in the Far East, and Services of Supply Headquarters

Col. George W. Rice, MC, continued as Surgeon, General Headquarters, until September 1944. Because of his experience and extensive knowledge of the area, he was transferred at that time to the position of Surgeon, Eighth U.S. Army, exchanging assignments with Col. John F. Bohlender, MC (fig. 109), and soon becoming elevated to the rank of brigadier general. The title, "Surgeon, GHQ," ended with the departure of General Rice, for Colonel Bohlender not only worked through G–4, General Headquarters, but was specifically assigned there. With the aid of one enlisted man, he continued his predecessor's work on the medical phases of the campaign plans initiated by G–4 at General Headquarters, coordinating plans for water evacuation with the Navy and those for air evacuation with the Far East Air Forces and the Pacific Wing, Air Transport Command. Plans were then worked out in greater detail by Medical Department officers at the headquarters of U.S. Army Forces in the Far East and the Services of Supply. General Headquarters moved from Brisbane to Hollandia in August 1944, to Leyte in October, and to Manila in February 1945.[11]

Throughout most of 1944, the office of the Surgeon, USASOS (U.S. Army Services of Supply), had also been at Brisbane, but in September, when the northward movement of troops resulted in a shift of Services of Supply headquarters, this office moved by echelons to Hollandia, then in early 1945 to Leyte, and finally in March and April to Manila. In March 1945, General Denit commented upon the diffusion of offices under his control by noting that he then had medical offices for the Services of Supply in three places—an office with the advance echelon in Manila, one at main headquarters on Leyte, and one with the rear echelon in Hollandia. As surgeon for the U.S. Army Forces in the Far East, he had a few officers working under his direction at that command's two headquarters in Manila and Leyte. During the shift of forces from New Guinea to the Philippines, the coordination of medical planning by these small offices was difficult.

The total officer personnel on General Denit's staff was even less than it had been during the period 1942–August 1944 and totally inadequate for diffusion among several physical locations. In February 1945, for instance, only 22 officers were under his direction, 4 working with the theater headquarters and 18 at Services of Supply headquarters. Of the latter number, exactly half were on detached service only; that is, their principal assignments were with other commands. The Services of Supply medical office still had no chief of preventive medicine at that date. The only assignments to preven-

[11] (1) Report, Chief Surgeon, General Headquarters, U.S. Army Forces, Pacific, 9 June–Dec. 1945. (2) Quarterly Report, Surgeon, 2d Port of Embarkation, 4th quarter, 1942. (3) Memorandum, Col. J. F. Bohlender, MC, to Surgeon, U.S. Army Services of Supply, 17 Sept. 1944. (4) Essential Technical Medical Data, U.S. Army Services of Supply, 20 Nov. 1944. (5) Letter, Surgeon, U.S. Army Services of Supply, to The Surgeon General, 12 Oct. 1944.

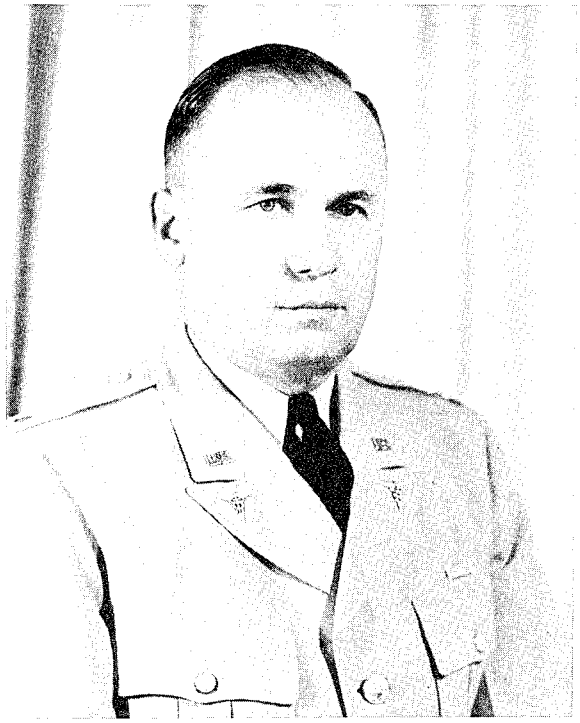


FIGURE 109.—Col. John F. Bohlender, MC.

tive medicine functions were those of a venereal disease officer and a nutrition officer. By May, however, preventive medicine had become a recognized entity. The office then had, in addition to a deputy chief surgeon, executive officer, historian, and nutrition officer, chiefs of the following divisions: Administrative, Supply, Personnel, Hospitalization, Evacuation, Plans and Training, Preventive Medicine, Dental, Veterinary, Nurses, and Consultants.[12]

A small allotment for administrative positions hampered not only enlargement of General Denit's scattered staff but the development of an adequate medical staff at the headquarters of base sections and bases as well. In the fall of 1944 the War Department allotment of Medical Corps officers for overhead—that is, the medical sections at headquarters of U.S. Army Forces in the Far East and of the Services of Supply and its area commands—was 134 officers. Of these, only eight could be colonels. The chiefs of divisions in General Denit's office at Services of Supply headquarters and his consultants, as well

[12] (1) Annual Report, Chief Surgeon, U.S. Army Services of Supply, 1944. (2) 2d Lt. R. C. Folwell, MAC, Historical Division, U.S. Army Forces Western Pacific, for the record, no date, subject: Information Concerning the Office of the Chief Surgeon, USASOS and AFWESPAC. (3) Letter, Chief Surgeon, U.S. Army Services of Supply, to The Surgeon General, 23 Mar. 1945. (4) Minutes, Conference of General and Special Staff Sections, Headquarters, U.S. Army Services of Supply, 5 Sept. 1944. (5) Memorandum, Chief Surgeon, U.S. Army Services of Supply, for Chief of Staff, 16 May 1945, subject: List of Key Personnel in the Medical Section, With a Brief Summary of Their Duties.

as the surgeons of bases and of base, intermediate, and advance sections, had a claim on the rank of colonel.

The difficulty of obtaining sufficient officers of adequate rank for important administrative assignments in the Services of Supply setup led the theater surgeon to activate the headquarters of six "hospital centers" in late 1944 and early 1945 at bases in New Guinea and the Philippines. The table of organization for headquarters of the hospital center amounted to 8 officers (including a lieutenant of the Army Nurse Corps), 1 warrant officer, and 23 enlisted men. Hospital centers were not needed in the Southwest Pacific Area. In contrast to the situation in the European theater, fixed hospitals were located in close proximity to the base headquarters rather than at various sites within a large base section. Moreover, general hospitals did not usually remain for any length of time at a single location in the Southwest Pacific Area (most of the bases being of short-range value); hence the specialization in handling certain types of cases which administration under fully developed hospital centers would have fostered was never feasible at the New Guinea and Philippine bases. The table of organization for the headquarters of hospital centers served, however, to give the theater surgeon a number of additional positions, some carrying advanced rank, to which he could assign Medical Department officers. For the most part, such personnel did not perform the duties of the positions to which they were assigned but the duties of the staff of a base surgeon's office. Most of the officers and a good many of the enlisted men assigned to the so-called "hospital centers" were placed on detached service or temporary duty with the base surgeon's office. In a good many instances, the officers had already been serving for some time as base surgeons or in the base surgeon's office. They were then assigned to the centers, being promoted to the next higher rank, but placed on detached service in their former positions. In the case of three or four of the "hospital centers," a small portion of the assigned staff did perform a few of the duties—such as the operation of a pool of vehicles and a postal service—for the hospitals assigned to the center, but under the circumstances which prevailed in the Southwest Pacific Area such services could be more advantageously performed by the base surgeon's office for all installations located at the base. Although it was expected that the headquarters of hospital centers in the Philippines, transferred in some cases from New Guinea with a fairly complete roster of personnel, would administer the large network of hospitals designed to take care of evacuees from the invasion of Japan, as matters turned out they were never called on to do so. The headquarters of hospital centers served, therefore, the primary purpose, important to the theater surgeon, of augmenting the staffs of base surgeons.[13]

[13] (1) Letter, Chief Surgeon, U.S. Army Services of Supply, to Lt. Col. Lamar C. Bevil, MC, Office of The Surgeon General, 16 Oct. 1944. (2) Deputy Chief Surgeon, to Chief Supply Officer, Advance Echelon, Services of Supply, 22 Dec. 1944. (3) Quarterly Reports, 25th, 26th, 27th, 29th, 30th, and 31st Hospital Centers, 1945.

The lack of an efficient medical supply system, together with acute shortages prevailing in some areas, especially during the early days of heavy combat on Leyte, was considered by the Voorhees mission a serious defect in medical administration in the Southwest Pacific Area. A basic cause, the mission found, was the prevailing practice of requisitioning on a theaterwide basis. Since command was highly decentralized and depots in New Guinea and the Philippines were spread over a distance of 2,500 miles, direct requisitioning on San Francisco by a particular base would have been more efficient. Moreover, medical supplies for the Philippines might come in at any point in the theater. They were moved from base to base chiefly by water, and many difficulties had to be overcome before hospitals and dispensaries could receive medical supplies: an uncharted coast, congested ports, inadequate facilities for overland transport, and heat and humidity which hampered movement and caused swift deterioration of items and containers. The mission failed to establish in the Southwest Pacific Area, as well as in the Pacific Ocean Areas, any coordinated and workable system of medical supply for future operations. Its major contributions were certain measures which it advocated to meet the heavy demands for troops on Leyte, and its recommendations as to individuals to fill certain medical supply posts.[14]

In early 1945, The Surgeon General and his Deputy Chief of Plans and Operations, Col. Arthur B. Welsh, MC, visited the Southwest Pacific Area and inquired into the status of medical service in Australia, at several New Guinea bases, and on Leyte. At that date the Surgeon, U.S. Army Forces in the Far East and U.S. Army Services of Supply, as well as the Surgeon, Eighth U.S. Army, and the surgeon with G–4 of General Headquarters, were on Leyte. Col. Maurice C. Pincoffs, MC, and the consultants were on Luzon. Back in Hollandia were the rear echelons of the theater command and the Services of Supply and their medical sections.

Colonel Welsh was "not particularly impressed with the theater organization from the medical viewpoint." He observed failure on the part of the theater command to consult General Denit on theaterwide medical problems and noted conflicting claims by General Denit and the medical officer at G–4, USAFFE, as to responsibility for medical planning for combat operations. Lacking knowledge of the plans of the Pacific Ocean Areas command for future operations, medical officers in the Southwest Pacific Area found it difficult to arrange for the transfer of excess medical units from the South Pacific Base Command to the Southwest Pacific Area. Colonel Welsh stressed the need for organizing Army troops in the Pacific into a single theater. The Surgeon General reported to General Somervell that the theater surgeon lacked sufficient officers of high grades to staff his own office and those of the surgeons of base sections and other headquarters. Many hospital staff officers in the Southwest Pacific Area had been removed

[14] (1) See footnote 2(3) and (4), p. 454.

to fill administrative positions at various headquarters or had been used in dual assignments; the morale of hospital staffs had been weakened and hospital administration had been crippled.[15]

Armies and Air Forces in New Guinea and the Philippines

By September 1944, major combat forces with surgeons' offices in the Southwest Pacific Area were the Sixth and Eighth U.S. Armies, the 14th Antiaircraft Command, and the Far East Air Forces, which included the Fifth and Thirteenth Air Forces. At this time the Sixth U.S. Army surgeon's office was at Hollandia, New Guinea (where most of the staff medical sections of top commands were congregated late in the year); it was occupied with planning the medical aspects of the coming campaigns on Leyte and Luzon. As of 1 October, shortly before Sixth U.S. Army headquarters took the field, the office of its surgeon, Col. (later Brig. Gen.) William A. Hagins, MC, was composed of 22 Medical Department officers, including, in addition to dental and veterinary officers, officers assigned to inspection, supply, statistics, and operations, as well as 3 malariologists. The staff varied little in number during the Philippine campaigns (although there were many changes in personnel), but a surgical consultant was added late in 1944, and a medical and an orthopedic consultant from the Services of Supply headquarters served for a time on temporary duty. No neuropsychiatric consultant was assigned to the office of the Sixth U.S. Army surgeon during the campaigns on Leyte and Luzon until early June 1945 when the fighting was practically over; hence policy in the handling of psychiatric cases was not issued from the army level but remained a matter for determination by divisional neuropsychiatric consultants.

The Sixth U.S. Army included several corps during its Philippine campaign. The corps surgeon's office typically included two or three Medical Corps officers, two Medical Administrative Corps officers, and a few enlisted men. Besides the customary duties, the corps surgeon in the Southwest Pacific Area had to make frequent trips by air to divisional staging areas on scattered islands to determine the readiness of Medical Department units of the various divisions for combat. To inspect medical units preparing for the invasion of Mindanao, for example, the Surgeon, X Corps, visited, in addition to the Leyte staging area controlled by X Corps, the staging area of the 24th Infantry Division on Mindoro, and that of the 31st Infantry Division on Morotai. After a trip to Davao in the 24th Division staging area on 1 June 1945, he was missing in action. Apparently his plane had been shot down after one of his customary low-level reconnaissance flights over the frontlines to view the terrain preparatory to planning the advance of field medical units into enemy territory.

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[15] (1) See footnotes 4(4), p. 457; and 8(1), p. 461. (2) Interview, Dr. Maurice C. Pincoffs, 22 May 1952.

For the Leyte and Luzon invasions the Sixth U.S. Army had attached to it an "army service command," consisting of troops from the Services of Supply, which was to found bases when the landing forces were firmly established. These service troops included the medical sections for Base K established on Leyte and Base M established on Luzon. After the Leyte landings in mid-October, the Sixth U.S. Army surgeon's office worked at several locations on the island; with the move of Sixth U.S. Army to Luzon early in 1945 it made similar rapid moves.[16]

Eighth U.S. Army headquarters arrived in New Guinea in September 1944, taking over control of combat units in Netherlands New Guinea, the Admiralty Islands, and Morotai from the Sixth U.S. Army. Col. George W. Rice, MC (promoted to brigadier general in June 1945), shortly became Eighth U.S. Army surgeon, replacing Colonel Bohlender, the original surgeon who had arrived in Hollandia with the advance echelon of the headquarters. In October 1944, Colonel Rice had on his staff a medical consultant, a surgical consultant, a neuropsychiatric consultant, a preventive medicine officer, a dental officer, and a veterinarian. Surgeons were assigned at that date to the following units of the Eighth U.S. Army: I Corps, XI Corps, and eight infantry divisions (the 6th, 31st, 33d, 38th, 40th, 41st, 43d, and 93d).

Eighth U.S. Army followed Sixth U.S. Army from New Guinea into Leyte and later carried out the amphibious operations in the southern Philippine Islands, Mindanao, and the central Visayas (as well as two operations on Luzon), while Sixth U.S. Army went on to the main invasion of Luzon. The medical section of Eighth U.S. Army shifted from Hollandia to Leyte in three echelons during the period from November 1944 to January 1945, leaving an officer and two enlisted men in Hollandia to follow them later in January. During the first half of 1945, the army medical section drew up plans for coming operations in the archipelago, inspected the training and supply of units, and supervised the medical service in the forward areas of the army in the central and southern Philippines—Leyte-Samar, Cebu, Negros, Panay, Mindoro, Palawan, and Mindanao and the Zamboanga Peninsula—and in its rear areas in New Guinea. It kept in close touch with medical service of the Sixth U.S. Army in Luzon.[17]

A major ground force command in addition to the Sixth and Eighth U.S. Armies was the 14th Antiaircraft Command, which had been activated at Brisbane in November 1943. A staff surgeon's office was set up for the command in March 1944. At first distributed over Australia and New Guinea, antiair-

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[16] (1) Quarterly Reports, Surgeon, X Corps, 3d and 4th quarters, 1944, and 1st quarter, 1945. (2) Quarterly Reports, Surgeon, I Corps, 1944 and 1945. (3) Quarterly Reports, Surgeon, XIV Corps, 4th quarter, 1944, and 1st quarter, 1945. (4) Report of Operations in the Luzon Campaign, 9 Jan. 1945–30 June 1945, Sixth U.S. Army. (5) Quarterly Reports, Surgeon, Sixth U.S. Army, 1st and 2d quarters, 1945. (6) Quarterly Reports, Surgeon, XXIV Corps, 2d, 3d, and 4th quarters, 1944.

[17] (1) Quarterly Reports, Surgeon, Eighth U.S. Army, 2d, 3d, 4th quarters, 1944, 1st and 2d quarters, 1945. (2) See footnote 11(4), p. 468.

craft troops later spread to islands north of New Guinea and then into the Philippines. In the middle of 1944, only about half of the approximately 50,000 troops of the command were under its direct control, the rest being under the administrative as well as operational control of Sixth U.S. Army and XIV Corps. In the fall of 1944, the surgeon's office was still in Brisbane, although his malariologist maintained an office at the command's advance echelon in Finschhafen in order to indoctrinate units in malaria control. The scattered character of the command and the attachment of a goodly portion of its units to other commands created some obstacles to centralized control of its medical service. The surgeon's office found it difficult to estimate the medical personnel needed by the antiaircraft units attached to other commands and to obtain statistics on their disease rates as well as to supervise the work done by the medical detachments of the scattered units.[18]

The medical section of the highest headquarters of the Army Air Forces in the Southwest Pacific Area, the Far East Air Forces, was at Hollandia, New Guinea (Base G), in the fall of 1944. It coordinated the medical activities of its two major components, the Fifth and Thirteenth Air Forces; air force elements were scattered over Australia and New Guinea and later the Philippines. In November the medical section transferred with Headquarters, Far East Air Forces, to the Philippines and by the end of March 1945 was near Tolosa on the Gulf of Leyte. Headed by Col. Robert K. Simpson, MC, it contained only about half a dozen medical officers. The strength of the Far East Air Forces varied from about 135,000 to about 145,000 from the fall of 1944 to the spring of 1945.

An attempt was made to develop the central medical establishment for use in the Southwest Pacific Area. One had been organized at Guadalcanal in June 1944 as a unit of the Thirteenth Air Force, evolving concurrently with the central medical establishments for the Eighth and Ninth Air Forces in Europe. The establishment set up in the Thirteenth Air Force in the South Pacific Area grew out of the work of examination and disposal of flying personnel by flight surgeons which had been originally done in the Auckland rest area of New Zealand and later at a screening center established on Guadalcanal in April 1944.

The Second Central Medical Establishment, organized originally with 10 officers and 25 enlisted men, was not very active during its early months at Guadalcanal. In September 1944, after the transfer of the Thirteenth Air Force to the Southwest Pacific Area, this unit was assigned to the Far East Air Forces and in November to the Far East Air Forces Combat Replacement and Training Center at Nadzab, New Guinea. Plans were made for a research section to study factors affecting the health and safety of flying personnel and

[18] Quarterly Reports, Medical Department Activities, 14th Antiaircraft Command, Jan. 1944–June 1945.

the methods and equipment to aid them to survive in cases of crashes over sea and jungle areas. The establishment was also to include a screening center to examine flying personnel before granting them leave, a central medical board to review the status of individuals whose physical or mental fitness for flying was in doubt, an aircrew indoctrination section, and a rehabilitation section. Not all of these units ever developed, nor did some others which were proposed. Frequent changes in location of the central medical establishment, the separation of some of its elements from each other, the scattering of air force units in many locations, and the interference of theater organization apparently prevented its progress along the lines that Medical Department officers in the Far East Air Forces and the Office of the Air Surgeon would have liked. Moreover, the end of the war removed any need for it and for two more such establishments requested for the Far East Air Forces.[19]

The Air Surgeon (Maj. Gen. David N. W. Grant) accompanied by the Surgeon, Far East Air Forces, and the Surgeon, Army Air Forces, Pacific Ocean Areas, visited air force units on New Guinea, the Philippines, and various islands in November 1944. General Grant attempted to enlarge the medical service within the Far East Air Forces by advocating a large increase in personnel—the addition of 61 medical officers and 80 dental officers—and other measures. He declared that doctors in the theater Services of Supply organization did not understand the "highstrung, sensitive mechanism" of aviators; only flight surgeons could keep aviators in flying condition. General Grant stressed the need for central medical establishments to classify and dispose of flying personnel discharged by the general hospitals. He also urged the desirability of direct control of general hospitals by the Far East Air Forces, pointing out that a precedent for such control had already been established in the Mediterranean theater.

Although his recommendations were largely sustained by the Far East Air Forces, both the theater medical staff and the Chief Surgeon, USASOS (General Denit), were unalterably opposed to control of hospitals by the air forces. The U.S. Army Services of Supply continued to control the fixed hospitals of the Southwest Pacific Area; the air forces in the area (and in the South Pacific) were restricted to control of 25-bed portable surgical hospitals assigned to them, and hospitals, termed dispensaries, operated by the XXI Bomber Command. The assignment of a flight surgeon to General Carroll's office as a liaison officer from the Far East Air Forces proved helpful in convincing medical officers of the latter headquarters that the staff of the Services

[19] (1) See footnote 2(2), p. 454. (2) Memorandum, Commanding Officer, 2d Central Medical Establishment, Special, for Chief Surgeon, Headquarters, U.S. Army Forces in the Western Pacific, 25 July 1945, subject: Location of Medical Installations. (3) Quarterly Reports, Medical Department Activities, 2d Central Medical Establishment, Special, covering period, 5 June 1944–31 Dec. 1945. (4) 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, pp. 751–756.

of Supply medical section understood the "peculiar and highly sensitive characteristics of Air Corps personnel." [20]

Base Sections and Bases: Australia, New Guinea, and the Philippines

In the latter part of 1944, the area organization of the U.S. Army Services of Supply in Australia was declining, while it was still building up in New Guinea and just getting underway in the Philippines. Base Section, USASOS, established in June 1944 with headquarters at Brisbane, administered Army medical service for all troops in Australia with only three area subcommands—Bases 2, 3 (later absorbed by the base section), and 7 at Townsville, Brisbane, and Sydney, respectively. In the fall of 1944 this medical office consisted of eight officers, including a veterinary consultant, a dental consultant, and a nutrition consultant, four enlisted men, and six civilians. Since war had moved far away from Australia, Medical Department officers stationed there were able to give more time and effort to acquainting themselves with recent developments in medical and dental techniques; in 1944 a number of interallied dental meetings and conferences took place. Liaison with local Australian authorities continued in connection with the program for control of venereal disease, food inspection, and the maintenance of adequate nutritional standards, as well as with respect to medical service provided for Australian civilians employed by the U.S. Army. At the end of 1944, one general and three station hospitals sufficed to care for troops remaining in Australia. After further retrenchment, including consolidation of Army and Navy medical facilities, in the first 6 months of 1945, less than half a dozen officers and a few enlisted men and Australian civilians comprised the medical section of Australian Base Section.[21]

In the fall of 1944 Intermediate Section, with headquarters at Oro Bay, controlled all seven New Guinea bases (including the last one, Base H, established on Biak Island). During that period the chiefs of technical services at the New Guinea bases were given command control of the installations maintained by their services. The base surgeon was thus placed in actual command of medical units, hospitals, and other medical installations at the base.[22] As in the case of the Central Pacific Base Command, the surgeon re-

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[20] (1) Letter, The Surgeon General, to Chief Surgeon, U.S. Army Services of Supply, 28 Nov. 1944. (2) Letters, Chief Surgeon, U.S. Army Services of Supply, to The Surgeon General, 7 and 8 Dec. 1944. (3) Memorandum, the Air Surgeon for Commanding General, Army Air Forces, 23 Nov. 1944, subject: Reports on Special Mission. (4) See footnote 2(2), p. 454. (5) Quarterly Reports, Medical Department Activities, Headquarters, Far East Air Force, 3d and 4th quarters, 1944, and 1st and 2d quarters, 1945. (6) Letter, Chief Surgeon, U.S. Army Services of Supply, to The Surgeon General, 18 Nov. 1944.

[21] (1) Quarterly Reports, Medical Department Activities, Base Section, U.S. Army Services of Supply, 3d and 4th quarters, 1944, 1st quarter, 1945. (2) Quarterly Report, Medical Department Activities, Australian Base Section, U.S. Army Forces in the Western Pacific, 3d quarter, 1945. (3) See footnote 11(4), p. 468.

[22] Letter, Surgeon, Intermediate Section, to Chief Surgeon, U.S. Army Services of Supply, 2 Sept. 1944.

ceived the full control over the medical resources of the command which staff surgeons invariably welcomed.

By the end of 1944 several New Guinea bases, especially those at Milne Bay, Port Moresby, and Lae, had declined markedly in importance. Base G at Hollandia, on the other hand, was receiving a large share of the evacuees from the Philippines. The base at Biak (Base H) was also getting many casualties and was the point of departure for air evacuation to the United States. In February 1945, when the Services of Supply was building up its bases in the Philippines, all seven New Guinea bases were placed under the newly established New Guinea Base Section (successor to Intermediate Section) with headquarters at Oro Bay. Although the New Guinea Base Section surgeon originally had a full complement of staff officers, before the end of March a number of the members of his medical section were sent forward to bases in the Philippines.[23]

The original bases in the Philippines were developed by the Army Service Command which accompanied Sixth U.S. Army and established the Services of Supply bases in the wake of the army. At Hollandia in the fall of 1944 it assembled the nucleus organization, including medical sections, of the two bases initially established in the Philippines, Base K at Tacloban, Leyte, and Base M, originally at San Fabian, Luzon (January–April 1945), and finally at San Fernando, Luzon. Army Service Command moved to Leyte in the late fall of 1944 and put together at Tacloban the organization for two additional bases of minor importance, Base R which was to be at Batangas on Luzon and Base S to be on Cebu. Early in 1945, Army Service Command moved on to Luzon where, renamed Luzon Base Section, it reverted to the control of the Services of Supply and directed the activities of Base M and three subbases.

The medical organization of the bases established in the Philippines was largely a repetition of that of the New Guinea bases, although the medical section that entered a Philippine base was usually more nearly full fledged than the usual office which had had to tackle the initial medical job at a New Guinea location. The San Fernando Base (Base M), for example, had about 25 Medical Department officers assigned to it from the outset. Besides the base surgeon and the usual dental officer, veterinarian, and medical supply officer, the Philippine bases had in their initial setup certain medical assignments which some of the New Guinea bases (or, at least, those earliest established) had not received until they had been in existence for some months: A malariologist, a port surgeon, an area command surgeon, a hospitalization officer, an evacuation officer, and a personnel officer. The assignment of one or more venereal disease control officers to the Philippine bases from the out-

[23] (1) Quarterly Reports, Medical Department Activities, various New Guinea bases, 3d and 4th quarters, 1944, and 1st and 2d quarters, 1945. (2) Quarterly Report, Medical Department Activities, Intermediate Section, U.S. Army Services of Supply, 3d and 4th quarters, 1944. (3) See footnote 11(4), p. 468.

set betokens the Medical Department's memory of the high venereal disease rates that had prevailed among U.S. Army troops in the Philippines before the war. An early attempt was made to sponsor measures, including the adoption of special local legislation, which had been found effective in coping with the problem in Australia.[24]

Several Medical Department officers present in the early days of the Leyte invasion left a graphic picture of the geographic, climatic, and administrative obstacles which they encountered in getting the medical service of Base K into running order. Like the other Army logistic officers, they encountered the adverse weather and terrain which Sixth U.S. Army engineers had prophesied would make the founding of a base in Leyte Valley a difficult undertaking. On the 13th day of the invasion, the Base K surgeon, Lt. Col. Paul O. Wells, MC (fig. 110), reported:

> Have been in this base for 8 days and have spent most of that time on reconnaissance. I am sorry to have to report that it is the most undesirable terrain on which to build a base that I have ever seen * * *. Every service is scrambling for suitable area and it is not to be had. I would estimate that only 5–10% of the land can be used for dumps or any other installation. The remainder is swamp and rice paddy * * *. There are some optimists who think that they can hang hospitals on these hill sides but I am convinced that they cannot do so without the use of more earth moving equipment than the engineers can make available for hospital construction * * *.
>
> The civilian population here is in good shape with 3 months supply of looted rice and two hospitals running with native doctors. The civilian situation around Dulag is bad since the town and adjacent district was destroyed and there are several thousand huddled on the beach without much food and no shelter or medical care. The PCAU [Philippine Civil Affairs] units were swamped and have called for help. Sent one doctor down and they have been given Jap medical supplies. Have no other supplies of my own as yet so have to refer them to 6th Army. Col. Hagen [Hagins, Sixth U.S. Army Surgeon?] will give them help as the military needs will permit. Wish I could do more.[25]

Within a few days, Colonel Wells had been able to survey much more desirable valley terrain around Burauen but could not locate his hospitals there as it was necessary to place them close to other base installations near the port of Tacloban. On 22 November he recounted additional difficulties.

> Jap bombing has slacked off considerably though we have had a number of planes crash dive on ships with heavy casualties in some cases. * * * the ship on which the 101st and 91st Station Hospitals were located was one of the victims. They lost a total of 4 killed, 4 missing and 6 injured at latest report. * * * I continue to have serious difficulties in retaining suitable sites for hospitals. Have been allocated and subsequently lost a majority of the desirable area in the base. The latest happened today when I lost the site of my convalescent hospital to an air strip (They have had to give up on one of the strips because of the mud, etc.) and the site of a 500 bed station to an ordnance dump! * * *

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[24] (1) Historical Record of Army Service Command, 23 July 1944 to 13 February 1945 (M–1 Operation). [Official record.] (2) Quarterly Reports, Medical Department Activities, Bases K and M, 4th quarter, 1944, 1st quarter, 1945. (3) Krueger, Walter: From Down Under to Nippon. Washington: Combat Forces Press, 1953, p. 353. (4) See footnote 12(1), p. 469.

[25] (1) Cannon, M. Hamlin: Leyte: The Return to the Philippines. United States Army in World War II. Washington: U.S. Government Printing Office, 1954, ch. XI. (2) Letter, Lt. Col. Paul O. Wells, MC, to Brig. Gen. Guy B. Denit, 1 Nov. 1944.

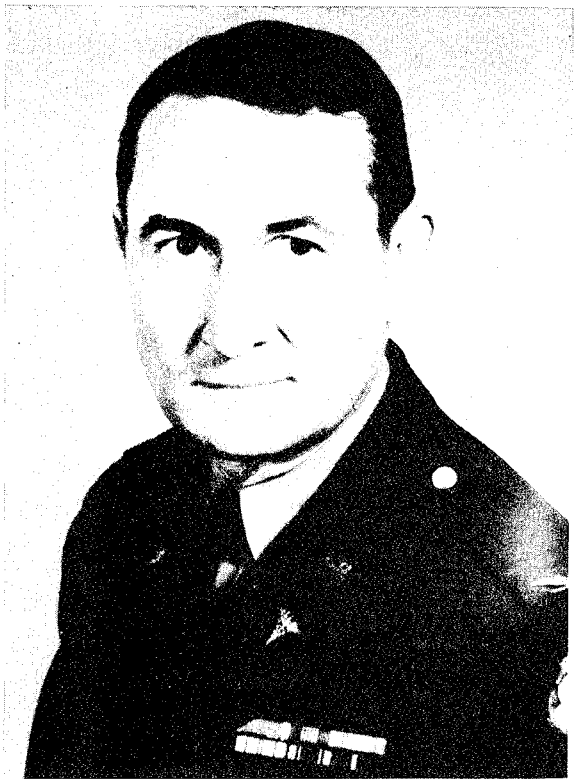


FIGURE 110.—Col. Paul O. Wells, MC.

