MEDICAL DEPARTMENT

UNITED STATES ARMY

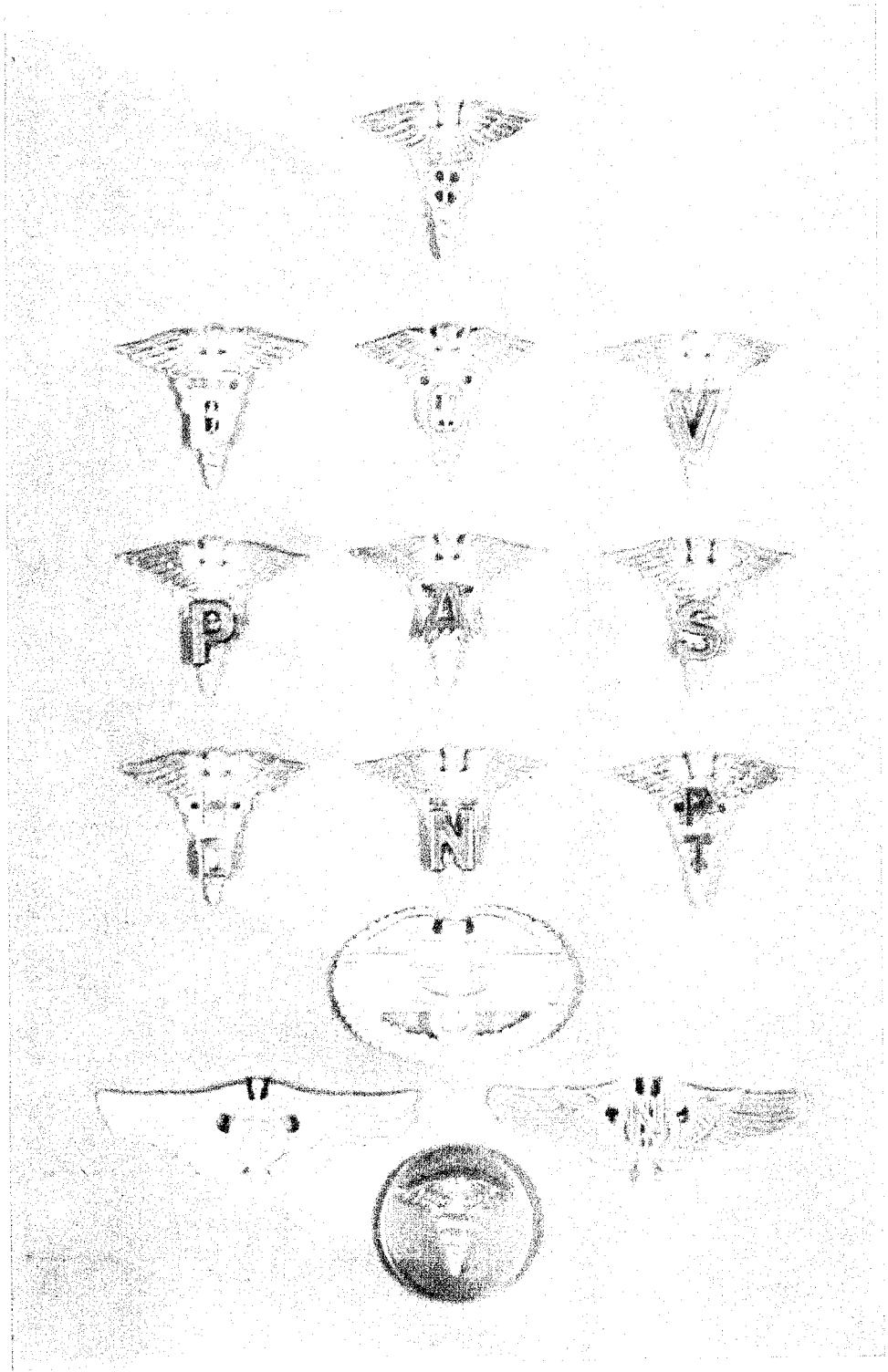
IN WORLD WAR II

DTIC
ELECTE
MAR 09 1995
S D
G

Accesion For
NTIS CRA&I [X]
DTIC TAB [ ]
Unannounced [ ]
Justification .....
By .....
Distribution /
Availability Codes
Dist | Avail and / or Special
A-1

19950307 053

DISTRIBUTION STATEMENT A
Approved for public release;
Distribution Unlimited


B
V
P
A
S
N
T

MEDICAL DEPARTMENT, UNITED STATES ARMY

PERSONNEL IN WORLD WAR II

Prepared and published under the direction of
Lieutenant General LEONARD D. HEATON
The Surgeon General, United States Army

Editor in Chief
Colonel JOHN BOYD COATES, Jr., MC, USA

Editor for Personnel
CHARLES M. WILTSE, Ph. D., Litt. D.

OFFICE OF THE SURGEON GENERAL

DEPARTMENT OF THE ARMY

WASHINGTON, D.C., 1963

PERSONNEL IN WORLD WAR II

The Historical Unit, United States Army Medical Service

Colonel JOHN BOYD COATES, Jr., MC, USA, *Director*
Colonel REX P. CLAYTON, MSC, USA, *Executive Officer*
Colonel R. L. PARKER, MSC, USA, *Special Assistant to Director*
Lieutenant Colonel R. J. BERNUCCI, MC, USA, *Special Assistant to Director*
Lieutenant Colonel DOUGLAS HESFORD, MSC, USA, *Chief, Special Projects Branch*
CHARLES M. WILTSE, Ph. D., Litt. D., *Chief, Historians Branch*
ERNEST ELLIOTT, Jr., *Chief, Editorial Branch*
Lieutenant Colonel LEONARD L. COLLIER, MSC, USA, *Chief, Information Activities Branch*
Major ALBERT C. RIGGS, Jr., MSC, USA, *Chief, General Reference and Research Branch*
HAZEL G. HINE, *Chief, Administrative Branch*

Library of Congress Catalog Card Number: 63–60001

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington 25, D.C. - Price $6 (Buckram)

PERSONNEL IN WORLD WAR II

by

JOHN H. MCMINN, Ph. D.

and

MAX LEVIN, A.M.

MEDICAL DEPARTMENT, UNITED STATES ARMY

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

VOLUMES PUBLISHED

ADMINISTRATIVE SERIES

Hospitalization and Evacuation, Zone of Interior
Organization and Administration in World War II

CLINICAL SERIES

Internal Medicine in World War II:

Vol. I. Activities of Medical Consultants
Vol. II. Infectious Diseases

Preventive Medicine in World War II:

Vol. II. Environmental Hygiene
Vol. III. Personal Health Measures and Immunization
Vol. IV. Communicable Diseases Transmitted Chiefly Through Respiratory and Alimentary Tracts
Vol. V. Communicable Diseases Transmitted Through Contact or By Unknown Means
Vol. VI. Communicable Diseases: Malaria

Surgery in World War II:

Activities of Surgical Consultants, vol. I
General Surgery, vol. II
Hand Surgery
Neurosurgery, vol. I
Neurosurgery, vol. II
Ophthalmology and Otolaryngology

Surgery in World War II—Continued

Orthopedic Surgery in the European Theater of Operations
Orthopedic Surgery in the Mediterranean Theater of Operations
The Physiologic Effects of Wounds
Thoracic Surgery, vol. I
Vascular Surgery

Miscellaneous:

Cold Injury, Ground Type
Dental Service in World War II
Veterinary Service in World War II
Wound Ballistics

Foreword

During World War II, the U.S. Army Medical Department reached a personnel strength which it had never before attained. Its peak strength of 700,000 was three times that of the entire Regular Army in 1939 and four times that of the combined Union and Confederate Forces at the Battle of Gettysburg.

In contrast to personnel procurement in most other arms and services, the entire officer corps of the Medical Department, exclusive of the Medical Administrative Corps, had to be procured directly from qualified civilian professional groups. It could not be obtained through officer candidate schools. Furthermore, the personnel required were in a critical category, and the need for them was immediate and urgent.

This volume of the history of the U.S. Army Medical Department in World War II is the story of how the enormous personnel expansion was achieved; of how qualified medical personnel were secured; of how the wartime military medical establishment was utilized and the highest standards of professional medical care were maintained; and, finally, of how the wartime Medical Department was contracted to a peacetime level.

The magnitude of the medical achievement in World War II should not be permitted to obscure the difficulties that attended it. They were numerous and fundamental.

Although the health of the Army rested with The Surgeon General throughout the war, he was very early placed in an anomalous situation, which violated all the principles of sound command, in that he had responsibility without complete authority. He lost overall control of procurement, classification, promotion, and assignment of personnel, and it was well after V–E Day before he was able to implement many plans that he made for the utilization of the entire medical force. His difficulties were compounded early in 1942, at the highest level of the War Department, when a reorganization of the Army interposed the Headquarters Army Service Forces between The Surgeon General and the General Staff and gave the medical component of the Army Air Forces, along with its other components, more independence than it had previously possessed.

Emergencies had to be met, and obstacles and obstructions had to be eliminated, as they were encountered. It was almost impossible to prevent them. Square and round holes both had to be plugged, though those making the assignments and those being assigned frequently did not see eye to eye in the matching process. Tensions were strong. Many newly commissioned medical officers found it difficult to adapt to military life, while certain medical personnel in the Regular Army sometimes seemed reluctant to modify, much

less discard, its time-honored traditions, policies and operations and adjust to the larger organization and procedures required by global war.

By the middle of 1943, when Maj. Gen. James C. Magee was succeeded as The Surgeon General by Maj. Gen. Norman T. Kirk, personnel policies for the remainder of the war had been established for the most part. Many of the problems, however, which had existed up to this time persisted almost to the end of the war.

1. The most important of these problems was the procurement of sufficient medical personnel for all purposes, though how many persons were needed in a given situation depended to a considerable extent upon how those available were used. A reported shortage might mean a genuine lack of sufficient personnel to carry out an assigned mission. All too often, however, the so-called shortage had no reference to real need and was no more than the numerical difference between actual and authorized strength. Rank, promotion, pay, and morale were also part of the general picture.

The absence of an aggressive procurement policy on the part of the Medical Department probably accounts, at least to some extent, for the shortages experienced early in 1942. Shortages became particularly acute a year later, when Medical Officer Recruiting Boards were abolished by the Army Service Forces. Thereafter, medical officers had to be recruited chiefly from graduates of medical schools as they completed shortened internships.

Procurement of medical officers from recent graduates was accomplished, and on the whole satisfactorily, by issuing to undergraduates temporary commissions in the Medical Administrative Corps, and, later, by the Army Specialized Training Program. On the other hand, as will be pointed out shortly, the need for securing initially sufficient numbers of physicians from the civilian profession, from which most newly commissioned medical officers had to be secured, was less acceptably dealt with, not only from the point of view of the Army Medical Department but also, perhaps, from that of the national interest.

2. A second major problem was the correct utilization of available personnel. Medical officers were used with increasing efficiency as the war progressed, but large increments continued to be necessary, both during the war and immediately afterward, when replacements for those who were being separated from military service were the principal need.

To utilize personnel correctly, it was essential on many occasions that an individual be transferred promptly from one assignment to another as the need for his services changed. Under the happiest circumstances, this was frequently—particularly in the Zone of Interior—a somewhat cumbersome process. Under the circumstances that prevailed in World War II, it was further complicated by division of authority over reassignments, with the result that transfers were often delayed and sometimes were not accomplished at all.

Part of the difficulty has already been mentioned, the lack of authority by The Surgeon General to control disposition of medical personnel plus the interposition of the Army Service Forces Headquarters between him and the Gen-

eral Staff and his unfortunate subordination to the former. Shortly after this reorganization had occurred, his authority was further reduced when the commander of each corps area became virtually the final authority on transfer of personnel within his jurisdiction, while at the same time this commander gained an important voice in transfers between his own area and other corps areas. It was not until almost the end of the war that this trend was partly reversed and The Surgeon General secured greater control over the reassignment of Medical Department personnel within the Zone of Interior.

When mobilization began in 1940, the classification of civilian occupations was still sketchy, and military occupational specialties had not yet been devised. It is only fair to say that, in spite of its inflexibility in certain respects, the Medical Department early recognized the need for improved classification of medical personnel and developed this method more thoroughly than any other branch of service. As the classification processes improved, genuine shortages were reduced or eliminated by employment of available personnel to the best possible advantage. By the end of the war, the great majority of medical officers were properly classified and were assigned where it was believed that they would be most useful, even if, in some instances, the assignment was not always in conformity with the officer's precise classification.

There were a number of ways in which medical personnel in short supply were used with great efficiency. An outstanding example was the establishment of centers for specialized treatment and the use of specialist personnel in them. Another was the replacement, whenever possible, of scarcer categories of personnel with those more easily obtained. The use of Medical Administrative Corps officers instead of Medical Corps officers in many types of administrative work was an illustration. The substitution was frankly repugnant to many officers steeped in the traditions of the prewar Medical Department, and some urging was necessary before the potentialities of this plan were fully investigated and implemented. Before the war ended, however, the 7,500 Medical Administrative Corps officers envisaged by The Surgeon General in April 1942 had grown to 20,000. Another similar, and similarly fruitful, policy was the substitution of members of the Women's Army Corps for able-bodied enlisted men in the performance of many specialized duties.

3. Even after the Medical Department adopted a strengthened procurement policy in 1942, procurement difficulties continued, chiefly because other branches of the military were involved and more comprehensive action was required than this Department could provide alone. No single agency existed for this purpose, or, at least, none that could reconcile the conflicting demands of the Army, the Navy, and other Federal services with those of the civilian community; that could determine how many physicians each of these groups should have; and that could then see that each of them received its proper share of physicians through the exercise, if necessary of compulsion on individuals.

The closest approach to such an agency was the Procurement and Assignment Service, which could, and did, fix the minimum physician-civilian popu-

lation ratio that must be maintained in any given area. This Service, however, operated under decided limitations. For one thing, it could neither compel physicians who were in excess of minimum requirements in any area to serve the Government nor could it determine how physicians recruited for military and other public service were to be divided among claimant agencies. About the only power the Service exerted over these agencies was to prevent them, in the course of their recruiting efforts, from encroaching upon the minimum physician-population ratios which it had established. Within that limit, it was of considerable assistance in obtaining volunteers.

The Procurement and Assignment Service was further handicapped by the fact that it could not compel civilian practitioners to move from areas of lesser need to those of greater need. All that it could do in this respect was to use persuasion, and persuasion was, in many instances, much less than what the situation called for. The Surgeon General contended, and correctly, that the real source of complaints about inadequate civilian medical care was not the inroads of the Armed Forces upon the professional supply but the concentration of physicians in some parts of the country far above the minimum established by the Procurement and Assignment Service and the inability of that Service to distribute them equitably.

On the other hand, while the Procurement and Assignment Service saw to it, within the limitations just mentioned, that medical service was in adequate supply for civilian communities, many were of the opinion that its assistance to the military left much to be desired. Attempts of the Armed Forces to obtain a draft of physicians under special rules came to nothing, chiefly because of the opposition of this Service, whose successful resistance to this policy demonstrated that such powers of compulsion as it possessed were chiefly directed against the military. It proved able not only to prevent the armed services from recruiting physicians on a voluntary basis beyond the limits it had established but also proved able to enjoin them from drafting physicians even within these limits.

In short, the Selective Service System was the only agency with power to compel physicians to enter the Armed Forces, and its authority was limited to persons within the general draft age, which meant that it could not affect a very large number of the physicians in the United States. The effectiveness of the Selective Service System was further limited by the hesitancy of local draft boards in drafting physicians, even within the specified age group.

Procurement difficulties continued into the postwar period. When the war ended, large numbers of casualties were in Army hospitals in the Zone of Interior, as well as overseas, many of them still to receive definitive treatment and many of them requiring specialized care. Yet this was the very time that tremendous pressure was brought upon The Surgeon General for the early, and sometimes the immediate, release of physicians, not only by civilian groups and communities, but also by members of the U.S. Congress.

It would be unfair to end this foreword on such a note. It is true that conflicts and misunderstandings were numerous and that they persisted

throughout the war, but it is equally true that working cooperation and the desire to get on with the job generally prevailed on local levels. It was an enormous task to assemble the Medical Corps and allied medical services; to utilize them to the best purposes during the war; to accomplish this task with as little disruption of civilian medical service as possible; and then to return these personnel to civilian life. The task was, nonetheless, carried out competently and sometimes brilliantly, and the U.S. Army received from its Medical Department the best medical service an army at war had ever known.

No history of the personnel, including civilian employees, of the U.S. Army Medical Department in World War II would be complete without testimony to their skill, loyalty and devotion, both as a group and as individuals. Officers and enlisted personnel, those who were in the Regular Army and those who entered service from civilian life, gave of themselves unstintingly throughout the entire war. They shared the dangers of combat. Many of them were wounded. Some of them lost their lives. To each of those who served, the U.S. Army Medical Department, the U.S. Army, and the Nation will be forever indebted.

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

Preface

This volume is one of a series on the history of the U.S. Army Medical Department in World War II. It deals most fully with the commissioned and enlisted members of the Army's medical service, less fully with the large number of civilians, the sizable contingent from the Women's Army Corps, and the numerous prisoners of war who were employed in the Department's work. Other groups that assisted the medical service but which were comparatively small in size—the body of Red Cross workers, for example—are given much briefer consideration.

Inevitably, the subject matter of the volume overlaps that of others in this series. The uses to which personnel were put can hardly be discussed without touching on their employment in hospitals and, thus, entering on a small portion of the field covered by the volume dealing with hospitalization and evacuation in the Zone of Interior. To make clear one way of alleviating personnel shortages, it has been necessary to give certain facts about training, even at the cost of encroaching on the history of that subject. Similarly, such apparent inadequacies as the relatively superficial coverage of Army Ground Forces medical and paramedical personnel are made up in more appropriate contexts in other volumes.

For reasons made clear in the narrative, the volume covers not only the years during which the United States was at war but a space of time before and afterward—roughly the years 1939 through 1946. In a few instances, the account of some train of events begins at a considerably earlier or concludes at a rather later date if such a departure makes for a better understanding of the subject.

Most of the actions and decisions on personnel matters recorded in this volume emanated from the higher authorities of the War Department, particularly the Surgeon General's Office, the General Staff, the Air Surgeon's Office, the headquarters of Army Service Forces, and the offices of the commanding generals of service commands and theaters of operations or their surgeons. The actions that figure most prominently in the account are those of the Surgeon General's Office, since it had comprehensive responsibility for—though not equally full power over—the Army's Medical Department. That power, as regards personnel, was shared by other agencies, not only inside but outside the War Department. Of great influence in this respect were Congress and its committees, certain civilian branches of the Executive—the Selective Service System, the War Manpower Commission, and the latter's Procurement and Assignment Service—and nongovernmental agencies such as the American National Red Cross, professional organizations in the field of medicine and their journals, other groups intent on promoting special interests, and finally

unorganized public opinion in its various forms of expression. The influence of all these agencies, so far as it was brought to bear on the personnel administration of the Army's medical service, is therefore also taken into account.

Statistics have been used extensively in this volume, not only to record in quantitative terms personnel developments in the Medical Department but also to compare them with developments in the Army as a whole. For these purposes, the authors have, as a rule, used the statistical source which gives the most detailed and comprehensive data on the particular point under discussion. A number of agencies produced these data. However, most of the time series compiled for the volume are based on data assembled by the Office of The Adjutant General, the chief agency of the Army for preparing personnel actions and maintaining records of them.

The Adjutant General's summaries of Army strength (including distribution according to race, rank, branch of service, and losses of personnel) derive added authority from the fact that they are compiled from information entered on each unit's morning report, which "is a permanent, statistical, and historical record" (AR 345–400, 7 May 1943, 1 May 1944, 3 January 1945). Each month, the information in these reports was consolidated for a particular cutoff date, a summary being made first on an area level and then by The Adjutant General, for all areas combined. The most important time series used which do not entirely follow The Adjutant General's figures are the worldwide strength of the Medical Department and its individual components from Pearl Harbor to mid-1946. These series were supplied to the authors in 1950 by the Resources Analysis Division, Office of The Surgeon General. They incorporate many of The Adjutant General's figures but for the most part differ, often very substantially, from them. The differences result primarily from using summaries of orders for accessions and separations of personnel instead of The Adjutant General's summaries of head counts based on the morning reports. The authors have made use of these series both in stating Medical Department strengths and in computing ratios and percentages involving them. One reason for doing so is that the Resources Analysis Division in the latter part of the war and for some years afterward was The Surgeon General's chief authority on statistics of Medical Department personnel; the series may therefore be regarded as virtually the official statement of the Medical Department on its strength and, as such, appropriate for use in this volume. The series are also somewhat more comprehensive than those of The Adjutant General. The reader may compare the two sets of figures for himself as they are reproduced in table 1.

The statistical approach proved to be particularly useful in the discussion of oversea matters. It lent itself to a treatment of the oversea personnel situation as a whole, rather than by individual theaters, and at the same time facilitated comparisons among different areas, thus enabling the demands of space to be more readily met than would otherwise have been possible. Nevertheless, much attention is focused on the European theater, not merely because it gave rise to more comprehensive personnel statistics than any other theater,

but because it was the largest theater in terms of both medical and general Army strength.