The need for beds is critical with only about 150 vacant beds in the base. Had a conference with Colonel Hogan [Hagins?] today and he wanted to know how many beds I could provide in 48 hours. I told him none unless he could get the hospital equipment unloaded from the ships and some engineer effort on hospital construction. Sixth Army is still in control here and sets all priorities on unloading and engineer effort. He stated that he was presenting the facts to the Chief of Staff this afternoon and insisting on immediate action. He was very critical of the 6th Army Engineer.

We have had two mild typhoons and one other alarm. Have kept my hospitals back a distance from the open beach in anticipation of possible big blows from the open sea. Couldn't have gotten them on the beach anyway in view of the number of headquarters arriving here.[26]

As late as 9 January 1945, a Medical Corps officer with Advance Headquarters, USASOS, corroborated Colonel Wells' account of his difficulties.

From the planning stage we have progressed to the construction and development era. * * * To be frank with you, we love it. We always work best with our feet on terra firma and canvas overhead. * * * in fact we are very well pleased with the cooperation we have received from everyone. We are doing our damnedest to help, but we feel that it will take an act of God to correct the deficiencies present in this Base. We do not understand how Colonel Wells has been able to remain a sane person after what he has gone through.

[26] Letter, Lt. Col. Paul O. Wells, MC, to Brig. Gen. Guy B. Denit, 22 Nov. 1944.

He has had to deal with Sixth Army, GHQ, ASCOM, USAFFE, USASOS, ADSOS, Base "K," Leyte Engineer Command, Eighth Army, XXIV Corps, Philippine Civil Affairs Units, and other agencies too numerous to mention.

Colonel Voorhees noted extreme confusion with respect to the channels of medical supply as well:

> The red tape passed any belief. Even a radio requisition had to go from the medical supply officer to the Base Headquarters, from Base Headquarters to Advance [should be "Army"] Service Command Headquarters (known as ASCOM1; I felt that the accent should be strongly on the first syllable), from there to Sixth Army Headquarters, from there to USASOS Headquarters at Hollandia, and from there to Intermediate Section 1,000 miles farther away at Oro Bay.

This was, of course, an extreme situation which developed in the course of establishing, during heavy combat, a large new base at the end of an extended supply line. But similar difficulties, though in less severe form, attended the early stages in developing medical service at other bases in the Philippines.[27]

Public Health in the Philippines

The Philippine Islands were the major region of the Southwest Pacific Area where U.S. Army doctors had responsibility for reestablishing public health services for a people formerly under enemy domination.[28] Effective health measures in these island possessions after more than 2 years of Japanese domination would contribute significantly to the regeneration of American prestige. The civil affairs program in the Philippines was a wholly unilateral operation of the United States, and the U.S. Army planned as well as administered it. Hence policy and top direction of the program stemmed from a staff section created at the top U.S. Army headquarters—Headquarters, U.S. Army in the Far East—in November 1944. The Civil Affairs Section, USAFFE, which had general responsibilities for coordinating all matters of civil administration until responsible government could once again be established throughout the archipelago, had the specific responsibility for planning and supervising health and sanitary measures. Other tasks which it undertook, such as the restoration of destroyed or damaged public utilities, were, as elsewhere, closely related to the public health program. Colonel Smith, recently theater malariologist, was put in charge of the small medical section. As in other theaters, a similar medical section was created in G–5 at lower levels of command, both area and tactical.

A Civil Affairs Detachment was formed at Headquarters, USAFFE, to develop Philippine Civil Affairs Units. The first eight such units to be created, made up largely of personnel from the First Filipino Regiment and

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[27] (1) Letter, Maj. U.S. Steinberg, to Col. R. O. Dart, MC, 9 Jan. 1945. (2) See footnote 2(3) and (4), p. 454. (3) Letter, Lt. Col. David A. Chambers, MC, to Brig. Gen. Guy B. Denit, 28 Dec. 1944. (4) Engineers of the Southwest Pacific, 1941–1945, vol. VI; Airfield and Base Developments. Washington: U.S. Government Printing Office, 1951, pp. 311-312.

[28] Civil Affairs in New Guinea, New Britain, and the Admiralties had been handled by the Australian-New Guinea Administration Unit (ANGAU).

the Second Filipino Battalion of the U.S. Army, were trained by this detachment at Oro Bay, New Guinea.[29] Eventually 30 units were developed, all being used during the campaign for the Philippines. One of the 10 officers in each unit was a medical officer, and 4 or 5 of the 39 enlisted men had medical duties. Many of the personnel, particularly the officers, had received training at the civil affairs training schools in the United States. The civil affairs units were attached to army commands (the Sixth and Eighth U.S. Armies) at the army, corps, or division level or to base commands. Eventually they worked in every province of the archipelago.

In the early stages of a campaign, Philippine Civil Affairs Units were usually allocated to the division or corps. When Sixth U.S. Army went into the Leyte campaign, for example, two Philippine Civil Affairs Units were attached to X Corps, two to XXIV Corps, two to the Army Service Command, while two were kept in reserve under Sixth U.S. Army control. Initially the units were further attached by corps headquarters to the divisions. Services which their personnel could perform at the corps or division level in the initial stages of a campaign included giving initial care to wounded and sick refugees in Army hospital units, salvaging Japanese medical supplies for use among Filipino civilians, hunting out civilian doctors, and establishing dispensaries and some hospitals for civilians. The successive phases of divisional, corps, and Army control of civil affairs units passed quickly, of course. In Tacloban, for example, responsibility for civil affairs passed from divisional to Sixth U.S. Army control late in October 1944, and Base K relieved X Corps of responsibility in Leyte Valley on 1 January 1945. The greatest difficulty encountered by medical officers assigned to the units was a lack of medical supplies for civilian use. Shortages were due, as were shortages of relief supplies in general, to shipping shortages and the inadequate capacities of ports. As in other areas it was necessary to divert to civilian use medical stores intended for troops.

The largest task of restoring normal health facilities lay in Manila, where widespread destruction in the wake of prolonged street-to-street combat intensified health problems. The rapid rehabilitation of Manila was important not solely because it was the capital and the key city for economic renaissance of the Philippines. At that date it was considered vital to supply lines for an invasion of Japan, and for a few months the U.S. Army had the additional motive of self-interest in reestablishing good health conditions and preventing epidemics in the city.

Eight Philippine Civil Affairs Units accompanied XIV Corps as it fought its way into Manila in February 1945. One entered the burning city on 5 February, 2 days after the first troops went in. Reports of widespread disease, starvation, and death reached the advance echelon of General Headquarters

[29] The Civil Affairs Detachment, U.S. Army Forces in the Far East, corresponded to the European Civil Affairs Division, the training entity of the European theater, while the Philippine Civil Affairs Units were similar to units which performed the fieldwork in the European theater.

located north of Manila. Colonel Pincoffs, Chief Medical Consultant, USAFFE, was sent forward with other officers to survey the city and found a complete breakdown of water, sewage, lighting, telephone, and transportation systems. Those civilian hospitals still in operation were overcrowded with wounded citizens and lacked medical supplies, as well as food, water, and light. Bodies were "stacked like cordwood" in the morgues; many lay in the streets. No organized medical service existed; the central office of the Manila Department of Health had been abandoned and three Government hospitals were the only elements of the city health service in operation. The civil affairs units were attempting, with the aid of the Surgeon, XIV Corps, who had his own wounded to care for, to distribute food and medical supplies to the population.

Colonel Pincoffs recommended the establishment of a provisional Department of Health and Welfare under American auspices and outlined the needs in Medical Department officers and units. Near the end of February, President Sergio Osmena asked General MacArthur to appoint a U.S. Army officer to take charge of the task of reestablishing the Manila Department of Health and Welfare. A provisional department was created at the beginning of March when Headquarters, USAFFE, took over direct control of civil affairs in Manila from Sixth U.S. Army. Colonel Pincoffs was attached to the Civil Affairs Section, USAFFE, and made Director of Health and Welfare of Greater Manila, with responsibility for administering a citywide public health program. He remained in charge of this office, located at the San Lazaro Contagious Disease Hospital, until May. With the aid of American Army doctors, the Philippine Civil Affairs Units, and Filipino physicians, he set about the task of getting citywide reports on communicable diseases as a preliminary measure toward checking incipient epidemics. Cholera, smallpox, and plague were the three diseases most dreaded by the civilian population. Many cases of tuberculosis were discovered. Diarrhea, dysentery, and the venereal diseases were the maladies which occurred with the greatest frequency during the early months.

Manila was divided into eight districts, in each of which operated a civil affairs unit, which was attached to Headquarters, USAFFE, and supervised by the latter's civil affairs section. The medical officer of each unit was made the district health officer, and his office obtained and forwarded to the San Lazaro headquarters the daily reports on cases of communicable diseases at the civilian hospitals. Later an epidemiologist was assigned to each health district and a clinical consultant to the San Lazaro headquarters. The latter checked for undetected cases of disease at hospitals throughout the city. The development of a statistics section at the headquarters, the reestablishment of requirements for the issuance of death certificates, and the restriction of burial to cemeteries run by the provisional health department were additional steps taken to reestablish normal controls over information on the incidence of communicable diseases.

The Division of Sanitation of Colonel Pincoffs' department, run by Col. Gottlieb L. Orth, MC, checked all water points for contamination during a 3 months' period while the Japanese kept Manila on short water rations by holding the major water reservoir in the mountains. Its chief job, however, was to clean up the city, a task carried out in each of the eight city health districts by a malaria control unit, now called a "sanitary group." The first and worst of the unorthodox tasks which the sanitary groups had to perform in Manila was the burial of thousands of dead. Other jobs were the cleaning of the city block by block, the restoration of public and private facilities for the disposal of sewage and garbage, as well as the abattoirs, and the inspection of public eating and drinking places. Colonel Orth's staff and the district sanitary groups also tackled the task of insect and rodent control, maintaining flycatching stations which checked on the results of regular spraying of Manila with DDT by planes of the Far East Air Force.

The period of control of the Manila public health service by Headquarters, U.S. Army Forces in the Far East, and its successor, U.S. Army Forces, Pacific, ended on 1 August 1945. Preceding months witnessed a gradual, well-planned transfer of control from the Army to the civilian authorities of Manila. The Philippine Civil Affairs Units were withdrawn from the city during April and May, being replaced by similar units provided by the Philippine Government. Civilian district health officers were chosen, but Sanitary Corps officers assigned to the districts continued to aid with the collection of reports on communicable diseases, the distribution of medical supplies, and the sanitary inspections of civilian hospitals and refugee centers. On 1 August the Army turned over the Department of Health, now staffed by Filipino civilians, to the Philippine Government.[30]

Thus Army tactical elements and then U.S. Army Forces in the Far East exercised successively the major responsibility for reestablishing a public medical program in the Philippines. Apparently the intent of Headquarters, USAFFE, was that the tactical commander should retain responsibility for all civil administration and relief until the theater headquarters of the Philippine Government should assume it.[31] The Services of Supply and its elements had little responsibility. However, the base surgeons were called upon to furnish

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[30] (1) Pincoffs, M. C.: Health Problems in Manila. Transactions, American Clinical and Climatological Association, vol. LVIII, 1947. (2) History of U.S. Army Forces in the Far East, 1943–1945. [Official record, Office of the Chief of Military History.] (3) Letter, Surgeon, U.S. Army Forces in the Far East, to The Surgeon General, 23 Mar. 1945. (4) Report of Civil Affairs Operation on Leyte-Samar by Chief of Civil Affairs, Headquarters, Sixth U.S. Army, 4 March 1945. (5) Memorandum, Col. M. C. Pincoffs, MC, for Commanding General, U.S. Army Forces in the Far East, 17 Feb. 1945, subject: Report on Civilian Health and Welfare in Manila in Relation to Disease Control and Care of Battle Casualties. (6) Interview, Col. Maurice C. Pincoffs, MC, 22 May 1952. (7) Letter, Col. Maurice C. Pincoffs, MC, to Brig. Gen. Guy B. Denit, 20 June 1945. (8) Letter, Col. Maurice C. Pincoffs, MC, to Col. John Boyd Coates, Jr., MC, USA, Director, The Historical Unit, U.S. Army Medical Service, 1 Sept. 1955.

[31] In some areas of the Philippines responsibility for civil affairs passed from Army control (with more responsibility shared by the base) directly to the Commonwealth Government, without an interim period of control by theater headquarters.

medical supplies for civilian relief. In Base K, the base surgeon set aside two small station hospitals for the care of civilians. Moreover, in performing the base surgeon's usual duties in the control of venereal disease and the prevention of malaria and other insectborne diseases—for example, the spraying of entire towns in the base section with DDT—the base surgeon contributed to the protection of civilian health.[32]

DEVELOPMENTS AFTER APRIL 1945: THE PACIFIC THEATER

In April 1945 General MacArthur, while retaining his Allied command unchanged, was made Commander in Chief of AFPAC (U.S. Army Forces, Pacific). For the first time U.S. Army forces in the Pacific (with the exception of the Twentieth Air Force and troops assigned to the North Pacific Area) were placed under a single command to constitute one Army theater of operations for the entire Pacific. The two major area commands under AFPAC were the U.S. Army Forces in the Far East and the U.S. Army Forces, Pacific Ocean Areas. In June, the former command was absorbed by the U.S. Army Forces, Western Pacific, and the latter was superseded by the U.S. Army Forces, Middle Pacific, consisting of Hawaii and other islands.

Surgeon, U.S. Army Forces, Pacific, and Subordinate Medical Elements

U.S. Army Forces, Pacific, had no surgeon until June 1945. At that time Brig. Gen. Guy B. Denit (who had acted in the dual assignment of Chief Surgeon, U.S. Army Forces in the Far East, and Chief Surgeon, U.S. Army Services of Supply) was made Chief Surgeon, General Headquarters, U.S. Army Forces, Pacific. In his new assignment he headed an office which exercised general technical supervision over the medical service within all the following major commands under the U.S. Army Forces, Pacific: U.S. Army Forces, Western Pacific (which took over the former functions of both USAFFE and USASOS) and U.S. Army Forces, Middle Pacific, which were the two main territorial commands (map 10); the Far East Air Forces; the Sixth U.S. Army; and the Eighth U.S. Army. At the close of June 1945, Army strength in the Southwest Pacific Area totaled 866,214 and Medical Department strength 69,665. General Denit served additionally as Surgeon, U.S. Army Forces, Western Pacific, until August, when a separate surgeon was appointed for that command.

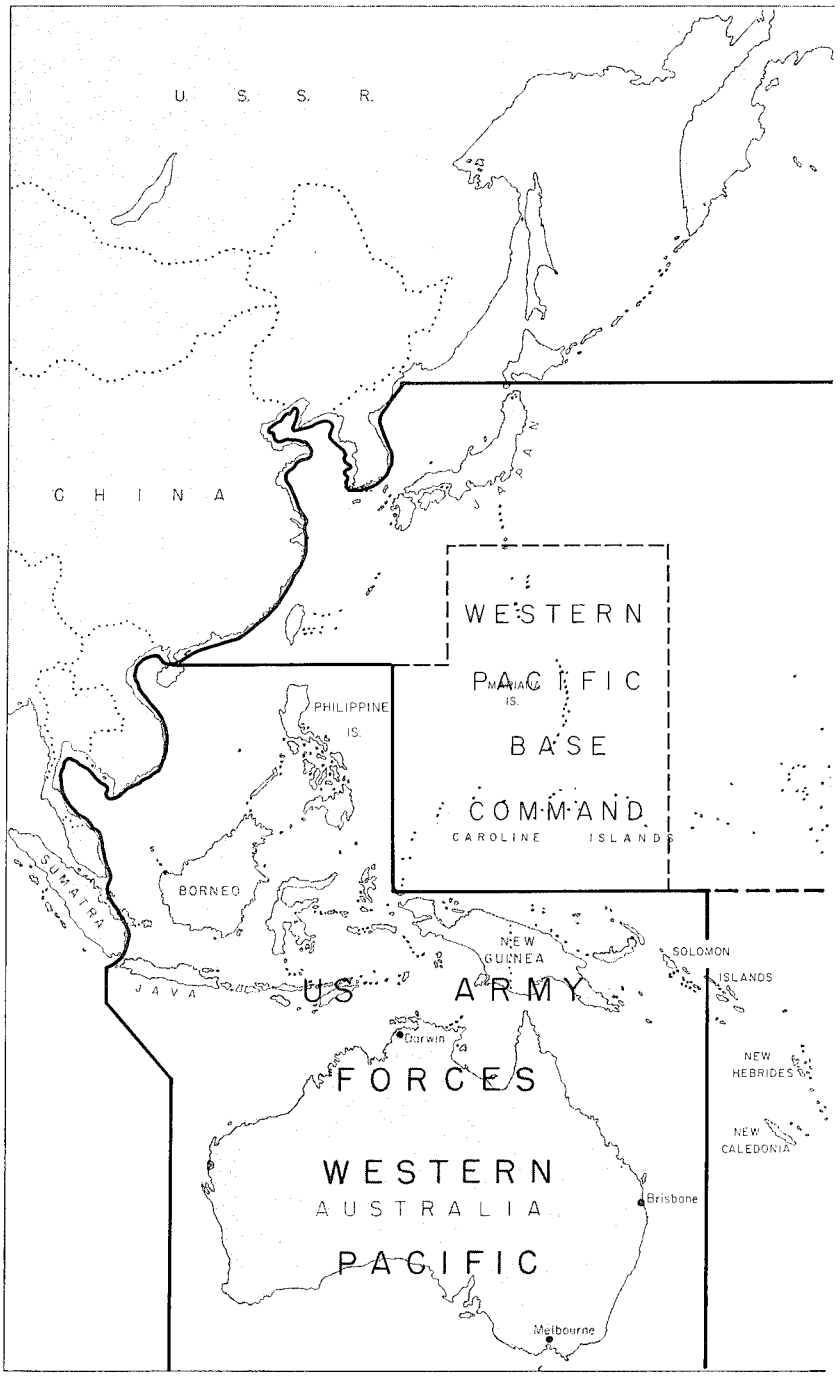
Thus after June 1945 a surgeon headed a complete medical section at an Army theater headquarters for the entire Pacific (except the North Pacific Area). The office remained in Manila throughout 1945 and in the months just

[32] Quarterly Reports, Medical Department Activities, Bases K and M, October 1944–December 1945. (2) Annual Report, Medical Department Activities, Base M, 1946. (3) Quarterly Report, Medical Department Activities, Base R, February–December 1945. (4) Quarterly Report, Medical Department Activities, Base S, 4th quarter, 1945. (5) Quarterly Report, Medical Department Activities, Base X, 3d quarter, 1945.

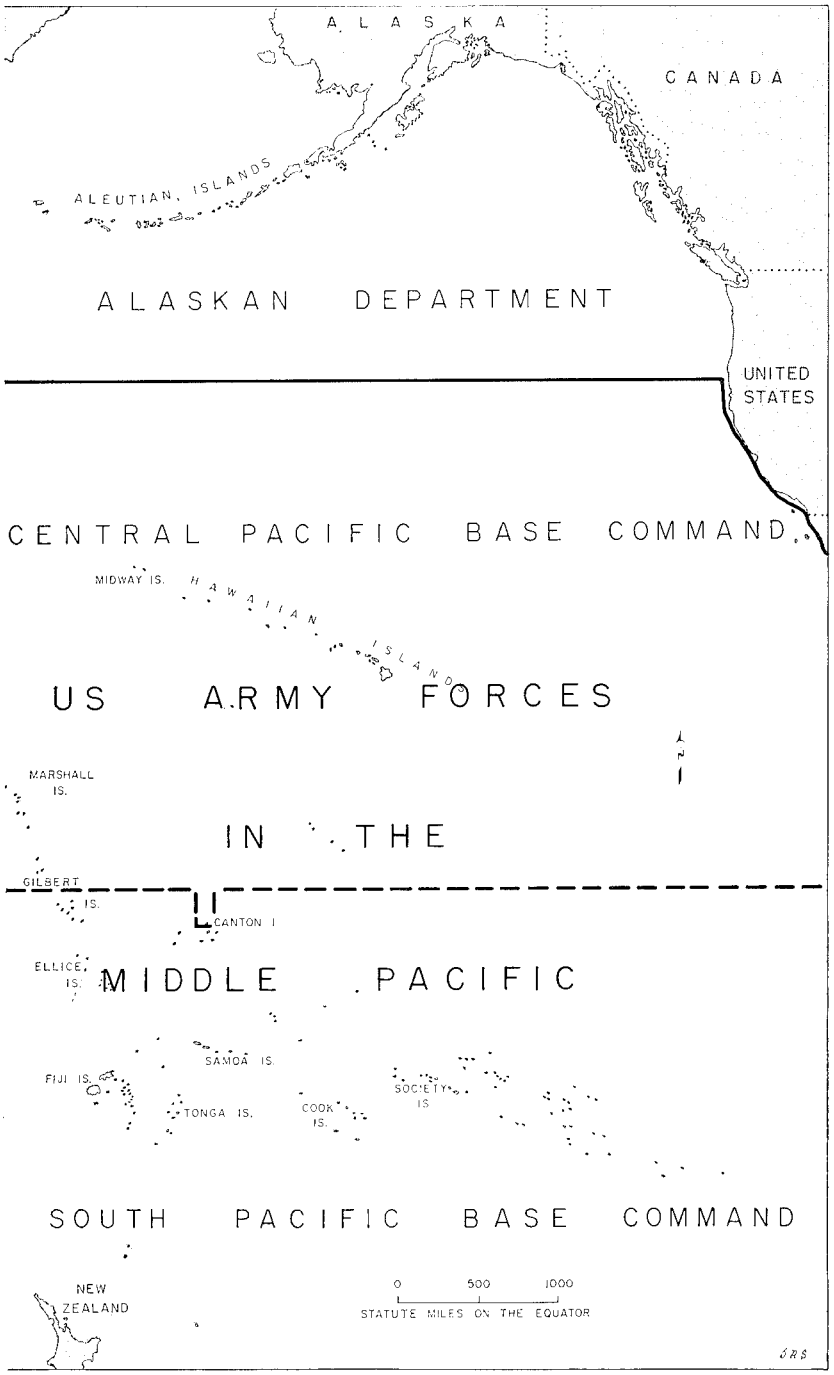
before the Japanese surrender was occupied with making medical plans for the expected Allied invasion of Japan. General Denit apparently intended originally to keep his main office small, as had been his medical staff at his principal office at Headquarters, U.S. Army Forces in the Far East, and to restrict it to policymaking. The medical section at Headquarters, U.S. Army Forces, Western Pacific, would contain personnel to handle medical supply, medical records, hospitalization, and so forth. However, since his office supervised medical service for troops scattered throughout the Pacific and since increased incidence of certain diseases—trenchfoot and venereal disease, in particular—was anticipated with the invasion of Japan, the office underwent temporary expansion. At the end of 1945 it consisted of 40 officers and 57 enlisted men. Throughout the latter months of the year, General Denit had consultants for a few months in the fields of medicine, surgery, neurosurgery, neuropsychiatry, and nutrition, but practically all of these had left by the end of the year. In October 1945 a "veterinary consultant," a "nursing consultant," and a "dental consultant" were appointed; these were relatively permanent positions.

The unification of Pacific areas into a single theater responsible for striking directly at Japan facilitated cooperation between the medical service of the Army and that of the Navy in making invasion plans. It also made possible a concerted effort by the Surgeon General's Office and the theater medical organization to build up well-developed medical staffs for high-level commands in the Pacific. Many Medical Department officers had noted that the division of the Pacific into separately controlled areas, remoteness of these areas from the United States, the complexity of the command structure, and the concentration on problems of the European theater at the expense of the Pacific areas had led to insufficient contact between the Surgeon General's Office and medical authorities in the Pacific. The Director of the Control Division, the Surgeon General's Office, commented early in 1945, shortly after his trip to the Pacific, upon the waste in personnel, as well as supplies, that had occurred on some islands and at certain levels of command and concluded that "theater walls have been too often water-tight compartments." The lack of adequate staff, especially consultants, at the headquarters of higher commands which he had observed throughout the Pacific (as well as in the China-Burma-India theater) was immediately attributable to the limits placed by the area's top Army commands upon suballotment to the medical service. It was ultimately attributable, he emphasized, to the War Department, which had set the area's allotment in the first place. Central planning of oversea medical staffs by the Surgeon General's Office, furthered by direct contact between The Surgeon General and his staff and the War Department General or Special Staffs in drawing up these plans, was sorely needed.[33]

[33] Memorandum, Col. Tracy S. Voorhees, JAGD, for Maj. Gen. George F. Lull, 29 Jan. 1945, and inclosure, subject: Suggestions as to Need for Changed Methods in Utilization Overseas of Medical Department Units.



MAP 10.—U.S. Army



Forces, Pacific, June 1945.

During the summer months before the sudden surrender of Japan, the Surgeon General's Office and the Pacific theater surgeon engaged in concerted planning of this type. The latter made known his needs for officers with various types of training, especially those who could fill administrative positions. He asked the Surgeon General's Office for men qualified to replace those chiefs of surgery in his general hospitals who were being returned to the United States after long service in the Pacific, and for additional officers trained in venereal disease control. The Surgeon General's Office calculated needs for officers trained in some other special fields—pathologists and bacteriologists in laboratories—and selected men with such skills to send to the Pacific. The surrender of Germany had made it possible to release for the Pacific officers experienced in medical administration who were serving in the European and Mediterranean theaters.

The Director of the Control Division, the Surgeon General's Office, promoted the development of a consultants' system comparable to that which had worked so profitably in Europe. Shortly before the Japanese surrender, he issued a report which compared the medical service afforded in the Pacific theater, particularly in the Southwest Pacific Area, with that in the European theater, relating difficulties encountered in medical service in the former directly to organizational handicaps which had faced the medical section at the highest level of command in the Southwest Pacific Area: its position at a level which restricted its power to function in forward areas and which limited its access to high command and its participation in planning the medical support of forward movements. He called attention to the lower priority of the Pacific theater compared with that of the European and Mediterranean theaters, especially for medical specialists. He recommended measures designed to improve the quality of medical service in the Pacific preparatory to the expected invasion of Japan, including the assignment of specialists who had served in Europe and North Africa as consultants. He stressed the importance of vesting technical control over all medical service in the Pacific in the Surgeon, U.S. Army Forces, Pacific. The Surgeon, U.S. Army Forces, Western Pacific—that is, the surgeon of the communications zone—should act as his deputy, he thought. Furthermore, the Pacific theater surgeon should take an active part in planning the medical support for the invasion of Japan. A medical staff of adequate size, including consultants, might function either in the office of the theater surgeon or in that of the surgeon of the communications zone, he thought, but in either case its work should be directed by the theater surgeon.

The theater surgeon sent Col. Maurice C. Pincoffs, MC, to Washington to obtain additional Medical Department officers for administrative positions in the theater, especially an officer with expert knowledge of trenchfoot and one trained in venereal disease control. He requested four officers who had had training at the Command and General Staff School at Fort Leavenworth, Kans., and at the Medical Field Service School at Carlisle Barracks, Pa., for the positions of corps and division surgeons, a nurse with administrative experience to

act as chief nurse, and a chief quarantine officer from the U.S. Public Health Service. Entry into Japan would greatly magnify problems of quarantine. Colonel Pincoffs discussed personnel problems with officers of the Surgeon General's Office and higher elements of the War Department. General Denit himself went to the United States for consultation on these matters soon afterward. Since no invasion of Japan took place, the more fully developed theater surgeon's office and the innovations in medical service advocated by the Surgeon General's Office and the theater surgeon were never fully tested.

In the autumn, after the Japanese capitulation, the principal Army medical offices supervised by the theater surgeon were practically the same as those which he had directed since June: the medical offices of the two territorial commands, the U.S. Army Forces, Western Pacific, and the U.S. Army Forces, Middle Pacific; the office of the surgeon of the Far East Air Forces (renamed Pacific Air Command in December); and the medical sections of two ground commands, the Eighth U.S. Army occupying Japan and XXIV Corps occupying Korea. During the fall General MacArthur made Tokyo his headquarters for the discharge of his duties as SCAP (Supreme Commander for the Allied Powers). General Headquarters, SCAP, was at the top of an additional chain of control, its functions being primarily concerned with the Allied occupation of Japan rather than with the internal administration of the U.S. Army. The major medical work of this command was its program for rehabilitation of public health services in Japan.

The sudden surrender of Japan presented the U.S. Army medical service with the immediate problem of providing medical care for liberated prisoners of war and internees of the Allied countries in addition to that of serving the occupation troops. An advance echelon of General Denit's office, located in Tokyo and headed by Col. A. H. Schwichtenberg, MC, took care of these duties in the latter months of 1945. Besides advising on hospitalization, evacuation, and preventive medicine for the occupation forces, this office served as a clearinghouse for officers and special committees sent by the War Department or General Denit's office to Japan during the early months of occupation to make technical studies; for example, for the Committee for the Technical and Scientific Investigation of Japanese Activities in Medical Sciences which inquired into Japanese research on the prevention of tuberculosis, new dengue vaccines, antimalaria drugs, and drugs for the treatment of leprosy. Another group of officers served on the commission established by General MacArthur to investigate the effects of the atomic bomb in Japan.[34]

[34] (1) Administrative History, Medical Section, U.S. Army Forces, Pacific. [Official record, Office of the Chief of Military History.] (2) Annual Reports, Medical Department Activities, U.S. Army Forces, Pacific, 1945, 1946, 1947. (3) Annual Report, Medical Department Activities, Far East Command, 1947. (4) Letter, Chief Medical Consultant, Office of The Surgeon General, to Chief Surgeon, U.S. Army Services of Supply, 25 June 1945. (5) Notes in Pacific Medical Conference, 3 Aug. 1945, by Director, Control Division, Office of The Surgeon General. (6) Memorandum, The Surgeon General, for the Chief of Staff, 10 Aug. 1945, subject: Report With Recommendations as to Medical, Surgical, and Neuropsychiatric Problems in the Pacific. (7) Memorandum [letter], Brig. Gen. Guy B. Denit, to Col. Maurice C. Pincoffs, MC, 25 May 1945. (8) Letters, Col. Maurice C. Pincoffs, to Brig. Gen. Guy B. Denit, 8 June 1945; Brig. Gen. Guy B. Denit, to Col. Maurice C. Pincoffs, 20 June 1945.

U.S. Army Forces, Middle Pacific

U.S. Army Forces, Middle Pacific, which largely superseded U.S. Army Forces, Pacific Ocean Areas, on 1 July 1945, took over the latter's subordinate commands—three area commands, the Tenth U.S. Army, and AIRMIDPAC. The most recently created of its subordinate area commands was the Western Pacific Base Command (map 9), established the preceding April. It had the same logistic responsibility that the Central and South Pacific Base Commands had within their respective boundaries. It included the Army garrison forces on islands of the Marianas and Western Carolines—Saipan, Guam, Tinian, Iwo Jima, Peleliu, Ulithi, and Angaur; it had headquarters on Saipan. Col. Eliot G. Colby, MC, was surgeon and cooperated closely with the surgeons of various Navy commands in the area. On Saipan, Guam, Tinian, Angaur, and Iwo Jima a command termed "army garrison force" was the top command for Army troops on the island; each had the usual surgeon's office. Until V–J Day many general and station hospitals and a variety of surgical, veterinary, dental prosthetic, and optical repair detachments were briefly stationed on these islands. The Western Pacific Base Command gave medical support to the invasion of Iwo Jima and Okinawa and made plans to furnish personnel, units, and supplies for the expected invasion of Japan. After the Japanese surrender, medical service still had to be provided for Army garrison forces stationed on some of the islands—Saipan, Tinian, and Iwo Jima—and throughout 1946 a small surgeon's office existed at command headquarters on Saipan (moved to Guam in October of that year).[35]

The other two area commands subordinate to U.S. Army Forces, Middle Pacific—the Central and South Pacific Base Commands (map 9)—were undergoing further decline in 1945. In October, shortly after V–J Day, the office of the Surgeon, Middle Pacific, Brig. Gen. John M. Willis, contained 31 Medical Department officers. This number represented substantial growth since the establishment of the predecessor command (U.S. Army Forces, Pacific Ocean Areas) in the middle of the preceding year, but was not up to the existing allotment of 45 officers. Although consultants were still assigned, several were soon released. The medical consultant and laboratory consultant became members of the atomic bomb commission which went to Hiroshima and Nagasaki for 90 days' study of the effects of the atomic bomb on these cities and their inhabitants. In November 1945, when the Central Pacific Base Command was discontinued and its elements transferred to the direct control of Headquarters, U.S. Army Forces, Middle Pacific, the staff of the base command surgeon was transferred to the office of the Surgeon, U.S. Army Forces, Middle Pacific.[36]

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[35] (1) Annual Report, Veterinary Service, Headquarters, U.S. Army Forces, Middle Pacific. (2) See footnote 3(1) and (2), p. 455. (3) Annual Reports, Medical Department Activities, Western Pacific Base Command, 1945, 1946.

[36] (1) General Orders No. 61, Headquarters, U.S. Army Forces, Middle Pacific, 20 Oct. 1945; and No. 75, 1 Nov. 1945. (2) Annual Report, Medical Department Activities, Headquarters Detachment, Oahu Medical Service, Army Ground Forces, Pacific, 1946. (3) See footnote 3(1), p. 455.

In the South Pacific Base Command, the staff surgeon's office in New Caledonia supervised medical service for the remaining Army service troops, which by September 1945 had dwindled to about 14,600 men. Most of the 209 Medical Department officers who served the command were stationed on the two islands of troop concentration, New Caledonia and Guadalcanal. The chief Medical Department installations and units—including a 1,000-bed general hospital and a 50-bed station hospital on New Caledonia, a 500-bed station hospital on Guadalcanal, and a few platoons of medical supply depot companies—were also on these two islands.

During 1945, the widespread use of DDT dramatically decreased the rates of incidence of malaria and filariasis in the South Pacific Base Command, both diseases being chiefly transmitted in this region by the same mosquito vector. The abatement of most other Army health problems in the South Pacific islands derived mainly from the absence of combat and the decline of troop strength.[37]

U.S. Army Forces, Western Pacific

The Manila office of the Chief Surgeon, U.S. Army Forces, Western Pacific (General Denit was surgeon during the period June–August 1945 and Brig. Gen. Joseph I. Martin from the latter date to January 1946), had essentially the same job as the office of the Surgeon, U.S. Army Services of Supply, Southwest Pacific Area, had had. The area which it served at its inception in June 1945 (map 9) included more than 10,000 islands extending along the 6,000-mile route of advance from Australia to Japan. Of its subordinate territorial commands, Australia Base Section, with headquarters at Sydney, had only a skeletal organization; the last remaining Australian bases, at Townsville and Sydney, were discontinued in June 1945. New Guinea Base Section and Philippine Base Section had several subordinate bases each. Army Service Command I, formed on 1 August 1945 by merging the island commands established on Okinawa and Ie Shima, also came under the control of U.S. Army Forces, Western Pacific.

During the summer of 1945, while bitter local fighting was still going on in the Philippines, the medical section of U.S. Army Forces, Western Pacific, distributed large-scale shipments of whole blood from the United States to Manila and Leyte and directed large-scale air evacuation. The operations of nearly every division of the surgeon's office were being expanded to meet the demands of the expected invasion of Japan. Plans were under way for expansion of hospital beds in Manila. At the time of the surrender Manila had one of the largest medical depot systems developed in any theater of operations during the war. A major continuing problem in the Philippines which reached its peak in mid-1945 was the control of venereal disease among troops. Two officers from the Surgeon General's Office made a special survey of the situation. Throughout the spring and summer of 1945 the War Department and theater

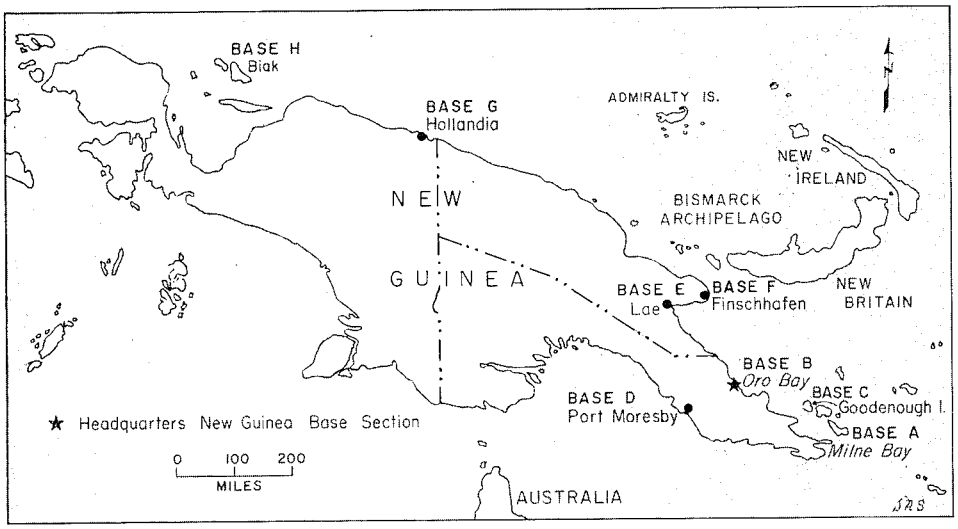
[37] Annual Report, Medical Department Activities, South Pacific Area, 1945.

headquarters (Headquarters, AFPAC) brought pressure on the Western Pacific command and all its subordinate tactical and area commands to take measures, including those for the repression of prostitution, to lower mounting venereal disease rates among troops in the Philippines.

After the Japanese surrender the major problems of the medical section at Headquarters, U.S. Army Forces, Western Pacific, were the usual ones involved in readjusting medical facilities, supplies, and personnel to meet the needs of a rapidly shifting military population. The rear bases in New Guinea were being "rolled up," and troops and units were being sent forward to the Philippines and Japan. Men and units in forward areas were being returned to the United States. Hospital beds were reduced by more than half between V–J Day and the end of 1945. Permanent buildings occupied by general hospitals in the Philippines were returned to civilian authorities. Medical care for prisoners of war liberated in Japan and China was a heavy responsibility in the last months of 1945. Emergency packs of medical supplies, assembled by the medical depots of Base X in Manila, were dropped by air to thousands of Allied prisoners of war in remote areas of China and Japan until these men could be evacuated. The surgeon's office, U.S. Army Forces, Western Pacific, supervised this immediate job and the longer range ones, continuing into 1946, of evacuating and hospitalizing the recovered Allied soldiers and civilians. The disposal of surplus medical supplies, which continued into 1946, was largely handled by a "surplus property disposal officer" in the surgeon's office. He visited the New Guinea bases and made arrangements for the sale of nearly 5 million dollars' worth of medical supplies and equipment, including a general hospital at Biak, to the Netherlands Government. The Office of the Chief Surgeon, U.S. Army Forces, Western Pacific, also assisted with some phases of medical service in the Philippine Army, including the giving of physical examinations to about 150,000 Philippine Army personnel being demobilized and processing their medical papers. In April 1946, similar work was begun for the 37,000 Filipino troops to be turned over to the new republic on 1 July 1946.

The formal dismissal of the Combined Advisory Committee on Tropical Medicine, Hygiene, and Sanitation took place shortly after the Japanese surrender. The committee had remained somewhat dormant throughout 1945 while General Headquarters, under whose aegis it met, had gone forward to Hollandia and Manila. It had continued in existence, however, because General MacArthur wanted its aid if future combat operations should again call for close coordination of preventive measures against disease between the Australians and Americans. It was formally dissolved as of 1 November 1945, and the Western Pacific command attended to the details of winding up its affairs.[38]

[38] (1) Semiannual Reports, U.S. Army Forces, Western Pacific, 1 July–31 Dec. 1945, and 1 Jan.–30 June 1946. (2) Memorandum, Col. M. C. Pincoffs, MC, for Chief Surgeon, U.S. Army Forces, Western Pacific, 25 Sept. 1945, subject: Combined Advisory Committee on Tropical Medicine, Hygiene, and Sanitation. (3) Letter, Adjutant General, U.S. Army Forces Western Pacific, to Chairman, Combined Advisory Committee, 14 Oct. 1945, subject: Discontinuance of the Combined Advisory Committee, etc.



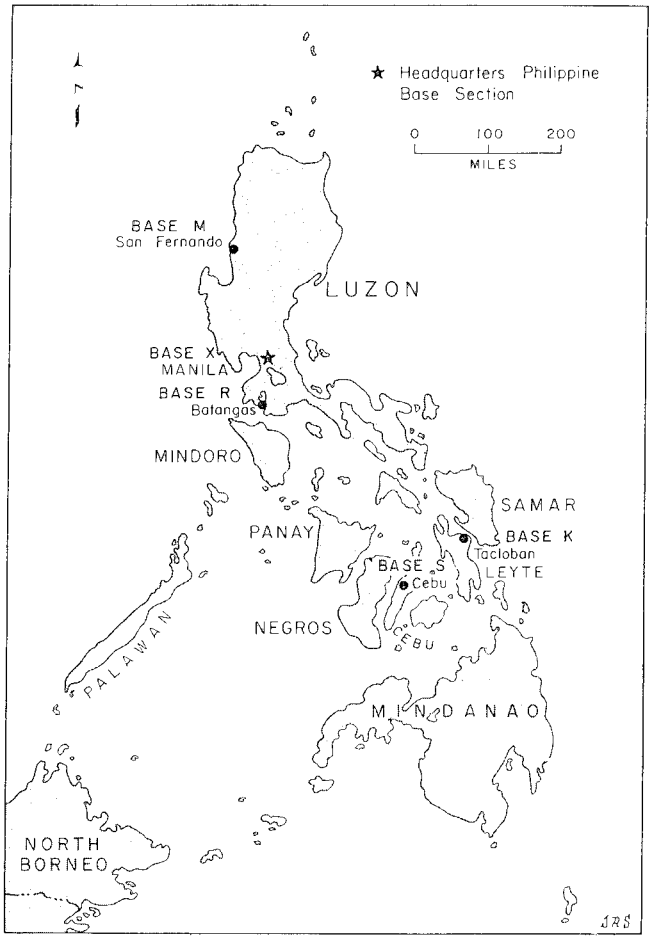
MAP 11.—New Guinea Bases, U.S. Army Forces, Western Pacific, June 1945.

Territorial commands of U.S. Army Forces, Western Pacific.—The three major territorial commands under U.S. Army Forces, Western Pacific, in April 1945, were the Australian, New Guinea, and Philippine Base Sections (maps 11, 12). Only the last of these was of importance. Australian Base Section, with headquarters at Sydney by late June 1945, lasted as a skeleton organization throughout the year and the New Guinea Base Section until August 1945, when it was dissolved and its four remaining bases—at Lae, Finschhafen, Hollandia, and Biak—placed directly under U.S. Army Forces, Western Pacific. These declined and by April 1946 all had closed.[39]

The Philippine Base Section developed during the spring of 1945 from the former Army Service Command and assumed charge of directing Services of Supply activities, first on Luzon and later throughout the Philippines.[40] When it was established in April, it controlled all five bases in the Philippine Islands: The earlier established Base K on Leyte and Base M at San Fernando, Luzon, and the recently established Base R at Batangas Bay, Luzon, Base S at Cebu City, Cebu, and Base X (merged with Philippine Base Section from April to July) in Manila. These various bases came under direct control of U.S. Army Forces, Western Pacific, in October. During the period February–April 1945, Medical Department officers assigned to the former Army Service Command were occupied in establishing medical service on Luzon, with concentration in the area of Greater Manila. During March, they evacuated about 3,500 patients from Luzon by plane and hospital ship, and located buildings in Greater Manila

[39] Quarterly Reports, Medical Department Activities, New Guinea Base Section, 2d and 3d quarters, 1945.

[40] A Luzon Base Section lasted from mid-February to April 1945, when the Philippine Base Section took control of all the bases in the Philippines.



MAP 12.—Philippine Bases, U.S. Army Forces, Western Pacific, June 1945.

to house several hospitals and a medical supply depot for the base section and put these installations into operation. In April seven dispensaries, including three dispensaries to serve the port and a dental dispensary, were functioning. Manila became the largest center of fixed hospitals in the Southwest Pacific Area in the expectation that a large hospital center would receive thousands of patients from an invaded Japan. The problem of venereal disease among troops crowding into Manila after fighting through the Luzon campaign was one of the most serious faced by the base section. Venereal disease control officers assigned to tactical elements (Sixth U.S. Army, XIV Corps, and 37th Division) and to the base section cooperated in efforts to prevent venereal disease, opening eight prophylactic stations in March. The problem continued in succeeding months as soldiers spent their leave in the urban areas of the Philippines.

When a single base section was set up for all the Philippines in April, its staff medical section became a full-fledged one. A major job in Manila was work done in connection with hiring medically trained Filipino civilians for the U.S. Army. Although a civilian employment service did the actual hiring, personnel of the surgeon's office (of the combined Philippine Base Section and Base X headquarters when they were operating jointly during the period April–July, and of Base X alone when they were separate) established job classifications and pay scales for this group, and maintained records on them. In addition, they supervised the work of Filipino civilian employees used by all medical units in the Philippine Base Section Area Command.[11]

Shortly after the Japanese surrender, two large area commands in the Philippines began clearing up regions occupied by the Sixth and Eighth U.S. Armies after the departure of troops and handling arrangements for the surrender and disarmament of Japanese troops in the Philippines. These were the Southern Islands Area Command, which included the Middleburg and Hollandia areas of Netherlands New Guinea, as well as the southern islands of the Philippines and the islands of Biak, Wakde, and Morotai, and the Luzon Area Command, including a few islands adjacent to Luzon. A few Medical Department officers directed the medical work connected with the removal of the Japanese. The medical section of Luzon Area Command, for instance, drew up the plan for evacuating sick and injured Japanese prisoners of war from Luzon; it made detailed arrangements for assembling evacuees at chosen locales, providing temporary hospitalization for them on Luzon, and specifying methods of evacuation. In November the two area commands were split into smaller area commands in charge of various Army divisions; these continued the cleanup.[12]

The tactical forces: occupation of Japan and Korea.—On 1 July 1945, the Eighth U.S. Army was given responsibility for all tactical troops in the entire Philippine Archipelago, taking over Luzon from the Sixth U.S. Army. With the end of the Luzon campaign, the Sixth U.S. Army surgeon's office at San Fernando, Pampanga, Luzon, was free to begin training and equipping medical units preparatory to the expected invasion of Japan. In July, corps and subordinate units were transferred and regrouped in anticipation of the invasion. Following the sudden Japanese capitulation, the office of the Surgeon, Sixth U.S. Army, moved in September with the headquarters to Kyoto, Japan, where it undertook duties typical of a medical staff office with an army of occupation. Early in 1946, the Eighth U.S. Army took over the entire task of Japanese occupation.

The Eighth U.S. Army had originally occupied only northern Japan. In August 1945 its surgeon, General Rice, arranged, after conference with officers at General Headquarters and Headquarters, Army Forces, Western Pacific, for hospital ships, as well as medical supplies and equipment, for evacuating

[11] Report, Medical Department Activities, Philippine Base Section, 25 Sept. 1945.
[12] Report, Medical Department Activities, Luzon Area Command, 17 Oct. 1945.

Allied prisoners of war and civilian internees from Japan. In late August, his office was established in the Customs House in Yokohama and began the work of caring for and evacuating these groups, while providing the usual medical service for elements of the Eighth U.S. Army. The office of the Surgeon, XI Corps, settled in September in Tokyo, and the office of the Surgeon, XIV Corps, moved in the same month from Luzon to Sendai in northern Honshu. A medical liaison group at Base X in Manila aided with the transfer of medical units and supplies from that base to the Eighth Army in Japan.

For fulfilling initial medical responsibilities toward those freed from the Japanese camps, the Eighth U.S. Army surgeon had organized four medical teams to go to the various camp areas. These arrived in Yokohama on 30 August. Supplementing the work of the so-called "recovery teams," they gave initial care to the sick and evacuated the prisoners of war and internees to Tokyo. On 3 September, the 42d General Hospital, which had arrived in Tokyo near the end of August, assumed charge of the liberated, processing medical records related to them. At Atsugi airfield, whence they were started on their way home, via Manila, a medical clearing company, operating under the direction of the Eighth U.S. Army surgeon, served as a holding station to arrange the order of transport. Most of the liberated prisoners and internees, amounting to about 24,000, had been evacuated from Japan before the end of September.

Throughout the summer and early fall of 1945, the medical sections of two service commands, Army Service Commands O and C (with the Sixth and Eighth U.S. Armies, respectively) and their bases were built up in the Philippines in anticipation of the Japanese occupation. Their medical sections had obtained information on diseases endemic in the areas which they expected to occupy, requisitioned the necessary medical supplies, and trained enlisted men in newly assigned duties. The channels of command established for the move to Japan were similar to those that would have been followed had an invasion been necessary, in that the base commands developed within the service commands were temporarily assigned to corps or divisions. After a month or two of development at their Japanese sites, they were placed again under the Army service commands.

When the Eighth U.S. Army took over control from the Sixth U.S. Army early in 1946, Army Service Command O was absorbed by Army Service Command C, whose medical section was given direction of the base medical sections. Medical sections were in operation at major bases at the Japanese cities of Kobe, Kure, Nagoya, Fukuoka (on Kyushu Island), and Yokohama. The size of these medical sections varied considerably, usually being smaller than those that had existed at the larger New Guinea and Philippine bases. At the beginning of 1946, the Kure Base medical section had, in addition to the surgeon, an executive officer, a veterinarian, a port surgeon and venereal disease control officer, a chief nurse, a medical inspector, an administrative officer, and seven enlisted men. These officer assignments were more or less

typical. A base venereal disease control officer was particularly necessary, for in the early days of the occupation the rise in incidence of venereal disease among American troops in Japan presented a major problem.[43]

The XXIV Corps on Okinawa had been selected for the occupation of Korea shortly before the Japanese surrender. While still on Okinawa, the office of the Surgeon, XXIV Corps, and that of the Surgeon, Army Service Command 24, prepared medical plans for the allocation of medical responsibilities during the occupation. The office of the corps surgeon opened in Seoul, Korea, on 11 September. It established dispensaries and began reconnaissance for hospital sites. The medical inspector examined bars and restaurants, and the veterinary inspector, slaughterhouses and food storage plants. The venereal disease control officer inspected geisha districts and houses of prostitution and recommended sites for prophylactic stations. Late in 1945 the longer range programs, such as typhus control and reimmunization of troops, to be undertaken during the Korean occupation, were initiated. The medical office of Army Service Command 24 operated at the command's headquarters, known as ASCOM City, near Inchon. Various types of hospitals and other Medical Department units served at Inchon, at ASCOM City, and at Seoul in the northern sector at Taejon in the central sector, and at Kwangju and Pusan in the southern sector. Troops given medical service, totaling about 81,000 in November 1945, were those of XXIV Corps (6th, 7th, and 40th Divisions), the Fifth Air Force, the military government, and Army Service Command 24.[44]

In mid-1945 the office of the Surgeon, Far East Air Forces, was in Manila. It supervised the work of medical sections of the Clark Field headquarters of the Fifth Air Force, of the Leyte headquarters of the Thirteenth Air Force, and of the Hollandia headquarters of the Far East Air Service Command. During this lull in combat, it made special effort to standardize the technical medical work among air force troops by having surveys and recommendations made in three fields; namely, psychiatric problems, ophthalmological problems, and dental deficiencies. An extensive survey of procedures in air evacuation within and from the Pacific theater was also made. An officer was sent to the European theater to acquaint medical units to be shifted from Europe to the Pacific with the medical problems which they might encounter in their new

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[43] (1) Quarterly Report, Medical Section, Eighth U.S. Army, 3d and 4th quarters, 1945. (2) Quarterly Report, Medical Department Activities, XIV Corps, 2d quarter, 1945. (3) Quarterly Reports, Medical Department Activities, X Corps, 1945; and fiscal report, January 1946. (4) Quarterly Reports, Medical Department Activities, XI Corps, 1945 and 1st quarter, 1946. (5) See footnote 38(1), p. 492. (6) Periodic Reports, Surgeon, U.S. Army Service Command C, August–December 1945. (7) Periodic Reports, Medical Department Activities, Kobe Base, August 1945–December 1946. (8) Periodic Reports, Medical Department Activities, Kure Base, July 1945–Jan. 1946. (9) Quarterly Report, Medical Department Activities, Otaru Base, November–December 1945. (10) Quarterly Report, Medical Department Activities, Nagoya Base, 4th quarter, 1945. (11) Final Report, Medical Department Activities, Kyushu Base, 9 Dec. 1945–2 Apr. 1946. (12) Annual Report, Medical Department Activities, Yokohama Base, 1946.

[44] (1) Quarterly Report, Medical Department Activities, XXIV Corps, 3d and 4th quarters, 1945. (2) Quarterly Report, Medical Department Activities, U.S. Army Service Command 24, 4th quarter, 1945. (3) Annual Report, Medical Department Activities, U.S. Army Forces in Korea, 1948.

location. Shortly after the Japanese surrender, the Far East Air Forces dropped emergency supplies, including medical supplies, to prisoners of war and internees held by the Japanese, and an officer of the medical section hastened to Japan to supervise their evacuation from Japan by air. An officer of the Second Central Medical Establishment (by then reassigned to Far East Air Forces headquarters) also went to Japan to interrogate Japanese specialists in aviation medicine on equipment developed for the protection of fliers and on their research into aviation medical problems.

Late in 1945, the Far East Air Forces was renamed Pacific Air Command, absorbing former components of Army Air Forces, Middle Pacific. The medical section of Pacific Air Command, which moved in toto to Tokyo only in May 1946, directed the medical service of five greatly reduced components: the Fifth Air Force, with headquarters at Nagoya, Japan; the Thirteenth Air Force, with headquarters at Fort McKinley, Luzon; the 1st Air Division (former Eighth Air Force) in the Ryukyus; the Twentieth Air Force, which included the XX and XXI Bomber Commands in the Marianas; and the Seventh Air Force, with headquarters at Hickam Field.[45]

Launching the Army's Public Health Program in Japan and Korea

For several years after the close of the war, the U.S. Army undertook long-range public health programs in both Japan and Korea.[46] During the months of 1945 when the Army's plans for an invasion of Japan were being drawn up, the G–5 system for the conduct of civil affairs employed in other theaters was developed; advance planning for the revival of public health facilities in Japan took advantage of the experience with public health programs in Europe and the Philippines. However, the sudden capitulation of Japan presented the Medical Department with larger immediate responsibilities over a much wider area than would have been the case had the Army undertaken an invasion. At the same time it simplified the task; the administration did not go through the usual steps of control by division, corps, and army but was promptly divorced from a complex chain of command.

The organization that directed the program during the postwar years was set up on 2 October 1945, when a Public Health and Welfare Section was established at the staff level at General Headquarters, Supreme Commander for the Allied Powers. Col. (later Brig. Gen.) Crawford F. Sams, MC (fig. 111), formerly Surgeon, U.S. Army Forces in the Middle East, and more recently assigned to G–4 of the War Department General Staff, was made chief of the section and headed the program during most of the years of the occupation.

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[45] (1) Quarterly Reports, Medical Department Activities, Headquarters, Far East Air Force, 1st, 2d, 3d quarters, 1945. (2) See footnotes 2(2), p. 454; and 19(4), p. 475. (3) Annual Report, Medical Department Activities, Pacific Air Command, 1946. (4) Annual Report, Medical Department Activities, Fifth Air Force, 1945.

[46] The military government in the Ryukyus (Okinawa) was initially run by the Navy, but the Army assumed control in July 1946, when the large task of providing dispensary service, camp sanitation, and quarantine service for Okinawans repatriated from Japan was still under way.

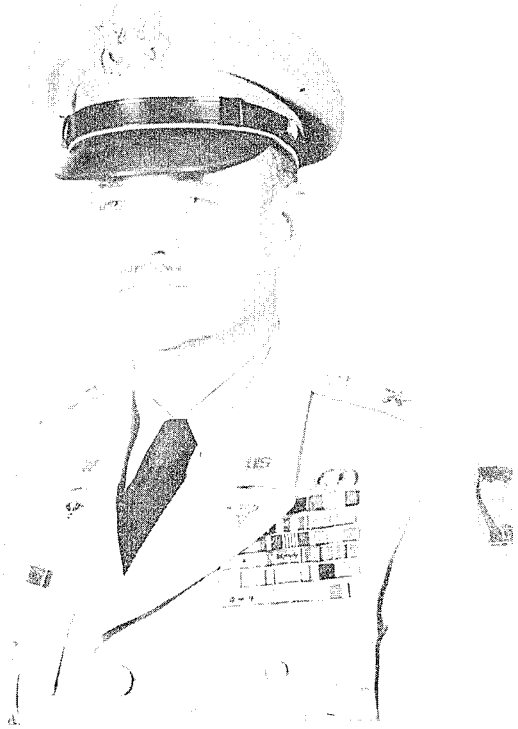


FIGURE 111.—Brig. Gen. Crawford F. Sams, MC.

His office was originally responsible for the prevention of diseases in the civil population of both Japan and Korea (later of Japan only), for the establishment of normal procedures for health control, and for promoting public health and welfare activities and the establishment of health facilities. Colonel Sams thus headed what became one of the largest health programs ever undertaken among the population of an occupied country. Early in 1946, his office was faced with epidemics of smallpox and typhus near Kobe and Osaka. In addition, epidemics of smallpox, typhus, and cholera occurred in China. As thousands of Japanese were returning to their native country from China, the Public Health and Welfare Section, SCAP, undertook a quarantine program for the incoming repatriates in order to prevent transmission of these diseases to Japan and U.S. Army troops occupying that country.

From September 1945 when American troops entered southern Korea to June 1949 when they withdrew, the U.S. Army undertook a similar health program among Korean civilians. In the last months of 1945 military government activities, including the health program, were conducted as a staff responsibility. When the U.S. Military Government was established in Korea early in 1946, the military governor created a Department of Public Health and Welfare in Seoul; it had top responsibility for the program. The account

of the Army's protracted public health work in Japan and Korea falls outside the scope of this volume, as it belongs to the history of the occupation period.[47]

SUMMARY: MEDICAL ADMINISTRATION IN THE PACIFIC

After 7 months' experience with medical administration in the Southwest Pacific Area, the Chief Surgeon, USAFFE (General Denit), wrote to the Chief Surgical Consultant, the Surgeon General's Office (Brig. Gen. Fred W. Rankin), as follows:

> I have been able, to some degree, to put into effect some of my ideas, but you are quite correct in stating that our problems here are entirely different from those in ETO. In fact the staff relationships and procedures are so complicated that I often find myself bewildered in attempting to carry out my functions.

Later, after Army troops in the Pacific areas had been organized into a single theater of operations, he analyzed the difficulties which the geographic features of the combat areas in the Pacific had imposed upon the administration of Army medical service:

> You are of course aware that the geographic problems peculiar to this theater have imposed decentralized operations to an extent never before required. "Perimeter warfare," with the establishment of large bases separated by thousands of miles of ocean or jungle and connected only by communications systems taxed to capacity in the transmission of urgent business and further isolated by difficulties of transportation, has made it essential to delegate considerable authority to subordinate commands. The higher headquarters, of course, have coordinated activities by frequent inspections. Nevertheless, a successful operation of such a system is obviously dependent upon the assignment of highly qualified personnel to positions of authority in the subordinate commands. Unusually large numbers of such key personnel are required and they are woefully lacking.[48]

This brief summary points out some of the basic obstacles encountered in administering Army medical service in the Pacific. The scattering of the land masses over long stretches of water led to a complex division of responsibilities among Army and Navy commands and to considerable decentralization of authority to lower commands. From the beginning of the war until April 1945, most Army forces in the Pacific region were organized into three elements, each of which constituted an orthodox Army theater organization. Not until April 1945 was Army organization in the Pacific revamped into the structure characteristic of a single theater of operations. During this period medical staffs were theoretically necessary for both a theater and a Services of Supply headquarters in each of three "theaters" of the Pacific—the Central, South, and Southwest Pacific Areas—as well as for numerous bases and base sections,

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[47] (1) See footnote 3(2), p. 455. (2) Letter, Col. Maurice C. Pincoffs, MC, to Brig. Gen. Guy B. Denit, 20 June 1945. (3) Report, Public Health and Welfare in Japan, no date, but includes 1948, by Brig. Gen. Crawford F. Sams, Chief, Public Health and Welfare Section, General Headquarters, Supreme Commander for the Allied Powers. [Official record.] (4) Annual Report, Medical Department Activities, Headquarters, U.S. Military Government in Korea, 1946. (5) Historical Report, Allied Operations in Southwest Pacific Area, vol. I, supplement: MacArthur in Japan, The Occupation, chs. I and VI. [Official record, Office of the Chief of Military History.]

[48] (1) Letter, Brig. Gen. Guy B. Denit, to Brig. Gen. Fred W. Rankin, 10 August 1944. (2) Letter, Brig. Gen. Guy B. Denit, to Chief, Personnel Service, Office of The Surgeon General, 16 June 1945.

field armies, air forces, and subordinate commands which formed links in the chain of evacuation by land, sea, and air. This situation led to the demand for the unusually large number of Medical Department personnel for administrative positions noted in the theater surgeon's analysis.