Max Levin is responsible for the sections on oversea developments and for most of the statistical compilations. For all other parts of the volume, John H. McMinn is responsible. The entire manuscript was prepared in the first instance under the direction of Donald O. Wagner, Ph. D., whose contributions extended to various changes in organization and a number of textual revisions. After both the authors and the original editor had left The Historical Unit, the volume was further reorganized and substantially reduced in length by Dr. Charles M. Wiltse, assisted by Mrs. Lucy W. Lazarou. The basic content of the volume and much of its language, however, is still that of Dr. McMinn and Mr. Levin, whose names appear on the title page as coauthors.

The bibliographical note mentions the most important documents, types of recorded material, and file collections used in preparing the volume. Much information also came from personal interviews and correspondence with officers and civilians familiar with the Medical Department's personnel operations during the war and from comments on chapters of the manuscript which a rather large number of them were kind enough to review. The names of reviewers are listed under "Acknowledgments." Without their willing cooperation, many valuable facts would not have come to the writers' attention, and many official documents could hardly have been properly interpreted. Singled out for particular mention here must be Maj. Gen. George F. Lull, USA (Ret.), and Dr. Durward G. Hall, Colonel, MC, USAR, both wartime chiefs of the Personnel Service, Office of The Surgeon General; and Miss Anna E. Carey, whose long and intimate connection with the personnel service makes her authority preeminent in all matters concerning it. These three individuals reviewed all of the manuscript in each of its revisions and acted collectively as an ad hoc advisory editorial board in the finalization of the text. The writers are also indebted to Mr. Joseph A. Logan of the Office of the Comptroller of the Army, whose advice and assistance as a statistical expert could always be counted upon, and to the former Chief Historian, Dr. Kent R. Greenfield, his successor, Dr. Stetson Conn, and other members of the Office of the Chief of Military History, Department of the Army, who made many useful suggestions as to form and content. Finally, they wish to acknowledge the contributions made by the Director of The Historical Unit, U.S. Army Medical Service, Col. John Boyd Coates, Jr., MC; by Mrs. Josephine P. Kyle, former Chief of the General Reference and Research Branch; by Miss Rebecca L. Duberstein, who performed the final publications editing and prepared the index; and by their coworkers in all branches of The Historical Unit.

CHARLES M. WILTSE

Acknowledgments

The following members of the Medical Department and others who were directly concerned with its personnel administration during World War II have reviewed and commented on the manuscript either in whole or in part. Their invaluable contributions are gratefully acknowledged.

Stewart F. Alexander, M.D., formerly Colonel, MC, AUS
Col. Florence A. Blanchfield, ANC, USA (Ret.)
Miss Anna E. Carey
Mr. Isaac Cogan
Robert Cutler, formerly Brigadier General, GS, AUS
Maj. Gen. Guy B. Denit, MC, USA (Ret.)
Harold Diehl, M.D.
Maj. Gen. Howard W. Doan, MC, USA
Col. Richard H. Eanes, MC, USA (Ret.)
Robert W. W. Evans, M.D., formerly Lieutenant Colonel, MC, AUS
Col. Fred J. Fielding, MC, USA (Ret.)
Col. Francis M. Fitts, MC, USA (Ret.), deceased
Maj. Helen B. Gearin, WMSC, USA (Ret.)
Eli Ginzberg, Ph. D.
Maj. Gen. Alvin L. Gorby, MC, USA (Ret.)
Durward G. Hall, M.D., formerly Colonel, MC, AUS
Maj. Gen. Thomas J. Hartford, MC, USA (Ret.)
Maj. Gen. Paul R. Hawley, MC, USA (Ret.)
Col. James R. Hudnall, MC, USA (Ret.)
Col. George F. Jeffcott, DC, USA (Ret.)
Maj. Gen. Norman T. Kirk, MC, USA (Ret.), deceased
Frank H. Lahey, M.D., deceased
Col. David E. Liston, MC, USA (Ret.)
Brig. Gen. Albert G. Love, MC, USA (Ret.)
Brig. Gen. Harold G. Lueth, MC, AUS (Ret.)
Maj. Gen. George F. Lull, MC, USA (Ret.)
Maj. Gen. James C. Magee, MC, USA (Ret.)
Col. Agnes A. Maley, ANC, USA (Ret.)
Brig. Gen. Earl Maxwell, USAF (MC)
Maj. Gen. Joseph H. McNinch, MC, USA (Ret.)
Mr. Paul V. McNutt, deceased
Brig. Gen. Harry D. Offutt, MC, USA (Ret.)
Col. Paul A. Paden, MC, USA
Brig. Gen. John A. Rogers, MC, USA (Ret.)
Maj. Gen. William E. Shambora, MC, USA (Ret.)
Maj. Gen. Earle Standlee, MC, USA (Ret.)
Thomas T. Stevenson, M.D., formerly Colonel, MC, AUS
Harvey B. Stone, M.D.

Miss Mary E. Switzer
Col. Gerald H. Teasley, MC, AUS (Ret.)
Col. Emma E. Vogel, WMSC, USA (Ret.)
Bruce P. Webster, M.D., formerly Colonel, MC, AUS
Col. Arthur B. Welsh, MC, USA (Ret.), deceased
Maj. Gen. Floyd L. Wergeland, MC, USA
Brig. Gen. Robert P. Williams, MC, USA (Ret.)

Contents

		Page
FOREWORD		IX
PREFACE		XV
ACKNOWLEDGMENTS		XIX
Chapter		
I	Composition of the Medical Department	1
	Introduction	1
	Military Components	4
	Civilian Components	19
II	Organization and Administration	21
	Zone of Interior	21
	Theaters of Operations	47
III	Requirements: 1939–41	53
	Strength of Medical Department Components	53
	War Department Responsibilities	54
	Factors Affecting Determination of Requirements	58
IV	Requirements: 1941–45	67
	Medical Corps	67
	Dental Corps	75
	Veterinary Corps	76
	Sanitary Corps	77
	Pharmacy Corps	78
	Medical Administrative Corps	78
	Army Nurse Corps	84
	Dietitians and Physical Therapists	88
	Enlisted Men	91
	Enlisted Women	99
	Civilians	100
	Additional Unit Requirements Overseas	102
V	Procurement During the Emergency Period	111
	Preemergency Procedures	111
	Early Reserve Measures	112
	The Beginning of Mobilization	124
	Deferment of Service for Reserve Officers	127
	Extension of Reservists' Tour of Duty	129
	Effect of Selective Service Legislation	131
	Army Nurse Corps	134
	Students in Professional Schools	136
	Reserve Units	141
	Other Sources of Officer Personnel	148
	Contributions of Organized Medicine and Nursing	156
	Procurement of Enlisted Men	164
VI	Procurement, 1941–45: Medical, Dental, and Veterinary Corps	167
	Legislation	167
	Medical Corps	168
	Dental Corps	195

Chapter		*Page*
VI	Procurement, 1941-45: Medical, Dental, and Veterinary Corps—Continued	
	Veterinary Corps	196
	Deferment of Professional Students	198
	The Affiliated Units After Pearl Harbor	206
VII	Procurement, 1941–45: Other Military Components	211
	Sanitary Corps	211
	Pharmacy Corps	213
	Medical Administrative Corps	214
	Army Nurse Corps	221
	Dietitians and Physical Therapists	231
	Enlisted Personnel	233
VIII	Procurement of Civilian Personnel	247
	Zone of Interior	247
	Oversea Theaters	253
IX	Classification	267
	Officers and Nurses, 1939–41	267
	Officers and Nurses, 1941–43	270
	Male and Female Officers, 1943–45	274
	Enlisted Personnel, 1939–45	284
X	Utilization of Personnel	289
	Assignment of Medical Department Personnel	289
	The Replacement System	297
	Organizational and Procedural Changes	306
	Utilization of Negro Personnel	317
	Utilization of Prisoners of War and Native Labor Troops	324
	Morale Factors in Efficient Utilization of Personnel	329
XI	Strength and Distribution of Military Personnel	339
	Overall Strength	339
	Distribution, Overseas and in the Zone of Interior	339
	Composition of the Medical Department Overseas	405
	Permanent Losses of Personnel	420
XII	Rank, Promotion, and Pay	451
	Zone of Interior	451
	Promotion Overseas	476
XIII	Redeployment, Retraining, and Demobilization	487
	Period of Partial Demobilization	487
	Full-Scale Demobilization	491
	Offsetting Factors	495
	Professional Retraining	500
	Postwar Planning	505
BIBLIOGRAPHICAL NOTE		511
INDEX		515

Illustrations

Figure		
1	Maj. Gen. James C. Magee, USA, The Surgeon General, 1 June 1939–31 May 1943	18
2	Brig. Gen. William L. Sheep, MC, prewar chief of Military Personnel Division, Office of The Surgeon General	22
3	Brig. Gen. (later Maj. Gen.) George F. Lull, MC, first wartime chief of Military Personnel Division, Office of The Surgeon General	23

Figure		*Page*
4	Brig. Gen. Charles C. Hillman, MC, wartime chief of the Professional Service Division, Office of The Surgeon General	24
5	Brig. Gen. Larry B. McAfee, MC, Chief, Administrative Division, Office of The Surgeon General, when the United States entered the war	25
6	Col. Francis C. Tyng, MC, Chief, Finance and Supply Division, Office of The Surgeon General	26
7	Brig. Gen. James S. Simmons, MC, Chief, Preventive Medicine Division, Office of The Surgeon General	29
8	Col. James R. Hudnall, MC, Chief, Personnel Service, Office of The Surgeon General, 1943–44	30
9	Col. Durward G. Hall, MC, Chief, Personnel Service, Office of The Surgeon General, 1944–46	31
10	Brig. Gen. Albert W. Kenner, MC, being decorated by Gen. George C. Marshall	32
11	Maj. Gen. Norman T. Kirk, USA, The Surgeon General, 1 June 1943–31 May 1947	33
12	Col. Arthur B. Welsh, MC, wartime Deputy Chief, Operations Service, Office of The Surgeon General	34
13	Eli Ginzberg, Ph. D., Resources Analysis Division, Office of The Surgeon General	35
14	Maj. Gen. Raymond W. Bliss, MC, wartime Deputy Surgeon General, Office of The Surgeon General	36
15	Lt. Col. Paul A. Paden, MC, of the Personnel Division, Office of The Surgeon General	41
16	Representative theater chief surgeons	50
17	Maj. Gen. Charles R. Reynolds, The Surgeon General, 1935–39	57
18	Representative Army surgeons	70
19	Brig. Gen. Robert Mills, DC, wartime director of the Dental Division, Office of The Surgeon General	75
20	Brig. Gen. Edward Reynolds, MAC, Chief, Medical Administrative Corps	78
21	Col. David E. Liston, MC, Deputy Chief Surgeon, European Theater of Operations, U.S. Army	82
22	Col. Fred J. Fielding, MC, Office of The Surgeon General, U.S. Army	83
23	Col. Florence A. Blanchfield, ANC, Superintendent of the Army Nurse Corps	85
24	Maj. Emma E. Vogel, WMSC, Superintendent of Physical Therapists	89
25	Members of the Women's Army Corps learning from Army nurse how to change surgical dressing	100
26	Nurses' aides, Camp Fannin, Tex	101
27	Col. Richard H. Eanes, MC, Chief Medical Officer, Selective Service System	131
28	Early appointments as commanders of affiliated units	145
29	Lt. Col. Harold C. Lueth, MC, liaison officer from the Office of The Surgeon General, to American Medical Association, 1942–45	158
30	Col. Sam F. Seeley, MC, Executive Officer, Directing Board, Procurement and Assignment Service	163
31	Directing Board, Procurement and Assignment Service	169
32	Col. George L. Caldwell, VC, Assistant Chief, Veterinary Division, Office of The Surgeon General	198
33	Col. Francis M. Fitts, MC, Director of Military Training, Army Service Forces	202
34	Nurses' duty uniform, 1943	220
35	Nurses' dress uniforms, 1943	221
36	Native litter bearers carrying a wounded American soldier from the frontlines, vicinity of Buna, New Guinea, November 1942	256
37	Natives building a covered bomb shelter, under the direction of a medical technician, Southwest Pacific Area, January 1944	257

Figure *Page*

38 Indian laundry workers, 371st Station Hospital, Rāmgarh, India, 28 February 1945 ---- 258
39 German prisoners of war assist in unloading a hospital train. Liége, Belgium, 18 March 1945, Hospital Train No. 8 ---- 328
40 Medical Department enlisted men awarded the Congressional Medal of Honor, in World War II ---- 338

Tables

1 Strength of Medical Department by components (exclusive of general officers), 30 June 1939–30 June 1946 ---- 10
2 Procurement objectives (10 July 1939), and actual strengths (30 June 1939), of Medical Department Officers Reserve Corps ---- 56
3 Numbers of Medical and Medical Administrative Corps officers suggested (1944) for Zone of Interior general hospitals of various sizes ---- 82
4 Proposed distribution of nurses, June 1945 ---- 88
5 Medical Department enlisted strength, worldwide and overseas, 31 July 1941–30 September 1945 ---- 92
6 Guide for utilization of personnel in named general hospitals, Zone of Interior ---- 94
7 Guide for utilization of personnel in convalescent hospitals, Zone of Interior ---- 95
8 Table-of-organization changes in certain types of hospitals, 1940–44 ---- 96
9 Table-of-organization changes in the medical detachment of the infantry regiment (T/O 7–11), 1938–45 ---- 98
10 Medical Department overstrengths and understrengths in various oversea theaters or areas, 30 November 1943 ---- 105
11 Authorized and actual strengths of medical personnel, Eighth U.S. Army, 31 May 1945 ---- 108
12 Active-duty strength of Medical Department groups, by Army components, 30 June 1939–30 November 1941 ---- 113
13 Strength of Medical Department Reserves (Regular Army Reserve and Reserve Corps), 1939–41 ---- 116
14 Strength of Medical Department Reserves (National Guard), 1939–41 ---- 119
15 Medical Department officers of affiliated Reserve in affiliated medical units, February 1941 ---- 146
16 Medical Department officers in affiliated units, 30 June 1941 ---- 147
17 The Army Specialized Training Program: Students of medicine, dentistry, and veterinary medicine assigned, separated, and discharged and transferred through curtailment of the program ---- 206
18 Civilians employed by the Medical Department from various funds, March 1940–December 1941 ---- 249
19 Economies in enlisted personnel through utilization of local labor, 815th Hospital Center, European theater, 1945 ---- 255
20 Ratio of civilian hospital workers to military medical personnel, Persian Gulf Command, 30 April 1943–31 July 1945 ---- 259
21 Utilization of civilian workers and Italian prisoners of war, by Medical Department service-type units, Mediterranean theater, 1 May 1945 ---- 261
22 Medical Department civilian labor, Communications Zone, European theater (exclusive of headquarters), June–December 1945 ---- 262
23 Geographic distribution of medical personnel, European Theater of Operations, Communications Zone, April to October 1945, inclusive ---- 264
24 Movement of Medical Department personnel in and out of Ground Forces Reinforcement Command, European Theater of Operations, D-day to V–E Day (6 June 1944–8 May 1945) ---- 299

Number		*Page*
25	Monthly Medical Department strength in Services of Supply or Communications Zone, European Theater of Operations (exclusive of Iceland), 30 September 1942–31 October 1944	308
26	Negroes in the Medical Department, 1943–45	319
27	Number of Medical Department officers assigned to the Veterans' Administration, January 1944–June 1946	339
28	Oversea strength of the Medical Department, 30 June 1939 and 30 June 1940	340
29	Development of Medical Department strength overseas, as compared with development of service strength, November 1941–September 1945	341
30	Movement of Medical Department troops overseas, compared with movement of all Army, all combat, and all service troops, July 1942–August 1945	342
31	Oversea strength of the Medical Department and oversea Negro medical strength by area, 31 July 1941–30 September 1945	345
32	Oversea strength of the Medical Department corps and other officer components, 31 July 1941–30 September 1945	373
33	Authorized allotment of Medical Department officers to oversea areas (less Reserve officers assigned to duty with the Air Corps) for the fiscal year 1942	384
34	Estimated table-of-organization strength of attached medical personnel and divisional medical battalions in oversea areas, 30 September 1944	385
35	Percentage distribution of Army strength among ground-, air-, and service-type units and overhead in theaters of operations, 30 September 1944	386
36	Operating strength of Medical Department units in oversea areas, 30 April 1943–31 August 1945	387
37	Types of Medical Department units in use in the various theaters of operations, by area, 30 September 1944	396
38	Estimated additions by Air Transport Command to theater medical strength per 1,000 troops, 1944	397
39	Strength of Medical Department personnel assigned to Air Forces, 30 September 1942–31 May 1945	399
40	Strength of Medical Department by Army components, worldwide and overseas, 31 January and 31 August 1942	404
41	Strength of male personnel by Army components, worldwide and overseas, on 31 July 1941	410
42	Negro Medical Department units overseas, Pearl Harbor to V–J Day	412
43	Proportion of Army female personnel in the Medical Department	413
44	Oversea strength of Medical Department, male and female officer components, 30 September 1942–30 September 1945	414
45	Medical Department officer strength, worldwide and overseas, 30 November 1941–30 September 1945	415
46	Strength and proficiency ratings of Medical Corps specialists, worldwide and overseas, 20 June 1945	417
47	The American National Red Cross: Oversea hospital workers on duty and en route, 1942–45	420
48	Battle casualties of the Medical Department, officers and enlisted men: Total battle casualties, deaths among battle casualties, and killed in action, 7 December 1941–31 December 1946	421
49	Battle casualties of the Medical Department, officers and enlisted men: Wounded and injured in action, 7 December 1941–31 December 1946	424
50	Battle casualties of the Medical Department, officers and enlisted men: Captured and interned, 7 December 1941–31 December 1946	427
51	Battle casualties of the Medical Department, officers and enlisted men: Missing in action, 7 December 1941–31 December 1946	430

Number *Page*

52 Nonbattle deaths in the Medical Department: Actual, 7 December 1941–31 December 1946; estimated, 7 December 1941–30 September 1945 433
53 Deaths from enemy action: Medical Department and Army as a whole, 7 December 1941–30 September 1945 436
54 Returns to civil life: Officers of the Medical Department and of the Army as a whole, 7 December 1941–30 September 1945 437
55 Returns of male Medical Department officers to civilian life, December 1941–September 1945 439
56 Returns of Medical Department enlisted men to civilian life, October 1943–June 1945 442
57 Returns to civil life: Enlisted men of the Medical Department and of the Army as a whole, October 1943–June 1945 442
58 Rates of discharge for mental and physical disability: Male officers of the Medical Department and of the Army as a whole, December 1941–September 1945 443
59 Disability-discharge rate: Enlisted men of the Medical Department and of the Army as a whole, October 1943–June 1945 444
60 Discharges for disability: Army Nurse Corps, Dietitians, and Physical Therapists, 1 September 1944–30 September 1945 445
61 Rank of Medical Department officers, 1939–45 457
62 Army Nurse Corps first lieutenants and second lieutenants: Numbers in grade and numbers of promotions, September 1944–August 1945 468
63 Rank of Medical Department officers overseas (excluding general officers), 31 July 1941–31 May 1944 472
64 Temporary promotions of Medical Department officers, worldwide and overseas, January 1943–September 1945 478
65 Temporary promotions of Medical Department officers by rank, by corps, and by other components, worldwide and overseas, November 1944 to June 1945, inclusive 480
66 Rank of Medical Department enlisted men overseas, 31 July 1941–31 May 1944 484
67 Medical Department officers separated, V–E Day–31 December 1946 (cumulative) 498
68 Civilians and prisoners of war employed in medical activities within Army Service Forces in the United States, 30 March 1945–30 April 1946 499

Charts

1 Organization of the Surgeon General's Office for personnel administration, January 1939 27
2 Organization of the Surgeon General's Office for personnel administration, August 1942 28
3 Organization of the Surgeon General's Office for personnel administration, February 1944 38
4 Organization of the Surgeon General's Office for personnel administration, May 1945 39
5 Percent of total Army and Medical Department strength, in oversea areas, on selected dates, 1941–45 371
6 Percent of total Army strength and Medical Department officers of Medical, Dental, Veterinary, and Medical Administrative Corps, in oversea areas, on selected dates, 1941–45 372
7 Percent of total Army strength and Medical Department officers of Sanitary and Army Nurse Corps and Hospital Dietitians and Physical Therapists, in oversea areas, on selected dates, 1941–45 372

CHAPTER I

Composition of the Medical Department

INTRODUCTION

In the years immediately following World War II, changes in organization and policy were made that should eliminate or modify some of the personnel difficulties that make up much of the subject matter of this book. Important among these postwar developments is the centering of responsibility for health and medical aspects of mobilization planning and for the maintenance of effective relations with the public health and medical professions at the level of the Secretary of Defense. Other improvements include the continuously current professional classification of both civilian and Army doctors; adjustments in rank and pay of medical and dental officers; the extension of compulsory military service to special groups; desegregation throughout the Army; the appointment of women doctors in the Regular Army Medical Corps, and of male officers in the Army Nurse Corps; and the establishment of standards for graduates of foreign medical schools. All of these changes deal with areas in which the problems of the Medical Department differ in kind or in degree from those of the Army as a whole—problems accentuated by the same wartime conditions that demanded they be resolved.