In the Central and South Pacific Areas, where the top U.S. Army headquarters never moved to a location in advance of the Services of Supply headquarters, medical service was so organized within the command structure, by the use of the same Medical Department personnel at both headquarters, as to minimize the demand for officers to fill the higher administrative positions. In the Southwest Pacific Area, on the other hand, during part of the period 1942–April 1945, considerable numbers were needed to staff the medical sections of both U.S. Army Forces in the Far East and the Services of Supply, whose headquarters were located at some distance from each other. At the same time the allocations of Medical Department officers to these headquarters were too low to permit of a well-developed staff at either. Much of the demand for key personnel in administrative positions in all these areas resulted from the necessity of assigning medical staffs to scattered bases, with relatively scant numbers of troops, which because of the geographic layout could not be amalgamated into fewer bases.

In the Central and South Pacific Areas, medical service received direction from a surgeon's office at the highest level of Army command. The use of a single surgeon for both theater and Services of Supply headquarters prevented any uncertainty as to what medical officer was in the administrative position of major importance. In the Southwest Pacific Area, on the other hand, considerable confusion, aggravated during the period September 1942 to August 1944 by the presence of a surgeon with ill-defined duties at the Allied command headquarters, prevailed with respect to this point. No single medical office was situated for any length of time at a headquarters which had authority to issue technical medical instructions to all Army troops in the Southwest Pacific Area.

The Southwest Pacific Area, which had more Army troop strength than either of the other two Pacific Areas, was the least satisfactory of all the major theaters of operations insofar as the organization of medical service within the command structure before June 1945 was concerned. Many Medical Department officers who served there, as well as men who went out on special missions, emphasized the detrimental effects of its position within the command structure. In the absence of a single surgeon with power to put plans into effect on the theaterwide basis, it was difficult to shift hospitals, medical personnel, and medical supplies to localities or commands where they were most needed. Neither the highest U.S. Army headquarters nor the Allied headquarters had a group of consultants to direct a theaterwide consultants' system. Neither had a preventive medicine division to supervise a theaterwide system of disease prevention in an area where environmental disease hazards made a strongly organized preventive program necessary. The more centralized

control over antimalaria efforts and other preventive programs which developed in the Southwest Pacific Area with time was achieved only the hard way after experience forced a recognition of the necessity for it.

In addition to the lack of a single medical office vested with centralized responsibility, the many changes in command structure and in jurisdiction of commands, together with the frequent moves of multitudinous headquarters (or parts of them) to new locations, were prejudicial to close liaison of medical offices in the Southwest Pacific Area with each other. Medical Department officers, particularly those who came from civilian life, were often uncertain as to how the structure above them worked and as to what their own medical responsibilities were. Frequent shifts in command structure tended to confuse their understanding of the channels of communication and to make more difficult the coordination of medical reports. Officers who came into the Southwest Pacific Area on special medical missions without having spent sufficient length of time there to study Army organization in the area in detail stated that they found its complex command structure an almost insurmountable barrier to effective conclusion of their missions.

Decentralization of medical responsibility forced upon base and base section surgeons, and surgeons of other small commands in the Southwest Pacific Area, more diverse and nonmedical duties and problems than were the lot of most such staff surgeons in other theaters. Some base and base section surgeons enjoyed more control over the medical resources allotted to the command which they served than did surgeons in similar positions elsewhere, since they had command control over the medical units and installations of the base or base section. Surgeons with this authority were better able to see to it that the medical resources within their small areas were employed to the best advantage. However, the decentralization of command which was capable of leading to more economic and efficient use of medical resources within a small local command tended to hinder effective use of the total medical resources of the Southwest Pacific Area.

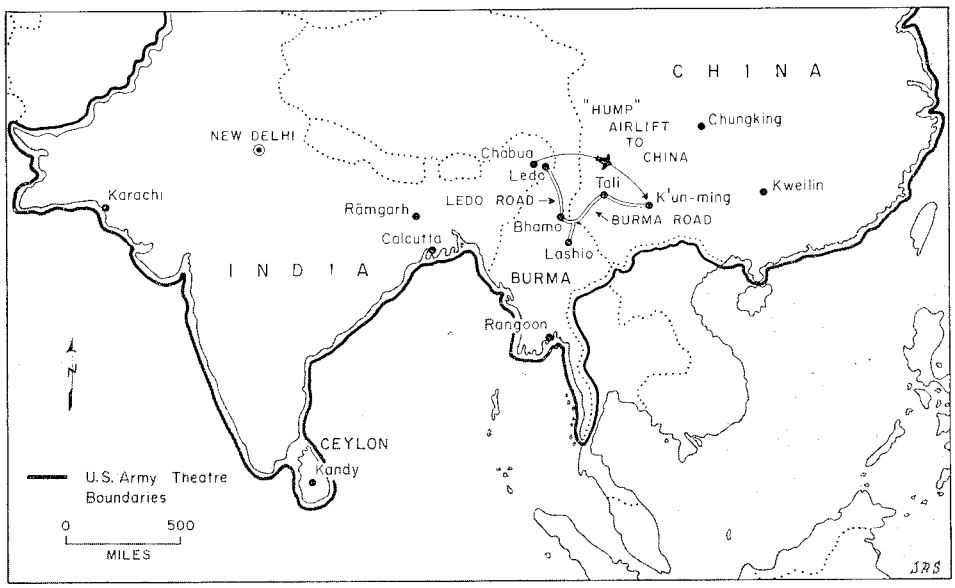
Another factor, not alluded to in the passage quoted but frequently pointed out by Medical Department officers in administrative posts, was the lack of contact between Medical Department officers in the theater and the Surgeon General's Office. This derived in part from the great distance between the Southwest Pacific Area and the United States. In the case of some officers, the lack of awareness of developments at home sprang from the fact that they had come to their assignments from other oversea areas where they had been stationed during the prewar years; they had not been in close contact with the Surgeon General's Office during the planning period of 1940 and 1941. Hence they were less well informed as to the broad preventive medicine program formulated by the office and the medical consultants system than were those who were sent overseas by the Surgeon General's Office. Officers of the Surgeon General's Office exhibited, in their turn, a good deal of uncertainty as to what surgeon they should address when they wrote letters outlining

proposals for improvement of one phase or another of medical service. Their channels of information were apparently inadequate to give them satisfactory information on the medical responsibilities of commands not in accord with the Army doctrine that they had studied; the many changes in high levels of command in the Southwest Pacific Area compounded the uncertainty. While it seems that, given the geographic features of the area, a high degree of decentralization of command would always have prevailed, smoother working of the medical service could presumably have been achieved by the early establishment and consistent maintenance of a full-fledged medical section at General MacArthur's Allied headquarters.

CHAPTER XII

Medical Department in China, Burma, and India

The responsibility for giving field medical training to thousands of foreign (Chinese) troops and for supporting them with a considerable portion of their hospitalization and medical supplies distinguished the Medical Department's experience in the China-Burma-India theater from that in other areas. Besides supporting the U.S. Army Air Forces and the relatively few ground troops in the area, the U.S. Army Medical Department was called on to train and support medically Chinese divisions for the the struggle against the Japanese in Burma and China. Army doctors in the theater labored under two handicaps which affected all U.S. Army effort there: the low priority of the theater for supplies and personnel, and the isolation of the China side of the theater from the India side by the Japanese invasion of Burma (map 13).



MAP 13.—Area of operations, Asiatic mainland, 1942–45.

With the lowest priority of all the theaters of World War II, the China-Burma-India theater was treated like a "stepchild" from the outset, as the surgeon of its Services of Supply put it.[1] Throughout the period 1942–44, the medical sections of its top commands lacked sufficient Medical Department

[1] Letter, Col. John M. Tamraz, MC, to Col. Joseph H. McNinch, MC, Editor, History of the Medical Department in World War II, 13 Feb. 1950, and inclosure.

officers qualified for major administrative positions. Other difficulties derived from the Japanese invasion of Burma in 1942. As a result of Japanese occupation, the theater had two distinct areas of combat operations—one in northeast India and Burma, and the other in China. Only by the hazardous flight across the Hump could medical men and supplies be transferred between China and India. The few U.S. Army doctors who served in an administrative capacity in China could keep in touch with the medical plans of Chinese military and civil authorities, but it was hard to coordinate these with supplementary medical resources to be furnished by British and Indian authorities on the western side of the theater. The division of the theater into two areas of military operations accounts in large measure for the unorthodox location and functions of the top medical offices maintained by the American Army during the period 1942–44, as well as for the lack of centralized direction of medical service.

The Army's medical work was also affected by the lack of unity in the top commands. Although U.S. Army commands worked in close cooperation with commands and governments of the various Allies throughout the area, the China-Burma-India theater was never dominated by a strongly unified Allied command as were the North African and European theaters and the Southwest Pacific Area. The Chinese and the British theaters of operations comprehended areas distinct from those of the American China-Burma-India theater. Lt. Gen. (later Gen.) Joseph W. Stilwell was responsible to Generalissimo Chiang Kai-shek as the latter's chief of staff and later to Admiral Lord Louis Mountbatten, Supreme Allied Commander, Southeast Asia, as Admiral Mountbatten's deputy. The divided responsibilities entailed by General Stilwell's subordination to commanders whose interests diverged at times from paramount American interests—as well as from each other's—have been frequently pointed out.[2]

Nor was the organization of the American theater a well-integrated one. During the early period of the theater's existence, General Stilwell had four distinct and widely separated headquarters, each of which issued orders, sometimes in conflict with each other, to the theater surgeon in his name. Friction among the purely American commands—the theater command, the Services of Supply, and the Tenth and Fourteenth Air Forces—was unceasing. This dissonance naturally hindered attempts to estimate theaterwide medical requirements and to maintain centralized control of medical service. The fact that the Tenth and Fourteenth Air Forces constituted the major American combat forces in the theater (most other U.S. Army troops were those of the Services of Supply) abetted the characteristic effort of air force doctors to operate independently of a theater surgeon. It is interesting to note that such freewheeling "old China hands" as the commander of the Fourteenth Air Force, Maj. Gen. Claire L. Chennault, had a few medical counterparts. Dr. (later Lt.

[2] (1) Romanus, Charles F., and Sunderland, Riley: Stilwell's Mission to China. United States Army in World War II. Washington: U.S. Government Printing Office, 1953, pp. 87–89. (2) Romanus, Charles F., and Sunderland, Riley: Stilwell's Command Problems. United States Army in World War II. Washington: U.S. Government Printing Office, 1956, pp. 28–31, 138–139.



FIGURE 112.—Lt. Col. Gordon Seagrave, MC.

Col., MC) Gordon Seagrave (fig. 112), the well-known "Burma surgeon," whose hospital served at Rāmgarh, India (fig. 113), and later along the Ledo Road, struggled hard to maintain the separate identity of his mission hospital group within the complex U.S. Army medical organization.[3]

The geographic regions comprised in the theater varied greatly in climate and terrain. In this area of multitudinous diseases and much famine, medical resources were meager. The variety of national and cultural types, military and civilian, thrown together during the campaigns in Burma made it difficult to effect uniform measures to prevent disease. The fighting forces were Americans, Chinese, British, Indians, and Africans; many local tribesmen—Nagas, Karens, Shans, Kachins, and others—were employed by the American Army. The total effect of this cultural heterogeneity upon U.S. Army medical service

[3] (1) Interview, Brig. Gen. Robert P. Williams, MC, 22 Aug. 1951. (2) Diary, Col. John M. Tamraz, MC, vol. I, 29 Mar. 1942–1 June 1944. (3) See footnote 1, p. 505. (4) Letter, Brig. Gen. R. P. Williams, MC, to Col. Calvin H. Goddard, MC, Editor, History of the Medical Department in World War II, 24 Dec. 1952, and attachments.

See also Seagrave, Gordon: Burma Surgeon Returns. New York: W. W. Norton & Co., 1946, especially pp. 199ff., for Seagrave's own account of his experience with Army administration. In order to obtain a regular flow of medical supplies for the Seagrave Hospital, it was necessary that it be carried, at least on paper, as an orthodox unit. The theater surgeon solved the problem by requesting assignment to the theater of the 896th Clearing Company "minus personnel." Seagrave absorbed the equipment of the clearing company, and doubled as its commanding officer, although he continued to fear that his own unit might lose its identity.

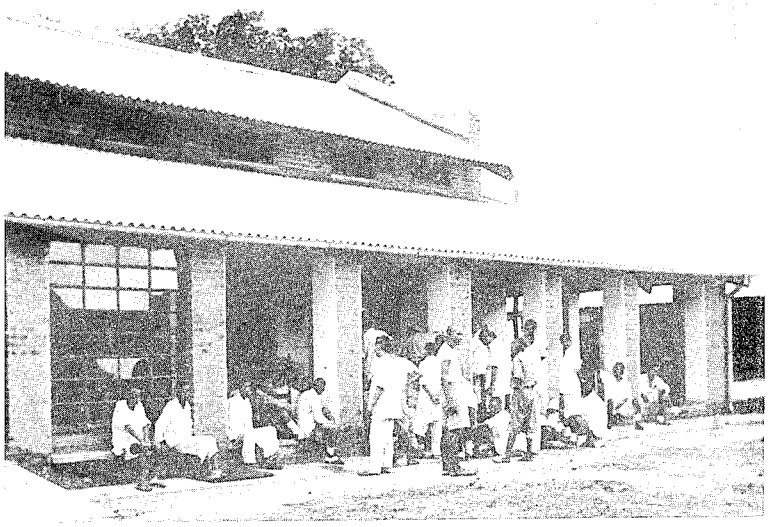


FIGURE 113.—Seagrave's hospital, Rāmgarh, India.

is not measurable, but differences in dietary habits undoubtedly complicated the administration of Army hospitals, while customs and taboos of religion and caste sometimes hampered efforts at disease prevention. The fact that under the caste system in India only the lowest caste could engage in certain duties, such as the handling of water supplies, became an important factor to Army doctors in a theater where it was necessary to depend heavily upon local labor.

THE CHINA-BURMA-INDIA THEATER: 1942 TO OCTOBER 1944

When General Stilwell set up headquarters for the U.S. Army Forces in China, Burma, and India at Chungking, the wartime capital of China, in March 1942, he had at his disposal a few Medical Department officers who had come to China with special missions. Two had accompanied the mission headed by Brig. Gen. John Magruder which had arrived in the fall of 1941 to expedite the sending of lend-lease supplies to China. Two others had accompanied General Stilwell's own American Military Mission which had superseded General Magruder's mission after the United States had entered the war.

No formal organization of medical service was possible at this date. The Japanese capture of Rangoon in March had closed the Burma Road, severing communication between China and India. China was practically cut off from supplies in every direction. General Stilwell, who had been made chief of staff for Generalissimo Chiang Kai-shek and commander of Chinese troops in Burma, as well as commanding general of the American theater, went into action with the Chinese troops in the First Burma Campaign. Three of the Medical Department officers who had come with the special missions went to Burma to give direct care to U.S. Army troops serving there. The senior officer, Col. Robert



FIGURE 114.—Brig. Gen. Robert P. Williams, MC.

P. Williams, MC (fig. 114), became General Stilwell's staff surgeon. These officers accompanied General Stilwell during his retreat on foot from Burma to India. During the trek out of Burma, Colonel Williams had firsthand experience with the health hazards of the region, treating cases of malaria, dysentery, sore feet, and other ailments of the weary force accompanying General Stilwell.

Major Medical Offices in 1942

Only after the return to India could Colonel Williams build up his medical staff. When he reached India in May, a medical section had already been created for the Services of Supply (established in April). It was headed by Col. John M. Tamraz, MC (fig. 115), who had been assigned to Brig. Gen. (later Lt. Gen.) Raymond A. Wheeler's U.S. Military Mission to Iran and Iraq and had been transferred with General Wheeler to the Services of Supply for the China-Burma-India theater. The Services of Supply headquarters, briefly in Karachi, was set up in New Delhi in May 1942 and remained there throughout the life of the theater (fig. 116). Colonel Williams established his own office at General Stilwell's rear echelon headquarters, also in New Delhi. His staff at this date consisted of only a few Medical Department officers who arrived in the theater in late May of 1942. Meanwhile one of the officers who had come out with the



FIGURE 115.—Col. John M. Tamraz, MC.

Magruder mission had been left behind in Chungking to represent Colonel Williams at General Stilwell's forward echelon headquarters there.

During this period, the middle of 1942, the theater surgeon and the Services of Supply surgeon, both in New Delhi, were able to keep in close touch with each other. Both Colonel Williams and Colonel Tamraz spent much time in 1942 in tasks that would customarily have been delegated to subordinates: personal inspection of troop areas and hospital buildings being constructed by the British and Indian Armies under reverse lend-lease, investigation of the extent to which American troops sent to India had been immunized against various endemic diseases, and other activities in preventive medicine. Colonel Tamraz' chief task was to establish the station and general hospitals of a Services of Supply. During the first half of 1942, the British furnished hospitalization to the 3,000 American troops in India.

For some time Colonel Tamraz had to use the Dental Corps officer who headed his dental service for the very uncommon assignment of chief medical supply officer as well. But Colonel Tamraz fared somewhat better as to staff when his office was enlarged by the addition of 14 U.S. Public Health Service officers. These men had been sent as a commission, under the direction of Lt. Col. Victor H. Haas, late in 1941 to aid the Chinese Nationalist Government with public health services for thousands of Chinese workers building the

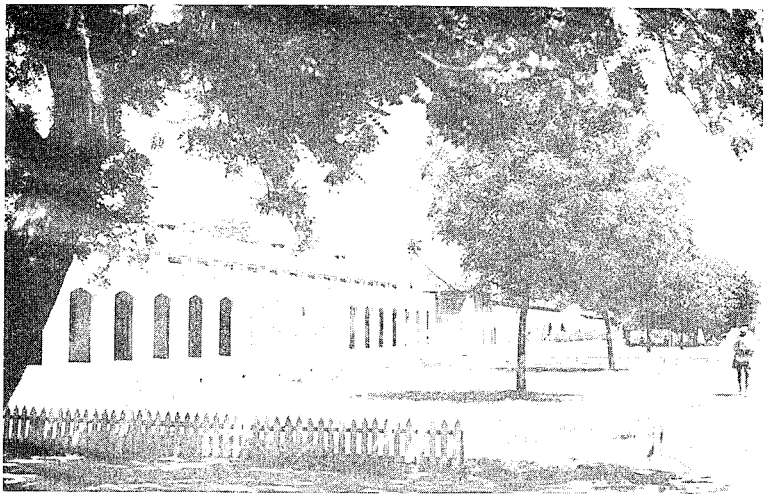


FIGURE 116.—New Delhi headquarters, Services of Supply surgeon, China-Burma-India theater.

Yünnan-Burma Railway. Financed with lend-lease funds, the railway had been designed to carry supplies into China from Burma. The U.S. Public Health Service officers had been forced out by the Japanese invasion of Burma.

This group included men qualified in medical specialties, as well as sanitary engineers, entomologists, epidemiologists, and malaria control experts. Those trained in preventive medicine were the only experts in that field available to the Army for about the first year of the theater's existence. The U.S. Public Health Service officers did not become permanent assets to the Services of Supply headquarters but were soon sent to its area commands. Most went to sites between Karachi and Chabua, India, tentatively selected as bases for the Tenth Air Force, to make sanitary and malaria surveys, thus initiating the theater's malaria control program. In 1942, trained personnel and antimalaria supplies were wholly inadequate.[4]

Medical intelligence work for the theater was carried out at New Delhi under the auspices of the American Observer Group sent in March 1942 to get advance information on British and Indian experience which might be useful to incoming American troops. This group was transferred within a few months to G–2 of General Stilwell's command. Throughout 1942 and early 1943, Maj. (later Col.) Earle M. Rice, MC, the medical officer originally assigned, was engaged in appraising medical problems and practices of the British and Indian Armies. He prepared many intelligence reports on the

[4] (1) Van Auken, H. A.: History of Preventive Medicine in the United States Army Forces in the India-Burma Theater, 1942 to 1945. [Official record.] (2) Stone, James H.: Organization and Administration of the Medical Department in the China-Burma-India Theaters, 1942–1946. [Official record.] (3) See footnote 1, p. 505. (4) Williams, Ralph C.: The United States Public Health Service, 1798–1950. Washington: U.S. Public Health Service Commissioned Officers Association, 1951, pp. 685–691.



FIGURE 117.—Col. H. B. Porter, MC.

following subjects, among others: Yellow fever quarantine; the prevalence of malaria, cholera, filariasis, and other tropical diseases in various areas of India and Burma; methods of immunization against and treatment of tropical diseases; medical problems connected with evacuating troops and refugees from Burma during the retreat; and assessment of stocks of quinine and other medical stores in various areas.

The Tenth Air Force was built up in India in 1942, around a nucleus of air force personnel newly arrived from Java and the Philippines, under the command of Maj. Gen. (later Lt. Gen.) Louis Brereton. It, too, had headquarters at New Delhi at a later date. In these early days of theater organization, the Tenth Air Force constituted most of the American military establishment in India. Its medical section, headed by Col. H. B. Porter, MC (fig. 117), worked in a dual capacity throughout 1942 as the headquarters medical section for the Tenth Air Force and for the Air Service Command, India-Burma Sector, China-Burma-India theater.

In China, General Chennault's American Volunteer Group, which eventually became the Fourteenth Air Force, was still under the control of Generalissimo Chiang Kai-shek. In July 1942, what remained of it was inducted into the U.S. Army as the China Air Task Force, a complement of the India Air Task Force, both of which were elements of the Tenth Air Force. Dr.



FIGURE 118.—Col. T. C. Gentry, MC.

(later Col., MC) T. C. Gentry (fig. 118), who had been surgeon of the American Volunteer Group, continued to head the medical work under General Chennault until the latter relinquished command of the Fourteenth Air Force in August 1945. Throughout the life of the China-Burma-India theater, General Chennault's air element constituted the bulk of the U.S. Forces in China—an element greatly outnumbered by the troops of the Services of Supply and the Tenth Air Force in India.[5]

In the fall of 1942, a shift of emphasis took place in the responsibilities of the theater surgeon. It had become clear that Chinese Government authorities at the wartime capital, Chungking, would not cooperate with the young major who was assistant to the theater surgeon. Indeed, Colonel Williams' own lack of rank was a handicap in dealing, as he was constantly required to do, with lieutenant generals of the Chinese, British, and Indian Armies.[6] With the defeat in Burma, however, the urgency for on-the-spot action in

[5] (1) Medical History of the Tenth Air Force, 22 Aug. 1944. [Official record.] (2) Annual Report, Surgeon, Fourteenth Air Force, 1943. (3) Medical History of the Fourteenth Air Force in China, 28 Aug. 1944. [Official record.] (4) See footnote 4(2), p. 511.

The American Volunteer Group included, in addition to Dr. Gentry, two surgeons, a dentist, two nurses, and six medical orderlies.

[6] Letter, Brig. Gen. Robert P. Williams, USA (Ret.), to Col. John Boyd Coates, Jr., MC, USA, Director, The Historical Unit, U.S. Army Medical Service, 22 Aug. 1955.

India by the theater surgeon had subsided. U.S. interests were consistently focused on China, and close cooperation with the Chinese Nationalist Government was vital to the success of the medical training of the two Chinese divisions which had escaped from Burma. These young men, malnourished and ill with dysentery, malaria, and tropical ulcers, were to be rehabilitated in India for the return to Burma. In addition, Colonel Williams was to plan the medical phases of the training program for 30 Chinese divisions which General Stilwell expected to mobilize in southwest China. Hence he transferred his main office to General Stilwell's forward echelon headquarters at Chungking and placed his deputy in charge of the office at rear echelon headquarters in New Delhi.

After the transfer, Colonel Williams' main effort was devoted for some months to liaison activities in connection with the training of Chinese troops in India and China. Until July 1943, he was the only medical officer on duty at the Chungking headquarters. At first his office consisted of a typewriter at the foot of his bunk; he did his own typing. Housing was scarce in the much-bombed Chungking, and at this date few men had been flown over the Hump. After some weeks Colonel Williams had a battered desk and a few enlisted men to help him; he worked in a room with several other members of the special staff. It was not until 1944 that a headquarters was built and he got an office of his own.

Colonel Williams' main office remained in Chungking until the spring of 1944, although most of his staff stayed at his rear office in New Delhi. The division of the theater medical section into two offices, one at Chungking and the other at New Delhi, lasted until the theater was split into two theaters in the fall of 1944.

At the end of 1942, the following major medical offices were located at New Delhi: The theater surgeon's rear headquarters office (consisting of only two Medical Department officers and two enlisted men until early the following year), the Services of Supply surgeon's office, and that of the Tenth Air Force surgeon. The surgeon of the Indian Sector of the Air Transport Command's Africa-Middle East Wing was then stationed at Karachi, the eastern terminal of the wing. The theater surgeon's main office was in Chungking. General Chennault's China Air Task Force, later incorporated into the Army as the Fourteenth Air Force, was also based in China, at Kun-ming.[7]

Beginning in the autumn of 1942, the U.S. Army undertook at Rāmgarh (Bihar Province) the rehabilitation and training of two divisions of Chinese troops. These escapees from Burma, together with men later flown over the Hump from China, made up the Chinese Army in India under General Stilwell's command. The Services of Supply was responsible for giving hospital care to the Chinese troops and for furnishing them medical supplies, obtained

[7] (1) See footnotes 4(2), p. 511; 5(1) and (6), p. 513; and 6, p. 513. (2) History of the Medical Department Air Transport Command, May 1941–December 1944. [Official record.] (3) Letter, Brig. Gen. Robert P. Williams, MC, to Col. Joseph H. McNinch, MC, Editor, History of the Medical Department in World War II, 21 Feb. 1950, and inclosure.

from the British in India. Under direction of the theater command, American staff officers and training instructors of the Chih Hui Pu, or headquarters for the Chinese Army in India (activated in October 1942 and located at Rāmgarh), developed and put into effect the training program. Over 53,000 Chinese officers and men, most of them flown in from China, were trained at Rāmgarh between August 1942 and October 1944.

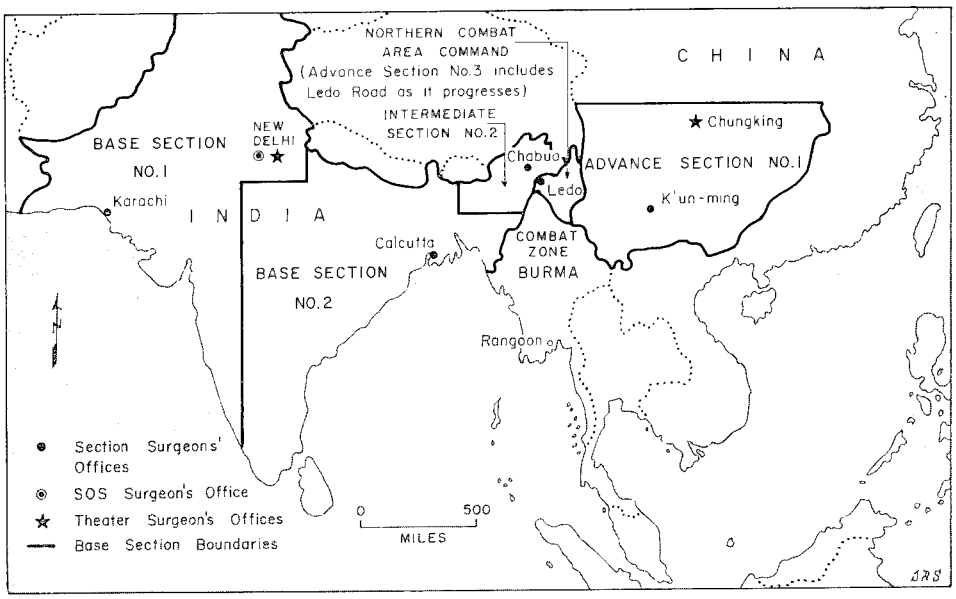
The office of the post surgeon at Rāmgarh had charge of sanitation in and around the approximately 1,000 buildings on the post, which was located in partially cleared jungle and abandoned rice paddies. This office directed the work in control of malaria and venereal disease. It also supervised the post hospital, which for some months was operated by Dr. Gordon Seagrave, the "Burma surgeon," who had accompanied General Stilwell on the trek out of Burma. The same office was responsible for the work of veterinarians on the post, both in animal care and food inspection. As the commander of the Rāmgarh Training Center was directly responsible to the Commanding General, Services of Supply, rather than to the commander of the base section in which the center was located, the post surgeon reported to the Services of Supply on the technical aspects of his duties.

A separate group of Medical Department officers, together with some English-speaking Chinese medical officers and 11 European civilian doctors hired by the Chinese Red Cross, gave medical training to the Chinese officers and soldiers at Rāmgarh. Chinese officers and men were trained as members of field medical units; medical officers were given both basic and refresher courses in anatomy, practical surgery, preventive medicine, and other subjects. Officers of the Pharmacy Corps were given dental training; in the Chinese Army the pharmacy corps officer was responsible for dental as well as pharmaceutical work. The group of Army Medical Department officers in charge of training was responsible to the theater surgeon, reporting to him through his deputy at his rear echelon office in New Delhi. Some were assigned as liaison officers with the larger Chinese units and helped Chinese surgeons to establish unit dispensaries and field hospitals, later accompanying them to Assam, where in the fall of 1943 the front was reopened for the invasion of Burma.[8]

Base and Advance Sections

Colonel Tamraz' office had responsibility, through surgeons assigned to advance, intermediate, and base sections, for the usual medical functions of a Services of Supply in a theater of operations. Fixed hospitals for the theater got under way when a station hospital began receiving patients in May 1942. By October 1944, when the China-Burma-India command was divided into 2 theaters, 7 general hospitals, 22 station hospitals, 3 medical depots, and a

[8] (1) See footnotes 4(1) and (2), p. 511; and 7(3), p. 514. (2) History of the Services of Supply, China-Burma-India, 28 Feb. 1942–24 Oct. 1944. [Official record, Office of the Chief of Military History.] (3) Annual Reports, Camp Surgeon, Rāmgarh Training Center, 1943 and 1944. (4) Annual Reports, Medical Sub-section, Rāmgarh Training Center, 1943 and 1944.



MAP 14.—China-Burma-India theater, August 1944.

medical laboratory were serving the Services of Supply organization; the great majority of these installations were in India. The Services of Supply furnished medical supplies and hospitalization to the Tenth Air Force in India, a few U.S. Army ground troops, the Fourteenth Air Force fighting in China, Air Transport Command personnel, the troops of the Services of Supply itself, and to patients of the Chinese divisions (or X-Force) based in India and committed in the Second Burma Campaign.

The area commands of the Services of Supply were created during and after the summer of 1942 (map 14). The layout of the theater, with two separate fighting fronts, led to advance sections in both India and China. Some area commands were of brief duration, and the usual changes in names and boundaries to accord with shifts in the tactical situation took place. Five regions of the theater remained fairly stable entities for Services of Supply administration, however, despite their shifting roles.

Army stations on the western half of India were organized into a base section with headquarters at Karachi, the principal American military port in the early months of the theater's existence. In 1942 the medical supply depot at Karachi was very active; it had inherited many tons of lend-lease medical supplies, including equipment for more than a dozen small hospitals, intended for the Yünnan-Burma Railroad. Several small station hospitals and one general hospital served in this base section. But the base section in eastern India later became more important, for Calcutta, headquarters of the base section, became the major receiving port. Here troop concentration became heavy with

the buildup of the air forces for carrying supplies over the Hump to China. At one time the base section surgeon had as many as 10 Army hospitals under his supervision. The provision of hospitals for XX Bomber Command elements based west of Calcutta was a major project of 1944. An important job in Calcutta, requiring joint action with British and Indian authorities, was the maintenance of satisfactory sanitary conditions in the notoriously ill-kept restaurants of the city. Toward the end of 1943, British and American military forces created an Allied Hygiene Committee to make regular inspections of the restaurants and recommend as to whether they should be placed out of bounds to Allied troops. This work, important in the control of enteric diseases, continued to the end of the war.

In the advance section (later an intermediate section), located in the upper Brahmaputra valley of northeast India, the commander of the station hospital at Chabua, headquarters of the section, doubled as section surgeon. In the spring of 1943 some veterinary officers and a Sanitary Corps officer were added to the medical staff, but not until April 1944 was the position of section surgeon separated from that of hospital commander. This was a highly malarious area and troops were greatly dispersed, both among the airbases and along the railway, pipe, and signal lines leading to Ledo. Some half dozen small station hospitals, a number of malaria control units and food inspection detachments, and a medical laboratory served the advance section. Within the boundaries of the section, but not a part of its organization, was the office of the Surgeon, India-China Wing, ATC (Air Transport Command), which was also at Chabua, the western terminal of the Air Transport Command's route over the Hump between India and China. The wing surgeon supervised medical service for aircrews transporting men and supplies back and forth across the Hump, as well as for personnel stationed at the India-China Wing's bases.

The base section which included the northeastern province of Assam eventually became, with the advance into Burma, an advance section which embraced the neighboring reconquered parts of Burma. Its headquarters was at Ledo, the starting point of the Ledo (Stilwell) Road, being constructed to connect with the Burma Road to China. Its original surgeon, Lt. Col. Victor H. Haas of the U.S. Public Health Service, faced the difficulties posed by the task of the base section and its location—at the end of a tenuous line of supply, in a region of enervating climate, many disease vectors, and contaminated water sources. The base section served the thousands of laborers, as well as service troops, who were building and protecting the Ledo Road—a medley of British, American, and Chinese soldiers and Indian workmen. The surgeon's office, established toward the end of 1942, included a "Chinese Liaison" unit and an "Indian Medical Service" unit to handle arrangements made with the Indian and Chinese Governments for furnishing hospitalization and other medical care to Chinese and Indian troops. The threat of malaria was recognized early; three specialists in malaria control were assigned to the surgeon's office before malaria control and survey units arrived from the States. The small number

of officers allotted to the medical section—only 5 in mid-1944—had to be supplemented by 11 others attached for "special duty." Troops of the Chinese Army in India and the Northern Combat Area Command engaged in Burma received hospitalization at installations—including the large 20th General Hospital, a University of Pennsylvania-affiliated unit of 2,000 beds—maintained by the advance section. At the end of 1944, when the Ledo area had become part of the new India-Burma theater, the advance section, as it was now termed, was responsible for medical service for about 160,000 Chinese and American troops and 15,000 animals.

Units of General Chennault's Fourteenth Air Force predominated throughout the advance section (Advance Sections 3 and 4 until January 1944) in China. The air force had its own dispensaries, actually small hospitals, at towns such as Kun-ming and Kweilin, where its units were based. Since the Chinese Government supplied these rapidly shifting air units with food and lodging, and since the U.S. Army had no responsibility for supporting Chinese troops in China with fixed hospitalization, the role of the Services of Supply in China was a limited one. At K'un-ming, the eastern terminal of the Hump route, the India-China Wing, ATC, maintained the usual separate medical service. Hence the advance section surgeon at K'un-ming never had any extensive staff. His duties—supervision of the section's only hospital at K'un-ming, a small medical supply depot, and a few other medical installations—were originally performed by a medical officer on General Chennault's staff and later by the commanding officer of a station hospital. Only in March 1943 was a Medical Corps officer separately assigned as surgeon. The SOS (Services of Supply) Advance Section in China later established a provisional hospital at Kweilin, as well as the station hospital at K'un-ming; these installations furnished fixed hospitalization to the troops of the Fourteenth Air Force and to the XX Bomber Command elements that moved to China bases in 1944.[9]

Functions and Staffs in 1943

The tasks performed respectively by the theater surgeon and the Services of Supply surgeon, as well as their relations with each other, were affected by a number of factors, some of which were mentioned at the beginning of the chapter: the split of the theater into two distinct regions; the numerical preponderance of American air force and Services of Supply troops over ground troops; responsibility of the Army Medical Department for large numbers of Chinese troops in India, later in Burma; and the lack of coordination and scattered locations of headquarters of the top commands. Close rapport between the theater surgeon and the Services of Supply surgeon was not possible, although Colonel Williams conferred with Colonel Tamraz whenever he flew across the

[9] (1) Annual Reports, Medical Department Activities, Base Section 1, 1943 and 1944. (2) Annual Report, Medical Department Activities, Base Section 2, 1942. (3) Annual Reports, Medical Department Activities, Base Section 3 (Advance Section 3), 1943 and 1944. (4) See footnotes 4(1), (2), and (4), p. 511; 6, p. 513; 7(2), p. 514; and 8(4), p. 515.

Hump to inspect medical installations and units on that side of the theater. During the 17 months that he was stationed in Chungking, Colonel Williams made six flights over the Hump to India, conferring with Colonel Tamraz on each occasion. Not until mid-1943 did Colonel Williams have any commissioned assistant; thereafter he had only one or two officers and clerical assistants. His rear echelon office in New Delhi was headed by a number of deputies, most of whom served for short periods, several being sent back to the United States because of illness. The frequent change of deputy hampered effective coordination between the theater surgeon's two offices.

Colonel Tamraz, lacking a medical inspector, had to spend much time in inspection of hospitals and medical supply depots throughout the base sections of India—at Calcutta, Gaya, Rāmgarh, Chabua, Agra, and so forth. He handled problems of medical supplies and equipment, which entered the theater at Indian ports, and of station and general hospitals. The theater surgeon was chiefly concerned with developing plans, in conjunction with Chinese governmental authorities in Chungking, for the medical training of the Chinese troops in India and China and for furnishing medical care in U.S. Army field hospitals to the Chinese on the Assam front; he also personally inspected the training and care furnished. Beginning in the spring of 1943, his responsibility for planning for Chinese troops was greatly expanded when the development of the Y-Force got under way in southwest China. In this situation the Services of Supply medical office developed somewhat independently of the theater surgeon.[10]

Largely through force of circumstances, Colonel Williams' job came to be unlike that of the orthodox theater surgeon. His chief activities—planning in cooperation with Chinese authorities and inspection of the medical service for Chinese and American troops during the Second Burma Campaign—resembled those of General Kenner at Supreme Headquarters in the European theater. Colonel Williams found that he encountered difficulty in seeing General Stilwell and, since the latter did not readily delegate authority to subordinates, getting command decisions. Not until the advent of Maj. Gen. Daniel I. Sultan as General Stilwell's deputy early in 1944 did Colonel Williams find it possible to get prompt command backing for his recommendations.[11]

In 1943, during periods of stay at the Chungking office, Colonel Williams had conferences about once a week with the Surgeon General of the Chinese Army and with the Director General of the National Health Administration. Both had offices near Chungking. With the former and with Madame Chiang Kai-shek, then the Generalissimo's representative on medical affairs, he frequently discussed matters of lend-lease medical supply for the Chinese and medical training and hospitalization for Chinese troops. The task of building

[10] (1) See footnotes 1, p. 505; 3(1), (2) and (4), p. 507; and 4(2), p. 511. (2) Letter, Col. John M. Tamraz, MC, to Col. Joseph H. McNinch, MC, Editor, History of the Medical Department in World War II, 27 Feb. 1950.

[11] See footnote 3(4), p. 507.

up the Chinese Army's medical service was arduous, both because of the dearth of doctors and because of the diffusion of responsibility.[12]

During 1943, Colonel Williams traveled to many areas of India and China, inspecting dispensaries, evacuation, station, and general hospitals, medical depots, and other medical installations, both American and Chinese, particularly in Base Section 3, where work on the Ledo Road was in progress. After the opening of the Second Burma Campaign in October, he visited many sites in the combat zone by plane, concentrating upon the "trouble spots" of medical service for the Chinese troops and conferring with Chinese and American medical officers. During 1943, the chief surgical and the chief medical consultant of the Surgeon General's Office, the chief of preventive medicine of that office, General Fox of the U.S.A. Typhus Commission, and the Secretary of War's representative on bacteriological warfare (John P. Marquand, a novelist) visited the theater. Colonel Williams conferred with all of these. The chief medical consultant, accompanied by Colonel Williams, made a thorough study of American and Chinese hospitals in eastern India.[13]

The theater surgeon had to make a special effort to exercise any supervision over the medical service of certain subordinate commands; the geography of the theater aggravated the difficulty of integrating their medical service into a theaterwide system. Medical Department officers of the air forces, especially of General Chennault's Fourteenth Air Force and of the Air Transport Command wing, made the usual efforts to achieve an autonomous medical service. The XX Bomber Command, which was based in India and China from June 1944 to March 1945 during its long-range bombing of Japan, was a part of the Twentieth Air Force, which for some time was under direction of the Washington headquarters of Army Air Forces; its headquarters medical staff dealt directly with the Air Surgeon in Washington in outlining its medical requirements. Medical Department officers assigned to the infantry regiment known as "Merrill's Marauders" and those of the "secret hospital" serving with Detachment 101 of the Office of Strategic Services worked entirely on their own for some months after their arrival in the theater, as the existence and missions of the outfits which they served were perforce kept highly secret. Colonel Williams was not informed of the arrival of either of these elements. When he learned of their presence by accident he sought out their surgeons personally and made special arrangements to assure them medical supplies and to evacuate and hospitalize their patients.[14]

The Services of Supply surgeon, Colonel Tamraz, found his assignment difficult, and the diary which he kept during the war years is tinged with melancholy. In his opinion, his office was never properly staffed. He received complaints about some seven or eight Medical Department officers in adminis-

[12] See footnotes 4(2), p. 511; and 7(3), p. 514.

[13] (1) See footnote 4(2), p. 511. (2) Letter, Col. Robert P. Williams, MC, to Lt. Gen. Daniel I. Sultan, 16 Apr. 1946, attached to letter cited as footnote 7(3), p. 514. (3) Diary, Col. Robert P. Williams, MC.

[14] See footnote 3(4), p. 507.

trative positions in the Services of Supply (commanding officers of hospitals in a few instances). The charges included drunkenness, malingering, undue harshness, and mental or physical deterioration. In some instances he shifted these officers to other localities or other types of work. In July 1943, he wrote to the Personnel Division of the Surgeon General's Office, complaining of the quality of Medical Corps and Medical Administrative Corps personnel being sent to the theater.

To Colonel Tamraz, the low rank of Medical Department officers—there was no Medical Department general officer in the theater at any time during the war—compared with the rank held by officers of other services constituted ground for further dissatisfaction. He lamented, as did Medical Department officers in all theaters in which the British were present, the higher rank commonly held by a British medical officer performing the same tasks as an American medical officer. Occasionally he recorded his objections to being bypassed on decisions on medical matters by line officers, to adverse decisions on his recommendations by line officers who seemed unsympathetic to the medical service, and to the shifting of Medical Department enlisted men to duties other than medical. He noted the usual efforts by air force commands to set up their own medical supply depots and station hospitals and deprecated duplications in medical service caused by the presence of several commands within a given area. He experienced some of the usual difficulties with medical supply: low priority in transport, losses when ships were sunk, and occasional theft. In May 1943, he reprimanded a Medical Department officer for a reason not commonly recorded: in a station hospital's monthly sanitary report the officer "had criticized the activities of the Medical Department something scandalous." [15]

Although some additions were made to the staffs of the theater and Services of Supply surgeons during 1943, no consultants were added to either. The chief trend in the organization of these two offices during 1943 was the transfer of personnel responsible for major phases of preventive medicine, particularly malaria control and venereal disease control, from the office of the Services of Supply surgeon in New Delhi to the theater surgeon's rear echelon office in the same city. Colonel Williams wanted as complete a staff as possible in his New Delhi office to prepare and issue theaterwide directives.

As a result of sending the U.S. Public Health Service officers to the bases where they had directly initiated malaria control programs, by early 1943 malaria control had become largely a Services of Supply responsibility. The Services of Supply surgeon's office had acquired a Sanitary Corps specialist in food and nutrition and a venereal disease control officer. In early 1943, the theater surgeon transferred the venereal disease control officer to his own office in New Delhi and made a similar move with respect to the malaria control staff. When the standard type of malaria control organization recommended by the Surgeon General's Office was under discussion early in 1943, Colonel Tamraz'

[15] See footnotes 1, p. 505; 3(2), p. 507; and 10(2), p. 519.

office drew up a plan for malaria control organization under the aegis of the Services of Supply, to be supervised by a malariologist on Colonel Tamraz' staff, with malaria control officers attached to the headquarters of base, intermediate, and advance sections.

With the assignment of Colonel Rice as theater malariologist in February 1943 and the arrival about 3 months later of antimalaria units from the States, the theaterwide program for malaria control got under way. Colonel Rice was assigned to the theater surgeon's office from the outset, and in June four assistant theater malariologists who had arrived with the units were assigned to the same office. Thus by mid-1943, the theater surgeon had concentrated in his office the direction of two important phases of preventive medicine—venereal disease control and malaria control. The trend continued in the fall when the Chief of Preventive Medicine, SOS, who had arrived in the theater early in the year, was transferred to the theater surgeon's office. In Colonel Williams' opinion it was preferable, in the absence of sufficient Medical Department personnel to staff both offices with preventive medicine specialists, to station those assigned to major control programs at the higher level in order to enable them to make their policies effective throughout the theater. From this level they could issue theaterwide directives and could enter the combat zone, where General Stilwell was unwilling for Services of Supply personnel to go. Colonel Tamraz, on the other hand, came to regard removal of personnel from his medical section to Colonel Williams' New Delhi office as interference with the medical work of the Services of Supply.

By the end of 1943, the theater surgeon's New Delhi office had the following personnel engaged in preventive medicine: A medical inspector, a venereal disease control officer, a malariologist, and three assistant malariologists. One aspect of preventive medicine—nutrition—remained in the office of the Services of Supply surgeon throughout the existence of the theater; studies of the troop ration, Army messes, and hospital diets were made by nutritionists assigned to the base, intermediate, and advance sections. Since the Services of Supply was responsible for supply of rations, it was logical to handle the medical aspects of nutritional problems through that command.[16]

At the end of 1943, Colonel Williams had in his office at forward echelon headquarters in Chungking only an assistant dental surgeon (actually on duty as station dental officer at the K'un-ming headquarters of the Fourteenth Air Force), an administrative assistant, and four enlisted men. As assistant theater surgeon, Col. George E. Armstrong, MC (fig. 119), entered on duty in the Chungking office early the following year. At his New Delhi office, Colonel Williams had, besides the preventive medicine group mentioned above, a deputy, a theater dental surgeon, a theater veterinarian, a medical supply officer, an executive officer, and seven enlisted men. At the same date the Services of

[16] See footnotes 3(1), p. 507; and 4(1) and (2), p. 511.



FIGURE 119.—Col. George E. Armstrong, MC.

Supply surgeon had in his office, besides the nutrition officer, the following staff: An executive officer; a dental surgeon; a chief of veterinary service, SOS; an administrative assistant and records officer; and a medical supply officer and four assistants.[17]

Training of Chinese Combat Forces

Plans for the training of Chinese troops contemplated two groups of 30 divisions each; one group was to consist of the divisions being trained in India, separately referred to as X-Force, and of the divisions, termed Y-Force, which would be developed in Yünnan Province in southwest China. The other group of 30 divisions, called Z-Force, would be assembled and trained in southeast China. The job of planning the medical phases of this training fell to the small group of Medical Department officers who comprised the theater surgeon's Chungking staff during 1943 and 1944. As noted above, training of the X-Force took place at Rāmgarh, India. An operation staff was established for Brig. Gen. Frank Dorn's Y-Force in April 1943 and one for Z-Force in January 1944. To each staff a few U.S. Army Medical Department officers and men were assigned to aid in giving field medical training to the Chinese and to act as liaison or staff officers in the field with Chinese units.

[17] See footnote 4 (2), p. 511.

A surgeon and a veterinarian were included in the medical section at Y-Force Operations Staff headquarters in K'un-ming, other Medical Department officers being assigned as liaison officers with the units. Medical training given the Chinese was designed to supply medical personnel to accompany the combat troops, and to staff units concerned with evacuation; that is, to equip the Chinese divisions with the first and second echelon medical service similar to that in the U.S. Army. The Infantry Training Center at K'un-ming was the prototype of several centers at which medical training was given. The Surgeon, Y-Force Operations Staff, with the aid of six U.S. Army officers and the same number of enlisted men, set up the medical section at this center. Medical, dental, and veterinary training was given to Chinese officers and men of Y-Force at training centers at Kweilin, Tali, and Yenshan, as well as at K'un-ming.

At the outset of the Salween River campaign, one U.S. Army medical officer, one veterinary officer, one Medical Department enlisted man, and one veterinary enlisted man were detailed to each army group, army, and division of the Y-Force. Officers who had lived in China or who spoke Chinese were used as American staff officers insofar as they were available. The Chinese Army Medical Department supplied the chain of evacuation as the Y-Force cleared the Burma Road and thrust westward to join the X-Force advancing through northern Burma. Ten U.S. Army portable surgical hospitals and three field hospitals had to be used to strengthen this chain, for the Chinese Army Medical Department was inadequately supplied with hospitals of these types, chiefly because of the dearth of surgeons to handle emergency surgery near the front. Eighteen U.S. Army veterinary detachments were used in the care of thousands of pack animals transporting personnel and equipment of the Y-Force. The field and portable surgical hospitals were among the units moved by pack animals.

The 30 Chinese divisions planned in southeastern China never really developed; the Japanese offensive toward K'un-ming in the summer of 1944 suppressed Z-Force in its infancy. The significant medical work undertaken by U.S. Army Medical Department officers assigned to this force was the conduct of a training program similar to that for Y-Force. Medical training for Z-Force was centered in the Infantry Training Center at Kweilin, where Z-Force had its headquarters, from late 1943 to the summer of 1944. Dental and veterinary training were also given. When the school closed on 25 July 1944 it had graduated 535 Chinese medical officers, 24 pharmacy officers (given dental training), and 412 veterinary officers, enlisted technicians, and horseshoers. The coordination of procedures for handling medical supply became, as in Y-Force, a major problem. Again the U.S. Army had to take over. Beginning in July 1944, two medical maintenance units per month were delivered to Chabua and flown over the Hump to K'un-ming for the use of Z-Force. By October 1944, the Japanese drive had doomed Z-Force to extinction as an effective fighting force. In November, the Y-Force and Z-Force Operations Staffs combined

to make up the Chinese Combat and Training command of the newly formed China theater.[18]

The Air Forces

The medical section of Tenth Air Force, the chief American combat element in the theater, was at New Delhi in 1943; it doubled as the medical section of the air force service command. Until March 1943, when the Fourteenth Air Force was created, the Tenth Air Force theoretically supervised the medical activities of two major fighting components—India Air Task Force which protected the air route between India and China from its bases in Assam, and General Chennault's China Air Task Force based at K'un-ming. Because of the remoteness of General Chennault's component from the New Delhi headquarters of Tenth Air Force, little effective control was exercised over its medical service by the Tenth Air Force surgeon, although the Tenth Air Force Service Command gave medical support to the Fourteenth Air Force.

In August 1943 the Army Air Forces, India-Burma Sector, was created with three major components: the China-Burma-India Air Service Command, China-Burma-India Air Forces Training Command (engaged in training of Chinese personnel at Karachi), and the Tenth Air Force. First surgeon of the new India-Burma Section was former Tenth Air Force Surgeon, Col. Hervey B. Porter. He was relieved in March 1944 by another former Tenth Air Force Surgeon, Col. Clyde L. Brothers, MC (fig. 120). At this time the medical section consisted of five officers—two Medical, two Veterinary, and one Dental—a warrant officer, and eight enlisted men. This office served also as the medical section for the China-Burma-India Air Service Command. Both the training command and the Tenth Air Force had separate medical sections. The China-Burma-India Air Service Command furnished medical supplies to the Fourteenth as well as to the Tenth Air Force.

In October 1943, the Tenth Air Force medical section moved with its headquarters to Calcutta. The following April the Medical Section, Army Air Forces, India-Burma Sector, made the same move. While the latter medical office remained there, that of Tenth Air Force went forward to various sites in Burma during the Northern Burma Campaign in 1944. The chief diseases faced by air force troops on the India-Burma side of the theater were malaria, the gastrointestinal diseases, and venereal disease. During the summer of 1943, unit and group surgeons of the Tenth Air Force took refresher courses at the Tropical School of Medicine in Calcutta.[19]

On the China side of the theater was the Fourteenth Air Force, as General Chennault's fighting force was named after March 1943. Its K'un-ming head-

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[18] Smith, Robert G.: History of the Attempt of the United States Army Medical Department to Improve the Efficiency of the Chinese Army Medical Service, 1941–1945. [Official record.]

[19] (1) See footnote 5(1), p. 513. (2) Medical History, Headquarters, Army Air Forces, India-Burma Sector, and Headquarters, China-Burma-India Air Service Command, 8 Nov. 1944. [Official record.] (3) Annual Report, Medical Department Activities, Headquarters, Army Air Forces, India-Burma Theater, and Headquarters, India-Burma Air Service Command, 1944.



FIGURE 120.—Col. Clyde L. Brothers, MC.

quarters and its China bases, amounting to 28 by the end of 1943, were far removed from Services of Supply and the various air force headquarters in India. Medical supplies had to be flown to Fourteenth Air Force over the Hump. The complete dependence upon air transport prohibited the construction of the usual living facilities at the bases, and Fourteenth Air Force units had to live off the land. The Chinese Government maintained hostels close to the airbases to house and feed Fourteenth Air Force troops. Throughout the life of the theater this dependence upon the Chinese for food and lodging subjected Fourteenth Air Force personnel to the unsanitary conditions and diseases prevailing among the Chinese people. The refusal of the Chinese to accept pay for the services rendered made it difficult to insist upon U.S. Army standards of diet and sanitation. Another factor affecting its medical service was the extreme mobility of the air force. General Chennault shuffled his squadrons from base to base. As bases outnumbered squadrons, most bases were occupied only a part of the year, and maintenance of a stable medical service was correspondingly difficult.

An interesting feature of the Fourteenth Air Force was its Chinese-American Composite Wing (Provisional) which was composed of from 30- to 40-percent American and from 60- to 70-percent Chinese personnel. It was created and trained in Karachi, whence its squadrons were fed to the Fourteenth Air Force in China. Although Chinese patients from this unit were

usually cared for in hospitals of the Chinese air forces, the close cooperation of Chinese and American medical personnel in the outfit afforded some experience with the process of building up an integrated medical service among Allied air troops.

The Fourteenth Air Force had, of course, the usual flight surgeons assigned to units. By the end of 1943, 10-bed dispensaries operated by a surgeon and a few enlisted men were being established at each base. Besides receiving emergency cases arising from accident and combat, these installations took care of minor cases which would otherwise have had to be evacuated by air to the station hospital maintained at K'un-ming for air force personnel. Dental officers were scarce and were rotated among the base dispensaries. Nursing service was provided by nine Chinese nurses; General Stilwell opposed the use of American nurses in China, although the air force surgeon stressed the need for American nurses. By July 1944, the medical strength of the Fourteenth Air Force, which had been served by 10 Medical Department officers (including a dentist) and 34 enlisted men when it was created in March 1943, amounted to about 50 Medical Department officers, including 10 dental officers, and approximately 150 enlisted men. The strength of the command was then a little over 8,000.[20]

Elements of the XX Bomber Command that came into the theater in 1944 with the mission of bombing enemy-held industrial targets in Japan, Manchuria, and southeast Asia, settled into bases in the Kharagpur area west of Calcutta, in Assam and northern Burma, and in China between K'un-ming and Chengtu. The command's medical section was located at command headquarters at Kharagpur. The usual air force dispensaries served XX Bomber Command bases. Patients requiring hospitalization were sent to the fixed hospitals maintained by the Services of Supply base, advance, or intermediate sections.[21]

The air forces in the China-Burma-India theater never developed such specialized means of coping with special stresses to which flying personnel were subject as did the air forces in some oversea areas, probably because of their small size and lack of the necessary medical resources. They developed no central medical establishment, and instead of creating convalescent centers they sent men who had been under severe physical and mental strain for long periods to mountain resorts to recuperate. The Tenth and Fourteenth Air Force surgeons agreed with the Air Surgeon in Washington that the air forces in the theater should control hospitals caring for air force personnel. Colonel Gentry voiced the most telling argument, basing his objection to hospitalization of troops of his air force in Services of Supply hospitals on the remoteness of the Fourteenth Air Force from the India bases where the hospitals of the

[20] (1) See footnote 5(2) and (3), p. 513. (2) Annual Report, Surgeon, Fourteenth Air Force, 1944. (3) Medical History of the Fourteenth Air Force in China (second submission), May-October 1944. (4) "Stilwell Report": History of the China-Burma-India Theater, 21 May 1942–25 October 1944. [Official record.]

[21] Monthly Reports, Medical Section, XX Bomber Command, November 1943–June 1945.

Services of Supply were located. The Services of Supply maintained no general hospitals in China, and only one station hospital. Colonel Gentry stated that delays had occurred in returning Fourteenth Air Force patients hospitalized in India back over the Hump to China.

Colonel Gentry expressed the opinion that the theater surgeon had treated Medical Department officers of the Fourteenth Air Force like stepchildren in consonance with the policy of the theater organization toward all Army Air Force activities. This charge reflected not only the Air Force's usual tendency toward autonomy; it was also a faint echo of the quarrel between General Stilwell and General Chennault over the combat role of General Chennault's Fourteenth Air Force in the theater. Air force surgeons also complained of insufficient medical supplies. As late as June 1944, shortages still existed in some items of basic equipment for air force medical units. Their protests led to the sending of the Voorhees mission to the theater to investigate the situation in 1944.[22]

The India-China Wing of the Air Transport Command, a semiautonomous command within the theater, was first established under that name in December 1942. It originally had headquarters at Chabua, where the headquarters of Advance Section 2 was located. About a year later, it moved to New Delhi and in April 1944 to Calcutta. Its primary mission was the transportation of supplies and personnel from India over the Hump to China. During 1942, after the disaster in Burma, the air shipments into China over the Himalayas had been accomplished by planes of the China National Aviation Corporation, the Tenth Air Force, and the First Ferrying Group, a forerunner of the India-China Wing. These agencies had also undertaken air evacuation of the sick and wounded from Burma into India. They had flown out thousands of men and dropped supplies by parachute to those retreating on foot.

Within a few months after the newly created India-China Wing assumed the ferrying task, a wing dental officer was assigned, and Lt. Col. (later Col.) Don Flickinger, MC, was appointed surgeon. The strength of the wing was then only about 300 officers and 1,500 enlisted men. As in other Air Transport Command wings, the wing surgeon supervised the aviation medical dispensaries—in reality small hospitals—assigned to the wing. Six such units arrived in July 1943 and were located at wing bases in Assam. The chief health menaces with which Medical Department officers of the command had to cope were malaria and dysentery, unsatisfactory food and water supplies, and neuroses among the aircraft crews flying at the extreme altitudes of the Hump route. The surgeon of the Air Transport Command's Washington headquarters, who visited the wing in May 1943, labeled Colonel Flickinger's task as the "toughest job in the Air Transport Command." Colonel Flickinger estimated that 70 pilots of his wing would need replacement monthly for medical reasons.

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[22] (1) Letter, Surgeon, Army Air Forces, India-Burma Sector, to Deputy Air Surgeon, 2 Oct. 1944. (2) Memorandum, Lt. Col. Lamar C. Bevil, for the record, 10 June 1944, subject: Interview With Colonel DeWitt.

The India-China Wing came to have heavy responsibility for air evacuation of the sick and wounded. It handled air evacuation of casualties en route to the United States and intratheater air evacuation from station hospitals to general hospitals along Air Transport Command routes from China to India and within India. A medical air evacuation transport squadron, the 803d, stationed at Chabua, performed this phase of the wing's work, while another, the 821st, evacuated thousands of wounded Chinese, Burmese, Kachins, Gurkhas, and Japanese from airstrips near the Assam and Burma fronts to U.S. Army hospitals in India. The terrain and flying conditions in the Himalayas called at times for spectacular efforts on the part of medical personnel of the wing. In August 1943, for instance, Colonel Flickinger and two enlisted men landed by parachute in a remote area southeast of Chabua to aid a group (including the war correspondent, Eric Sevareid) who had to bail out of a C–47 after motor trouble over the Hump. All except the copilot, killed in the landing, came out alive. In a number of instances, missionaries stationed in remote areas of China aided in rescuing downed aviators and nursing them back to health.

Provision of pure food and water at the wing's bases proved to be a major problem. In 1944, a sanitary engineer was given the task of insuring a pure water supply, and a nutritionist was assigned to the wing to analyze foods received at the various bases and to make recommendations to improve the healthfulness of the diet. Trained entomologists carried on experiments in malaria control in the wing laboratory.

By August 1944, the India-China Division (as the wing was now called) had 17 stations in the theater—12 in India, 4 in China, and 1 at Colombo, Ceylon. At this date, the strength of the command amounted to about 15,600 men, including approximately 1,600 attached personnel. Medical Department officers serving the command totaled 81 near the end of July. Nearly 400 Medical Department enlisted men served the wing.[23]

The Allied Chain of Command

Col. Earle M. Rice, MC, was the only U.S. Army doctor assigned to the Medical Advisory Division on the staff of Admiral Mountbatten's Southeast Asia Command, created in the fall of 1943.[24] The Allied command had operational control over United States and British land, sea, and air forces in Burma, Siam, Malaya, Sumatra, and Ceylon, and the northeastern fighting front in

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[23] (1) See footnotes 7(2), p. 514; and 20(4), p. 527. (2) Memorandum, Brig. Gen. Fred W. Rankin, for The Surgeon General, 2 Nov. 1943, subject: Remarks on Recent Trip Accompanying Senatorial Party. (3) Report, Col. I. B. March, MC, Office of Air Inspector, 21 Aug. 1944, subject: Summary of Medical Inspection of Air Transport Command and Stations in the China-Burma-India Wing.