At peak strength in 1944, the Department comprised approximately 700,000 military personnel, about 8.5 percent of the entire Army. This figure does not include a substantial number of individuals from other branches of the military service who served under Medical Department command—among them chaplains, engineers, and about a fifth of the members of the Women's Army Corps. In addition, the Department employed perhaps as many as 150,000 civilians in the Zone of Interior and overseas. In both areas, some 80,000 prisoners of war were also detailed to the Medical Department to assist in its work. The variety of personnel was reflected particularly in the number of officer components. Before the end of the war, there were nine of these—the Medical, Dental, Veterinary, Sanitary, Medical Administrative, Pharmacy, and Nurse Corps, the Hospital Dietitians, and the Physical Therapists.

Although the responsibilities of the Department were administrative as well as medical, the availability of doctors was the major limiting factor in officer procurement throughout the war. The output of the medical schools was never great enough to meet the demand, nor was it possible to draw enough physicians from civilian practice to make up the deficit.

The functions of the Medical Department were preventive as well as curative, and extended not only to men and women but also to the relatively small

number of animals—chiefly dogs, horses, and mules—that were used by the Army. The preventive program included sanitation in connection with messes, waste disposal, water supplies, and housing; measures for the control of venereal disease; immunization against many common and some uncommon diseases; personal hygiene; food inspection; proper nutrition; and insect and rodent control. The program also extended to epidemiological studies, and the supervision of public health in occupied territories. Another essentially preventive function of the Medical Department was the physical examination of all persons entering or leaving the Army and of many on numerous occasions in between. In addition to research of a strictly clinical nature, the Medical Department was required to engage in "research and experimentation connected with the development and improvement of Medical Department material, equipment, and supplies." [1]

At the higher levels, administrative functions, too, were performed by doctors, since Medical Corps officers alone could command organizations dealing with the treatment, hospitalization, and evacuation of patients, except in an emergency when no such officers were available.[2] Medical Corps officers also performed staff functions such as directing the medical service of nonmedical units, advising commanders and their staffs on medical matters. The commander of every nonmedical organization the size of a battalion or larger normally had a medical officer on his staff. Specific staff responsibilities extended to medical supply, training, and the maintenance of clinical and allied medical records.

Although not legally bound to do so, the Medical Department, insofar as practical, had always cared for Army dependents and for certain civilians overseas. This was extended during the war to include prisoners of war and patients belonging to the U.S. Navy, other Federal agencies, American enterprises engaged in the war effort, and Allied forces when their treatment elsewhere was impracticable. This particular demand on the Medical Department was offset to some extent by the medical service of our Navy and by those of Allied countries, especially Great Britain.

In the 2 years before Pearl Harbor, the Medical Department, like the Army in general, attained a size unprecedented in peacetime. The problems related to this growth were certainly more difficult than any the Department had encountered since the First World War. Starting with a small complement of officers, nurses, and enlisted men and a personnel organization more suited to the needs of peace than of war, the Medical Department had to carry out the process of rapid expansion at the same time that it adjusted its recruiting effort to the quotas permitted by the War Department. The expansion involved building up the Reserves as well as the active forces, and was partly achieved by re-creating a system of unit reserves, or affiliated units. In enlarging its strength, the Medical Department encountered further problems,

[1] Army Regulations No. 40–5, 15 Jan. 1926.
[2] Army Regulations No. 40–10, Changes No. 1, 25 July 1935.

among others the difficulty—at a time when civilian medical service was more than ever in demand—of inducing professional people to enter the Army in large numbers and of keeping them in it once they had been secured. Partly as the result of these difficulties, the Medical Department had to improve its methods of classifying and assigning personnel so as to make the best use of its manpower. Meanwhile, the Department had to consider how or whether to utilize certain special groups, such as Negroes (doctors, dentists, and nurses) and graduates of foreign medical schools.

The first 2 years of war likewise had their special characteristics. Perhaps the most salient feature was that procurement became more important than it was before or afterward; the Medical Department, like the rest of the Army, obtained most of its personnel at this time. The advent of war made the affiliated units available for use, and the process of bringing them into service during 1942 and 1943 raised new problems of personnel administration. At this time, also, the final steps were taken to conserve the supply of students of medicine for the future use of the Army and of the civilian community.

In late 1943, definite ceilings were placed on certain important categories of medical personnel. As a result, the problem from then on became not so much one of obtaining more personnel as of using the men and women already in service as efficiently as possible. Measures for the latter purpose were developed or initiated during this period, even though they were carried still further later on. Thus, at the very beginning of the war, certain congressional enactments and War Department directives relaxed the physical standards required for officers, extended the term of military service, and enabled the Army to deploy its personnel more as it saw fit.

Also, during the first 2 years of the war, the system of rank and promotion Army-wide was basically remodelled. The only pay increase of the war for enlisted men and officers was provided by Congress in 1942. Late in the same year, two new female components of the Medical Department were created—the Physical Therapists and the Hospital Dietitians—and in 1943 a new male officer component, the Pharmacy Corps. These were the only Medical Department components added during the war.

Also, toward the end of 1942, a Committee to Study the Medical Department of the Army examined, as one of its fields of inquiry, various phases of medical personnel administration. The Committee, appointed by the Secretary of War and consisting of six civilian and two retired Army doctors, a hospital administrator, and a representative of Headquarters, Army Service Forces, ranged over a wide area in the course of its investigation including, besides personnel matters, the organization of the Surgeon General's Office and its place in the War Department structure, medical supply, and the efficiency of Medical Department installations.[3]

[3] For a full account of the Committee and all aspects of its work, *see* Medical Department, United States Army. Organization and Administration in World War II. Washington: U.S. Government Printing Office, 1963, pp. 145–185.

In certain other fields of personnel administration, developments occurred which continued into the later war years. Thus, the organization and responsibilities for personnel management began to change radically in a number of ways shortly after the beginning of the war, but did not reach their final form until later. During this period, also, the Medical Department considerably widened its use of special groups, but without arriving at a final solution of the problem.

The later war years were marked by several new trends, beginning in the summer and fall of 1943. In the realm of organization and responsibility for personnel affairs in the Zone of Interior, there was a tendency to revise the organization of the Surgeon General's Office so as to obtain more detailed knowledge of personnel resources; at the same time, the movement continued to centralize in his Office more control over personnel, and also to restore the personnel authority of the service command surgeons, all of which reversed the trend of the early war years. In this matter of procurement, while that process continued to occupy much of the Medical Department's attention, it was restricted not only by the ceilings imposed on Medical and Dental Corps strength but by the greater difficulty of obtaining doctors, nurses, and enlisted men. As a result, more emphasis was placed on measures to offset these restrictions on procurement. For one thing, there was a greater tendency to supplement the categories of personnel in short supply—or to replace them in certain kinds of work—with other types of personnel more readily obtainable. There were also new estimates of personnel requirements and further improvements in utilization. At the same time that these developments were taking place, policies concerning promotion and rank were revised, while conditions surrounding the use of Negroes and Japanese-Americans also changed. The outstanding feature of this period in the field of personnel, however, is that the Medical Department adjusted itself to the exigencies of war by more intensive cultivation of the resources at hand. Nevertheless, long before the end of the war, the business of adjustment to a restricted area of war and ultimately to a peacetime situation came under consideration; the problems of redeployment and demobilization seemed to press for an even quicker settlement than those of worldwide war itself.

MILITARY COMPONENTS

At the head of the Medical Department before, during, and after the war was The Surgeon General. A Federal statute provided that he should have the rank of major general and should be appointed by the President with the advice and consent of the Senate.[4] A further statute provided for four assistants, appointed in the same way, with the rank of brigadier general, one of whom must be an officer in the Dental Corps.[5]

[4] 41 Stat. 766.
[5] 52 Stat. 8. The law, approved on 29 January 1938, was made retroactive to 1 July 1937.

Prewar Period, 1939–41

Until the passage of the Selective Training and Service Act on 16 September 1940, the Army contained three traditional components: The Regular Army, the Reserves, and the National Guard. The Regular Army comprised officers and enlisted men who were on active duty at all times; the Reserves were intended to meet the need for additional officers and enlisted men during an early period of mobilization; and the National Guard was designed to serve in case of emergency or actual hostilities. Both the Reserves and National Guard were organized into units similar to those of the Regular Army, but the Reserve units were largely paper ones.

After the passage of the Selective Service Act, the Army contained a body of officers and enlisted men who were referred to simply as "Army of the United States personnel"; that is, officers commissioned in the Army of the United States but not necessarily in any of the components just mentioned, and enlisted men not designated as members of one of these three components.[6] During the war, this Army of the United States personnel came to constitute by far the largest part of the Army.

Prior to World War II, the Medical Department contained seven military components—five officer corps whose members held full commissioned rank (the Medical, Dental, Veterinary, Sanitary, and Medical Administrative Corps), one whose members held relative rank (the Army Nurse Corps), and a body of enlisted men.

In 1939, all Medical Department officer corps except the Sanitary Corps were represented in the Regular Army, the National Guard, and the Reserves; the Sanitary Corps existed only in the Reserves. Reserve officers took correspondence courses, upon the completion of which they were awarded certificates of capacity entitling them to promotion when they had served the prescribed time in grade. Many of the older officers were men who had transferred to the Reserve Corps after World War I. Others had been commissioned upon the completion of professional training, having taken the prescribed training in the Reserve Officers' Training Corps units in medical schools. Medical Department officers and enlisted men of the National Guard had considerable experience with military medicine through their year-round armory-instruction program and the extensive training provided at camps each summer. The Regular Army had a complement of nurses, the National Guard had none, while the Reserve of the Nurse Corps consisted of nurses registered with the American National Red Cross. The Regular Army, National Guard, and Reserves each had a complement of Medical Department enlisted men.

Prior to the establishment of the CCC (Civilian Conservation Corps), only small numbers of Medical Department Reserve officers served on active duty for longer periods than the usual 14-day tour each year. After the initiation of

[6] Many Regular Army officers held temporary commissions with higher rank in the Army of the United States. In the War Department statistics, the term "AUS enlisted personnel" is reserved for volunteers in that category; others are listed separately as "selectees."

the CCC, however, medical, dental, and veterinary officers were assigned to it in substantial numbers, and during the fiscal year ending on 30 June 1939, a total of 889 Reserve officers were on duty with the corps. Thereafter, Reserve officers so engaged, instead of serving on active military duty were to serve as contract surgeons or as civilian employees.[7]

The Medical Corps

The Medical Corps was the original component of the Medical Department and remained the core of that organization. As it consisted only of officers who held the degree of doctor of medicine from an acceptable college or university and who had passed the required examinations, its professional duties could be defined mainly as those incident to the practice of military medicine. Medical officers also performed certain command and staff functions, as already mentioned.[8]

Both professional and administrative duties ordinarily assigned to members of the Medical Corps were also shared on occasion by contract surgeons, although no firm determination was ever made as to their actual legal status in the Medical Department. They spanned the military and civilian components, being deprived of certain advantages of military service but sharing in some of the civilian ones. In the early days of the Medical Department, they were used extensively even on foreign service, and from this group, many outstanding members of the Regular Army were recruited. In the interim between the wars, they furnished the only medical service provided to troops stationed at arsenals and armories throughout the country and gave emergency treatment to the civilians employed at these stations. Some served on a full-time, others on a part-time basis, but the pay either way was relatively small. They had a small complement of enlisted men who usually served long periods at one station. Both the contract surgeon and his enlisted assistants were held in high regard by the officers and their families. Children, it is said, would often run to the infirmary for treatment of minor injuries, or for comfort, instead of going home. Later, many contract surgeons were used to furnish medical care to the enrollees of the Civilian Conservation Corps. During the war, they were to make a notable contribution at depots and industrial plants under Army control.

The Dental Corps

The Dental Corps, established in 1911, was responsible for the dental service of the Army. Members of the corps ordinarily were assigned duties directly connected with the prevention and treatment of dental diseases and deficiencies. They were also declared to be eligible for employment in other duties determined by the needs of the service and the training and experience of the officers

[7] Annual Report of The Surgeon General, U.S. Army, Washington: U.S. Government Printing Office, 1939, p. 183.

[8] Army Regulations No. 40–10, 9 Jan. 1924.

concerned.[9] Each officer of the corps was a graduate of an acceptable dental college. The dental officer who served as one of the four assistants to The Surgeon General[10] administered the dental service of the Army and headed the Dental Division of the Surgeon General's Office.

The Veterinary Corps

The Veterinary Corps, created by the National Defense Act of 1916, required its officers to be graduates of approved veterinary schools. Their duties fell into two general classes—those pertaining to the inspection of foods of animal origin procured or used by the Army and those having to do with the care and management of Army animals. The members also trained and directed the enlisted personnel of the Medical Department assigned for duty to the corps. The inspection of foods rather than animal care was the principal activity of Veterinary Corps officers in World War II. This inspection, in the United States and overseas, covered the sanitary and other quality factors in foods of animal origin during their procurement, storage, shipment, issue, and other handling by the Army. Only veterinary officers commanded veterinary units.[11]

The Medical Administrative Corps

While the duties of Medical Administrative Corps officers were nowhere stated in Army regulations, an act of 24 June 1936 provided that appointments to the Regular Army component thereafter should be made from pharmacists who were graduates of recognized schools or colleges of pharmacy.[12] But neither this component nor the one which absorbed it in 1943—the Pharmacy Corps—was ever made up exclusively of pharmacists, nor was training in pharmacy ever made a prerequisite to commissioning in either the Reserve or Army of the United States sections of the corps. Most members therefore performed a variety of other duties, serving, for example, as adjutant, medical supply officer, mess officer, and training officer.

The Sanitary Corps

The Sanitary Corps Reserve had no members on active duty at the beginning of 1939. Qualifications for appointment were possession of a degree signifying completion of a 4-year technical or scientific college course in the specialty for which the candidate was selected and 3 years' experience in a "highly specialized occupation or scientific specialty pertaining to the functions of the Medical Department such as chemistry, food and nutrition, hospital architecture, procurement and manufacture of medical supplies, psy-

[9] Army Regulations No. 40–15, 20 Apr. 1939. This eligibility was eliminated from the regulation in the revision of 8 August 1945.

[10] See footnote 5, p. 4.

[11] Army Regulations No. 605–20, 1939, and Army Regulations No. 40–2260, 1939.

[12] 49 Stat. 1902.

chology,[13] public health, sanitary engineering, and other appropriate vocations." In lieu of a college education, the candidate might present evidence of sufficient general and technical knowledge gained by study, training, and years of experience to demonstrate his fitness for the corps. The requirement became somewhat more rigid in 1940; nevertheless, the prewar conditions for appointment have been described as "very loosely drawn." [14] In 1942, however, it became necessary for a sanitary engineer or an entomologist entering the corps to possess not only the appropriate academic degree but 4 years of satisfactory experience. About 2 years later, the pressing need for personnel caused a cut in the experience requirement to 2 years. Afterward, the processes of the Army Specialized Training Program replaced these requirements. Members of the Sanitary Corps, besides performing duties appropriate to their special training, came to be used frequently to relieve Medical Corps officers of certain administrative duties.

The Army Nurse Corps

At the outbreak of the war, the Army Nurse Corps consisted of a superintendent, assistant superintendents, chief nurses, and nurses. Until 1944, when the nurses achieved full commissioned status, all held "relative rank," [15] with some of the rights and privileges accorded commissioned officers. To be professionally qualified for appointment to the corps, the applicant had to be a registered nurse with at least 2 years of general hospital training or equivalent experience.[16] The duties of nurses, defined in detail by Army regulations, were the customary functions of hospital nurses, with the additional ones of supervising and administering the nursing service—which included responsibility for overseeing the work of enlisted personnel serving on the wards.

The Nurse Corps was composed entirely of women, although, in late 1942, a suggestion was made that men should be appointed to it for service in psychiatric and genitourinary wards.[17] Toward the end of the war, after the nurses had attained full commissioned rank, there was some agitation in favor of appointing men to the corps for general nursing service, but the Army argued against it successfully on the ground that the performance of certain

---

[13] Army Regulations No. 140–33, 30 July 1936. Psychology was omitted from the list in Army Regulations No. 140–38, 15 Dec. 1940.

[14] Hardenbergh, W. A.: Organization and Administration of Sanitary Engineering Division. [Official record.]

[15] "Relative rank" as officially defined meant "comparative rank or position of authority among officers holding the same grade" (War Department Technical Manual 20–205, Dictionary of U.S. Army Terms, 18 Jan. 1944). Unofficially, the term generally denoted something less than full military rank. For convenience, it is used in the latter sense in this volume.

[16] Army Regulations No. 40–20, 31 Dec. 1934, with changes thereto. Although the wording of this regulation was changed subsequently in such a way that it could be interpreted to mean that formal training could be entirely replaced by experience, there is reason to believe that only applicants having formal training were appointed. Also, the requirement that applicants for the "permanent establishment" had to be registered nurses was omitted, perhaps inadvertently, from the issue of the same regulation for 5 April 1943, but was restored by Changes No. 6, 22 June 1944.

[17] Report of the Committee to Study the Medical Department of the Army, 1942.

nursing tasks would ruin a man's usefulness as an officer in the eyes of enlisted men.[18] Since World War II, male nurses have been accepted, first in the Reserve and more recently in the Regular Army, where they have amply proved their worth.

Enlisted personnel

The enlisted component, unlike other components of the Medical Department, had no special entrance requirements; qualifications were simply those for admission to the enlisted ranks of the Army as a whole. Certain practices were adopted which can hardly be called real exceptions to this rule, such as the recruitment of technicians by the Women's Army Corps for the use of the Medical Department. The Army also made an effort, by its classification and assignment system, to channel enlisted personnel with appropriate experience into the Medical Department. But the vast majority came into the Department with no such special background and had to be trained after they arrived.

World War II, 1941–45

The strength of the Medical Department on 7 December 1941 was approximately 131,600 (table 1).[19] Throughout the rapid expansion that followed American entry into the war, the five original male officer corps retained their sections in the Regular Army, the Reserves, and the National Guard. The Nurse Corps, too, retained its Regular Army section, and nurses also began to come on duty as members of the Reserve. Eventually, officers of all of these corps were directly commissioned in the Army of the United States.

New military components were added to the Department in the course of the war, the hospital dietitians and the physical therapists in 1942, and the Pharmacy Corps in 1943. Dietitians and therapists, like the nurses, at first held only relative rank, but all three groups achieved commissioned status in 1944.

Dietitians and physical therapists

The administrative histories of the dietitian and physical therapist groups, including the process by which their members attained officer status, are so similar that they can be considered together.[20]

---

[18] Letter, The Deputy Surgeon General, to Miss Inez D. Mooney, Houston, Tex., 27 Feb. 1945.

[19] Strength figures for the war years vary depending on whether they are based on records kept in the Surgeon General's Office or on records of The Adjutant General.

[20] Unless otherwise noted, the account which follows is based on (1) the manuscript history of each group written by its director and (2) letter, Col. Emma E. Vogel, USA (Ret.), to Col. J. B. Coates, Jr., MC, USA, Director, Historical Unit, U.S. Army Medical Service, 28 Mar. 1956. Both groups are treated in greater detail in a forthcoming volume in this series dealing with the Army Medical Specialist Corps, into which they were eventually absorbed.

TABLE 1.—*Strength of Medical Department, by components (exclusive*

[Office of The Surgeon General's data in Arabic

End of month	Total Army Strength [1]	Total Medical Department		Total officers Medical Department		Male Medical Department officers							
						Total		Medical Corps [2]		Dental Corps		Veterinary Corps	
		Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]
1939													
June	188,565	11,540	61.2	2,181	11.6	1,509	8.0	1,098	5.82	221	1.17	126	0.668
1940													
June [4]	267,767	18,093	67.6	3,119	11.6	2,177	8.1	1,578	5.89	354	1.32	171	.639
1941													
June [5]	1,460,998	118,607	81.2	20,238	13.9	14,805	10.1	10,311	7.06	2,636	1.80	563	.385
November	1,644,210	131,586	80.0	23,484	14.3	16,673	10.1	11,327	6.89	3,081	1.87	695	.423
December	1,686,403	131,757	78.1	23,890	14.2	16,847	10.1	11,342	6.73	3,124	1.85	687	.407
		131,060	*77.7*	*23,193*	*13.8*	*16,150*	*9.6*						
1942													
January	1,889,943	151,538	80.1	26,677	14.1	17,464	9.2	11,786	6.23	3,225	1.70	734	.388
		148,294	*78.5*	*23,433*	*12.4*	*15,949*	*8.4*						
February	2,144,601	174,688	81.4	28,767	13.4	17,989	8.4	12,139	5.65	3,327	1.55	779	.363
		171,752	*80.1*	*25,261*	*11.8*	*16,697*	*7.8*						
March	2,386,138	201,162	84.3	31,535	13.2	18,759	7.9	12,450	5.21	3,446	1.44	803	.337
		197,252	*82.7*	*27,056*	*11.3*	*17,343*	*7.3*						
April	2,661,237	219,098	82.3	34,659	13.0	20,049	7.5	13,230	4.97	3,750	1.40	843	.316
		214,254	*80.5*	*28,561*	*10.7*	*18,367*	*6.9*						
May	2,834,610	236,734	83.5	38,645	13.6	22,632	8.0	15,264	5.38	4,117	1.45	877	.309
		230,519	*81.3*	*32,430*	*11.4*	*20,852*	*7.3*						
June	3,074,184	253,707	82.5	43,755	14.2	26,508	8.6	17,954	5.84	4,783	1.55	950	.309
		245,978	*80.0*	*36,026*	*11.7*	*23,551*	*7.7*						
July	3,272,803	275,719	84.2	50,764	15.5	32,518	9.9	22,020	6.72	6,024	1.84	1,051	.321
		267,663	*81.8*	*42,708*	*13.1*	*29,817*	*9.1*						
August	3,585,120	312,238	87.0	57,299	16.0	38,161	10.6	25,958	7.24	6,970	1.94	1,349	.376
		304,753	*85.0*	*49,814*	*13.9*	*35,373*	*9.9*						
September	3,971,016	349,253	87.9	65,922	16.6	45,778	11.5	31,309	7.88	8,432	2.12	1,408	.354
		339,384	*85.5*	*56,053*	*14.1*	*41,183*	*10.4*						
October	4,413,816	395,396	89.5	70,582	16.0	49,427	11.2	33,488	7.58	9,017	2.04	1,438	.325
		386,714	*87.6*	*61,900*	*14.0*	*45,766*	*10.4*						
November	4,932,469	439,844	89.1	73,877	15.0	51,997	10.5	34,992	7.09	9,334	1.89	1,482	.300
		432,458	*87.7*	*66,491*	*13.5*	*48,801*	*9.9*	*33,148*	*6.72*	*8,395*	*1.70*	*1,329*	*.270*
December	5,397,674	475,999	88.1	76,525	14.2	53,913	10.0	35,594	6.59	9,773	1.81	1,532	.283
		469,981	*87.1*	*70,507*	*13.1*	*51,313*	*9.5*	*34,369*	*6.37*	*8,832*	*1.64*	*1,366*	*.250*
1943													
January	5,824,517	497,252	85.3	79,945	13.7	56,401	9.7	36,173	6.19	9,929	1.70	1,571	.269
		499,385	*85.7*	*75,415*	*13.0*	*53,839*	*9.2*	*35,243*	*6.05*	*8,899*	*1.53*	*1,416*	*.240*
February	6,139,362	530,746	86.4	82,790	13.5	58,166	9.5	36,584	5.95	10,101	1.64	1,592	.259
		527,144	*85.9*	*79,188*	*12.9*	*55,596*	*9.1*	*34,867*	*5.68*	*9,790*	*1.59*	*1,469*	*.240*
March	6,508,854	558,010	85.7	85,878	13.2	59,505	9.1	36,801	5.65	10,381	1.59	1,655	.254
		555,858	*85.4*	*83,726*	*12.9*	*57,663*	*8.9*	*36,008*	*5.53*	*9,529*	*1.46*	*1,547*	*.240*
April	6,719,827	588,330	87.5	88,673	13.2	61,079	9.1	36,780	5.47	10,726	1.59	1,753	.260
		586,935	*87.3*	*87,278*	*13.0*	*59,165*	*8.8*	*36,015*	*5.36*	*10,029*	*1.49*	*1,632*	*.240*

See footnotes at end of table.

of general officers), by months, 30 June 1939–30 June 1946

numerals; The Adjutant General's data in italics]

Male Medical Department officers—Con.						Female Medical Department officers								Enlisted men Medical Department	
Sanitary Corps		Pharmacy Corps		Medical Administrative Corps		Total		Army Nurses		Medical Department Dietitians		Physical Therapists			
Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]
				64	0.34	672	3.6	672	3.56					9,359	49.6
8	0.030			66	.25	942	3.5	942	3.52					14,974	55.9
187	.128			1,108	.76	5,433	3.7	5,433	3.72					98,369	67.3
227	.138			1,343	.82	6,811	4.1	6,811	4.14					108,102	65.7
224	.132			1,470	.87	7,043	4.2	7,043	4.17					107,867	64.0
						7,043	*4.2*	*7,043*	*4.18*					*107,867*	*64.0*
235	.124			1,484	.78	9,213	4.9	9,213	4.87					124,861	66.0
						7,484	*4.0*	*7,484*	*3.96*					*124,861*	*66.1*
252	.117			1,492	.69	10,778	5.0	10,778	5.02					145,921	68.0
						8,564	*4.0*	*8,564*	*3.99*					*146,491*	*68.3*
315	.132			1,745	.73	12,776	5.4	12,776	5.35					169,627	71.1
						9,713	*4.1*	*9,713*	*4.07*					*170,196*	*71.3*
414	.155			1,812	.68	14,610	5.5	14,610	5.48					184,439	69.3
						10,194	*3.8*	*10,194*	*3.83*					*185,693*	*69.8*
483	.170			1,891	.66	16,013	5.6	16,013	5.64					198,089	69.8
						11,578	*4.1*	*11,578*	*4.08*					*198,089*	*69.9*
635	.206			2,186	.71	17,247	5.6	17,247	5.61					209,952	68.2
						12,475	*4.1*	*12,475*	*4.06*					*209,952*	*68.3*
781	.238			2,642	.80	18,246	5.6	18,246	5.57					224,955	68.7
						12,891	*3.9*	*12,891*	*3.94*					*224,955*	*68.7*
803	.223			3,081	.85	19,138	5.3	19,138	5.33					254,939	71.1
						14,441	*4.0*	*14,441*	*4.03*					*254,939*	*71.1*
983	.247			3,646	.91	20,144	5.1	20,144	5.07					283,331	71.3
						14,870	*3.8*	*14,870*	*3.75*					*283,331*	*71.4*
1,032	.233			4,457	1.00	21,155	4.8	21,155	4.79					324,814	73.5
						16,134	*3.7*	*16,134*	*3.66*					*324,814*	*73.6*
1,132	.229			5,057	1.02	21,880	4.4	21,880	4.43					365,967	74.1
998	*.200*			*4,931*	*1.00*	*17,690*	*3.6*	*17,690*	*3.59*					*365,967*	*74.2*
1,154	.213			5,860	1.08	22,612	4.2	22,612	4.18					399,474	74.0
1,052	*.190*			*5,694*	*1.05*	*19,194*	*3.6*	*19,194*	*3.56*					*399,474*	*74.0*
1,228	.210			7,500	1.28	23,544	4.04	23,544	4.04					417,307	71.6
1,093	*.190*			*7,188*	*1.23*	*21,576*	*1.23*	*21,576*	*3.70*					*423,970*	*72.8*
1,324	.215			8,565	1.39	24,624	4.0	24,624	4.01					447,956	72.9
1,181	*.190*			*8,289*	*1.35*	*23,592*	*3.8*	*23,592*	*3.84*					*447,956*	*73.0*
1,448	.222			9,220	1.41	26,373	4.1	25,709	3.94	448	0.067	216	0.033	472,132	72.5
1,301	*.200*			*9,278*	*1.43*	*26,063*	*4.0*	*25,406*	*3.90*	*448*	*.070*	*209*	*.030*	*472,132*	*72.5*
1,565	.232			10,255	1.52	27,594	4.1	26,709	3.97	572	.085	313	.046	499,657	74.3
1,453	*.220*			*10,036*	*1.49*	*28,113*	*4.2*	*27,257*	*4.06*	*572*	*.080*	*284*	*.040*	*499,657*	*74.4*

TABLE 1.—*Strength of Medical Department, by components (exclusive*

[Office of The Surgeon General's data in Arabic

End of month	Total Army Strength [1]	Total Medical Department		Total officers Medical Department		Male Medical Department officers							
						Total		Medical Corps [2]		Dental Corps		Veterinary Corps	
		Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]
1943—Con.													
May	6,858,591	606,358	88.4	91,401	13.3	62,956	9.2	37,009	5.39	11,524	1.68	1,812	0.264
		604,475	*88.1*	*89,528*	*13.1*	*59,965*	*8.7*	*34,735*	*5.06*	*10,995*	*1.60*	*1,699*	*.250*
June	6,993,102	619,020	88.5	93,994	13.4	64,461	9.2	37,189	5.31	12,048	1.72	1,839	.264
		619,543	*88.6*	*94,517*	*13.5*	*63,212*	*9.0*	*36,786*	*5.26*	*11,639*	*1.66*	*1,751*	*.250*
July	7,126,818	628,360	88.1	99,000	13.9	68,257	9.6	39,074	5.48	12,769	1.79	1,858	.260
		628,965	*88.3*	*99,605*	*14.0*	*66,985*	*9.4*	*38,699*	*5.43*	*12,276*	*1.72*	*1,783*	*.250*
August	7,214,595	634,548	87.9	102,731	14.2	70,536	9.8	39,735	5.50	13,200	1.82	1,922	.266
		631,422	*87.5*	*102,675*	*14.2*	*69,077*	*9.6*	*39,348*	*5.45*	*12,873*	*1.79*	*1,791*	*.250*
September	7,273,784	622,275	85.5	105,294	14.5	71,517	9.8	39,951	5.49	13,579	1.86	1,909	.262
		622,226	*85.5*	*105,245*	*14.5*	*70,325*	*9.7*	*39,813*	*5.47*	*13,073*	*1.80*	*1,854*	*.250*
October	7,333,474	615,102	83.9	107,491	14.7	71,900	9.8	40,106	5.46	13,791	1.88	1,968	.268
		614,061	*83.7*	*106,450*	*14.5*	*70,741*	*9.7*	*39,577*	*5.40*	*13,295*	*1.81*	*1,848*	*.250*
November	7,405,665	619,030	83.6	110,163	14.9	73,134	9.9	40,203	5.42	14,241	1.92	1,993	.269
		617,009	*83.3*	*108,150*	*14.6*	*71,671*	*9.7*	*39,729*	*5.36*	*13,609*	*1.84*	*1,929*	*.260*
December	7,482,434	623,650	83.3	111,899	15.0	73,683	9.8	40,328	5.38	14,332	1.91	2,007	.268
		622,227	*83.2*	*110,492*	*14.8*	*73,286*	*9.8*	*40,287*	*5.39*	*14,074*	*1.88*	*1,934*	*.260*
1944													
January	7,556,157	628,758	83.2	113,994	15.1	75,663	10.0	41,859	5.54	14,193	1.88	1,957	.259
		628,727	*83.2*	*113,603*	*15.0*	*75,303*	*10.0*	*41,859*	*5.54*	*14,193*	*1.88*	*1,957*	*.260*
February	7,653,036	636,107	83.1	116,657	15.2	77,226	10.1	43,196	5.64	14,748	1.93	2,002	.262
		636,075	*83.1*	*116,625*	*15.2*	*77,226*	*10.1*	*43,196*	*5.64*	*14,748*	*1.93*	*2,002*	*.260*
March	7,757,629	638,642	82.3	117,965	15.2	77,644	10.0	43,503	5.61	14,818	1.91	1,984	.256
		638,632	*82.3*	*117,955*	*15.2*	*77,644*	*10.0*	*43,503*	*5.60*	*14,818*	*1.91*	*1,984*	*.250*
April	7,848,172	651,290	83.0	118,419	15.1	77,398	9.9	43,356	5.52	14,782	1.88	2,012	.256
		651,180	*83.0*	*118,409*	*15.1*	*77,398*	*9.9*	*43,356*	*5.52*	*14,782*	*1.88*	*2,012*	*.260*
May	7,910,496	661,256	83.6	119,417	15.1	78,005	9.9	43,690	5.50	14,971	1.89	1,993	.252
		661,225	*83.6*	*119,386*	*15.1*	*78,005*	*9.9*	*43,690*	*5.52*	*14,971*	*1.89*	*1,993*	*.250*
June	7,992,868	673,316	84.2	120,221	15.0	78,312	9.8	43,987	5.50	14,868	1.86	2,037	.255
		673,278	*84.2*	*120,183*	*15.0*	*78,312*	*9.8*	*43,987*	*5.50*	*14,868*	*1.86*	*2,037*	*.250*
July	8,049,770	679,576	84.4	120,748	15.0	78,646	9.8	43,995	5.47	14,952	1.86	2,068	.257
		679,633	*84.4*	*120,805*	*15.0*	*78,646*	*9.8*	*43,995*	*5.46*	*14,952*	*1.86*	*2,068*	*.260*
August	8,102,545	688,537	85.0	121,269	15.0	79,180	9.8	44,726	5.52	15,121	1.87	2,024	.250
		688,516	*85.0*	*121,248*	*15.0*	*79,180*	*9.8*	*44,726*	*5.52*	*15,121*	*1.87*	*2,024*	*.250*
September	8,108,129	680,859	84.0	121,532	15.0	79,038	9.7	44,577	5.50	14,948	1.84	2,012	.248
		680,817	*84.0*	*121,490*	*15.0*	*79,038*	*9.8*	*44,577*	*5.50*	*14,948*	*1.84*	*2,012*	*.250*
October	8,103,376	687,509	84.8	124,713	15.4	80,830	10.0	45,888	5.66	15,148	1.87	1,994	.246
		687,501	*84.8*	*124,705*	*15.4*	*81,030*	*10.0*	*45,888*	*5.66*	*15,148*	*1.87*	*1,994*	*.250*
November	8,102,061	682,038	84.2	126,814	15.7	82,787	10.2	46,747	5.77	15,292	1.89	2,014	.249
		682,026	*84.2*	*126,802*	*15.7*	*82,787*	*10.2*	*46,747*	*5.77*	*15,292*	*1.89*	*2,014*	*.250*
December	8,052,693	669,762	83.2	128,112	15.9	83,418	10.4	46,747	5.81	15,110	1.88	2,038	.253
		669,767	*83.2*	*128,117*	*15.9*	*83,418*	*10.4*	*46,747*	*5.80*	*15,110*	*1.88*	*2,038*	*.250*
1945													
January	8,070,929	667,207	82.7	129,544	16.1	84,080	10.4	46,970	5.82	14,895	1.85	2,045	.253
		667,188	*82.7*	*129,885*	*16.1*	*84,417*	*10.5*	*46,973*	*5.82*	*15,126*	*1.88*	*2,070*	*.260*
February	8,129,890	669,917	82.4	132,137	16.3	84,760	10.4	46,940	5.77	14,835	1.82	2,045	.252
		669,929	*82.4*	*132,149*	*16.2*	*84,820*	*10.4*	*47,214*	*5.81*	*14,991*	*1.84*	*2,059*	*.250*

See footnotes at end of table.

of general officers), by months, 30 June 1939–30 June 1946—Continued

numerals; The Adjutant General's data in italics]

Male Medical Department officers—Con.						Female Medical Department officers								Enlisted men Medical Department	
Sanitary Corps		Pharmacy Corps		Medical Administrative Corps		Total		Army Nurses		Medical Department Dietitians		Physical Therapists			
Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]
1,661	0.242	-------	------	10,950	1.59	28,445	4.1	27,459	4.00	601	0.087	385	0.056	514,957	75.0
1,562	*.230*	-------	------	*10,974*	*1.60*	*29,563*	*4.3*	*28,647*	*4.18*	*601*	*.090*	*315*	*.040*	*514,947*	*75.1*
1,755	.250	-------	------	11,630	1.66	29,533	4.2	28,423	4.06	707	.101	403	.057	525,026	75.0
1,674	*.240*	-------	------	*11,362*	*1.62*	*31,305*	*4.5*	*30,316*	*4.33*	*666*	*.100*	*323*	*.050*	*525,026*	*75.1*
1,876	.263	58	0.008	12,622	1.77	30,743	4.3	29,576	4.14	734	.102	433	.060	529,360	74.2
1,790	*.250*	*19*	*2.000*	*12,418*	*1.74*	*32,620*	*4.6*	*31,506*	*4.42*	*739*	*.110*	*375*	*.050*	*529,360*	*74.3*
1,938	.275	58	.008	13,633	1.88	32,195	4.5	30,922	4.28	825	.112	448	.062	531,817	73.7
1,964	*.270*	*28*	*2.000*	*13,073*	*1.81*	*33,598*	*4.7*	*32,377*	*4.49*	*785*	*.110*	*473*	*.060*	*528,747*	*73.3*
2,054	.282	58	.008	13,966	1.92	33,777	4.6	32,355	4.44	909	.124	513	.072	516,981	71.0
2,014	*.280*	*34*	*.010*	*13,537*	*1.86*	*34,920*	*4.8*	*33,602*	*4.62*	*882*	*.120*	*436*	*.060*	*516,981*	*71.1*
2,110	.288	58	.008	13,867	1.89	35,591	4.9	34,089	4.65	966	.132	536	.073	507,611	69.2
2,141	*.290*	*40*	*.010*	*13,840*	*1.89*	*35,709*	*4.9*	*34,276*	*4.67*	*937*	*.130*	*496*	*.070*	*507,611*	*69.2*
2,162	.292	58	.008	14,477	1.95	37,079	5.0	35,465	4.79	1,027	.139	537	.073	508,867	68.7
2,166	*.290*	*43*	*.010*	*14,195*	*1.92*	*36,479*	*4.9*	*35,012*	*4.73*	*969*	*.130*	*498*	*.070*	*508,859*	*68.7*
2,209	.295	58	.008	14,749	1.97	38,216	5.1	36,607	4.89	1,048	.140	561	.075	511,751	68.4
2,195	*.290*	*65*	*.010*	*14,731*	*1.97*	*37,206*	*5.0*	*35,711*	*4.77*	*995*	*.130*	*500*	*.070*	*511,735*	*68.4*
2,246	.297	58	.008	14,990	1.98	38,331	5.1	36,672	4.85	1,100	.146	559	.074	515,124	68.2
2,246	*.300*	*58*	*.010*	*14,990*	*1.98*	*38,300*	*5.1*	*36,672*	*4.86*	*1,069*	*.140*	*559*	*.070*	*515,124*	*68.2*
2,266	.296	47	.006	14,967	1.96	39,431	5.2	37,722	4.93	1,127	.147	582	.076	519,450	67.9
2,266	*.300*	*47*	*.010*	*14,967*	*1.95*	*39,399*	*5.2*	*37,714*	*4.93*	*1,101*	*.140*	*581*	*.080*	*519,450*	*67.9*
2,317	.299	45	.006	14,977	1.93	40,321	5.1	38,538	4.97	1,167	.150	616	.079	520,677	67.1
2,317	*.300*	*45*	*.010*	*14,977*	*1.93*	*40,311*	*5.2*	*38,538*	*4.97*	*1,157*	*.150*	*616*	*.080*	*520,677*	*67.1*
2,288	.292	58	.007	14,902	1.90	41,021	5.2	39,184	4.99	1,195	.152	642	.082	532,771	67.9
2,288	*.290*	*58*	*.010*	*14,902*	*1.90*	*41,011*	*5.2*	*39,184*	*4.99*	*1,185*	*.150*	*642*	*.080*	*532,771*	*67.9*
2,288	.289	53	.007	15,010	1.90	41,412	5.2	39,542	5.00	1,228	.155	642	.081	541,839	68.5
2,288	*.290*	*53*	*.010*	*15,010*	*1.90*	*41,381*	*5.2*	*39,542*	*5.00*	*1,197*	*.150*	*642*	*.080*	*541,839*	*68.5*
2,441	.305	55	.007	14,924	1.87	41,909	5.2	40,018	5.01	1,248	.156	643	.080	553,095	69.2
2,441	*.300*	*55*	*.010*	*14,924*	*1.88*	*41,871*	*5.2*	*40,018*	*5.00*	*1,210*	*.150*	*643*	*.080*	*553,095*	*69.2*
2,515	.312	56	.007	15,060	1.87	42,102	5.2	40,036	4.97	1,283	.159	783	.097	558,828	69.4
2,515	*.310*	*56*	*.010*	*15,060*	*1.87*	*42,159*	*5.2*	*40,108*	*4.98*	*1,268*	*.160*	*783*	*.100*	*558,828*	*69.4*
2,350	.290	57	.007	14,902	1.84	42,089	5.2	39,970	4.93	1,312	.162	807	.100	567,268	70.0
2,350	*.290*	*57*	*.010*	*14,902*	*1.84*	*42,068*	*5.2*	*39,970*	*4.93*	*1,291*	*.160*	*807*	*.100*	*567,268*	*70.0*
2,364	.292	59	.007	15,078	1.86	42,494	5.2	40,305	4.97	1,376	.170	813	.100	559,327	69.0
2,364	*.290*	*59*	*.010*	*15,078*	*1.86*	*42,452*	*5.2*	*40,305*	*4.97*	*1,334*	*.170*	*813*	*.100*	*559,327*	*69.0*
2,446	.302	60	.007	15,494	1.91	43,683	5.4	41,354	5.10	1,405	.173	924	.114	562,796	69.5
2,446	*.300*	*60*	*.010*	*15,494*	*1.91*	*43,675*	*5.4*	*41,354*	*5.10*	*1,397*	*.170*	*924*	*.120*	*562,796*	*69.5*
2,394	.295	63	.008	16,277	2.01	44,027	5.4	41,604	5.13	1,449	.179	974	.120	555,224	68.5
2,394	*.290*	*63*	*.010*	*16,277*	*2.01*	*44,015*	*5.4*	*41,604*	*5.13*	*1,437*	*.180*	*974*	*.120*	*555,224*	*68.5*
2,386	.296	66	.008	17,071	2.12	44,694	5.6	42,248	5.25	1,456	.181	990	.123	541,650	67.3
2,386	*.300*	*66*	*.010*	*17,071*	*2.12*	*44,699*	*5.6*	*42,248*	*5.25*	*1,461*	*.180*	*990*	*.120*	*541,650*	*67.3*
2,505	.310	67	.008	17,958	2.23	45,464	5.6	42,914	5.32	1,470	.182	1,080	.134	537,303	66.6
2,561	*.320*	*67*	*.010*	*17,620*	*2.18*	*45,468*	*5.6*	*42,914*	*5.32*	*1,483*	*.180*	*1,071*	*.130*	*537,303*	*66.6*
2,525	.311	65	.008	18,350	2.26	47,377	5.8	44,802	5.51	1,490	.183	1,085	.133	537,780	66.1
2,521	*.310*	*65*	*.010*	*17,970*	*2.21*	*47,329*	*5.8*	*44,802*	*5.51*	*1,466*	*.180*	*1,061*	*.130*	*537,780*	*66.2*