[24] When Maj. Gen. Raymond A. Wheeler, under whom Colonel Tamraz had served as Services of Supply surgeon, was made principal administrative officer to Admiral Mountbatten, General Wheeler proposed to take Colonel Tamraz with him as surgeon for the Southeast Asia Command, with the rank of brigadier general. Orders for the transfer were actually published, but were rescinded when it became known that the Quebec Conference, in setting up the Allied command, had agreed upon a staff of British and American experts in tropical medicine. (See footnote 3(2), p. 507.)

India. Its jurisdiction did not extend to American forces in China or to those with the Services of Supply in India. The group of experts in tropical medicine and hygiene who made up the Medical Advisory Division was headed by a British medical officer, Maj. Gen. Treffery Thompson. The Southeast Asia Command operated medical facilities for the British and American forces (ground, naval, and air) assigned to the command, but the chief work of this medical staff was to investigate the best means of disease prevention and recommend measures to be adopted. It met with the heads of medical service of the various commands of the Allies operating in Asia and with their senior experts in malaria control and sanitation. It kept in touch with such special projects as the control of scrub typhus, undertaken by a team of the U.S.A. Typhus Commission in cooperation with British and Indian experts.

Although Colonel Rice was stationed at the headquarters of the command at Kandy, Ceylon, he spent a good deal of time at various critical areas of malaria control. He took a leading part in experiments which the U.S. Army made with airplane spraying of DDT in India. In 1944 and 1945, he made trips to England and the United States to get sanction for large quantities of antimalaria supplies for the theater.

The Southeast Asia Command appears to have left the administration of medical service within the individual commands largely up to those commands. Although the existence of Admiral Mountbatten's Allied headquarters might presumably have caused some confusion as to medical responsibilities of subordinate commands of the Allies in Asia, as it did with respect to military responsibilities in general, no record has been found of any serious conflict over medical matters arising from its activities. Since the Southeast Asia Command did not have jurisdiction over the U.S. Forces in the China-Burma-India theater, the office of the surgeon of the latter command had little contact with the Medical Advisory Commission except with the American representative (Colonel Rice) at Admiral Mountbatten's command in connection with malaria control among the troops fighting in Burma.[25]

American, British and Indian forces—service and ground troops—reinvading Burma were organized into the Northern Combat Area Command, created in February 1944. Commanded by General Stilwell, it was subordinate to Admiral Mountbatten's Southeast Asia Command. Combat Troop Headquarters had been formed in October 1943 as an American headquarters for the American service units in the Chinese Army, and Col. Vernon W. Peterson, MC, was made its surgeon. He continued in this capacity for the final Allied tactical command. Colonel Peterson's medical section was never large. At its peak it contained an assistant surgeon, who acted as forward echelon sur-

[25] (1) See footnotes 3(2), p. 507; and 4(2), p. 511. (2) Letter, Lt. Col. Hardy A. Kemp, MC, to Col. Robert P. Williams, MC, 21 Nov. 1943. (3) Letter, Earle M. Rice, M.D., to Col. Calvin H. Goddard, MC, Editor, History of the Medical Department, U.S. Army, in World War II, 6 Dec. 1951, and attachment. (4) Letter, Lt. Col. B. L. Raina, Chief Collator and Editor, Official [India-Pakistan] Medical History of World War II, to Col. R. G. Prentiss, Jr., MC, Executive Officer, Office of The Surgeon General, 25 Mar. 1952.

geon and medical inspector, a company grade officer in charge of medical supply, and a few enlisted men. Certain officers in the field handled special problems for the surgeon. The commander of a malaria control unit, for example, acted as malariologist for the command, and Veterinary Corps officers assigned to Chinese troops acted as sector veterinarians. Colonel Peterson obtained his medical supplies from the medical supply officer at advance section headquarters in Ledo. On technical medical matters he dealt with the theater surgeon, or with his deputy in New Delhi. The U.S. Army Medical Department units assigned to Northern Combat Area Command treated over 20,000 Chinese patients for diseases, injuries, and battle casualties during the period 1 January–26 October 1944. Except for a continued shortage of personnel, which placed exceptional demands on the endurance of the Northern Combat Area Command Surgeon and his staff, no particular organizational problems occurred in this element of the medical service.[26]

Disease Control: Malaria

Among the insectborne diseases which menaced U.S. Army troops in the China-Burma-India theater were malaria, scrub typhus, and dengue. Other diseases which occurred among the civilian populations of the theater were the diarrheal diseases, which gave the U.S. Army serious trouble; the venereal diseases; typhus; cholera; plague; smallpox; typhoid and paratyphoid; and acute meningitis. Epidemics of several of these occurred at intervals among the civilian populations. Approximately 25,000 troops in the Calcutta area were menaced by a cholera epidemic during the period February–June 1945. Another cholera epidemic raged during the summer of that year in cities and towns of the Yangtze River Valley, resulting in six cases among American troops of the Fourteenth Air Force. The prompt institution of preventive measures prevented epidemic rates among troops, but rates of incidence of the dysenteries, malaria, and scrub typhus were high enough to demand extra efforts.[27]

Malaria incidence never became as serious a problem in the China-Burma-India theater as in some other theaters where ground troops were engaged in combat in highly malarious areas for long periods. In 1943, this theater's rates were appreciably below those for other theaters of comparable malaria incidence among the civilian population. On the other hand, the rate did not undergo a decline comparable with that of other theaters, and the lack of centralized authority for the antimalaria program led, as in some other theaters, to certain administrative difficulties.[28]

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[26] See footnotes 4(2), p. 511; and 20(4), p. 527.

[27] (1) See footnotes 4(1), p. 511; and 8(4), p. 515. (2) Memorandum, Brig. Gen. Raymond A. Kelser and others, for Commanding General, U.S. Army Forces, India-Burma Theater, 9 Nov. 1944, subject: Report of Medical Department Mission.

[28] Memorandum, Chief, Preventive Medicine Service, Office of The Surgeon General, for The Surgeon General, 29 Aug. 1944, subject: Preventive Medicine Program in China-Burma-India Theater.

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As noted above, initial attempts at malaria control in the theater were undertaken by the group of U.S. Public Health Service officers assigned to the office of the Surgeon, Services of Supply, who went to the various bases. The full malaria control organization for the theater—malariologists and control and survey units—was not established until early in 1943, concurrently with its development in other theaters. The three control and survey units which the Surgeon, Services of Supply, requested, together with some assistant malariologists, arrived within a few months. By late 1944, when the theater was divided into the India-Burma and China theaters, 6 survey units and 15 control units were in operation. Additional ones had just arrived, and still others were scheduled to go to the two new theaters.

In mid-1943, final responsibility for malaria control rested with the office of the theater surgeon. The theater malariologist, Colonel Rice, and the assistant malariologists were assigned to that office. The assistant malariologists and the units were attached to the Services of Supply but were responsible to the theater organization rather than to the base, intermediate, or advance section commanders in the areas where they were operating.

In August 1943, advance and base section commanders were given somewhat more authority over the men doing antimalaria work when a new directive authorized them to move malaria control personnel about within their areas without reference to higher authority. The Services of Supply commander was authorized to transfer them from one section to another, with the concurrence of the theater malariologist or his assistants. Thus the theater organization and the Services of Supply shared responsibility for the personnel engaged in malaria control. Similar dual control existed with reference to antimalaria supplies; Services of Supply depots procured and stored them, while the assistant theater malariologists supervised their allocation and distribution. Although the need for placing ultimate control at the highest level was satisfied by this organization, the interposition of two command headquarters between personnel supervising antimalaria work and those engaged in operations was awkward. Theoretically, in order to give a command to a malariologist attached to the staff of a Services of Supply section commander, the theater malariologist would have had to recommend that the theater commander advise the Services of Supply commander to direct his section commander to give the order to the malariologist. "Except for the fact that matters were commonly handled much more informally, it was a confusing house that Jack had built." [29]

The theater malariologist developed a plan, never put into effect, for a tactical type of organization designed to give administrators of the antimalaria program the power of command over antimalaria personnel. He proposed a malaria control "regiment" to be commanded by the theater malariologist and to be made up of battalions, each headed by a malariologist; the battalions would consist of malaria survey and malaria control companies. The regiment

[29] See footnote 4(1), p. 511.

would carry out the entire program in the theater, while the Services of Supply would come into the picture merely as the source for the necessary items of supply. This scheme went by the board when Colonel Rice proposed as an alternative an increase in the number of control units for the theater, to which the War Department agreed. His scheme is of interest in that it reflects the conviction of some malaria control personnel that the program could be more effectively run by a military type of organization which would exercise the power of command.

In August 1943, the Chief of the Tropical Disease Section of the Surgeon General's Office, Lt. Col. Paul F. Russell, MC, declared that that office was still giving insufficient emphasis to the planning of an effective malaria control program for the China-Burma-India theater. He wrote the theater surgeon that a large group of Medical Department officers to be sent to the theater under the leadership of Col. George E. Armstrong, MC, to train Chinese doctors in military medicine included 10 dentists but not a single man with special training in malaria control. With the exception of Colonel Armstrong, none had had experience in tropical medicine. "Apparently the idea is that the Chinese troops shall bite their way through the Japanese." [30]

By the spring of 1944, the antimalaria drive had received fresh impetus. The more vigorous program of that year reflected greater consciousness of the need for it both on the part of the War Department and by the theater organization; it also marked clearer emergence of Atabrine as the preferred malaria suppressive and of DDT as the outstanding insecticide. Admiral Mountbatten's headquarters in Ceylon, where Colonel Rice had entered on his new assignment, had clearly stated the responsibilities of command for antimalaria discipline. Experimental spraying of DDT by planes was undertaken in the spring of 1944, and the first use of Atabrine as a suppressive among large numbers of troops in the theater took place in April among the X- and Y-Forces in the combat zones. Neither Atabrine nor DDT was yet being received in quantities sufficient for large-scale use, however.

At this juncture, except for the theater malariologist who remained on the staff of the theater surgeon and some units which were assigned to the Northern Combat Area Command, authority over most elements in the malaria control organization was turned over to the Services of Supply. Malariologists and units assigned to the Services of Supply were reassigned to base, intermediate, and advance section commanders. The new scheme was not to the liking of the theater organization, the Services of Supply, or the Air Forces. In the first place, no control or survey units were assigned to the Air Forces, which were responsible, under War Department directives, for education of air troops in malaria control, for the individual airman's conformity to antimalaria precautions, and for enforcement of control measures around barracks

[30] Letter, Lt. Col. Paul F. Russell, MC, to Col. Robert P. Williams, MC, 21 Aug. 1943. Since the Chinese Army lacked dentists, a good deal of emphasis was placed on training the Chinese in first aid dentistry in order to reduce the number of casualties due to preventable conditions.

and troop areas of the air forces. As a result of the farflung dispersal of air force troops in the theater, an air force unit might be located in several territories under different command jurisdictions. The theater malariologist also objected to the new arrangement, believing himself too far removed from the personnel engaged in the control work to direct the program effectively. Finally, the Services of Supply encountered the usual difficulties resulting from the fact that the Army Air Forces was its coequal in the chain of command; in China the Fourteenth Air Force, with separatist tendencies, was the prominent American command. From the point of view of the Services of Supply, a poor feature of the latest realinement of authority was the fact that no malariologist was assigned to the office of its surgeon.

The consolidation of the staffs of the theater surgeon and Services of Supply surgeon in August 1944 largely solved the problem. After the Services of Supply surgeon became deputy theater surgeon, the fact that the top malariologist was assigned to theater headquarters and other elements handling malaria control to Services of Supply headquarters was of little importance.

After Colonel Rice observed experiments with airplane spraying of DDT during a return visit to the United States in the spring of 1944, he conducted similar experiments around Chabua in order to determine the most suitable equipment for spraying, the desirable weather conditions, and types of terrain where spraying from planes would be most effective. DDT began coming into the theater in greater quantities, and an organization for theaterwide spraying was worked out by fall. It consisted of 1 malaria survey unit to make entomological investigations, 2 control units to handle DDT, 10 pilots and ground maintenance personnel and the necessary modified planes and equipment. The "India-Burma Spray Flight," as the organization was called, was fully developed only by February 1945, after the new India-Burma theater was established. The Services of Supply was responsible for the program and controlled the units; the Air Forces had the planes and pilots; the Northern Combat Area Command was in charge of the combat area in Burma where large-scale spraying was done to keep down the mosquito population of newly captured areas. The "India-Burma Spray Flight" ran into the usual problems resulting from the participation of several top commands but apparently worked effectively. The large-scale use of insecticides to control malaria contributed to the control of the mosquitoborne dengue as well.[31]

By midsummer of 1944, 4 malaria survey and 15 control units had created a beehive of antimalaria activity in the theater:

> The anti-malaria units were deployed from the ports of debarkation at Calcutta and Karachi to the most forward point in the Theater (the Jap-surrounded Myitkyina airstrip). They were protecting the long lines of communication, the newly constructed B-29 Bases, the old "Hump" bases, the advance depots at Ledo and Shingbwiyang, the engineering outfits carving out the Ledo Road, and the combat bases at Shaduzup, Mogaung, and Myitkyina.

[31] See footnotes 3(4), p. 507; 4(1) and (2), p. 511; and 8(4), p. 515. See also Medical Department, United States Army. Preventive Medicine in World War II. Volume VI. Communicable Diseases: Malaria. [In press.]

They were using thousands of coolie laborers digging ditches, cleaning out tanks, and larviciding breeding areas. They were putting up roadside signs warning of the dangers of malaria, they were supervising mosquito-proofing projects, distributing mosquito repellent at outdoor theaters, and trucking supplies into forward areas. The survey men were out locating breeding areas, making blood and spleen surveys, and working in their laboratories. In the latter part of the season there was some DDT, and some experiments with its use, both from the ground and the air, were started. There was a constant educational program in progress utilizing radio, movies, GI newspapers, signs, posters, and personal contact. There was a degree of protection for every one, much more than in previous years, but still not all that was desired. More personnel, more equipment, more supplies, and more DDT were ordered for the next year.[32]

Critical Problems of 1944

The latter half of 1944 was the crucial period for medical service in the theater. By the middle of the year, serious problems had developed with regard to medical supply, hospitalization, personnel, certain aspects of preventive medicine, and the organization of, and relations between, the theater surgeon's office and the Services of Supply surgeon's office. Concern over these difficulties was shared by the theater surgeon and the Surgeon General's Office. Although staff surgeons of the theater's top commands had observed certain deficiencies in the course of inspection trips in 1942 and 1943, the lack of personnel had prevented remedial measures.

It was one thing to discover that messes were operated without adequate protection from flies, or with help of native personnel who were probably vectors of intestinal diseases, but it was another thing to procure screening or to persuade commanders, already overworking their personnel, to do away with civilian labor or use enough Americans to supervise the native kitchen help.

On the other hand, two special missions sent from Washington in 1944 and a visit of the theater surgeon to Washington to emphasize the theater's medical needs had a salutary effect.[33]

By the spring of 1944, it became clear that the theater lacked sufficient hospital beds to cope with casualties to be anticipated from the fighting in Burma and the expected rise of incidence of malaria and other diseases with the impending monsoon season. By midyear the situation in hospitals around Ledo and in northern Burma became critical. The medical resources of the Chinese forces fighting in Burma were inadequate to provide evacuation and hospitalization behind the regimental rear boundary, and the U.S. Army had been called on to provide the necessary units; that is, the usual field and evacuation hospitals of the combat zone, as well as the station and general hospitals which the Services of Supply operated in the base and advance sections. The U.S. Army hospitals had become crowded with disabled Chinese, as well as those requiring long periods of convalescence before they could return to combat.

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[32] See footnote 4(1), p. 511.

[33] (1) Memorandum, Director, Epidemiology Division, for Chief, Preventive Medicine Service, 27 Aug. 1944, subject: Preventive Medicine Program in CBI Theaters. (2) For the quotation, see footnote 4(2), p. 511.

For reasons which remain obscure, the theater's reports to Washington had included statistics on the hospitalization of American troops, but not of the Chinese, in Services of Supply hospitals. Hence, although the War Department had authorized beds in proportion to Chinese as well as American troop strength and the theater's beds were well below the authorization, Washington authorities were unconvinced of an immediate need for more hospital beds, since statistics seemed to show that a goodly proportion of the available beds were unoccupied. Moreover, the transfer of additional divisions of the Y-Force from China to the X-Force in Burma increased the number of Chinese troops for whose fixed hospitalization the U.S. Army was responsible. U.S. Army support of the X-Force with medical units behind the regimental rear boundary had been agreed upon, but this force had been augmented by three divisions flown from China into Assam and committed in the battles of Myitkyina and Bhamo. When the theater surgeon was called to Washington to explain requests for increases in hospital beds and medical personnel for the China-Burma-India theater, he found that the Operations Division of the General Staff recognized only 57,000 Chinese troops under General Stilwell—the authorized number—although the strength of General Stilwell's Chinese Army had reached approximately 83,000 by the close of July 1944. Colonel Williams' trip eventually bore fruit in 4,300 additional beds for the theater.[34]

Deficiencies had also developed in the handling of medical supply. A statement by an air surgeon returning to Washington that the Services of Supply in the theater had failed to fill air force requisitions for medical supplies led The Surgeon General to send a mission to investigate the medical supply situation in the China-Burma-India theater. The group, headed by Col. Tracy S. Voorhees, JAGD, inquired not only into the medical supply system, which by that date had suffered an acute breakdown, but also the status of hospitalization, the effectiveness of the preventive medicine program, and the quality and sufficiency of personnel in key administrative positions.

The Voorhees mission backed up statements which the theater surgeon had made in Washington on the need for more hospital beds and the need for more medical personnel. It traced most deficiencies in medical service in the theater back primarily to the lack of well-trained personnel in key positions, particularly in the theater surgeon's office and in posts in the medical supply system. Most of the incumbents in the theater surgeon's office were unqualified for the positions they then held, the report declared, either because they lacked the necessary training or experience, had attained an age which prevented extensive travel to the front, or lacked initiative or some other desirable trait. The report sized up the theater surgeon's staff as generally inadequate both as to numbers and as to qualifications. It noted that a list of positions proposed by the theater surgeon for his staff had recently been cut in Washington. A de-

[34] (1) See footnotes 3(4), p. 507; 13(3), p. 520; and 20(4), p. 527. (2) Stone, James H.: The Hospitalization and Evacuation of Sick and Wounded in the Communications Zone, CBI, and India-Burma Theaters, 1942–1946. [Official record.]



FIGURE 121.—Col. Alexander O. Haff, MC.

cision by the Surgeon General's Office to restrict consultants to the rank of lieutenant colonel made it difficult to get qualified men for those posts.

The Voorhees report stated that the theater surgeon had left responsibility for fixed hospitalization almost solely up to the former Services of Supply surgeon and that the latter had failed to give adequate supervision both to the hospitals and to the medical supply system. The Services of Supply medical section had also been inadequately staffed, and its present chief, Col. Alexander O. Haff, MC (fig. 121), had so far been unable to get the larger allocation of personnel which he had requested. The medical offices of the three base sections and the two advance sections were for the most part satisfactorily staffed. The major problem, as the mission's report saw it, was that the Services of Supply surgeon lacked control over the base and advance section surgeons because of a tendency towards decentralization of administration to the base and advance section commanders. The report advocated merging the theater surgeon's office with that of the Services of Supply surgeon (without indicating whether the combined medical section should be located at theater or at Services of Supply headquarters). Alternatively, it proposed, if the existence of a separate Services of Supply organization should preclude such a merger, to transfer all operating personnel from the theater surgeon's office

to the medical section at Services of Supply headquarters and to make the Services of Supply surgeon deputy theater surgeon.

The Voorhees report did not pin down responsibility for choice of incumbents. Some assignments had been made in the theater, while in other cases the individuals had been selected by the Surgeon General's Office. According to the report, the Surgeon General's Office lacked adequate knowledge of the men occupying posts in the China-Burma-India theater.

The Voorhees report stressed weaknesses in various phases of preventive medicine, terming the poor protection afforded to the food of troops and the unsanitary handling of food in messes the "most striking medical weakness" in the theater. It noted the commonness of acute diarrhea and stressed the danger of returning men with amebic dysentery to the United States. Unsanitary food conditions were ascribed to the lack of veterinary personnel to inspect food and supervise native personnel who handled food in the messes and to the lack of basic directives, bolstered by strong command support, for methods of eliminating improper food. In this theater the care of animals—and the training of the Chinese in their care—had loomed large as a veterinary responsibility because of the extensive use of animals for transport on fighting fronts in Burma and China. The available veterinarians had been needed for this work; hence, the number to cope with the unsanitary conditions surrounding the preparation of food had been insufficient. Since troops of the Fourteenth Air Force in China were housed and fed by the Chinese Government, rather than at bases maintained by the U.S. Army's Services of Supply, it was more difficult to insure proper protection of food for U.S. Army troops in China than in India.

The investigating group also called attention to special problems connected with air force medical service. Contrary to War Department policy, the report stated, aviation dispensaries were acting as hospitals, and one or two regular hospitals were being operated by the air forces in China. The Air Surgeon was currently demanding that additional hospitals be turned over to the Air Service Command.

The Voorhees report attempted to point out certain observed deficiencies rather than to appraise the total Medical Department program in the theater. It advised the dispatch of another special mission to the theater to investigate the following matters: The appointment of a surgeon to relieve Colonel Williams who had already been in the theater 2 years; consolidation of the offices of the theater and services of supply surgeons; the sending of consultants to the theater; status of the preventive medicine program, especially in control of diarrhea and dysentery; adequacy of food inspection; a survey of hospitalization in India and along the Ledo Road; and personnel problems.[35]

[35] (1) "Miscellaneous Notes" as to Medical Department Matters in CBI Theater Outside the Scope of the Supply Survey, 17 Aug. 1944, by Col. Tracy S. Voorhees. [Official record.] (2) Memorandum, Col. Tracy S. Voorhees and others, for Commanding General, U.S. Army Forces in China-Burma-India, 25 July 1944, subject: Medical Supply in CBI. (3) Letter, Col. Tracy S. Voorhees, to Deputy Theater Surgeon (Colonel Armstrong), 18 Aug. 1944. (4) See footnote 8(4), p. 515. (5) Account of Visit to China-Burma-India Theater to Survey Medical Supply, 11 Sept. 1944, by Col. Tracy S. Voorhees. [Official record.]

As a sequel to the Voorhees survey, The Surgeon General sent a mission headed by Brig. Gen. Raymond A. Kelser, Chief of the Veterinary Corps, to the theater in October and November 1944 to survey sanitary conditions and veterinary and other professional services. Since a reorganization into two theaters was then under way, this mission did not tackle the more purely organizational problems to which the Voorhees report had called attention. The theater commander informed the Kelser mission that he would concur in the reassignment of the present theater surgeon and that, not desiring to replace him with any medical officer then in the theater, he preferred that The Surgeon General select a new theater surgeon.[36]

The members of the mission inspected many Army Medical Department offices, including those of base and advance section headquarters, Northern Area Combat Command headquarters at Myitkyina, and Fourteenth Air Force headquarters at K'un-ming. They surveyed the situation as to hospital beds, and inspected medical laboratories and supply depots, veterinary dispensaries, butcheries, piggeries, ice cream plants, egg candling plants, chicken slaughterhouses, and even a puffed-rice plant run by the Services of Supply. The group concentrated on problems of disease prevention, with particular stress on the procurement, inspection, and handling of food and the care of animals; that is, the tasks of Veterinary Corps officers. The mission's report pointed out that reliance on local sources of food was necessary in the China-Burma-India theater, because of the distance from home sources of food supply, coupled with slow transit, local climatic conditions, and poor facilities for storage and refrigeration. As the Voorhees mission had noticed, unusually heavy responsibilities for food inspection and supervision of food-producing establishments, as well as for care of animals and the training of the Chinese in animal care, had fallen to the lot of the Veterinary Corps in this theater. Some major reforms urged by the Kelser group were the reduction to a minimum of foodhandling in messes by native personnel, together with close supervision of the necessary native foodhandlers by American personnel; the assignment of a Sanitary Corps engineer to the headquarters of each base and advance section to train personnel in the processes of water purification and to advise each Army installation on problems of pure water supply, and the assignment of a few additional malaria control units to the theater. The report also emphasized the immediate need for medical, surgical, and neuropsychiatric consultants.[37]

Results of the Voorhees and Kelser Missions

As long as the theater surgeon's medical section was divided between the Chungking and New Delhi offices, the functions of the two offices were rather distinct from each other and their work was not well integrated. The Chung-

[36] Memorandum, Brig. Gen. R. A. Kelser and Col. R. H. Kennedy, for The Surgeon General, 18 Nov. 1944, subject: Confidential Notes for The Surgeon General.

[37] (1) Memorandum, Brig. Gen. R. A. Kelser and Col. R. H. Kennedy, for The Surgeon General, 18 Nov. 1944, subject: Report of Medical Department Mission to CBI and inclosures. (2) See footnotes 4(1), p. 511; and 36.

king office formulated theater medical policies and worked closely with Chinese authorities, while the New Delhi office gave technical supervision to Army medical service in India, developed medical supply policy for the theater, conducted a theaterwide program in preventive medicine, and prepared vital statistics. Although frequent interchange of letters and transmission of "information copies" of important papers had taken place between the two offices, the usual problems arose. Typical of them all were separate instructions from the commanding general in Chungking and his deputy in New Delhi as to the same project; and the necessity for completion of plans by the deputy theater surgeon in India before he had time to submit them to the distant theater surgeon.

In the fall of 1943 and the first half of 1944, Colonel Williams made efforts to increase his medical section, including both the New Delhi and Chungking offices, to 34 Medical Department officers, 2 warrant officers, and 36 enlisted men—numbers greatly in excess of those then authorized. War Department restrictions on allotments of personnel for the theater prevented official approval. In the spring of 1944, General Stilwell decided to turn over all operating functions to the Services of Supply, restricting his special staff, including the theater surgeon, to an advisory capacity, and transfer his personal headquarters to New Delhi; these changes affected the responsibilities of the theater surgeon's two offices. Colonel Williams moved to General Stilwell's personal headquarters in New Delhi, leaving only three officers, including an assistant theater surgeon, at forward echelon headquarters in Chungking. This move eliminated problems which the separation of Colonel Williams from the bulk of his staff had brought about.

Although replacements arrived during this period to relieve Medical Department officers due for return to the States, restrictions on personnel allotments forced the theater surgeon to forego offers from the Surgeon General's Office to send him specialized personnel, including a director of nurses and professional consultants. Surveys made within the theater by personnel survey boards approved the positions of director of nurses and of consultants but did not approve as large sections for theater and Services of Supply headquarters as their respective surgeons considered necessary to accord with the expanding strength of the theater and cope with casualties expected from the fighting in Burma.

The merger of the offices of the theater surgeon and the Services of Supply proposed by Colonel Williams prior to his trip to the United States in June 1944, and endorsed on the Voorhees report, proved to be the solution. Since neither of these surgeons had succeeded in enlarging his staff, they agreed willingly to the proposal, and a semimerger was effected. All personnel of the theater surgeon's medical section, except Colonel Williams himself and his assistants in Chungking, were transferred to the office of the Services of Supply surgeon; the latter was made the theater surgeon's deputy. The addi-

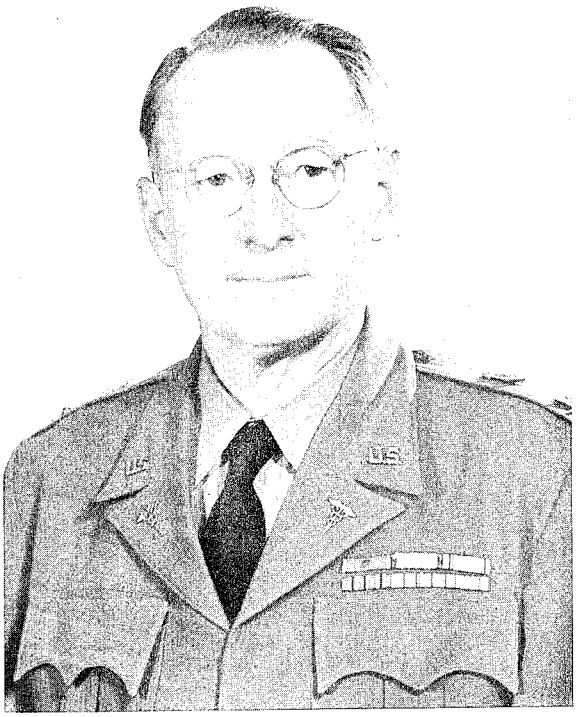


FIGURE 122.—Col. Karl R. Lundeberg, MC.

tional assignment as deputy strengthened the position of the Services of Supply surgeon, and the consolidation gave him the bulk of the staff. At the same time it preserved the superior authority of Colonel Williams as theater surgeon. Finally, it achieved the result contemplated in the Voorhees report—a more efficient use of the Medical Department personnel available for the top administrative offices. The combined staff totaled 23 officers and 1 U.S. Public Health Service officer.[38]

The theater surgeon and his new deputy, Colonel Haff, began to build up the quality of the combined staff as replacements became available for officers who had spent two or more years in the theater, and for those who had been chosen for their positions by reason of the scarcity of better qualified men. Col. Karl R. Lundeberg, MC (fig. 122), who had come to the theater with the Kelser mission, was retained as the head of preventive medicine for the theater and built up a largely new staff in this field. Development of the professional services staff, long contemplated, continued to incur delay on account of the limitation on rank of consultants to that of lieutenant colonel and insistence by the Surgeon General's Office that available officers of lower rank were not

[38] (1) See footnote 3(1), p. 507. (2) General Order No. 104, Headquarters, U.S. Army Forces, China-Burma-India, 22 Aug. 1944.

qualified for these posts. No consultants ever reached the area until after it was divided into two theaters.[39]

THE INDIA-BURMA AND CHINA THEATERS

In October 1944, shortly after General Stilwell's recall to the United States, the theater was split into the India-Burma theater and the China theater. At this date, over half of the approximately 204,000 U.S. Army troops in the theater were air troops (including the Air Transport Command and XX Bomber Command); less than a third, or about 57,000, were of the Services of Supply, while only about 25,000 were ground troops. Medical Department personnel serving in China, Burma, and India totaled approximately 13,700.[40]

After the capture of Rangoon in May 1945, the India-Burma theater was no longer an area of combat, but India continued to serve as a supply base for operations against the Japanese in China, and the India-Burma theater furnished medical supplies to the China theater. In China the U.S. Army continued its training and support of Chinese troops, its chief task there. For the most part, medical problems were not as acute as they had been during the days of the China-Burma-India theater.