TABLE 1.—*Strength of Medical Department, by components (exclusive*

[Office of The Surgeon General's data in Arabic

End of month	Total Army Strength [1]	Total Medical Department		Total officers Medical Department		Male Medical Department officers							
						Total		Medical Corps [2]		Dental Corps		Veterinary Corps	
		Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]
1945—Con.													
March	8,157,386	669,927	82.1	136,483	16.2	84,970	10.4	46,820	5.74	14,775	1.81	2,045	0.251
		670,151	*82.2*	*136,707*	*16.8*	*85,204*	*10.5*	*46,973*	*5.76*	*14,914*	*1.83*	*2,034*	*.250*
April	8,248,780	671,967	81.5	139,938	17.0	85,235	10.3	46,790	5.67	14,730	1.79	2,040	.247
		672,651	*81.6*	*140,622*	*17.1*	*85,906*	*10.4*	*47,133*	*5.71*	*14,807*	*1.79*	*2,046*	*.250*
May	8,291,336	666,710	82.2	142,298	17.2	85,430	10.3	46,750	5.64	14,705	1.77	2,050	.247
		666,930	*80.4*	*142,598*	*17.2*	*85,735*	*10.3*	*46,773*	*5.64*	*14,848*	*1.79*	*2,056*	*.250*
June	8,266,373	638,980	80.3	142,616	17.3	85,585	10.4	46,600	5.64	14,770	1.79	2,040	.247
		664,763	*80.4*	*143,481*	*17.4*	*86,394*	*10.5*	*47,071*	*5.69*	*14,758*	*1.78*	*2,059*	*.250*
July	8,186,444	659,853	80.6	145,342	17.8	86,700	10.6	47,990	5.86	14,325	1.75	2,050	.250
		661,019	*80.8*	*146,508*	*17.9*	*87,956*	*10.7*	*48,837*	*5.97*	*14,507*	*1.77*	*2,069*	*.250*
August	8,023,304	637,684	79.5	144,475	18.0	85,645	10.7	46,980	5.86	14,170	1.77	2,070	.258
		637,641	*79.5*	*144,432*	*18.0*	*86,805*	*10.8*	*47,834*	*5.96*	*14,370*	*1.79*	*2,116*	*.260*
September	7,564,514	593,644	78.5	138,655	18.3	82,890	11.0	45,040	5.94	13,760	1.82	2,040	.270
		598,793	*79.2*	*143,794*	*19.0*	*86,584*	*11.5*	*48,256*	*6.38*	*14,004*	*1.85*	*2,107*	*.280*
October	6,487,053	503,516	77.6	115,390	17.8	71,595	11.0	37,880	5.84	12,275	1.89	1,850	.235
		527,658	*81.3*	*139,532*	*21.5*	*84,871*	*13.1*	*48,093*	*7.41*	*13,637*	*2.10*	*2,008*	*.310*
November	5,333,978	408,190	76.5	96,820	18.2	61,465	11.5	32,010	6.00	10,845	2.03	1,660	.311
		443,322	*83.1*	*131,952*	*24.7*	*80,294*	*15.1*	*45,620*	*8.55*	*13,115*	*2.46*	*1,987*	*.370*
December	4,228,936	323,085	76.4	81,795	19.3	52,010	12.3	27,060	6.40	9,620	2.27	1,450	.343
		330,678	*78.2*	*116,388*	*27.5*	*73,397*	*17.4*	*41,339*	*9.78*	*12,662*	*2.99*	*1,929*	*.460*
1946													
January	3,469,272	226,735	65.4	66,700	19.2	41,290	11.9	21,610	6.23	7,390	2.13	1,260	.363
		261,291	*75.3*	*101,256*	*29.2*	*64,890*	*18.7*	*36,249*	*10.45*	*11,466*	*3.31*	*1,761*	*.510*
February	2,785,748	173,218	62.2	55,810	20.0	33,595	12.1	17,965	6.45	5,800	2.08	1,050	.377
		199,118	*71.7*	*82,410*	*29.6*	*53,488*	*19.2*	*29,459*	*10.57*	*9,867*	*3.54*	*1,574*	*.570*
March	2,430,779	146,807	60.4	47,713	19.6	28,798	11.8	16,291	6.70	5,011	2.06	878	.361
		165,674	*68.2*	*66,589*	*27.4*	*43,352*	*17.8*	*24,273*	*9.99*	*7,888*	*3.25*	*1,299*	*.530*
April	2,167,931	137,254	63.3	44,443	20.5	28,217	13.0	16,610	7.66	4,880	2.25	863	.393
		150,128	*69.3*	*57,317*	*26.4*	*37,845*	*17.5*	*22,041*	*10.17*	*6,707*	*3.09*	*1,146*	*.530*
May	2,008,494	121,752	60.6	38,987	19.4	24,786	12.3	14,948	7.44	4,010	2.00	766	.381
		132,426	*65.9*	*49,661*	*24.7*	*32,824*	*16.3*	*19,823*	*9.87*	*5,371*	*2.67*	*973*	*.480*
June	1,889,690	112,303	59.4	34,324	18.2	22,053	11.7	13,134	6.95	3,421	1.81	733	.388
		121,566	*64.3*	*43,587*	*23.1*	*28,738*	*15.2*	*17,347*	*9.18*	*4,684*	*2.48*	*874*	*.460*

[1] Strength for 1939 is male strength as shown in the Annual Report of the Secretary of War for 1939 plus strength of nurses for 1939 as shown in this table. Strengths for June 1940 to November 1941, inclusive, are from 1 Oct. 1945. All other strengths are from "Strength of the Army," 1 Mar. 1947, except the strength for March 1942 which has been corrected as explained in footnote 6 of table 31.

[2] Includes women doctors. One was on active duty at least as early as November 1942. By December 1943, they numbered 42. Their peak strength, reached in November 1944, was 76. On 30 June 1946, their number was 15.

[3] Per 1,000 of total Army strength.

[4] The Annual Report of the Personnel Service of the Office of The Surgeon General for fiscal year 1941 shows strengths for all Medical Department components as of 30 June 1940 which are equal to those stated here except in the case of the Sanitary Corps, which is credited with 6, and enlisted men, whose strength is reported as 13,585.

[5] The Annual Report of the Personnel Service of the Office of The Surgeon General for fiscal year 1942 gives the following strengths as of 30 June 1941: MC, 8,813; DC, 2,111; VC, 512; SnC, 173; MAC, 803; and enlisted men, 41,120.

of general officers), by months, 30 June 1939–30 June 1946—Continued

numerals: The Adjutant General's data in italics]

Male Medical Department officers—Con.						Female Medical Department officers								Enlisted men Medical Department	
Sanitary Corps		Pharmacy Corps		Medical Administrative Corps		Total		Army Nurses		Medical Department Dietitians		Physical Therapists			
Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]	Strength	Ratio to Army [3]
2,525	0.310	61	0.007	18,744	2.31	51,513	6.3	48,923	6.00	1,500	0.184	1,090	0.134	533,444	65.4
2,534	*.310*	*61*	*.010*	*18,688*	*2.29*	*51,503*	*6.3*	*48,923*	*6.00*	*1,495*	*.180*	*1,085*	*.130*	*533,444*	*65.4*
2,560	.310	70	.008	19,045	2.31	54,703	6.6	52,023	6.31	1,520	.184	1,160	.141	532,029	64.5
2,600	*.320*	*70*	*.010*	*19,250*	*2.33*	*54,716*	*6.6*	*52,023*	*6.31*	*1,537*	*.190*	*1,156*	*.140*	*532,029*	*64.5*
2,560	.309	60	.007	19,385	2.34	56,868	6.9	54,128	6.53	1,550	.187	1,190	.144	524,332	63.2
2,559	*.310*	*60*	*.010*	*19,439*	*2.34*	*56,863*	*6.9*	*54,128*	*6.53*	*1,549*	*.190*	*1,186*	*.140*	*524,332*	*63.2*
2,540	.307	58	.007	19,577	2.37	57,031	6.9	54,291	6.57	1,555	.188	1,185	.143	521,282	63.1
2,555	*.310*	*58*	*.010*	*19,893*	*2.41*	*57,087*	*6.9*	*54,291*	*6.57*	*1,623*	*.200*	*1,173*	*.140*	*521,282*	*63.1*
2,520	.308	57	.007	19,848	2.42	58,552	7.2	55,702	6.80	1,580	.193	1,270	.155	514,511	62.8
2,544	*.310*	*57*	*.010*	*19,942*	*2.44*	*55,552*	*7.2*	*55,702*	*6.81*	*1,585*	*.190*	*1,265*	*.150*	*514,511*	*62.9*
2,490	.310	68	.008	19,867	2.48	58,830	7.3	55,950	6.97	1,580	.197	1,300	.162	493,209	61.5
2,456	*.300*	*68*	*.010*	*19,961*	*2.49*	*57,627*	*7.2*	*54,779*	*6.83*	*1,580*	*.200*	*1,268*	*.160*	*493,209*	*61.5*
2,395	.317	61	.008	19,594	2.59	55,765	7.4	52,950	7.00	1,550	.205	1,265	.167	454,989	60.1
2,334	*.310*	*61*	*.010*	*19,822*	*2.62*	*57,210*	*7.6*	*54,291*	*7.18*	*1,596*	*.210*	*1,323*	*.170*	*454,989*	*60.2*
2,025	.312	57	.009	17,508	2.70	43,795	6.8	41,250	6.36	1,360	.210	1,185	.183	388,126	59.8
2,187	*.340*	*57*	*.010*	*18,889*	*2.91*	*54,661*	*8.4*	*51,851*	*7.99*	*1,538*	*.240*	*1,272*	*.200*	*388,126*	*59.8*
1,685	.316	62	.012	15,203	2.85	35,355	6.6	33,150	6.21	1,140	.214	1,065	.200	311,370	58.4
1,898	*.360*	*62*	*.010*	*17,612*	*3.30*	*51,658*	*9.7*	*48,946*	*9.18*	*1,426*	*.270*	*1,286*	*.240*	*311,370*	*58.4*
1,325	.313	48	.011	12,507	2.96	29,785	7.0	27,850	6.59	995	.235	940	.222	214,290	50.7
1,676	*.400*	*48*	*.010*	*15,743*	*3.72*	*42,991*	*10.2*	*40,654*	*9.61*	*1,234*	*.290*	*1,103*	*.260*	*214,290*	*50.7*
1,095	.316	57	.016	9,878	2.85	25,410	7.3	23,650	6.82	910	.262	850	.245	160,035	46.1
1,507	*.430*	*57*	*.020*	*13,850*	*3.99*	*36,366*	*10.5*	*34,291*	*9.88*	*1,063*	*.310*	*1,012*	*.290*	*160,035*	*46.1*
915	.328	48	.017	7,817	2.81	22,215	8.0	20,630	7.41	790	.234	795	.285	117,408	42.1
1,266	*.450*	*48*	*.020*	*11,274*	*4.05*	*28,922*	*10.4*	*26,996*	*9.69*	*989*	*.350*	*937*	*.340*	*117,408*	*42.2*
750	.309	44	.018	5,830	2.40	18,919	7.8	17,523	7.21	668	.275	728	.299	99,084	40.8
1,078	*.440*	*44*	*.020*	*8,770*	*3.61*	*23,237*	*9.6*	*21,604*	*8.89*	*814*	*.330*	*819*	*.340*	*99,085*	*40.8*
664	.306	47	.022	5,153	2.38	16,226	7.5	14,907	6.88	625	.288	694	.320	92,811	42.8
894	*.410*	*47*	*.020*	*7,010*	*3.23*	*19,472*	*9.0*	*18,024*	*8.32*	*704*	*.330*	*744*	*.340*	*92,811*	*42.8*
545	.271	51	.025	4,466	2.22	14,201	7.1	12,956	6.45	609	.303	636	.317	82,765	41.2
738	*.370*	*51*	*.020*	*5,868*	*2.92*	*16,837*	*8.4*	*15,499*	*7.72*	*655*	*.330*	*683*	*.340*	*82,765*	*41.2*
521	.276	47	.025	4,197	2.22	12,271	6.5	11,193	5.92	526	.278	552	.292	77,979	41.3
668	*.350*	*47*	*.020*	*5,118*	*2.71*	*14,849*	*7.9*	*13,617*	*7.21*	*598*	*.320*	*634*	*.340*	*77,979*	*41.3*

Source: Basic Medical Department data, 30 June 1939–30 November 1941, from table 12; does not include reservists on active duty on 30 June 1939. Except for enlisted strength on 31 December 1941 and 31 January 1942, which is reported in "Strength of the Army" (STM 30) for the corresponding dates, all basic Medical Department data for the period December 1941–June 1946 come from "Time Series on Medical Department Personnel by Corps, 1942–1946," which were supplied to J. H. McMinn by the Resources Analysis Division, on 24 January 1950. The series insofar as they cover the period from December 1941 through December 1944 existed as early as September 1945, when they were made available by the Resources Analysis Division for use in a statistical review under preparation by the Army Service Forces. (Memorandum, E. Ginzberg, Resources Analysis Division for Director, Control Division, Office of The Surgeon General, 28 Sept. 1945, subject: ASF Statistical Reference Book.) They incorporated within the material covering the period mentioned, strength data prepared by the Office of The Adjutant General embracing the following: All of 1944 except the Pharmacy Corps in January, the Army Nurse Corps in February and July, Physical Therapists in February, and Medical Department Dietitians during the entire year, the Medical

Continued at bottom of next page.

Both dietitians and physical therapists had worked in Army hospitals in World War I as civilians. In the years between the two World Wars, they continued to be employed as civilians in the Medical Department, being assigned in small numbers to all of the general and large station hospitals. In the early 1920's, training courses were established at Walter Reed General Hospital, Washington, D.C., and the graduates of these courses filled most of the vacancies in Army hospitals from 1922 to 1939. In 1938, both dietitians and physical therapists were brought into the competitive civil service system.

After Pearl Harbor, it became apparent that civil service registers could not fill the demand for these two categories and that recruitment, administrative control, and professional supervision should rest in the Office of The Surgeon General. In January 1942, Miss Helen C. Burns, Chief Dietitian at Walter Reed General Hospital, and Miss Emma E. Vogel, Chief Physical Therapist there, were assigned to the Surgeon General's Office on a part-time basis. Eight months later, both were appointed superintendents of their respective groups and part time became full time.

The need for military status for dietitians and physical therapists became more imperative as they assumed positions of greater responsibility in which they supervised military personnel. As civilian employees, they could not be ordered to stations outside the United States, where their services were badly needed, although they could volunteer for oversea service. Hospital units designated for oversea service, as well as those in the United States, seldom had their full quota in either category.

Source—Continued

Department Dietitians, March–May 1943; and enlisted men except for February–April 1942, January 1943, and August–December 1943. All other figures are diverse from those shown in "Strength of the Army" and were computed by use of the following sources:

For all male officer corps except the Pharmacy Corps Orders issued by The Adjutant General for accessions and separations.

Pharmacy Corps. Report on Active Duty Personnel, Last Week of the Month, Office of The Surgeon General.

Army Nurse Corps. "Procurement and Separations Account," Nursing Branch, Personnel Service, Office of The Surgeon General.

Medical Department Dietitians. Dietetics Branch, Personnel Service, Office of The Surgeon General.

Physical Therapists. Physical Therapist Branch, Personnel Service, Office of The Surgeon General.

It is probable that all the sources other than those pertaining to the Pharmacy Corps were based, despite the absence of a specific statement to that effect, on entrances into and departures from the service and were, specifically, orders issued by The Adjutant General for such actions. It is also probable that the strength figures obtained on this basis were prepared by the Resources Analysis Division a short time before they were dispatched for use by the Army Service Forces; but it is not impossible, in view of the dissatisfaction of the Office of The Surgeon General with strength data submitted by The Adjutant General, that they were computed much earlier in some other unit than the Resources Analysis Division.

The time series as compiled for the Army Service Forces extended through July 1945 but reproduced The Adjutant General's figures for all dates shown within that year except in the case of the dietitians. By 1950, however, the figures for 1945, including those pertaining to the dietitians had been revised by the Resources Analysis Division, and data going through the entire year 1946 had been added. For the period January 1945 to June 1946, inclusive, The Adjutant General's strength figures therefore appear only in the following cases: Pharmacy Corps throughout; enlisted men throughout except for a slight variation, probably due to a clerical error, in March 1946; Army Nurse Corps, January to July 1945, inclusive, and Dietitians, August 1945; in the case of the last, the agreement between The Adjutant General's and The Surgeon General's figures may be merely coincidental. The revision was made with a view to establishing conformity between the data on separations compiled by the Resources Analysis Division (table 67) and the strength figures utilized by the Office of The Surgeon General. The figures on separations covered orders for such actions rather than the separations themselves. Orders for accessions also were used in the computing of strengths.

Since considerable time might elapse between the issuance of an order for an accession or separation and the compliance with the order, the use of these orders in determining strength tends, in the early period of the war, to show greater strengths than those reported by The Adjutant General, who compiled figures on the basis of counts of individuals present at the time of the report.

On 22 December 1942, an act of Congress [21] provided that female dietetic and physical therapy personnel should be members of the Medical Department for the duration of the war and 6 months thereafter. Their rank was to be relative, but they were given the pay (including longevity pay), allowances for subsistence and rental of quarters, and mileage and other travel allowances for commissioned officers, without dependents, of the Regular Army in grades from second lieutenant through captain.[22] Early in January 1943, on recommendation of The Surgeon General, the Secretary of War appointed the directors of these two groups in the relative rank of major, the first appointments under the new law. It was not until June 1944 that Congress granted full commissioned rank in the Army of the United States to the three female components of the Medical Department—nurses, dietitians, and physical therapists.[23] This action placed them on a par with all other commissioned officers, male and female. It conferred on them certain important rights and privileges not granted by their previous status.[24] The same law also gave the members of the Army Nurse Corps full officer status.

Pharmacy Corps

Unlike the dietitians and physical therapists, pharmacists in the Army already had military status, most of them being enlisted men. In the late 1930's, Congress had decreed that only pharmacists should be eligible for the Medical Administrative Corps of the Regular Army and that the strength of this component should be limited to 16 members.[25] Since the law did not provide that the corps should be reduced immediately, the desired strength was achieved through attrition. Pharmacists, however, wanted not only a larger officer corps but one bearing their name, and their insistence increased following American entrance into the war.[26] But Maj. Gen. James C. Magee (fig. 1), The Surgeon General, did not favor legislation of a permanent character during the emergency and stated that "no purpose would be served by legislation affecting a minor component * * * at this time." He further stated that regulations assured the proper dispensing of drugs and prescriptions and that "the organization of a Pharmacy Corps to discharge this responsibility is not indicated." To charges that pharmaceutical service in the Army was "deplorable,"

---

[21] 56 Stat. 1072.

[22] Army Regulations No. 40–25, 9 Apr. 1943, formulated procedures and requirements for appointment to both groups and for personnel administration in them.

[23] (1) 58 Stat. 324. (2) Executive Order 9454, 10 July 1944.

[24] In 1947, an act of Congress (61 Stat. 41) combined the dietitians, physical therapists, and occupational therapists (who had never had officer status) into a new Regular Army element of the Medical Department, the Women's Medical Specialist Corps.

[25] (1) See footnote 12, p. 7. (2) 53 Stat. 559.

[26] (1) Letter, Hon. J. P. Wolcott, to Secretary of War, 13 Oct. 1942. (2) Letter, H. M. Burlage, Professor of Pharmacy, University of North Carolina, 17 Oct. 1942. (3) Postal card, Pat O'Malley (no address given) to General McAfee (SGO), 30 Nov. 1942.



FIGURE 1.—Maj. Gen. James C. Magee, USA, The Surgeon General, 1 June 1939–31 May 1943.

he replied that if any specific instances warranting such charges were brought to his attention, he would request an investigation.[27]

Despite the Surgeon General's opposition, Congress passed a law, approved by President Roosevelt on 12 July 1943, which established a Pharmacy Corps in the Regular Army to comprise 72 officers in grades from second lieutenant through colonel. Officers in the Regular Army Medical Administrative Corps, pharmacist and nonpharmacist alike (there were 58) were to be transferred to the new corps and carried there in addition to the 72 authorized.[28] The effect was to abolish the Regular Army Medical Administrative Corps. Unlike the law giving military status to the dietitians and physical therapists, this law made no mention of a director for the new corps and The Surgeon General did not name one. The strength authorized for the corps permitted only a few of the pharmacists then in the Army to have commissioned status.

[27] (1) Letter, Maj. Gen. James C. Magee, to L. E. Foster, General Manager, Chamber of Commerce, Birmingham, Ala., 6 Nov. 1942. (2) Letter, Assistant to The Surgeon General (Brig. Gen. Larry B. McAfee), to L. E. Foster, General Manager, Chamber of Commerce, Birmingham, Ala., 11 Nov. 1942. (3) Letter, Assistant to The Surgeon General (Brig. Gen. Larry B. McAfee), to Dr. H. M. Burlage, Professor of Pharmacy, University of North Carolina, 5 Nov. 1942.

[28] (1) 57 Stat. 430. (2) Regular Army Strength Book, Military Personnel Division, Office of The Surgeon General, U.S. Army.

CIVILIAN COMPONENTS

Civilians served in many types of Medical Department installations. In the Zone of Interior, the majority were employed in hospitals and medical supply depots but they were also employed in the Office of The Surgeon General, the offices of other command surgeons, in laboratories, and elsewhere. Oversea activities of civilian personnel, most of them nationals of the countries in which they served, were similarly widespread, extending even into the combat zones. Among the thousands who were employed in many parts of the world were to be found men and women of every degree of skill from laborers and trained artisans to technicians and even to physicians classified as specialists.

An important group of civilian workers for the Medical Department who received no Government pay were members of the American National Red Cross. The Red Cross, in addition to giving certain types of assistance to the able-bodied members of the Armed Forces, assigned many of its personnel to Army hospitals, both in the Zone of Interior and overseas. In the hospitals, Red Cross workers rendered the patient various kinds of nonmedical service, such as providing assistance in the adjustment of social, economic, and family problems that might otherwise retard recovery; obtaining social histories, including medical information, upon the request of medical officers, to be used as an aid in determining diagnosis, treatment, and disposition; making loans or grants of money for certain purposes; providing "comfort" items and services to patients unable to obtain them for themselves; and planning and directing approved recreation for patients.[29] For these purposes, the Red Cross recruited both volunteer workers and paid employees, providing salaries for the latter out of its own funds.

---

[29] Army Regulations No. 850–75, 30 June 1943. It should be noted that neither the Salvation Army nor the Young Men's Christian Association, both of which had rendered valuable services in World War I, was authorized as a welfare agency in World War II.

CHAPTER II

Organization and Administration

Throughout World War II, the authority for all Army personnel matters rested with the Secretary of War and through him with the Chief of Staff. On these matters, the Chief of Staff was advised by the Assistant Chief of Staff, G–1 (personnel), and acted through The Adjutant General. This procedure applied to all areas, but both organization for personnel administration and the actual operation of the system differed widely between the Zone of Interior and the oversea theaters. Briefly, as far as medical personnel were concerned, the oversea surgeons had far greater jurisdiction than did The Surgeon General in the Zone of Interior, particularly after the War Department reorganization in 1942. Following this latter event, The Surgeon General no longer had the authority derived from being the "immediate" adviser to the Chief of Staff on medical matters, whereas the theater and oversea command surgeons were virtually independent of further control by The Surgeon General or other authorities in the Zone of Interior.

ZONE OF INTERIOR

Early Organization for Personnel Administration

The Surgeon General's Office

As the Chief of Staff's immediate adviser on medical affairs, The Surgeon General was responsible for the overall administration of medical personnel affairs, although the Medical Division in the Office of the Chief of the Air Corps later achieved similar responsibility for medical personnel assigned to that corps.

According to Army regulations, The Surgeon General had "advisory supervision [1] over (1) the appointment, classification, and assignment of Medical Department personnel; (2) the procurement, appointment, classification, assignment, promotion, and discharge of members of the Medical Department sections of the Reserve Corps." He had, in addition, full control over personnel matters within units under his own command. This is implied in the provision which gave him "direct supervision over * * * the administration of all establishments for the care, treatment, and transportation of the sick and wounded personnel and animals of the Military Establishment, under the

[1] This meant the supervision he exercised through his power to advise commanders not under his direct control on the enumerated matters.



FIGURE 2.—Brig. Gen. William L. Sheep, MC, prewar chief of Military Personnel Division, Office of The Surgeon General.

immediate direction of the War Department." He was also charged with preparing, and keeping up to date, plans for the mobilization of Medical Department personnel and material required in war, or in a major emergency.[2]

The Military Personnel Division of the Surgeon General's Office administered a large share of these functions through its Commissioned, Reserve, and Enlisted Subdivisions, the remainder being performed by other branches of the Office which will be discussed below. The Reserve Subdivision had jurisdiction over Reserve officers in the Arm and Service Assignment Group, which was administered by the chiefs of arms and services. Each chief of a technical service placed officers in this group whom he could assign to his own installations in case of mobilization.[3] In 1939, the group contained only about 2 percent of the Reserve Corps of the Medical Department.[4] The remaining officers in these corps were assigned to the Corps Area Assignment Group, which will be discussed later. The Commissioned Subdivision kept individual records of all Medical Department officers on active duty. Until

[2] Army Regulations No. 40–5, 15 Jan. 1926.
[3] Army Regulations No. 140–5, 16 June 1936.
[4] Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1939, pp. 174–175.

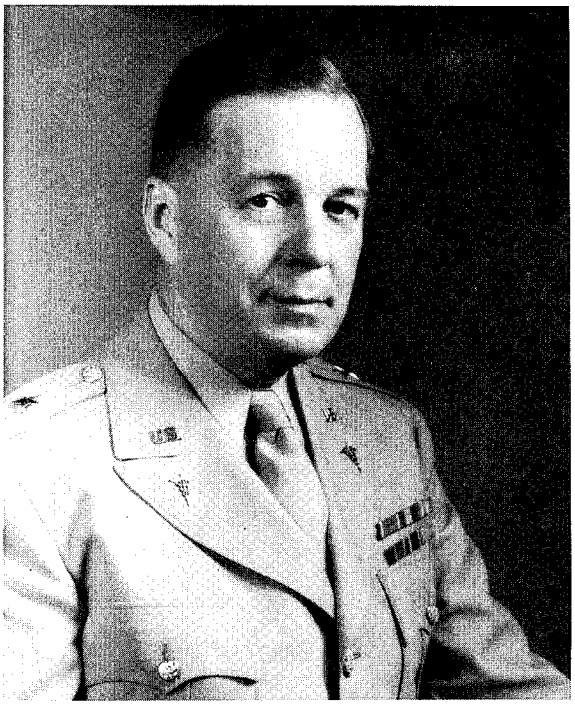


FIGURE 3.—Brig. Gen. (later Maj. Gen.) George F. Lull, MC, first wartime chief of Military Personnel Division, Office of The Surgeon General.

some time after the United States entered the war, the Enlisted Subdivision kept similar records of enlisted men.[5] Col. (later Brig. Gen.) William L. Sheep, MC (fig. 2), headed the Military Personnel Division, until June 1940, when Col. (later Maj. Gen.) George F. Lull, MC (fig. 3), became its chief.

The Nursing Division was responsible for personnel administration affecting Army nurses,[6] the Dental and Veterinary Divisions each had certain personnel functions relating to those particular corps, while the Professional Service Division (fig. 4) furnished advice to the chief of personnel in the selection of medical officers to fill key professional assignments.

The Office Management Subdivision of the Administrative Division (fig. 5) handled personnel matters of all civilians employed in the Office of The Surgeon General. Personnel employed in field installations were dealt with by the Civilian Personnel (Field) Subdivision of the Finance and Supply Division (fig. 6). The personnel duties of this subdivision were defined as the "supervision and management of the employment of civilians for Field Service * * * including their appointment, promotion, demotion, transfer,

[5] Memorandum, Director, Military Personnel Division, Office of The Surgeon General, for Colonel Love, Historical Division, Surgeon General's Office, 14 Mar. 1944.

[6] Office Order No. 1, Office of The Surgeon General, U.S. Army, 3 Jan. 1939.



FIGURE 4.—Brig. Gen. Charles C. Hillman, MC, wartime chief of the Professional Service Division, Office of The Surgeon General.

separation, classification, and retirement"; and the preparation of statistical reports concerning these functions and of estimates of appropriations required. The subdivision allotted funds to stations to pay civilians employed there.[7] The organization for personnel administration in the Surgeon General's Office is shown in chart 1.

Corps areas

The medical personnel functions of the corps area commander were exercised by the corps area surgeon. The latter reported on, or reviewed reports on, the efficiency of Medical Department officers in the corps area for the action of the commander. The corps area surgeon also was responsible for maintaining his allotted quota of Medical Department enlisted men by encouraging recruitment. He could recommend the transfer of members of the Medical Department from station to station within the corps area and also the transfer of enlisted men within the area into or out of the Medical Department.[8] He

[7] See footnote 6, p. 23.
[8] (1) See footnote 2, p. 22. (2) Army Regulations No. 615–200, 24 Nov. 1939.

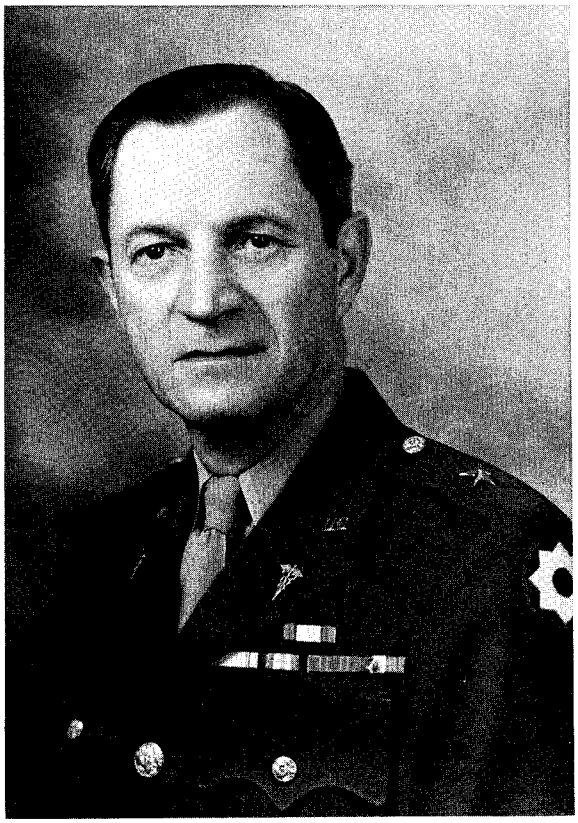


FIGURE 5.—Brig. Gen. Larry B. McAfee, MC, Chief, Administrative Division, Office of The Surgeon General, when the United States entered the war.

could make permanent appointments to the grades of sergeant and corporal in the Medical Department, appointments of this kind in the higher grades—staff sergeant, technical and first sergeants, and master sergeant—being reserved for The Surgeon General. Like The Surgeon General, he could make temporary appointments to all enlisted grades.[9] He distributed to the various stations within his jurisdiction the numbers and classes of enlisted specialist ratings allocated to the corps area by The Surgeon General. He could recommend enlisted men to The Surgeon General for ratings in the three higher classes and could himself give the lower ratings on the recommendation of the senior Medical Department officer concerned.[10]

Medical Department Reserve officers in the Corps Area Assignment Group fell under the jurisdiction of the corps area commander who, acting on the advice of his surgeon, placed such officers on active duty and made recom-

[9] Army Regulations No. 615–15, 25 May 1937.
[10] Army Regulations No. 615–20, 30 Nov. 1923.



FIGURE 6.—Col. Francis C. Tyng, MC, Chief, Finance and Supply Division, Office of The Surgeon General.

mendations for their assignment. This assignment group had a strength on 30 June 1939 of nearly 23,000, about 98 percent of the Reserve Corps of the Medical Department. Of these, almost 15,000 belonged to the Medical and 5,000 to the Dental Corps.[11]

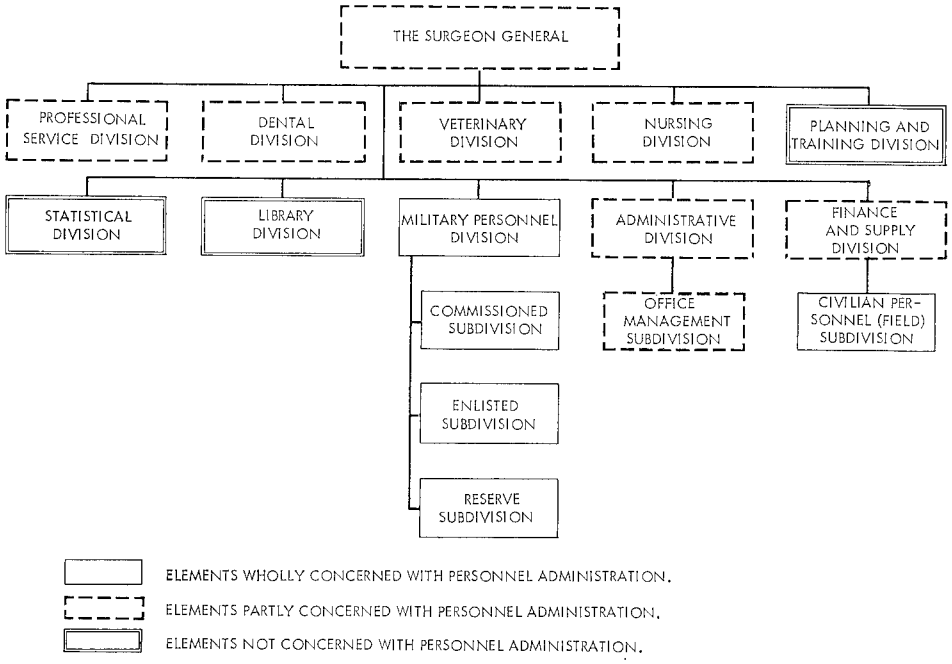
Air Corps

In the Air Corps, the Personnel Subsection of the Medical Division (so designated on 1 April 1939) administered Medical Department personnel affairs.[12] Prior to the creation of the Army Air Forces (June 1941), the Air Corps seems to have exercised much less control over Medical Department personnel assigned to it than it wielded later. The Surgeon General of the Army procured personnel, assigned them to the Air Corps, and acted on recommendations for promotions. Once the Air Corps received personnel from The Surgeon General, it apparently had freedom to assign individuals as it saw fit.

[11] See footnote 4, p. 22.

[12] Memorandum, Chief, Medical Division, Office of the Chief of Air Corps, for The Surgeon General, 25 July 1939, with enclosure thereto.

CHART 1.—*Organization of the Surgeon General's Office for personnel administration, January 1939*



In addition to the aforementioned offices, personnel sections and offices existed in hospitals, tactical organizations, and other units and installations of the Medical Department.

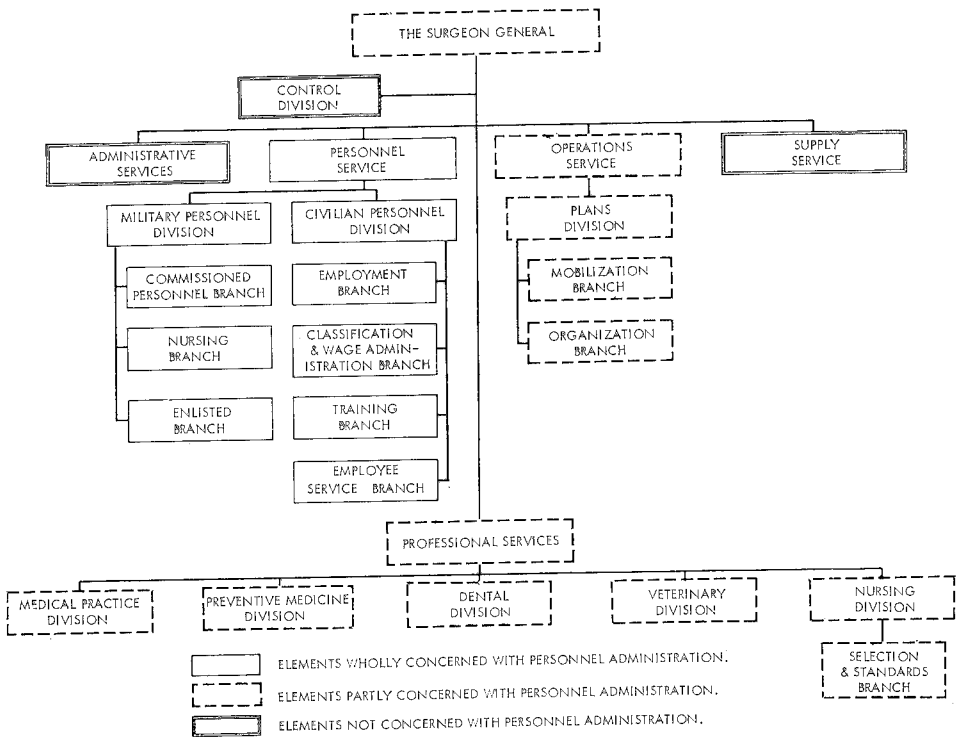
Changes in Organization, 1942

At the time of the reorganization of the War Department in March 1942, the Office of The Surgeon General also underwent reorganization. At that time, the Military Personnel Division was redesignated as the Personnel Service; Colonel Lull, who became its first chief, was promoted to the rank of brigadier general in March 1943. The former subdivisions (Commissioned, Enlisted, and Reserve) were renamed divisions. The Commissioned Division had three branches: Assignment, Classification, and Promotion; the Enlisted Division, two—Classification and Promotion. For some months, the Civilian Personnel Division remained separate from the Personnel Service, being placed under the Administrative Service. In August 1942, however, the administration of military and civilian personnel was united under the Personnel Service consisting of a Military Personnel Division and a Civilian Personnel Division.

The Military Personnel Division, as it was established in August 1942, had three branches: Commissioned, Nursing, and Enlisted. The Reserve Division had been dropped; Reserve activities had all but ceased, as almost all qualified

Reserve officers (except those in affiliated units) were already on active duty. The Nursing Branch, according to the organization manual, "accomplishes the appointment of all Army nurses and recommends their assignments, transfers, and other changes in status," nominally superseding the Nursing Personnel Division of the Nursing Service which had had similar duties and which were now discontinued. Actually, however, the Nursing Service (or Division, as it was now called) retained most of its personnel functions even though its new Selection and Standards Branch was mentioned only as being responsible in that field for evaluating nurses' educational and professional qualifications.[13] The announced functions of the Veterinary Division more obviously overlapped those of the Military Personnel Division, for the Miscellaneous Branch of the former (in the words of the same organization manual) "processes applications, makes recommendations as to appointments and assignments of veterinary personnel." The other professional divisions of the Surgeon General's Office—Medical Practice, Preventive Medicine (fig. 7), and Dental—likewise

CHART 2.—*Organization of the Surgeon General's Office for personnel administration, August 1942*



[13] (1) Blanchfield, Florence A., and Standlee, Mary W.: The Army Nurse Corps in World War II. [Official record.] (2) Services of Supply Organization Manual, 30 Sept. 1942.

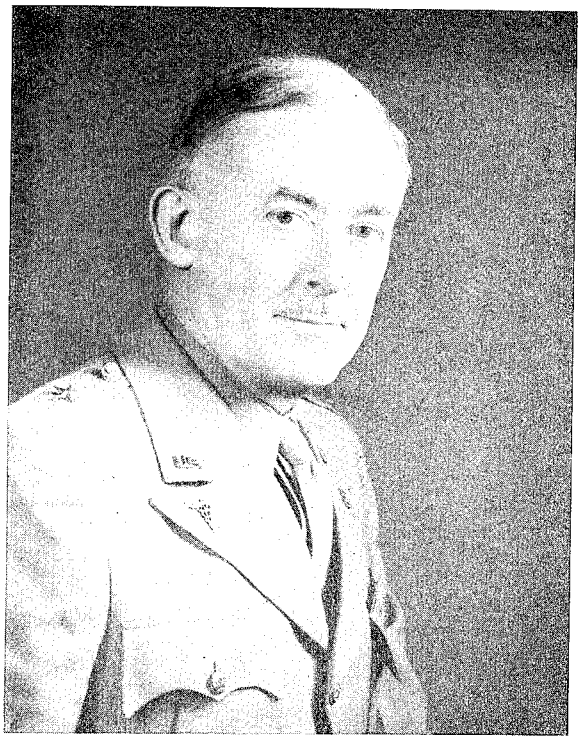


FIGURE 7.—Brig. Gen. James S. Simmons, MC, Chief, Preventive Medicine Division, Office of The Surgeon General.

performed more or less extensive personnel work even though this aspect was not always mentioned in the official manual (chart 2).

The Civilian Personnel Division had four branches: Employment, Classification and Wage Administration, Training, and Employee Service. Since the reorganization of March 1942, it had been concerned not only with civilian employees of the Medical Department outside the Surgeon General's Office but with those in the Office as well, the latter function being taken over from the Office Management Subdivision of the former Administrative Division. The names of the branches reflected other new duties. At the direction of Services of Supply headquarters, the Civilian Personnel Division assumed training and employee-relations functions. The work of placement and classification was greatly expanded, and the Division laid more stress on the effective utilization of personnel with a view to reducing the number of employees.[14] Until physical therapists and dietitians were given military status, their personnel administration was handled by the Civilian Personnel Division. Subsections were later established for them in the Procurement Section of the Commissioned Branch of the Military Personnel Division.