The India-Burma Theater

After consolidation of the offices of the theater surgeon and of the Services of Supply surgeon in August 1944, a single medical section located at Services of Supply headquarters in New Delhi served as the staff for both surgeons. A few officers at General Stilwell's Chungking headquarters, who represented the theater surgeon for the China side of the theater, still acted in only a theater capacity. When the India-Burma theater came into existence in October, the combined staff, which served immediately under the Surgeon, Services of Supply, included his deputy (who acted in addition as executive officer), a personnel officer, a chief of professional services, a dental officer, two veterinarians, two medical supply officers, a nutrition officer, a venereal disease control officer, a malariologist, an epidemiologist, a statistical officer, a sanitary engineer, and enlisted assistants. This medical section was inherited by the India-Burma theater, the theater surgeon's small staff in Chungking being transferred to the China theater. The theater surgeon for the former China-Burma-India theater, Colonel Williams, and the Services of Supply surgeon, Colonel Haff, who had served additionally as Colonel Williams' deputy in the former setup, had precisely the same assignments in the new India-Burma theater. In November 1944, a director of nurses (lieutenant colonel, Army Nurse Corps) was added to the medical staff of the India-Burma theater, and a colonel of the Medical Corps took charge of preventive medicine activities. In January 1945, consultants in

[39] (1) Letter, Col. Alexander O. Haff, MC, to Col. Tracy S. Voorhees, JAGD, 6 Dec. 1944. (2) See footnotes 4(2), p. 511; and 35(3), p. 538. (3) Letter, Col. Alexander O. Haff, MC, to The Surgeon General, 8 Sept. 1944.

[40] See footnote 20(4), p. 527.

surgery, medicine, neuropsychiatry, and reconditioning arrived, but they held only the rank of major or lieutenant colonel.[41]

The usual theoretical distinction between the medical functions of the theater organization and those of the Services of Supply organization prevailed in the new India-Burma theater. The following subordinate commands furnished field medical care and hospitalization to ground and air forces: the Northern Combat Area Command, the Tenth Air Force, and the Air Transport Command. The theater headquarters gave general supervision to their activities. The Services of Supply was responsible for the procurement of medical personnel from the United States, for fixed hospitalization, for the preventive medicine program, and for the procurement of medical supplies. The most active territorial command of the Services of Supply during the Second Burma Campaign late in 1944 and the following year was the advance section in Assam and India. In January 1945, it contained 3 general hospitals, 3 evacuation hospitals, 11 malaria survey and control units, and various other Medical Department units and installations.

On 9 December 1944, the War Department suggested to the commanding general of the India-Burma theater (General Sultan) that Col. John M. Hargreaves, MC, then Surgeon, Air Technical Service Command, whom the Air Surgeon considered "one of the most outstanding Regular Army doctors in the Air Forces," be made theater surgeon. Apparently The Surgeon General (General Kirk) intervened at this point, for 2 days later the War Department asked the theater commander to disregard this former offer and to consider instead Brig. Gen. James E. Baylis, MC (fig. 123), whom The Surgeon General had recommended. General Baylis was made theater surgeon, replacing Colonel Williams who had served as theater surgeon for about 3 years, in February 1945.[42] He became Services of Supply surgeon as well and was located with the entire medical section at Services of Supply headquarters. Colonel Haff became Deputy Surgeon, Services of Supply, and remained in that position until May when illness forced his return to the United States.

When the India-Burma theater was established, the top air command in the former theater took over the same role in the India-Burma theater. The

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[41] Except as otherwise noted, discussion of the India-Burma Theater is based on the following documents: (1) History of The India-Burma Theater, appendix 19, Medical Section, 21 May 1945–1 December 1945. [Official record, Office of the Chief of Military History.] (2) History of the India-Burma Theater, 25 Oct. 1944–23 June 1945, vol. II. [Official record, Office of the Chief of Military History.] (3) History of the Medical Department, Services of Supply, India-Burma Theater, 24 October 1944–20 May 1945. [Official record.] (4) See footnote 4(2), p. 511. (5) Annual Report, Medical Department Activities, Tenth Air Force, 1944. (6) Final Report, Medical Department Activities of Tenth Air Force in India-Burma Theater, 17 July 1945. (7) Periodic Report, Medical Department Activities, Headquarters, Army Air Forces, India-Burma Theater, and Headquarters, India-Burma Air Service Command, 11 Apr. 1945. (8) Memorandum, Chief, Operations Service, Office of The Surgeon General, for Commanding General, Army Service Forces, 22 Apr. 1944, subject: Professional Consultants for CBI Theater. (9) Memorandum, Col. William C. Menninger, MC, for The Surgeon General, 28 Aug. 1944, subject: Neuropsychiatric Consultant for CBI.

[42] Radios, Gen. George C. Marshall, to Lt. Gen. Daniel I. Sultan, 9 Dec. 1944 (War 75068), 11 Dec. 1944 (War 75639); Sultan to Marshall, 17 Dec. 1944 (CM–IN–16707); Marshall to Sultan, 17 Dec. 1944 (War 78757).



FIGURE 123.—Brig. Gen. James E. Baylis, MC.

medical section at the Calcutta headquarters of Army Air Forces, IBT (India-Burma theater), served also for the large India-Burma Air Service Command, which in April 1945 had a strength of 35,148. During the campaign in northern Burma (July–November 1944) the medical section of Tenth Air Force, the chief combat component of Army Air Forces, IBT, shifted to forward areas along with the air force headquarters. It was at Myitkyina, shortly after the fall of this city in November 1944. Later it moved southward to Bhamo and then back again to India briefly before Tenth Air Force was transferred, in July 1945, to the China theater.

By the spring of 1945, responsibilities of the air commands in the theater for the various stages of air evacuation had been clearly defined. The Surgeon, Army Air Forces, India-Burma Theater, was theater air evacuation control officer and had the job of coordinating all phases of evacuating casualties by air within the theater. The Tenth Air Force was responsible for routine, emergency, and mass evacuation by air within the area of tactical operations, the rugged mountainous terrain of eastern Assam and Burma, having taken over the previous unorthodox responsibility of the India-China Wing, ATC, for air evacuation from the front. The 821st Medical Air Evacuation Transport Squadron (minus Flight C, which went to China), operating out of

Ledo, carried out this task, using two C–47's placed on shuttle runs between Ledo and the frontlines in northern and central Burma. The India-China Division Air Transport Command was charged with air evacuation of sick and wounded back to the United States, as well as with intratheater air evacuation from station to general hospitals, both along its routes in India and from India to China. The 803d Medical Air Evacuation Transport Squadron, stationed at Chabua, carried out this mission.

Efforts to prevent disease—especially scrub typhus (tsutsugamushi disease), the dysenteries, and malaria—in India and Burma in late 1944 and 1945 were supported by additional experts and further supplies. Pursuant to the recommendations of the Kelser mission, a dozen veterinary food detachments arrived from the United States early in December 1944; eight more were organized within the theater. The aid of the U.S.A. Typhus Commission to combat scrub typhus was enlisted by the theater surgeon after a number of cases of this disease occurred among Merrill's Marauders fighting through the Hukawng Valley to Myitkyina in the spring and summer of 1944. The group known as the India-Burma field party of the commission arrived in the fall of 1944 and began work around Ledo in December. The field party made its headquarters at Myitkyina, which was the center of occurrence of the disease as well as the location of Tenth Air Force headquarters. It grew into a large research team of 50 individuals. The group made studies of rates of incidence, the seasonal distribution of cases, and the probable sites of contraction of scrub typhus. A total of 1,098 cases, with a case fatality rate of 8.9 percent, was reported among United States and Chinese troops during the period 1 November 1943 to 1 September 1945. The field party remained in the theater until November of 1945, following along with the advance on the Stilwell Road.[43]

In 1944 and early 1945, 32 malaria control and survey units were in the India-Burma theater. By the fall of 1944, Atabrine began arriving in quantities sufficient to place all troops east of the Brahmaputra on suppressive dosage. The theater surgeon (Colonel Williams) took his cue from the successful control program of 1944 among American and Australian troops in the Southwest Pacific Area, where in 1944 rates of incidence had dropped more rapidly than in the China-Burma-India theater. In December 1944, he personally explained to line and medical officers in northern Burma theories formulated in the Southwest Pacific Area on the use of Atabrine as a suppressive. He also called a conference at New Delhi of representatives from his office, the Southeast Asia Command, Northern Combat Area Command, the Air Transport Command, the India-Burma Air Service Command, and the Quartermaster Corps. As a result, various directives extending compulsory Atabrine suppressive dosage to additional troops and areas were issued in 1945. Both Colonel Rice, who

[43] Maxey, Kenneth F.: Scrub Typhus (Tsutsugamushi Disease) in the U.S. Army During World War II. *In* Rickettsial Diseases of Man. Washington: American Association for the Advancement of Science, 1948, pp. 36–46. (2 See footnote 4(1), p. 511. (3) Letter, Brig. Gen. James S. Simmons, to Brigadier Gordon Covell, Director, Malaria Institute of India, 6 Oct. 1944.

had brought copies of the Southwest Pacific Area studies on Atabrine suppression to the theater surgeon, and an officer, who had done pioneer work with Atabrine in the Fijis during 1943 and early 1944, participated in the preparation of the new antimalaria directives. Suppressive treatment and the mosquito control program, both furthered by greater cooperation from the War Department and the Surgeon General's Office, together with the cessation of combat, led to a marked decline in malaria rates in controlled areas in the summer and fall of 1945. In the Tenth Air Force, a sharp drop occurred in 1945, enduring even through the summer malaria season.[44]

By May 1945, the Services of Supply of the theater was abolished. Its area commands were placed directly under U.S. Army Forces, India-Burma Theater; their surgeons were under the direction of the theater surgeon. Thereafter, the theater medical section declined markedly.

China Theater

The small medical section at the forward echelon of the China-Burma-India theater in Chungking, which became the medical section of the new China theater headquarters, was headed by Col. George E. Armstrong, MC, who became theater surgeon. In early December 1944, Colonel Armstrong's office moved to K'un-ming, where the rear echelon of China theater headquarters was located. It remained there until this headquarters was dissolved in July 1945. By the end of 1944, the office contained five Medical Department officers and five enlisted men. Besides the normal tasks of a theater surgeon's office, it had to maintain close liaison with the office of the surgeon of the India-Burma theater in New Delhi. Medical supplies and personnel from the United States came by way of the India-Burma theater, and the New Delhi office was a link in the chain of evacuation of patients from China to the Zone of Interior. The New Delhi office also arranged for prolonged hospitalization of U.S. Army patients sent from China theater to hospitals in India. On its own side of the mountains, Colonel Armstrong's office cooperated closely with the Chinese Army medical administration in efforts to promote the health of Chinese troops with various Chinese medical authorities (particularly the National Health Administration) in the prevention of diseases among civilians, and with foreign philanthropic organizations giving medical aid to the Chinese.

Very shortly after becoming theater surgeon, Colonel Armstrong joined with Colonel Gentry, the Fourteenth Air Force surgeon, and with the Surgeon, Y-Force Operations Staff, in insistent demands for nurses for the China theater. General Stilwell's opposition no longer stood in the way. By March 1945, 62 American nurses were in China, the majority serving with the 95th Station Hospital in K'un-ming.

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[44] (1) See footnotes 3(1) and (4), p. 507; and 4(1), p. 511. (2) Memorandum, Col. Robert P. Williams, MC, for The Surgeon General, 5 Oct. 1945, subject: Medical Service in India-Burma.

A Services of Supply was established at K'un-ming for the China theater; it had five base sections, which by June 1945 had boundaries tallying with similar area commands of the Chinese Army's Services of Supply. The medical section at Services of Supply headquarters, headed by a separate surgeon, had a relatively large staff; at its height early in the summer of 1945, it contained 19 Medical Department officers, including the theater malariologist and the theater medical supply officer, and 22 enlisted men. Since it was located in the same city, K'un-ming, as the theater surgeon's office, the two staffs worked closely together. A medical officer and a veterinary officer were assigned in a liaison capacity with the Chinese Services of Supply.

The surgeon for each of the five base sections was concerned with medical and sanitary service for troops within his base section; district surgeons had the same responsibility for the districts into which the base sections were subdivided. In each base section was a general depot which contained a medical section to handle medical supply. The Services of Supply controlled the small amount of fixed hospitalization necessary for U.S. Army personnel in the theater—a general hospital, two station hospitals, and several field hospitals and dispensaries.

After the rout of the Z-Force in southeastern China in the fall of 1944, the Chinese undertook the retraining of a volunteer army of 100,000 men to stem the Japanese advance. Colonel Armstrong worked closely with the Director General of the Chinese Army Medical Services (Gen. Hsu Hsi Lin) in 1945 in creating a fresh medical training program. A system of "emergency medical service schools" which the Chinese had devised in the late thirties had been overshadowed by the training centers for Y- and Z-Forces. The director of the chief emergency medical service training school at Kweiyang, Gen. Robert Ko-Sheng Lim (later Director of the Chinese Army Medical Administration), had studied at the Medical Field Service School at Carlisle Barracks, Pa., in the fall of 1944. This school was selected as the prototype for expanding the Chinese system of emergency medical service training schools.

The Chinese Training and Combat Command, created in November 1944, was the American command concerned with training the newly planned Chinese divisions. Its staff was formed by merging the "operations staffs" of Y- and Z-Forces; the former surgeon of Y-Force operations staff, Lt. Col. Eugene J. Stanton, MC, became its surgeon. This command, termed merely Chinese Combat Command after January 1945, paralleled, as did the Services of Supply, its counterpart Chinese command. Six subordinate commands corresponded to Chinese Army groups. The Medical Department followed the same pattern, with a surgeon at general headquarters and a surgeon for each subordinate command. The theater surgeon assigned another former Y-Force operations staff surgeon who spoke fluent Chinese as liaison officer to the office of the Chinese Surgeon General to advise on medical matters, including training. A somewhat more effective job of medical training was possible than in the days of the

China-Burma-India theater, for Chinese doctors had been drafted into the army, for the first time during World War II, in October 1944.

At the request of the Director General of the Chinese Army Medical Administration (then General Lim), U.S. Army Medical Department officers also aided in reorganizing the Chinese Army Medical Administration. This assistance, requested in May 1945, was not forthcoming until after the Japanese surrender. In September, five officers were assigned to the task for a 6-month period under the direction of Col. Ralph V. Plew, MC. Colonel Plew drew up recommendations for changes in the central office of the Chinese Army medical service, using the Surgeon General's Office in Washington as a model at points where it seemed an improvement over the Chinese setup. Other Medical Department officers aided in establishing a model rehabilitation and reconditioning center at Yunnanyi, delivered lectures on organization and administration of the U.S. Army Medical Department to the training staff of the Chinese Army Medical Administration, supervised the creation of model supply depots and a medical battalion, and aided with the training of medical supply officers at K'un-ming.[45]

The loss of Fourteenth Air Force bases in south central China late in 1944 during the Japanese drive to separate east China from west China made for rapid changes in the always mobile medical service of Fourteenth Air Force units. They now had to wing over enemy-held territory in order to carry supplies to the eastern bases and to evacuate patients westward. One flight of a medical air evacuation transport squadron, serving with the Fourteenth Air Force, bore the burden of air evacuation in China.

In May 1945, a Fourteenth Air Force Service Command was organized and was assigned a separate surgeon, while Colonel Gentry remained staff surgeon of the Fourteenth Air Force. Base medical service was then put under the air service command. The various service groups of this command furnished medical officers and enlisted personnel to staff the 10-, 20-, and 40-bed dispensaries—some of which were housed in mission hospitals and ancient temples—maintained by four air service centers. Five medical dispensary (aviation) units operated the larger base dispensaries. One such unit, augmented by medical officers from other sources, had maintained a station hospital of 150-bed capacity at Chengtu to serve the northern air bases for about a year. The Services of Supply, China Theater, furnished regular medical supplies to the Fourteenth Air Force, but in order to get items peculiar to the air forces the medical supply officer at the headquarters of the air force's service command placed a requisition with the appropriate air medical depot of the India-Burma theater.

In June 1945, General Chennault's Fourteenth Air Force had assigned to it a total of 60 medical officers, 12 dental officers, 1 medical administrative officer, 1 veterinary officer, and 162 enlisted men. The surgeons of various

[45] (1) See footnote 18, p. 525. (2) History of Services of Supply in the China Theater, 19 Sept. 1945. [Official record.]

tactical units of four wings, which covered about the same territories as the four air service centers, were also available for hospital and other duties. Since personnel of the air force were widely scattered, about 10 dental officers assigned to the air force traveled to various outposts from time to time. Dispersal also led to close cooperation between dental officers of the Fourteenth Air Force and its air service command and those of the Services of Supply. Dental officers treated as many men as possible in the neighborhood of their own stations, regardless of the command to which they or their patients were assigned.

In July 1945, when the Tenth Air Force moved into China from the India-Burma theater—to be built up as a transport air force—the usual higher air force command, Army Air Forces, China Theater, was created. The small medical section at its Chungking headquarters coordinated the medical work of the Tenth and Fourteenth Air Forces with that of the ground forces in the theater. The medical section of the new China Air Service Command (a redesignation of the Fourteenth Air Service Command) was at K'un-ming. A medical supply platoon (aviation) assigned to it issued medical supplies to all air force installations in the China theater, obtaining regular items from Services of Supply Base General Depot No. 1 in K'un-ming and special air forces medical items from the Bengal Air Depot in India. The China Air Service Command was responsible for air evacuation until September, when this task was turned over to the Air Transport Command. The China Air Service Command maintained the dispensaries at the air bases, and undertook to reestablish medical service at bases in southeast China recaptured by American and Chinese forces in the latter half of 1945.

When General Chennault relinquished command of the Fourteenth Air Force in August 1945, his surgeon, Colonel Gentry, also left and was replaced. During the last months of the year many personnel and units, including medical dispensaries (aviation), of the Tenth and Fourteenth Air Forces were moved out of China. In December both air forces were disbanded; only units remained.[46]

In July 1945, the office of the China theater surgeon at the rear echelon of theater headquarters at K'un-ming reached its zenith. It then included three assistant theater surgeons, a theater veterinarian, a theater dental surgeon, a medical inspector, an executive officer and one assistant, a director of nurses, a venereal disease control officer, a historical recorder, a medical supply officer, and eight enlisted men. In the same month, when the theater rear echelon was dissolved, this office was transferred to theater headquarters at Chungking, but after the collapse of Japanese resistance in August it was temporarily returned to K'un-ming, where it was merged with the medical section at Services of Supply headquarters.

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[46] (1) Medical History of the Fourteenth Air Force in China, 10 March 1943–10 March 1945. [Official record.] (2) Periodic Report, Medical Department Activities, Fourteenth Air Force, 1 Apr. 1945–30 Nov. 1945, and inclosure. (3) Periodic Reports, Medical Department Activities, Headquarters, Army Air Forces in the China Theater, July 1945–January 1946.

From the date of the surrender, the military activity of the China theater came to be concentrated in the area around Shanghai. Medical tasks included rendering medical aid to the Chinese troops taking over areas occupied by the Japanese in north and east China; giving medical examinations and care to thousands of Allied prisoners of war and internees, largely concentrated in the Shanghai area; disposing of American medical supplies and equipment; and transferring or dissolving Medical Department units. Hence Colonel Armstrong's medical section was relocated in Shanghai. In September, some of the staff went there to establish dispensaries, a field hospital, and prophylactic stations, the rest arriving by early October. This group served as the medical staff both for theater headquarters, newly relocated in Shanghai, and for the Shanghai Base Command, until the latter was dissolved in November.

When the theater was dissolved on 1 May 1946, the medical section was transferred to a newly established China Service Command, having undergone possibly more shifts in location and jurisdiction than any other top medical office overseas in a comparable length of time. Colonel Armstrong retained his responsibility as senior surgeon for all U.S. Army troops in China. At Nanking, another medical section served with the Army Advisory Group, where it aided the Director General of the Chinese Army Medical Administration in reorganizing the Chinese Army medical service. This project involved setting up a large military medical center near Shanghai and arranging for a year's medicomilitary training for about 130 Chinese medical officers in the United States.[47]

SUMMARY: MEDICAL ADMINISTRATIVE PROBLEMS IN CHINA-BURMA-INDIA

No firm direction of medical service in the China-Burma-India theater was ever achieved by the theater surgeon and his medical section. The split of the theater into two areas, until the fall of 1944, with transport of men and supplies possible only by flight over the Hump, and the scattering of subcommands and bases, made it difficult to distribute Medical Department personnel, supplies, and facilities effectively. These features abetted the characteristic claims of the air forces that they should control medical supplies and facilities for their personnel. They also hampered the achievement of uniformity in policies for the prevention of disease.

The need to deal firsthand with the Chinese Nationalist Government led the theater surgeon to maintain his headquarters, from late 1942 to the spring of 1944, in Chungking far from the Indian bases where most of the Army's medical resources were located. Separation of the theater surgeon from the majority of his staff, coupled with the lack of a fully developed staff and frequent changes in the person of the deputy theater surgeon, made centralized control by the theater surgeon virtually impossible. Colonel Williams conceived of his re-

[47] (1) See footnotes 18, p. 525; and 45(2), p. 548. (2) Medical History of the China Theater for April 1946, Office of the Surgeon, Headquarters, China Service Command, 1 May 1946. (3) Letter, Col. George E. Armstrong, MC, to The Surgeon General, 2 May 1946.

sponsibility as one of assisting Chinese authorities to develop an adequate medical service for their troops which were under American control and of supervising and inspecting the U.S. Army medical service throughout the theater, especially the medical service being furnished to the American and Chinese troops in combat. In filling what he considered to be a necessary role, he undertook duties quite different from those of a theater surgeon whose responsibilities were limited to U.S. Army troops and who maintained centralized control by means of a large and specialized office staff.

The China-Burma-India theater had insufficient Medical Department officers trained and experienced in administrative work. It was particularly ill supplied with men qualified to staff the medical sections of the top commands, serve as surgeons of base, intermediate, and advance sections, and fill posts in the field of medical supply. The record also shows a dearth of personnel for preventive medicine duties and of Veterinary Corps personnel.

The fact that the theater had as its chief raison d'être the training and support of troops of an Ally, the Nationalist Government of China, meant that the character of work to be done by the Medical Department—and the personnel and units needed—differed markedly from those in other theaters. American troops for whom the Medical Department was responsible were largely air force and service troops. The dearth of U.S. Army ground troops lessened the need for tactical Medical Department units—such as medical battalions and other units employed in the chain of evacuation at the front. On the other hand, the usual resources of the Services of Supply—hospitals, laboratories, supply depots, and so forth—were needed in numbers sufficient not only to give service to U.S. troops present but also to serve Chinese patients of the X-Force. Moreover, Chinese medical service in the combat zones had to be supported wherever it was deficient. Poor liaison between the War Department and the theater command led to a misunderstanding in the War Department as to the number of Chinese for whose hospitalization the U.S. Army was responsible and as to the actual numbers being cared for in the U.S. Army hospitals.

The decline of disease rates, especially of malaria and the diarrheal diseases, in the India-Burma theater during the early months of its existence as compared with the rates prevailing in the days of the China-Burma-India theater testifies to the direct bearing of good and sufficient medical supplies, facilities, and trained personnel upon the quality of medical service. In the opinion of a chief of the Preventive Medicine Division in the office of the Surgeon, India-Burma theater, and later surgeon of that theater, no adequate preventive medicine organization ever existed in the days of the China-Burma-India theater. Colonel Williams expressed what he considered to be the principal lesson to be derived from the Medical Department's experience in the China-Burma-India theater: "Good public health is, within limits, a purchasable commodity and the results obtained will be proportionate to the numbers and quality of the personnel employed and the amount of material that is expended." [48]

[48] See footnote 4 (1), p. 511.

APPENDIX A

Chief Surgeons of Important U.S. Oversea Commands [1]

I. North African Theater of Operations, U.S. Army (NATOUSA), 4 February 1943; Mediterranean Theater of Operations, U.S. Army (MTOUSA), 1 November 1944

	Assumed Duty
Allied Force Headquarters (AFHQ), Deputy Director of Medical Services	
Col. John F. Corby, MC	Sept. 1942
Brig. Gen. Albert W. Kenner, MC	Feb. 1943
Brig. Gen. Frederick A. Blesse, MC	Apr. 1943
Maj. Gen. Morrison C. Stayer, MC	Mar. 1944
Col. Earle Standlee, MC	July 1945
Theater Surgeon	
Brig. Gen. Albert W. Kenner, MC	Feb. 1943
Brig. Gen. Frederick A. Blesse, MC	Apr. 1943
Maj. Gen. Morrison C. Stayer, MC	Mar. 1944
Col. Earle Standlee, MC	July 1945
Services of Supply (Communications Zone)	
Lt. Col. Theodore L. Finley, MC	Apr. 1943
Col. Benjamin Norris, MC	May 1943
Col. Charles F. Shook, MC	Aug. 1943
Army Air Forces, Mediterranean Theater of Operations	
Col. Richard E. Elvins, MC	Jan. 1944
Col. Edward Tracy, MC	Apr. 1944
Col. Otis O. Benson, MC	Jan. 1945
Col. Michael G. Healy, MC	June 1945
Army Air Forces Service Command	
Col. Louis K. Pohl, MC	Jan. 1944
Col. Marshall N. Jensen, MC	Jan. 1945
Lt. Col. Edward M. Holmes, MC	Nov. 1945
Twelfth Air Force	
Col. Richard E. Elvins, MC	Nov. 1942
Col. William F. Cook, MC	Jan. 1944
Col. Edward M. Sager, MC	Dec. 1944
Fifteenth Air Force	
Col. Otis O. Benson, MC	Nov. 1943
Col. Dan C. Ogle, MC	Jan. 1945
Fifth U.S. Army	
Brig. Gen. Frederick A. Blesse, MC	Jan. 1943
Col. (later Brig. Gen.) Joseph I. Martin, MC	Apr. 1943
Col. Charles O. Bruce, MC	July 1945
Seventh U.S. Army (to ETO, September 1944)	
Col. Daniel Franklin, MC	July 1943
Col. Myron P. Rudolph, MC	June 1944
Peninsular Base Section	
Col. Richard T. Arnest, MC	Nov. 1943
Col. Leo P. A. Sweeney, MC	July 1945

[1] Except for first incumbents, those serving less than 30 days are excluded. Ranks are those held while in the indicated position.

I. North African Theater of Operations—Continued

	Assumed Duty
Mediterranean Base Section (to Africa-Middle East Theater, March 1945)	
Col. Howard J. Hutter, MC	Dec. 1942
Col. John G. Strohm, MC	Dec. 1943
Col. Harry A. Bishop, MC	Mar. 1944
Col. Henry W. Meisch, MC	July 1944
Col. William O. H. Prosser, MC	Aug. 1944
Lt. Col. Samuel A. Merlin, MC	Nov. 1944
Lt. Col. George A. Tischler, MC	Dec. 1944
Mediterranean Base Section, Center District	
Lt. Col. Joseph P. Franklin, MC	June 1943
Col. Harry A. Bishop, MC	Mar. 1944
Atlantic Base Section	
Col. Guy B. Denit, MC	Dec. 1942
Col. Vinnie H. Jeffress, MC	Apr. 1943
Col. Burgh S. Burnet, MC	Aug. 1943
Col. Thomas R. Goethals, MC	Jan. 1944
Lt. Col. George A. Tischler, MC	May 1944
Eastern Base Section	
Lt. Col. William L. Spaulding, MC	Feb. 1943
Col. Myron P. Rudolph, MC	July 1943
Lt. Col. Samuel C. Ellis, MC	July 1944
Island Base Section	
Lt. Col. Lewis W. Kirkman, MC	Aug. 1943
Northern Base Section	
Lt. Col. Albert H. Robinson, MC	Jan. 1944
Col. Anthony J. Vadala, MC	Mar. 1944
Coastal Base Section, 1 July 1944; *Continental Base Section*, 10 September 1944; *Continental Advance Section*, 1 October 1944 (to ETO, November 1944)	
Col. Harry A. Bishop, MC	July 1944
Col. Joseph G. Cocke, MC	Oct. 1944
Delta Base Section (to ETO, November 1944)	
Col. Vinnie H. Jeffress, MC	Oct. 1944

II. European Theater of Operations, U.S. Army (ETOUSA)

Supreme Headquarters, Allied Expeditionary Force (SHAEF)	
Maj. Gen. Albert W. Kenner, MC	Feb. 1944
Theater Chief Surgeon	
Col. (later Maj. Gen.) Paul R. Hawley, MC	June 1942
Services of Supply (Communications Zone)	
Col. (later Maj. Gen.) Paul R. Hawley, MC	June 1942
U.S. Strategic Air Forces in Europe	
Brig. Gen. Malcolm C. Grow, MC	Mar. 1944
12th Army Group (originally 1st Army Group)	
Col. Alvin L. Gorby, MC	Jan. 1944
6th Army Group	
Col. Oscar L. Reeder, MC	Sept. 1944
Southern Line of Communications	
Col. Charles F. Shook, MC	Nov. 1944
Eighth Air Force	
Brig. Gen. Malcolm C. Grow, MC	June 1942
Col. Harry G. Armstrong, MC	Mar. 1944

II. European Theater of Operations—Continued

	Assumed Duty
Ninth Air Force	
Col. Edward J. Kendricks, MC	Oct. 1943
First U.S. Army	
Brig. Gen. John A. Rogers, MC	Oct. 1943
Third U.S. Army	
Col. (later Brig. Gen.) Thomas D. Hurley, MC	Mar. 1944
Col. Thomas J. Hartford, MC	Apr. 1945
Seventh U.S. Army (from MTO, September 1944)	
Col. Myron P. Rudolph, MC	Sept. 1944
Ninth U.S. Army	
Col. William A. Shambora, MC	June 1944
Fifteenth U.S. Army	
Col. L. Holmes Ginn, MC	Dec. 1944
Western Base Section	
Lt. Col. Charles B. Daugherty, MC	Aug. 1942
Col. Mack M. Green, MC	Jan. 1943
Eastern Base Section	
Lt. Col. Roy O. Hawthorne, MC	Aug. 1942
Col. John F. Lieberman, MC	June 1943
Col. Charles H. Beasley, MC	Sept. 1943
Southern Base Section	
Lt. Col. Howard J. Hutter, MC	Aug. 1942
Lt. Col. Joseph P. Franklin, MC	Oct. 1942
Lt. Col. Joseph W. Tiede, MC	Nov. 1942
Maj. Einar C. Andreassen, MC	Jan. 1943
Col. Robert E. Thomas, MC	June 1943
Central Base Section	
Lt. Col. Lester E. Beringer, MC	Apr. 1943
Col. Robert B. Hill, MC	Sept. 1943
Lt. Col. Thair C. Rich, MC	Jan. 1944
Northern Ireland Base Section	
Lt. Col. Gilman E. Sanford, MC	Oct. 1943
United Kingdom Base	
Brig. Gen. Charles B. Spruit, MC	Sept. 1944
Advance Section	
Col. Charles H. Beasley, MC	Feb. 1944
Normandy Base Section	
Col. Raymond E. Duke, MC	Aug. 1944
Brittany Base Section	
Col. Robert B. Hill, MC	Aug. 1944
Lt. Col. Gilman E. Sanford, MC	Dec. 1944
Loire Section	
Lt. Col. Gilman E. Sanford, MC	Sept. 1944
Seine Section	
Col. Thair C. Rich, MC	Sept. 1944
Channel Base Section	
Col. Mack M. Green, MC	Sept. 1944
Continental Advance Section (from MTO, November 1944)	
Col. John G. Cocke, MC	Nov. 1944
Delta Base Section (from MTO, November 1944)	
Col. Vinnie H. Jeffress, MC	Nov. 1944