[14] Annual Report, Personnel Service, Office of The Surgeon General, U.S. Army, 1943.



FIGURE 8.—Col. James R. Hudnall, MC, Chief, Personnel Service, Office of The Surgeon General, 1943–44.

Further Reorganizations, 1943–45

In May 1943, General Lull, appointed Deputy Surgeon General, was succeeded by Col. James R. Hudnall, MC, as chief of the Personnel Service (fig. 8). Colonel Hudnall remained in that position until October 1944, after which Col. Durward G. Hall, MC (fig. 9), became acting chief and then chief, serving in that capacity until April 1946.

During the administrations of both Colonel Hudnall and Colonel Hall, steps were taken to revise personnel resources for planning purposes and to centralize in the Surgeon General's Office greater control over medical personnel. Consequently, several groups were appointed to study the problems and make recommendations. One such group was the so-called Kenner Board, whose chairman was Brig. Gen. (later Maj. Gen.) Albert W. Kenner, MC (fig. 10). Another, less formally constituted, consisted of the personnel directors of Standard Oil of New Jersey, Atlantic Refining Corporation, and E. I. Dupont de Nemours, who contributed 6 weeks of their time to review the personnel policies of the Surgeon General's Office.[15]

[15] (1) Report, Kenner Board, 28 Oct. 1943. (2) Statement of Durward G. Hall, M.D., to the editor, 27 May 1961.

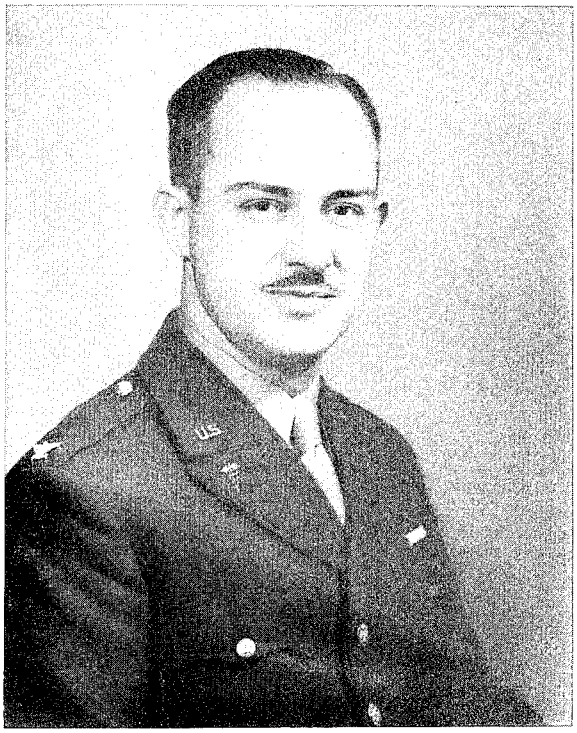


FIGURE 9.—Col. Durward G. Hall, MC, Chief, Personnel Service, Office of The Surgeon General, 1944–46.

Personnel planning

Revision of The Surgeon General's organization for personnel administration, like other organizational changes in his Office at this time, was largely inspired by criticism from Army Service Forces headquarters directed at the procedures which Maj. Gen. Norman T. Kirk (fig. 11), installed as The Surgeon General on 1 June 1943, inherited from his predecessor.[16] One of the critics was the newly established Control Division of Headquarters, Army Service Forces. In September 1943, that office suggested a survey of "the entire field of ZI hospitalization, to study possible savings in cost of operation, and in personnel, and as to the latter particularly in the scarce category of doctors and nurses."[17] As this proposal indicates, a close relationship existed between personnel administration and the hospital system, changes in the latter being largely influenced by the effort to save personnel without lowering the standards of medical care—a saving which became particularly necessary during the later

[16] Medical Department, United States Army. Organization and Administration in World War II. Washington: U.S. Government Printing Office, 1963, pp. 182–185, 202–214.

[17] Memorandum, Control Division, Office of The Surgeon General, (Col. Tracy S. Voorhees), for Col. A. H. Schwichtenberg, Chief, Liaison Branch, Operations Service, Office of The Surgeon General, 30 Sept. 1943.



FIGURE 10.—Brig. Gen. Albert W. Kenner, MC, being decorated by Gen. George C. Marshall.

war years when personnel resources were more strictly limited than formerly. Representatives of the Surgeon General's Office, the War Department Manpower Board, and the Army Service Forces, after making the proposed survey, concluded that "there is reason to believe that the present personnel system in TSGO needs revamping to insure that essential data requisite for staff planning are available in Washington and that proper guidance based upon such planning be given the service command surgeons. The Control Division, Headquarters, ASF, may be in a position to lend assistance in this matter." [18]

Some remodeling of The Surgeon General's organization for the purpose of obtaining fuller data as an essential of personnel planning had already begun. On 1 October 1943, a Personnel Planning and Placement Branch, to which was later added the former Records Branch, was formed in the Military Personnel Division. The new unit (later called the Records and Statistics Branch) kept individual records of all Medical Corps officers in the United

[18] Memorandum for Chief, Operations Service, Office of The Surgeon General (through Director, Control Division, ASF), 30 Nov. 1943, subject: Survey of General Hospitals.



FIGURE 11.—Maj. Gen. Norman T. Kirk, USA, The Surgeon General, 1 June 1943–31 May 1947.

States according to specialty, together with the requirements in these categories. It also developed statistics on medical officer oversea strength.[19] The work of the branch proved very useful. For instance, it enabled The Surgeon General to demonstrate to Army Service Forces headquarters and to the War Department General Staff in the fall of 1943 that the Army Air Forces had a larger share of doctors, considering its workload, than the Army Service Forces had; as a result, several hundred Army Air Forces Medical Corps officers were transferred to the Army Service Forces.[20]

Another fruitful result of the studies made in this branch was The Surgeon General's ability to demonstrate that the machine records submitted by the theaters to The Adjutant General were inaccurate. It was these records that formed the basis of the figures published by The Adjutant General in "Strength of the Army." Whatever the reasons for such inaccuracy, The Surgeon General was able to point out that the names of more than 1,100

[19] (1) Memorandum, Chief, Personnel Service, Office of The Surgeon General, for Executive Officer (attention: Historical Division, SGO), 15 June 1945, subject: Additional Material for Annual Report, Fiscal Year 1945. (2) Semiannual Report, Personnel Service, Office of The Surgeon General, U.S. Army, 1 July–31 Dec. 1944.

[20] Annual Reports, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1944, 1945.



FIGURE 12.—Col. Arthur B. Welsh, MC, wartime Deputy Chief, Operations Service, Office of The Surgeon General.

Medical Corps officers were erroneously included in machine-records rosters while 2,000 others not so listed were actually on duty. In compiling its own figures, the Records and Statistics Branch relied heavily on rosters of Medical Department personnel sent to it by all types of units. The branch also obtained worldwide head counts of officers. Once it was acknowledged that discrepancies existed between The Adjutant General's and The Surgeon General's figures, representatives of their offices were able to set about reducing them and by V–E Day had brought the difference down to only about 100.[21]

While personnel administration became steadily more efficient, the manpower requirements of the combat theaters more than kept pace. In January 1944, The Surgeon General, at the direction of the Commanding General, Army Service Forces, appointed a board of officers, two from Headquarters,

---

[21] (1) Annual Report, Personnel Planning and Placement Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1944. (2) Semiannual Report, Records and Statistics Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1 July–31 Dec. 1944. (3) Quarterly Report, Records and Statistics Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1 Jan.–31 Mar. 1945.

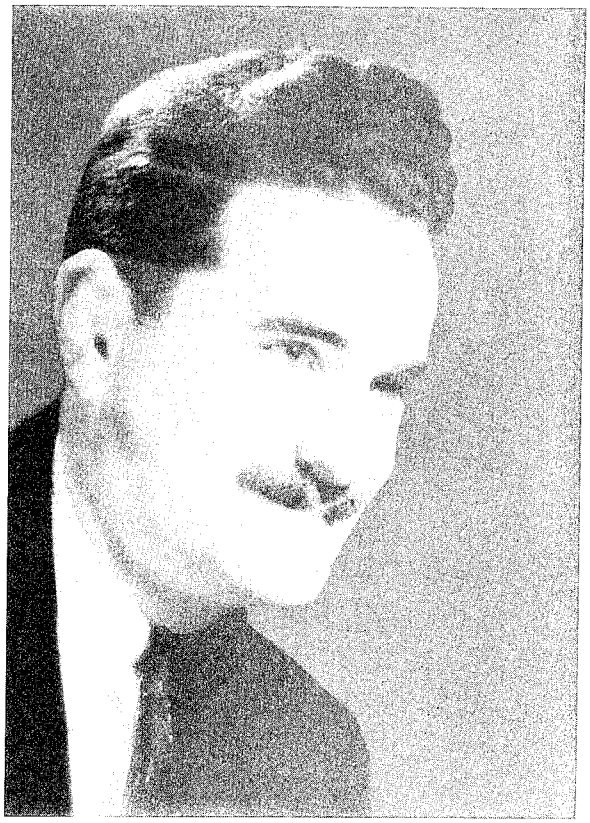


FIGURE 13.—Eli Ginzberg, Ph. D., Resources Analysis Division, Office of The Surgeon General.

Army Service Forces, and one from his own Personnel Division, to seek further improvements. The board recommended greater emphasis on overall, long-term planning and the transfer of this function to the Operations Service, although the Personnel Planning and Placement Branch of the Personnel Service could continue to supply the necessary data on availability of personnel. In the Operations Service, the staffing of oversea units was the direct responsibility of Col. Arthur B. Welsh, MC (fig. 12), Deputy Chief for Plans and Operations, while the continuous study of personnel resources for Zone of Interior hospitals was assigned to Eli Ginzberg, Ph. D. (fig. 13), recently obtained from the Army Service Forces to head the Facilities Utilization Branch under the Hospital Division. These two functions were merged later in the year, together with responsibility for personnel planning on a mass rather than an individual basis, in a new Resources Analysis Division, of which Ginzberg became the director. The unit received added status when Ginzberg was also named special assistant to Brig. Gen. (later Maj. Gen.)



FIGURE 14.—Maj. Gen. Raymond W. Bliss, MC, wartime Deputy Surgeon General, Office of The Surgeon General.

Raymond W. Bliss, MC (fig. 14), who served in the dual capacity of Chief, Operations Service, and Assistant Surgeon General.[22]

Meanwhile, demobilization and redeployment became an additional problem to the personnel planners of the Medical Department. The first office to be charged with planning for the reduction of operations as hostilities ceased was the Plans Coordination Branch, established within the Plans Division of the Operations Service, Office of The Surgeon General, in June 1943. The branch was renamed the Demobilization Branch and transferred to the Special Planning Division of the same service in February 1944. Its functions concerned not only planning for reduction in personnel, but in facilities and supplies, and it also worked on medical procedures to be used in demobilizing nonmedical personnel. Since demobilization affected almost every element of the Surgeon General's Office, the Resources Analysis Division was given the

[22] (1) Memorandum, Col. Charles D. Daniels, Lt. Col. Gerald H. Teasley, and Lt. Col. Hamilton Robinson, for The Surgeon General, 18 Feb. 1944, subject: Survey of the Handling of Medical Personnel in the Office of The Surgeon General. (2) Letter, Eli Ginzberg, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 25 Jan. 1956. (3) Interview, Eli Ginzberg and Isaac Cogan with Col. J. B. Coates, Jr., Donald O. Wagner, and Maj. I. H. Ahlfeld, 29 Feb. 1956 (hereafter referred to as Ginzberg Interview), pp. 15–17 and 29. (4) Office Order No. 175, Office of The Surgeon General, U.S. Army, 25 Aug. 1944. (5) Office Order No. 208, Office of The Surgeon General, U.S. Army, 23 Oct. 1944.

further responsibility of coordinating all demobilization and redeployment planning and all matters pertaining to civil affairs.[23]

Only 8 days before the defeat of Germany, the Resources Analysis Division received the responsibility for unified personnel planning for redeployment and allied planning problems. The division could call upon any other elements of the Surgeon General's Office, including the Demobilization Branch, for aid in these matters.[24] Dr. Ginzberg later stated that while The Surgeon General's previous planning for reduction of operations had probably been well coordinated with Army Service Forces headquarters and was satisfactory in evolving general principles, no adequate "logistical plan" for redeploying and reducing personnel had been worked out—a plan, namely, "for coping with the tremendous difficulty of which doctors and in what numbers you would be able to let out at what rate from which places."[25] The assembly of detailed facts concerning the distribution and other aspects (age, efficiency, length of service, and so forth) of medical personnel, the estimating of future personnel needs as medical operations declined and shifted geographically or in relation to the type of patient care required, and the periodic setting and resetting of criteria for discharge in the light of these facts and estimates became the function primarily of the Resources Analysis Division. Action of this sort was of course closely related to the division's work in planning the reduction of hospital facilities.[26] The organization of the Surgeon General's Office for personnel administration as it stood in the middle and latter part of the war is shown in charts 3 and 4.

The Personnel Control Branch

Besides the major changes in office organization which affected planning on a broad scale, another development, much more limited in scope, was taking place. This was the establishment of a means of controlling the allotment and distribution of personnel within The Surgeon General's installations to conform with directives from higher authority. As early as September 1942, General Magee, then The Surgeon General, had set up a board of officers for that purpose. General Kirk continued the board, with various changes of name and composition, and created the Personnel Control Branch in the Personnel Service (pursuant to an Army Service Forces directive of 30 July 1943) to supplement or assist its work.[27]

---

[23] Annual Report, Plans Coordination Branch, Plans Division, Operations Service, Office of The Surgeon General, U.S. Army, 1944.

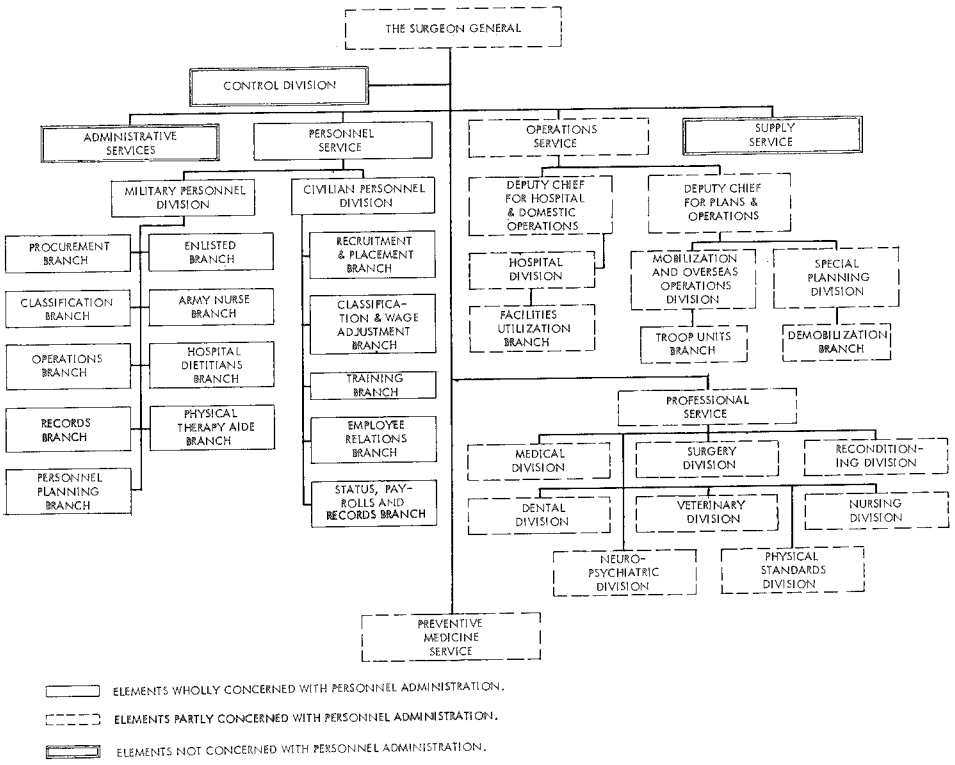
[24] Office Order No. 88, Office of The Surgeon General, U.S. Army, 28 Apr. 1945.

[25] Ginzberg Interview, pp. 33–36.

[26] For this phase of the division's work *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.

[27] (1) Office Orders No. 515, Office of The Surgeon General, U.S. Army, 9 Dec. 1942; No. 109, 3 Mar. 1943; No. 1050, 24 Mar. 1943; No. 24, 28 Jan. 1944; No. 206, 24 Aug. 1945; and No. 344, 3 Dec. 1945. (2) Report, Personnel Control Branch, Military Personnel Division, Office of The Surgeon General, 28 Jan. 1945. (3) Memorandum, Director, Control Division, Office of The Surgeon General, for Executive Officer, Office of The Surgeon General, 15 Nov. 1945, subject: Personnel Control Unit.

CHART 3.—*Organization of the Surgeon General's Office for personnel administration, February 1944*

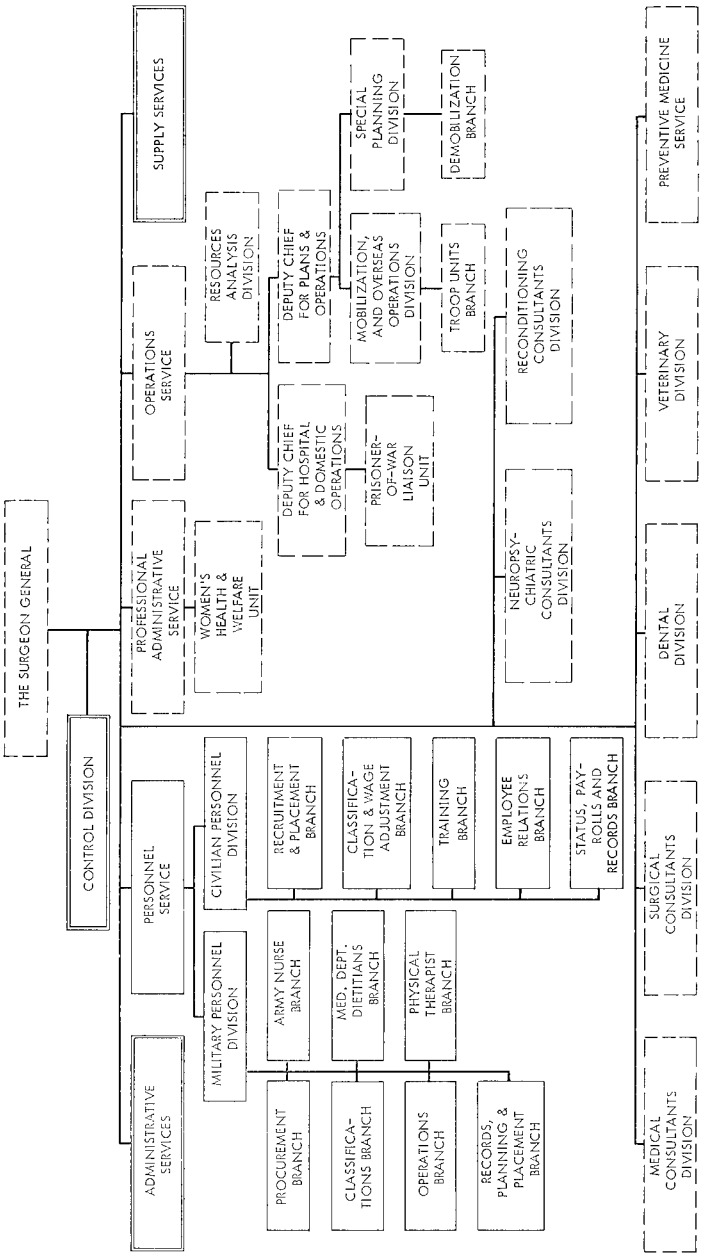


Organization of the Air Surgeon's Office

Since all medical personnel functions of the Air Corps had been handled by the Surgeon General's Office prior to February 1942, the Office of the Air Surgeon, which came into existence at that time, inherited a personnel unit of only limited authority.[28] The business of the Air Surgeon's Personnel Division, however, increased with the mounting numbers of medical personnel assigned to the Air Forces. Its authority also widened in scope, generally because of the increased prestige of the Air Forces and specifically because of the transfer of the responsibility for the procurement of Air Forces medical officers from the Surgeon General's Office. Late in 1942, by agreement with The Surgeon General, the Air Surgeon also established a Nursing Section in his office, and it was understood that the Air Forces should have the power to procure and appoint its own nurses, assign and transfer them, and discharge them "for unsuitability and conduct prejudicial to the service." The move was intended to speed nurse recruitment, but lack of personnel in the Nursing Section caused the recruiting program to be turned over to the Air

[28] See footnote 16, p. 31.

CHART 4.—*Organization of the Surgeon General's Office for personnel administration, May 1945*



663076°—63——5

Surgeon's Personnel Division. The latter directed publicity, forwarded application blanks, and handled correspondence with applicants.[29]

Decentralization of Personnel Administration

Until almost the end of 1943, perhaps the most important change of responsibility for medical personnel administration was the loss of certain elements of control by the Surgeon General's Office and the corps area (or service command) [30] surgeons' officers to certain other authorities, such as the commanding generals of the service commands, the Ground and Air Forces, and the commanders of local installations.