		Assumed Duty
II.	European Theater of Operations—Continued	
	Oise Section (Oise Intermediate, April 1945)	
	Col. Keith W. Woodhouse, MC	Oct. 1944
III.	Southwest Pacific Area	
	Philippines Department	
	Col. Wibb E. Cooper, MC	Sept. 1941
	U.S. Forces in the Philippines	
	Col. Wibb E. Cooper, MC	Mar. 1942
	U.S. Army Forces in Australia (briefly U.S. Forces in Australia)	
	Maj. George S. Littell, MC	Dec. 1941
	Col. Percy J. Carroll, MC	Feb. 1942
	General Headquarters, Southwest Pacific Area (G–4)	
	Col. George W. Rice, MC	Sept. 1942
	Col. John W. Bohlender, MC	Sept. 1944
	U.S. Army Forces in the Far East	
	Col. Percy J. Carroll, MC	Feb. 1943
	Brig. Gen. Guy B. Denit, MC	Jan. 1944
	U.S. Army Forces, Pacific (absorbed USAFFE as well as certain Central Pacific Commands)	
	Brig. Gen. Guy B. Denit, MC	Apr. 1945
	U.S. Army Forces, Western Pacific	
	Brig. Gen. Guy B. Denit, MC	June 1945
	Brig. Gen. Joseph I. Martin, MC	Aug. 1945
	U.S. Army Services of Supply	
	Col. Percy J. Carroll, MC	July 1942
	Col. Frederick H. Petters, MC	Feb. 1943
	Col. Percy J. Carroll, MC	Sept. 1943
	Col. Frederick H. Petters, MC	Dec. 1943
	Brig. Gen. Guy B. Denit, MC	Jan. 1944
	Far East Air Force	
	Lt. Col. William J. Kennard, MC	Dec. 1941
	Far East Air Forces	
	Col. R. K. Simpson, MC	June 1944
	Col. Duran H. Summers, MC	Dec. 1944
	Fifth Air Force	
	Col. Bascom L. Wilson, MC	Sept. 1942
	Col. R. K. Simpson, MC	Mar. 1944
	Lt. Col. Alonzo Beavers, MC	June 1944
	Col. V. A. Byrnes, MC	Aug. 1945
	Thirteenth Air Force (from South Pacific, June 1944)	
	Col. Frederick J. Frese, MC	June 1944
	Col. Kenneth J. Gould, MC	Sept. 1944
	Twentieth Air Force	
	Col. Harold H. Twitchell, MC	July 1945
	Sixth U.S. Army	
	Col. John Dibble, MC	Jan. 1943
	(Died 7 February 1943)	
	Col. William A. Hagins, MC	Feb. 1943
	Eighth U.S. Army	
	Col. John F. Bohlender, MC	June 1944
	Col. George W. Rice, MC	Sept. 1944
	Tenth U.S. Army	
	Col. Frederick B. Westervelt, MC	July 1944

III. Southwest Pacific Area—Continued

	Assumed Duty
Base Section 1 (Darwin, Australia)	
Maj. H. D. Johnson, MC	Jan. 1942
Maj. Gottlieb L. Orth, MC	Mar. 1942
Capt. John A. Gallorgly, MC	Oct. 1942
Capt. George F. Adams, MC	May 1943
Col. Walcott Denison, MC	Oct. 1943
Col. L. E. Dashiell, MC	Mar. 1944
Base Section 2 (Townsville, Australia)	
Maj. Lawrence G. Livingston, MC	Jan. 1942
Lt. Col. Carl R. Mitchell, MC	Mar. 1942
Lt. Col. W. H. Buckholts, MC	Apr. 1944
Base Section 3 (Brisbane, Australia)	
Maj. Jesse T. Harper, MC	Dec. 1941
Col. George W. Rice, MC	Mar. 1942
Col. Frederick H. Petters, MC	Sept. 1942
Col. Raymond O. Dart, MC	Feb. 1943
Col. William J. Bleckwenn, MC	Sept. 1943
Lt. Col. Joseph H. Steger, MC	June 1944
Col. George H. Yeager, MC	Sept. 1944
Base Section 4 (Melbourne, Australia)	
Maj. John R. Finkle, MC	Feb. 1942
Lt. Col. Roy F. Brown, MC	July 1942
Lt. Col. James R. Dean, MC	Sept. 1942
Maj. John R. Finkle, MC	Oct. 1942
Capt. Theodore C. Keramidas, MC	Dec. 1942
Col. Walcott Denison, MC	Mar. 1943
Lt. Col. Roger O. Egeberg, MC	Oct. 1943
Col. Frank W. Pinger, MC	Nov. 1943
Lt. Col. Clayton B. Mather, MC	Feb. 1944
Base Section 5 (Adelaide, Australia)	
Capt. Alfred T. Leininger, MC	Mar. 1942
Maj. Leon E. Robinson, MC	May 1942
Capt. Bernard E. Paletz, MC	Aug. 1942
Base Section 5 (Cairns, Australia)	
Lt. Col. Paul O. Wells, MC	June 1943
Lt. Col. James R. Dillard, MC	Sept. 1943
Col. Leland E. Dashiell, MC	Oct. 1943
Base Section 6 (Perth, Australia)	
Maj. George A. Wiltrakis, MC	Mar. 1942
Capt. James L. Evans, MC	Aug. 1942
Base Section 7 (Sydney, Australia)	
Lt. Col. Roy F. Brown, MC	Sept. 1942
Col. Julius M. Blank, MC	June 1943
Col. Walcott Denison, MC	Feb. 1944
U.S. Advance Base (Port Moresby, New Guinea)	
Col. Julius M. Blank, MC	Sept. 1942
Base A (Milne Bay, New Guinea)	
Maj. Roger O. Egeberg, MC	Oct. 1942
Col. C. W. Hardy, MC	Sept. 1943
Col. August W. Spittler, MC	Mar. 1944
Lt. Col. Lester E. Haentzchel, MC	Oct. 1944

		Assumed Duty
III.	Southwest Pacific Area—Continued	
	Col. Jonathan M. Rigdon, MC	Jan. 1945
	Col. Ben E. Grant, MC	Mar. 1945
	Lt. Col. Earl B. Ray, MC	June 1945
	Base B (Oro Bay, New Guinea)	
	Maj. Alva E. Miller, MC	Jan. 1943
	Col. Paul M. Ireland, MC	Jan. 1944
	Col. Nelson A. Myll, MC	June 1944
	Col. Emmett B. Litteral, MC	Sept. 1944
	Col. V. L. Bolton, MC Col. Preston T. Brown, MC	Jan.-June 1945
	Sub-Base C (Goodenough Island)	
	Maj. Theodore C. Keramidas, MC	Apr. 1943
	Lt. Col. Lawrence R. Custer, MC	July 1943
	Base D (Port Moresby, New Guinea)	
	Col. Allan W. Dawson, MC	July 1943
	Maj. (later Lt. Col.) Theodore C. Keramidas, MC	Aug. 1943
	Maj. William S. Dandridge, MC	Mar. 1944
	Col. Carl F. Steinhoff, MC	Apr. 1944
	Maj. George C. Hendrickson, MC	Aug. 1944
	Capt. Joseph DiNorica, MC	Oct. 1944
	Base E (Lae, New Guinea)	
	Lt. Col. Everett G. King, MC	July 1943
	Col. Nelson A. Myll, MC	Mar. 1944
	Lt. Col. Bruce P. Webster, MC	June 1944
	Lt. Col. Hans W. Lawrence, MC	Sept. 1944
	Maj. Abraham Gilner, MC	Feb. 1945
	Maj. Robert B. Martin III, MC	June 1945
	Base F (Finschhafen, New Guinea)	
	Lt. Col. Paul O. Wells, MC	Nov. 1943
	Col. Paul M. Ireland, MC	Oct. 1944
	Col. Allan B. Ramsay, MC	Feb. 1945
	Lt. Col. George H. Cochran, MC	Mar. 1945
	Maj. Cecil F. Barber, MC	May 1945
	Col. Donald M. Glover, MC	June 1945
	Col. George H. Cochran, MC	Oct. 1945
	Base G (Hollandia, New Guinea)	
	Lt. Col. Everett G. King, MC	June 1944
	Lt. Col. Thomas W. Mattingly, MC	July 1944
	Col. Charles S. Mudgett, MC	Jan. 1945
	Col. Samuel B. Ward, MC	July 1945
	Base H (Biak Island)	
	Col. August W. Spittler, MC	Aug. 1944
	Col. William A. Todd, MC	July 1945
	Lt. Col. Albert F. Luppens, MC	Aug. 1945
	Base K (Tacloban, Leyte, P. I.)	
	Lt. Col. Paul O. Wells, MC	Sept. 1944
	Col. Isaiah Wiles, MC	July 1945
	Base M (San Fabian, then San Fernando, Luzon, P. I.)	
	Col. Everett G. King, MC	Nov. 1944
	Lt. Col. Joseph H. Steger, MC	Feb. 1945

		Assumed Duty
III.	Southwest Pacific Area—Continued	
	Lt. Col. Walter H. Buckholts, MC	Mar. 1945
	Col. William H. Todd, Jr., MC	Oct. 1945
	Base R (Batangas, Luzon, P.I.)	
	Lt. Col. Raymond A. Fleetwood, MC	Feb. 1945
	Maj. Fred Meinhard, MC	May 1945
	Lt. Col. Charles B. Henry, MC	Sept. 1945
	Base S (Cebu City, Cebu Island, P.I.)	
	Maj. (later Lt. Col.) Joseph M. Stein, MC	Apr. 1945
	Maj. Gerald H. Dennis, MC	Oct. 1945
	Maj. David J. Farrell, MC	Nov. 1945
	Maj. Stanley E. Monroe, MC	Dec. 1945
	Advance Section (Milne Bay, Port Moresby, Lae)	
	Col. William J. Bleckwenn, MC	Aug. 1943
	Col. Raymond O. Dart, MC	Sept. 1943
	Lt. Col. Everett G. King, MC	Nov. 1943
	Intermediate Section (Port Moresby, Oro Bay)	
	Col. Raymond O. Dart, MC	Nov. 1943
	Col. Carl R. Mitchell, MC	Mar. 1944
	Col. Charles R. Lanahan, MC	Aug. 1944
	Base Section, USASOS (later *Australian Base Section, Brisbane, Sydney*)	
	Col. Paul M. Ireland, MC	June 1944
	Col. Carl R. Mitchell, MC	Sept. 1944
	Maj. Arthur B. Nightingale, MC	May 1945
	New Guinea Base Section	
	Col. Charles H. Lanahan, MC	Feb. 1945
	Maj. Lawrence E. Viola, MC	Aug. 1945
	Luzon Base Section (Manila, P.I.)	
	Col. Everett G. King, MC	Feb. 1945
	Philippine Base Section (Manila, P.I.)	
	Col. Everett G. King, MC	Apr. 1945
	Col. Lawrence R. Custer, MC	Apr. 1945
IV.	Central and South Pacific Areas	
	Hawaiian Department	
	Col. (later Brig. Gen.) Edgar King, MC	Aug. 1939
	U.S. Army Forces, Central Pacific Area	
	Brig. Gen. Edgar King, MC	Aug. 1943
	U.S. Army Forces, Pacific Ocean Areas (element of U.S. Army Forces, Pacific, after April 1945)	
	Brig. Gen. Edgar King, MC	Aug. 1944
	Brig. Gen. John M. Willis, MC	Nov. 1944
	U.S. Army Forces, Middle Pacific (element of U.S. Army Forces, Pacific)	
	Brig. Gen. John M. Willis, MC	July 1945
	Central Pacific Base Command	
	Col. Paul H. Streit, MC	July 1944
	Col. Harry D. Offutt, MC	June 1945
	U.S. Army Forces in the South Pacific Area	
	Col. Earl Maxwell, MC	Aug. 1942
	Services of Supply, South Pacific Area	
	Col. Earl Maxwell, MC	Nov. 1942

IV. Central and South Pacific Areas—Continued

	Assumed Duty
South Pacific Base Command	
Brig. Gen. Earl Maxwell, MC	Aug. 1944
Col. Laurent L. LaRoche, MC	Nov. 1944
Lt. Col. Amos R. Koontz, MC	May 1945
Western Pacific Base Command	
Col. Elliott G. Colby, MC	Apr. 1945
Lt. Col. Thomas A. N. Hindman, MC	July 1945
Col. Robert F. Bradish, MC	Aug. 1945
Army Air Forces, Pacific Ocean Areas	
Col. Walter S. Jensen, MC	Aug. 1944
Seventh Air Force	
Lt. Col. Andrew Smith, MC	Mar. 1942
Col. Ralph Stevenson, MC	Sept. 1944
Thirteenth Air Force (to Southwest Pacific, June 1944)	
Col. Frederick J. Frese, MC	Jan. 1943
XXI Bomber Command	
Col. Harold H. Twitchell, MC	June 1944
Hawaiian Services of Supply, 6 October 1942; *Hawaiian Department Service Forces,* 10 April 1943; *Army Port and Service Command,* 10 August 1943	
Lt. Col. (later Col.) George C. Mayfield, MC	Jan. 1944
Hawaii Service Command	
Lt. Col. William A. D. Woolgar, MC	Jan. 1943
Maui Service Command	
Lt. Col. Charles B. Perkins, MC	N. A.
Molokai-Lanai Service Command	
Capt. Solomon Greenberg, MC	N. A.
Kauai Service Command	
Lt. Col. Holcombe H. Hurt, MC	Aug. 1942
New Caledonia Service Command	
Lt. Col. Arthur G. King, MC	Nov. 1942
Lt. Col. Frank W. Pinger, MC	Jan. 1943
Col. Wallace I. Douglas, MC	Mar. 1943
New Zealand Command	
Lt Col. Amos R. Koontz, MC	N. A.
Fiji Service Command	
Col. Donald M. Ward, MC	May 1944
Guadalcanal Service Command	
Lt. Col. Russell J. Caton, MC	May 1943
Espiritu Santo Service Command	
Lt. Col. Arthur G. King, MC	Mar. 1943
Maj. Thomas S. Cumming, MC	May 1944
Lt. Col. Russell J. Caton, MC	
Efate Service Command	
Capt. Harold C. Cole, MC	Nov. 1943
Russell Islands Service Command	
Maj. John L. M. Neill, MC	July 1944
Green Islands Service Command	
Maj. Irving Werner, MC	July 1944
Emirau Service Command	
Maj. John Gardiner, MC	Mar. 1944

	Assumed Duty
IV. Central and South Pacific Areas—Continued	
Bougainville Service Command	
Lt. Col. Charles V. Snurkowski, MC	Apr. 1944
Lt. Col. James H. Melvin, MC	Aug. 1944
Lt. Col. Charles V. Snurkowski, MC	Oct. 1944
New Georgia Service Command	
Lt. Col. James H. Melvin, MC	Aug. 1943
V. China, Burma, and India	
China-Burma-India Theater	
Col. Robert P. Williams, MC	Mar. 1942
India-Burma Theater	
Col. Robert P. Williams, MC	Oct. 1944
Brig. Gen. James E. Baylis, MC	Feb. 1945
Col. Karl R. Lundeberg, MC	Sept. 1945
Lt. Col. Howard A. Van Auken, MC	Dec. 1945
Services of Supply, China-Burma-India	
Col. John M. Tamraz, MC	Mar. 1942
Col. Alexander O. Haff, MC	May 1944
Services of Supply, India-Burma Theater	
Col. Alexander O. Haff, MC	Oct. 1944
Brig. Gen. James E. Baylis, MC	Feb. 1945
China Theater	
Col. George E. Armstrong, MC	Oct. 1944
Tenth Air Force	
Col. Hervey B. Porter, MC	June 1942
Col. John E. Roberts, MC	Aug. 1943
Col. Clyde L. Brothers, MC	Oct. 1943
Lt. Col. James E. Kendrick, MC	June 1944
Col. Jay F. Gamel, MC	July 1944
Col. Everett C. Freer, MC	July 1945
China Air Task Force	
Lt. Col. Thomas C. Gentry, MC	July 1942
Fourteenth Air Force	
Lt. Col. (later Col.) Thomas C. Gentry, MC	Mar. 1943
Army Air Forces, India-Burma Sector, China-Burma-India Theater; Army Air Forces, India-Burma Theater after Oct. 1944	
Col. Hervey B. Porter, MC	Aug. 1943
Col. W. F. DeWitt, MC	Oct. 1943
Col. Clyde L. Brothers, MC	May 1944
XX Bomber Command	
Col. Robert J. Benford, MC	June 1943
Lt. Col. Jack Bollerud, MC	Aug. 1944

APPENDIX B

Summary of Functions of Divisions, European Theater Surgeon's Office, 1 May 1945

Administrative Division:

Prepares official documents.

Controls administrative activities.

Operations Division:

Projects theater requirements for hospitalization and evacuation based on present and past casualty experience data.

Prepares and coordinates medical planning for the chief surgeon based on command decisions.

Plans and implements communications zone medical operations.

Procures and controls the flow of medical units to the theater.

Allocates medical units to field forces, air forces, and the communications zone.

Exercises technical supervision and control of evacuation operations.

Maintains liaison with appropriate agencies for rail, sea, and air evacuation.

Analyzes tables of organization and equipment based on experiences of medical units in this theater.

Promulgates directives establishing theater training policies for medical units.

Supervises Medical Department technical training within the theater.

Collects, evaluates, and disseminates intelligence of a medicomilitary nature.

Supply Division:

Formulates supply and fiscal policies and plans.

Maintains fiscal and reciprocal aid accounts.

Determines theater requirements for medical supplies.

Controls procurement, storage, and issue.

Maintains control stock records.

Preventive Medicine Division:

Plans disease control program.

Investigates outbreaks of communicable diseases.

Initiates measures for venereal disease control.

Assists in solution of problems of sanitation, nutrition, and insect control.

Formulates policies and determines requirements for laboratory service.

Develops plans for military occupational hygiene.

Coordinates training, determines equipment requirements, and advises on treatment methods in chemical warfare medicine.

Professional Services Division:

Reviews and standardizes procedures of treatment.

Recommends assignment of specially trained medical personnel.

Controls activities of medical and surgical consultants including personal consultation service.

Cooperates and participates in professional educational programs.

Supervises essential researches in military medicine and surgery.

Determines physical standards in the ETO.

Personnel Division:
Formulates personnel policies.
Effects personnel adjustments between base sections and major commands.
Reviews assignments, promotions, reclassifications, and recommendations for awards.
Conducts personnel activities for the office of the chief surgeon.

Hospitalization Division:
Maintains liaison with engineers and G–4 in determining construction policies.
Coordinates fixed hospital bed requirements with Operations Division.
Develops construction design for fixed Medical Department installations.
Develops plans for physical facilities of fixed hospitals.
Acquires sites and approves plans for fixed treatment facilities.
Initiates and conducts special investigations and inspections pertaining to hospital administration and construction.
Controls hospitalization policies and technical operations (less professional services).
Audits hospital funds.

Dental Division:
Develops policies for dental services.
Prepares estimates for future requirements.
Evaluates dental activity.
Processes reports, returns, and records.

Veterinary Division:
Inspects animal food products, sources, transport, and storage.
Cooperates with other veterinary and food inspection agencies.
Develops plans and policies for veterinary service.
Estimates future requirements.
Evaluates training program.
Supervises professional care of public animals and their environmental sanitation.

Nursing Division:
Develops nursing policies.
Reviews nursing procedures.
Plans training programs.
Recommends assignments of nursing personnel.
Reviews recommendations for promotion of nurses.
Maintains liaison with French and British nursing services.

Medical Records Division:
Prepares reports and analyses of Medical Department experiences.
Revises logistic data.
Maintains current Medical Department indices.
Processes and maintains files on material for machine tabulation.
Prepares medical stock record reports.

Field Survey Division:
Observes the medical service functioning in the field.
Assists and advises field medical commanders concerning policies dictated by the chief surgeon or higher headquarters.
Makes recommendations based on field survey which will improve the medical service.
Conducts special investigations when directed by the chief surgeon.

Historical Division:
Maintains liaison with historical section of ETOUSA and with other agencies.
Collects and analyzes source material for medical history.
Collects and prepares illustrative materials.

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Historical Division—Continued

Prepares preliminary historical account complete with documentation.

Formulates policies for collection and compilation of historical records by lower echelons.

Conducts public relations for medical service.

Rehabilitation Division:

Directs and conducts research in rehabilitation procedures.

Controls rehabilitation technical operations.

Directs training of special personnel for the implementation of the rehabilitation program.

Formulates rehabilitation policies.

Note.—A Gas Casualty Division existed in the theater surgeon's office from the spring of 1943 until early 1945. It determined treatment methods and equipment requirements for gas casualties, conducted research jointly with the Chemical Warfare Service of the American and British Armies, and prepared training directives.

Bibliographical Note

Sources used in preparing this volume consist largely of official records relating to the Army Medical Department during the years 1939–45, found in a number of files as indicated below. As stated in the Preface, additional information was obtained from Medical Department officers and a few other individuals concerned with the Army's medical work in World War II.

Records of The Historical Unit, U.S. Army Medical Service

The official records used are contained in large measure, as of the date of writing, in the files of The Historical Unit, U.S. Army Medical Service. Because of the early incipience of the Medical Department's historical program, dating from August 1941 (referred to in chapter III), the Historical Division, as it was then called, built up during the war years a file of documents chosen primarily for its historical value. As to type, these documents are of wide variety. They include memorandums, letters, periodic and special reports of medical offices and medical units and installations, histories and monographs on various phases of Army medical service, rough drafts of plans and incomplete histories, and a few personal diaries, as well as a good deal of official serial material issued by the Surgeon General's Office and the War Department during the war years.

The periodic reports (usually covering the calendar or fiscal year) of the so-called "services" and "divisions" of the Surgeon General's Office and of the medical offices of major commands in the United States and overseas were extensively used for the present volume. The Historical Unit's file of annual reports of elements of the Surgeon General's Office for the war years is fairly complete. The internal files of a few divisions of the Office are also among the sources maintained by The Historical Unit, although most material of this sort is now in the custody of the Departmental Records Branch in the Office of the Adjutant General.

A few monographs on certain phases of the Medical Department's activities in the United States have served to direct the writer to chief developments which would otherwise have come to light only in the course of examining the hundreds of primary documents on which they were based. A monograph entitled "The Organization of the Medical Department in the Zone of the Interior" by Captain Edward J. Morgan and Dr. Donald O. Wagner has afforded this sort of guide for drafting those passages in the present volume which are devoted to the internal organization of the Surgeon General's Office and of the offices of surgeons of service commands in the United States. Volume I, Organization and Administration, of a series entitled "History of the AAF Medical Service in World War II," prepared in the Air Surgeon's Office under the direction of Dr. Hubert A. Coleman but transferred to the files of The Historical Unit, has served as a guide to chief developments in the Office of the Air Surgeon and the medical offices of the Army Air Forces commands in the United States. Inquiry into matters not covered in these two studies, but related to them, has led, however, to personal examination of a large proportion of the documents used in their preparation. A number of manuscripts prepared for the clinical volumes of the Medical Department's history have served to point out administrative developments in their respective fields.

Documentary sources in The Historical Unit for the administration of medical service in oversea commands are of uneven value. The annual reports of medical offices of oversea commands, extensively used in the preparation of this volume, include for the most part those of the medical sections (or offices) of the theater headquarters, Services of Supply headquarters, the headquarters of Services of Supply area commands, and of the chief ground force commands. The roster of these is fairly complete.

Another important body of material on the oversea theaters which is on file in The Historical Unit consists of histories, which vary as to fullness of coverage, of Army medical

service in certain theaters of operations and oversea base commands. These were prepared by historical units in the medical sections of theater headquarters. Fairly complete ones exist for the Mediterranean and China-Burma-India theaters, which have aided greatly in shaping the account of medical administration in those areas.

On the other hand, the "theater history" of medical service is conspicuously lacking for the two areas in which Medical Department work was most extensive in World War II, the European theater and the Southwest Pacific Area. The lack of theater histories or other documents of a summary nature, except for a history of the medical service of the Communications Zone of the European theater, has made the task of preparing an account of Army medical administration in those areas much more difficult, as well as more time consuming, than in other theaters. Summaries of certain phases of medical service for the European theater have proved helpful, but almost no documents of a summary nature—beyond the scope of periodic reports—exist for the Southwest Pacific Area. In order to piece together the story for the Southwest Pacific Area it was necessary to resort to hundreds of memorandums and letters produced in day-to-day operations of the chief medical offices there, as well as the periodic reports of many commands. The file of periodic reports of medical offices of the Southwest Pacific Area maintained in The Historical Unit is voluminous by comparison with similar reports made by the medical offices of other commands, for quarterly, rather than annual, reports were required of the medical offices at the headquarters of the many commands in the area. Although histories of certain phases of medical service were compiled for the Central and South Pacific Areas, they are somewhat fragmentary in nature, particularly for the latter. Sources for the South Pacific Area available in The Historical Unit are less satisfactory than those for any other oversea region, since no complete theater medical history was written for the area and the office files of the theater surgeon are not in the possession of The Historical Unit.

The files of The Historical Unit contain a good deal of the official material in series issued by the War Department, Army Service Forces headquarters, and the Surgeon General's Office during the war years. Such material became an important source for appointments of individuals, for changes in functions of elements of the Surgeon General's Office, and relations of the Office with the Army Service Forces headquarters. Among series which contributed to this volume were The Surgeon General's Office Orders, Army Service Forces Circulars, and the War Department Regulations. The annual reports of the Surgeon General's Office (discontinued in printed form after the fiscal year 1941) were the most widely used of the reports published in the War Department.

Records containing information which was gleaned from Medical Department officers after the war form another important source in The Historical Unit's file. Among them are recorded accounts of a good many of the interviews which historians held with Medical Department officers in the postwar period and a number of letters written by officers to answer specific questions raised by historians. Written comment which officers made on draft manuscript submitted to them for review served to correct errors of fact and interpretation.

Central Files of the Surgeon General's Office

Of secondary importance for the present volume, the central files of the Surgeon General's Office include copies of memorandums, letters, periodic and special reports, and various other documents produced in the course of the daily operations of the office throughout the war. They are now in the custody of the Army's major depository of historical records, the Departmental Records Branch in the Office of the Adjutant General.

Records of the Army Service Forces

The Departmental Records Branch, Office of the Adjutant General, is also in possession of another body of documents which proved of considerable value for the present volume. These are the files maintained by Headquarters, Army Service Forces. These, particularly

the records of the Control Division, Army Service Forces, and of the immediate offices of Gen. Brehon B. Somervell and his chief of staff, Gen. Wilhelm D. Styer, were a chief source for relations of The Surgeon General and his office with individuals and organizational elements of Headquarters, Army Service Forces.

Records of the Office of the Air Surgeon

A special collection of records of the Air Surgeon's Office, which was amassed for the purpose of preparing a separate history of medical service in the Army Air Forces, was on loan to The Historical Unit, U.S. Army Medical Service, for several years. These records consist primarily of periodic (chiefly annual) reports, special reports, reports on trips of inspection, and histories of the medical service of a number of air commands; they also include some correspondence of the Air Surgeon's Office with air force surgeons overseas. They were the chief source for medical administration within the commands of the Army Air Forces and contributed substantially to the various accounts in this volume of the dealings between the Air Surgeon and The Surgeon General.

Office of the Chief of Military History: Manuscripts and Studies

Various monographs and draft manuscripts for volumes to be published in "United States Army in World War II" contain brief summary accounts of the medical service within certain oversea commands. A number served to throw light on the command channels above the medical sections at the headquarters of these oversea commands. A few manuscripts dealing with the Army Service Forces and its elements aided in clarifying the relations of the Surgeon General's Office with the Army Service Forces.

Miscellaneous Files

A number of other files, both in the Washington area and elsewhere, have been less widely used. The records of some of the technical services—Quartermaster Department, Engineer Department, and Chemical Warfare Service—furnished a few documents dealing with the participation of these services in one phase or another of the Army's medical work. The Army's Kansas City Records Center has supplied a good many documents relating to the field medical service—that is, the medical service of headquarters, units, and installations in the United States outside of Washington and in oversea areas. The files of the Research Studies Institute, Air University, now at Maxwell Air Force Base, Ala., and of the Military Air Transport Service furnished supplemental information on the organization and administration of the medical service within the Army Air Forces. Some of the wartime records of the medical section (the so-called "Ground Surgeon's Office") at Headquarters, Army Ground Forces, have proved useful, but inquiry by the General Reference and Research Branch of The Historical Unit has failed to produce satisfactory records on the internal organization of that office. The personal files of a few individuals were also consulted.

Documents Relating to the Investigation of the Medical Department

One group of documents, which should properly have been found in a single file, had to be drawn together from a number of sources. These are the papers relating to the Committee to Study the Medical Department which form the basis for most of chapter V dealing with the work of the committee. A protracted search throughout the files of the Department of the Army has failed to turn up the official file known to have been maintained by the executive secretary of the committee. The author has been informed from time to time that this file was probably destroyed. Various papers relating to the Committee's work, including copies of the testimony before the committee and a number of supporting documents, are in The Historical Unit's files, while the important final report and various memorandums and other papers authored by officials of the Army Service Forces were obtained from the files of that organization maintained by the Departmental Records Branch, Office of the Adjutant General, mentioned above. The records which the Hospitali-

zation and Evacuation Branch, Army Service Forces, kept during the war were on loan to The Historical Unit for several years. By tracing down internal references within documents to other documents, it was possible to locate originals or copies of what appear to be all major documents relating to the work of the committee. The author has also had access to the personal files of Col. Sanford H. Wadhams, chairman of the committee, and those of Dr. Lewis H. Weed, who acted as representative of The Surgeon General on the committee. Additional information concerning the committee's work was elicited by addressing specific questions to committee members and others concerned with the investigation and by submitting the manuscript of chapter V to a number of them for comment.

Papers relating to the investigation proved of historical value beyond that of furnishing material for an account of the investigation itself. A number of them review developments during the early war years down to September 1942, the date of the investigation, in the internal administration of the Surgeon General's Office and its relations with higher elements of the War Department.

Published Works

Although a number of published works and some articles appearing in periodicals are cited in the footnotes, they are not listed here, as most were used only for the purpose of substantiating one or two specific passages. However, certain published books and series proved consistently useful in furnishing information on the command structure within which the Medical Department operated. The chief contributor of this sort was the "United States Army in World War II," published by the Office of the Chief of Military History. A similar contribution was made by the series entitled "The Army Air Forces in World War II." A few volumes of the official history of the Medical Department's experience in World War I, "The Medical Department of the United States Army in the World War"—principally Volume I, The Surgeon General's Office, and Volume II, Administration, American Expeditionary Forces—afforded a basis for comparison of Army medical administration in World War II with that in World War I.

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