The 1942 reorganization of the War Department

The reorganization of the War Department in March 1942 created three separate Zone of Interior commands: Army Ground Forces; Services of Supply, later known as Army Service Forces; and Army Air Forces, with commanders responsible for administrative details.[31] On paper, the General Staff was reduced in numbers and its functions limited to policymaking and supervision. Actually, the reorganization weakened the General Staff and caused unnecessary confusion because of the lack of clear-cut responsibility down through the major command channels of the Army. G–1, for example, was responsible for those duties "relating to the personnel of the Army as individuals, a function which * * * conflicted with the powers the same directive had delegated to the Army Service Forces." [32]

Under the new organization, The Surgeon General, though he remained chief of a technical service, was subordinate to the Commanding General, Services of Supply. He could not send supervisory instructions under his own name, directly and officially, to medical authorities in the Air and Ground Forces or the surgeons of the service commands, but unofficial channels were still open to him and he could issue official instructions concerning medical matters to the commanding officers of the service commands in the name of the Commanding General, Services of Supply.[33]

---

[29] (1) Memorandum, the Air Surgeon, for Col. Julia O. Flikke, Office of The Surgeon General, 22 Sept. 1942. (2) Memorandum, Col. Julia O. Flikke, for Col. W. F. Hall, Office of the Air Surgeon, 16 Nov. 1942.

[30] The corps areas were redesignated service commands on 22 July 1942.

[31] War Department Circular No. 59, 2 Mar. 1942.

[32] Lerwill, Leonard L.: The Personnel Replacement System, U.S. Army. Washington: U.S. Government Printing Office, 1954. p. 257. (DA Pamphlet 20–211.)

[33] Letter, Lt. Gen. Brehon Somervell, Commanding General, Services of Supply, to Commanding Generals, all Service Commands, 22 July 1942, with Service Command Organization Manual, 22 July 1942, enclosure 2 thereto.

On the other hand, according to a high ranking Medical Corps officer, this concession "as envisioned by regulation and the reorganization manual included only such things as broad policy concerning preventive medicine, evacuation, and similar subjects. By no stretch of the imagination, did they include utilization of personnel." Letter, Col. Paul A. Paden, to Col. C. H. Goddard, Office of The Surgeon General, 9 June 1952.

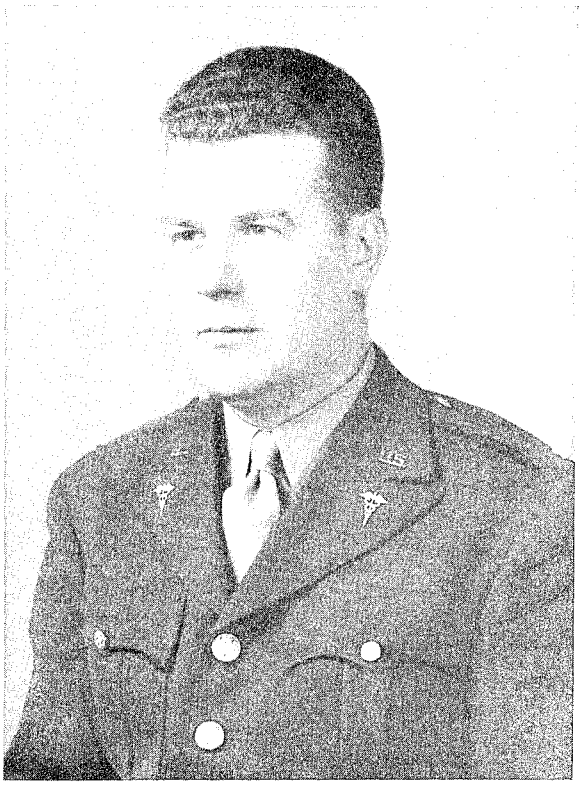


FIGURE 15.—Lt. Col. Paul A. Paden, MC, of the Personnel Division, Office of The Surgeon General.

Certain particular items of personnel control were redistributed in 1942 and early 1943 as a further expansion of the Services of Supply policy of decentralization.

For example, when The Surgeon General, acting through the Commanding General, Services of Supply, wished to transfer medical officers from one service command to another he might find himself hampered by the service command commanders involved; the latter did not complain too vigorously if officers were assigned to them, but did object if they were taken away. At first, the practice was to order an officer in or out and then, if complaint was forthcoming, to revoke the order. Lt. Col. (later Col.) Paul A. Paden, MC (fig. 15), an officer who served in The Surgeon General's Personnel Division during the war, wrote afterward that for some months after the reorganization of the War Department "we were often able to materially expedite the movement of personnel to all areas through good liaison with the Adjutant General's Sections * * * but as time went by we were no longer able to do this, as more and more staff sections had to process the papers. It was only by the most carefully guarded liaison with Medical Department officers, and other officers outside the ASF, as well

as within it, that we were able to accomplish the things we did, often despite 'the letter' of published directives." [34]

The doctrine of decentralization apparently proceeded so far that before undertaking to move a medical officer it became standard practice to obtain definite concurrence from the service command concerned. Moreover, this concurrence was obtained not from the chief of the service command's Medical Branch but from the director of personnel of that headquarters.[35] The restrictions that The Surgeon General suffered in his relationship with service commands, particularly in the early war years, also applied generally to his relations with oversea commanders throughout the war.

Another phase of the 1942 reorganization was the subordination of the corps area commanders (later called service command commanders) to the Commanding General, Services of Supply, and the subsequent realinement of the service command commander's headquarters. The realinement of service command headquarters moved the medical adviser of the service command commander—the service command surgeon—one notch lower in the official organization by subordinating him in personnel matters to the director of personnel of the service command—a nonmedical officer. The director's office, however, was to obtain "recommendations from the technical (including the medical) branches * * * on matters relating to technical military personnel" and "technical civilian personnel." [36] At the same time, physical therapists and dietitians who were still in civilian status, remained under control of the Medical Branch.

Still another phase of the reorganization was the transfer of installations from the direct command of The Surgeon General to the commanding generals of the service commands, which began in July 1942, thereby depriving the former of a very important share of personnel control. Included among these installations were medical training centers, certain schools, and all the general hospitals except Walter Reed. For a time, The Surgeon General kept some of his authority over all general hospitals, including the power to determine personnel allotments for their staffs—subject to Services of Supply headquarters approval—but this power was transferred to the service commands in April 1945.[37] There were other shifts of command authority, and the personnel control involved in it, back and forth between The Surgeon General and the

---

[34] Letter, Col. Paul A. Paden, MC, to Col. J. H. McNinch, MC, Office of The Surgeon General, 17 Jan. 1950.

[35] Memorandum, Director, Military Personnel Division, Office of The Surgeon General, for Colonel Love, Historical Division, Office of The Surgeon General, 14 Mar. 1944.

[36] Services of Supply Organization Manual, 24 Dec. 1942. Before the issuance of this manual, however, some service command personnel officers were apparently shifting Medical Department personnel (including scarce specialists) around as they saw fit, even though they lacked knowledge of their special qualifications. Letter, Col. E. C. Jones, Ret., to Col. R. G. Prentiss, Jr., Office of The Surgeon General, 8 Sept. 1951. Later, apparently as a consequence of such actions, a provision was inserted in the Services of Supply Organization Manual requiring the personnel officers to consult with the medical branch on Medical Department personnel assignments.

Commenting on how the reorganization worked in practice, Colonel Paden, who served in the Surgeon General's Office from 1941 to 1944, stated that the inference that service command personnel directors were to obtain such recommendations "was actually farcical, for they seldom did at first." Letter, Col. Paul A. Paden, to Col. C. H. Goddard, Office of The Surgeon General, 9 June 1952.

[37] See footnote 26, p. 37.

service command commanders during the course of the war. The Surgeon General retained command of a number of installations such as the medical depots, the Army Medical Center (including Walter Reed General Hospital), and the Army Medical Museum.[38] But he recovered control of a most important group of installations—the general hospitals—only after the end of the war.

Decentralization of personnel control within the Army Service Forces appears again in the direct transfer of authority over civilian personnel from The Surgeon General to the service commands during 1942; and in the transfers resulting from changes in the system of personnel authorizations.

Before 1 September 1942, the Surgeon General's Office, working partly through the corps area surgeons, had had virtually complete control of civilians employed in all Medical Department installations. On that date, however, Services of Supply headquarters transferred the administration of all civilian personnel except those employed in the installations directly under command of The Surgeon General (as well as in those under other chiefs of technical services) to the service command commanders. At first, there was some uncertainty as to where the 4,400 civilians employed in station hospitals at airbases belonged, and The Surgeon General kept them under his own jurisdiction. Within 2 months, however, Services of Supply headquarters directed him to transfer them to the Army Air Forces. These actions removed about 26,000 civilians from The Surgeon General's direct control, leaving him only about 9,500.[39] About the same time, Services of Supply headquarters directed The Surgeon General to transfer some of his authority over civilian employees in installations under his direct command "down to the lowest possible echelon." For this purpose, the latter set up civilian personnel offices in each of these installations and gave them almost complete authority in their field.[40]

System of bulk authorizations

From the beginning of the war, responsibilities for personnel administration were affected by changes in the system of personnel allowances. One of the most important of these changes was the establishment of bulk authorizations by the Army Service Forces headquarters in June 1943.

The general purpose of such authorizations, according to the Army Service Forces circular that introduced them, was "to afford a commander the utmost latitude in the administration of his personnel, and at the same time establish an effective control over numbers of personnel employed. The new procedure * * * alters the control over personnel exercised by the Commanding

---

[38] Morgan, Edward J., and Wagner, Donald O.: The Organization of the Medical Department in the Zone of Interior (1946). [Official record.]

[39] (1) Annual Report, Personnel Service, Office of The Surgeon General, U.S. Army, 1943. (2) Services of Supply Organization Manual, 24 Dec. 1942. (3) Letter, Col. J. A. Rogers, to Commanding General, Services of Supply, 19 Sept. 1942, subject: Medical Department Civilian Personnel at Army Air Forces Stations. (4) Letter, Director, Civilian Personnel, Office of The Surgeon General, to Headquarters, Army Air Forces, 22 Oct. 1942, subject: Civilian Personnel of Station Hospitals.

[40] Letter, Commanding General, Services of Supply, to The Surgeon General, 31 Aug. 1942, subject: Responsibility for Civilian Personnel Programs.

General, Army Service Forces, from a 'retail' to a 'wholesale' basis, and places correspondingly greater responsibility upon subordinate commanders to exercise close control of sub-authorization." [41]

Under the new system, Army Service Forces continued to set personnel ceilings, changing these authorizations as conditions required, for all medical installations directly responsible to it. The ceilings authorized the maximum strength for the numerous categories of officer personnel, such as Medical Department, Quartermaster, and others. However, there was no limit on the number of rank within a specific category. Rather, the limitation on rank was a percentage of overall strength in all categories. In other words, a certain percentage of all officers, regardless of category, were authorized as colonels, lieutenant colonels, and so forth.

The authorization of enlisted men was not divided into categories indicating where they must be assigned (as so many in Medical Department installations, and so many in Quartermaster installations) but was set at a total figure with a maximum percentage in each grade (master sergeant, technical sergeant, and so forth). This method of allotting officers and enlisted men applied to personnel not in table-of-organization units. Many such units (medical and other) were assigned, as a rule temporarily and for training, to the Army Service Forces, but the size of each and the number of doctors, nurses, and enlisted men assigned to it were fixed by the provisions of its table of organization.

Under the new system, the commander's allowance for civilian employees was brought into direct relationship with the allowance for military personnel. Previously, the number of civilians who could be employed was unrestricted except through the allotment of funds. Now, however, the number varied according to the number of military personnel in service. If, for example, the total ceiling for civilian and military personnel was set at 30,000 for a service command and the military numbered 20,000, the service command could therefore employ a maximum of 10,000 civilians.

Army Service Forces headquarters required its commanders and their subordinates down to the lowest installation in the command structure to follow similar practices in subauthorizations of personnel. A commander might make subauthorizations totaling less than the authorization he received; in fact, he was encouraged to do so, since Army Service Forces headquarters emphasized economy in the use of personnel.

The bulk-authorization system was designed to give subordinate commanders greater freedom in personnel administration, especially in the assignment of numbers, types, and grades of personnel for or within service command installations, as well as to give service command commanders greater freedom from direction by the technical services. As Brig. Gen. (later Maj.

[41] Army Service Forces Circular No. 39, 11 June 1943. The description which follows is based on this document and on the "Manual of Instructions for Preparation of Personnel Control Forms," Headquarters, Army Service Forces, 11 June 1943.

Gen.) Joseph N. Dalton, AGD, director of the Army Service Forces Personnel Division at the time the new system was introduced, explained it:

> We have done our utmost to free you from many burdensome rules and regulations under which you previously had to operate. No longer will some Headquarters Staff Officer tell you that you must have 120 enlisted men in a station hospital when you know from first hand experience that you could do the job with 100. No longer will you be prohibited from putting an intelligent captain in charge of a function because another Headquarters Staff Officer, in his great wisdom, decided that you must use a Major. No longer will you be hamstrung in assigning (enlisted) men according to their ability because they are ordnance men, or single men. Hereafter, the only consideration is, "Who is the best man for the job?" [42]

While there was no question that decentralization of control of personnel relieved The Surgeon General of much routine detail which could be handled more efficiently locally, it made the correction of inequities more difficult when these were found to exist, and restricted overall planning.

Partial Restoration of Authority

There was a growing awareness in the Army Service Forces headquarters that if the medical mission was to be accomplished a more centralized control of medical personnel should be reestablished in the Office of The Surgeon General and in the offices of the various service command surgeons. Consequently, personnel reports coming into the Office of The Surgeon General which had been considerably curtailed in the decentralization process were again authorized. These reports permitted an analysis of the personnel situation, both as to number and professional quality and made possible the operations of the control and planning branches in both Operations and Personnel Divisions.

In late 1943, the service command surgeons regained some of the power which they had lost as corps area surgeons through the reorganization of the service commands in August 1942. Now called service command surgeons, they were restored to their position of direct responsibility to the service command commander, as were the representatives of other technical services. The personnel division of the service command headquarters, while still charged with arranging for the selection and placement of all military personnel, was to make its assignments from then on "upon recommendation of service command Technical Services" (one of which was the surgeon's office).[43]

In a letter to the commanding generals of the service commands, Army Service Forces headquarters stated that the selection of Medical Department personnel for newly activated units had not been as successful as desired and gave directions concerning the new method of assignment. In each service command, a Medical Corps and a Medical Administrative Corps officer were to be placed on the staff of the Director of Personnel and put in charge of the Medical Department personnel records. Their office was to be convenient to

---

[42] Record of Proceedings, Personnel Conference, Army Service Forces, 21 June 1943.

[43] Letter, Headquarters, Army Service Forces, to Commanding Generals, all Service Commands, 12 Nov. 1943.

that of the service command surgeon. They would maintain necessary special records to assure adequate professional and technical evaluation and assignment of Medical Department personnel. The service command surgeon was empowered to initiate requests for assignment and reassignment of such personnel, and his recommendations were to be followed unless they were contrary to service command policies. The letter stated that continual supervision and control of assignments of medical personnel were necessary to prevent misassignments and to provide competent staffs for tactical units.[44] The changes ordered were important steps in assisting the Medical Department to place its officers in appropriate assignments.

In May 1944, 6 months after the service command surgeons regained more complete control of personnel within their commands, The Surgeon General also acquired limited authority to move personnel from one service command to another. In early 1944 when there was difficulty in properly staffing both table-of-organization units and installations in this country, a committee appointed by Army Service Forces headquarters to study the administration of military personnel by the Surgeon General's Office made recommendations[45] which when put into effect gave The Surgeon General a limited power of assignment. Under this arrangement, The Surgeon General had the responsibility for distributing Medical Corps officers and nurses within the Army Service Forces. He was to direct the transfer of doctors and nurses between service commands "to effect the indicated readjustment." In addition, he could transfer Medical Corps officers returning from overseas who were under the jurisdiction of Army Service Forces if officers having their particular qualifications were needed more in one place than in another. He was also empowered to request the transfer by name of certain key Medical Corps specialists, but he could not effect their transfer without the concurrence of the receiving commander under Army Service Forces jurisdiction.[46] Hence, The Surgeon General's authority to assign personnel, although increased, was not complete even for Medical Corps officers, and members of other Medical Department corps were not included in the new grant of authority. At the same time, The Surgeon General could review the rosters of commanding officers and Medical Corps specialists assigned to table-of-organization units then in the United States, and to fixed installations, and direct the commanders to make changes when the staff did not meet required standards or was not being properly utilized.

The control of The Surgeon General, and also of the service command surgeons, over the assignment and utilization of personnel was made more effective by the operation of the consultant system, which will be discussed in considerable detail in another chapter of this volume.

---

[44] Letter, Headquarters, Army Service Forces, to Commanding Generals, all Service Commands, 26 Nov. 1943, subject: Classification and Assignment of Medical Department Personnel.

[45] Memorandum, Lt. Col. Gerald H. Teasley, Office of The Surgeon General, and others, for The Surgeon General, 18 Feb. 1944, subject: Survey of the Handling of Military Personnel in SGO.

[46] Army Service Forces Circular No. 138, 12 May 1944.

THEATERS OF OPERATIONS

Personnel Functions of the Theater Commander

As early as 1940, the War Department declared that the Chief of Staff of the Army possessed the duty of specifying the personnel required for the field forces and establishing policies and priorities for its distribution. Preparation of the replacement plan, including determination of the number of replacements estimated to be necessary, was classified as a function of the War Department in the Zone of Interior,[47] a function that was extended in April 1942 to include estimating the number of replacements needed in oversea theaters. War Department policies relating to appointment, assignment, transfer, promotion, demotion, and elimination of personnel by discharge or retirement, likewise were expected, as early as 1940, to govern theater practice, as were, insofar as feasible, policies relating to promotion of morale authorized by the Department for the Zone of Interior. Nevertheless, broad powers over personnel matters were delegated to commanders of oversea theaters. Field service regulations issued before Pearl Harbor stated that such commanders were to control assignment and rank as well as discharge and retirement of personnel within their areas of operations. Their responsibility for proper functioning of both classification and assignment throughout their commands was emphasized in 1944. One exception to this rule was the granting of ratings as aviation medical examiner and flight surgeon, which was the function, at least until the end of September 1943, of the Commanding General, Army Air Forces.[48] During the latter half of 1944, however, this authority appears to have been delegated to the commanders of the air forces in the individual theaters. This was true, at least, in the Mediterranean Theater of Operations.[49] As early as 1942, the War Department granted individual theater commanders special authority to commission warrant officers and enlisted men in the Army of the United States. The authority was restricted during the course of the war, but throughout the period, a considerable number of Medical Department soldiers overseas received commissions in the Medical Administrative Corps.

Throughout the period of American participation in the war, it was the duty of these commanders to prescribe the system of leaves of absence and furloughs to be observed within their areas of jurisdiction and to establish uniform practices in the award of decorations. Mobilization Regulations 1–10, section 6, of 5 March 1943, permitted them to modify War Department regulations concerning the maintenance of good morale; field service regulations issued some months later empowered them to promote various welfare and other activities having that object. Under field service regulations in effect as early

---

[47] The following section is based largely on material incorporated in War Department Field Manual 100–10, "Field Service Regulations," 9 Dec. 1940 and 15 Nov. 1943 and the changes to them.

[48] Army Regulations No. 350–500, 11 Aug. 1942; 7 July 1943, and Changes No. 1, 30 Sept. 1943.

[49] History of Twelfth Air Force Medical Section, 1 June–31 Dec. 1944, p. 13. [Official record.]

663076°—63——6

as 1940, the theater commander was to inform the War Department as to his replacement requirements. He was also to give directions to his subordinate echelons concerning the submission of periodic replacement requisitions and was to make allotments of replacement personnel to the various armies in the theater. A War Department order of 19 June 1943 delegated to the commanding generals of theaters of operations, oversea departments, and defense commands outside of the United States the authority "for all phases of civilian personnel administration with respect to civilian personnel under their respective jurisdiction who are paid from funds appropriated to the War Department."

In turn, the theater commander delegated to his G–1 section the responsibility for formulating policies and supervising the execution of administrative matters pertaining to personnel. This extended to civilians under the supervision or control of the command and to prisoners of war.[50]

Replacement systems overseas were established as early as the spring of 1942, but each theater developed its own replacement policies largely by a trial and error method. It will not until after the G–1 conference in April 1944, which was attended by officers from the North African and European Theaters of Operations, that there was any uniformity in oversea replacement systems. As a result of the conference, on 4 May 1944, the War Department directed "all theaters to establish theater replacement and training commands which were to operate replacement installations and exercise control over casual personnel. These commands were to be responsible for the receipt, classification and training of all personnel in the replacement system * * *." It further directed each field force commander "to designate an adjutant general from his command for service at the headquarters of the theater replacement training command * * *." [51]

The adjutant general of the theater was also responsible for the classification of all individuals joining the command: their subsequent assignment, reclassification, and reassignment; their promotion, transfer, retirement, and discharge; actions for the procurement and replacement of personnel; bestowal of decorations, citations, honors, and awards; grants of leaves of absence and furloughs; measures for recreation and welfare and all other morale matters not specifically charged to other agencies. In addition, he was given custody of the records of all personnel belonging to the command which were not kept in subordinate units.[52]

Commanders directly or indirectly subordinate to the theater headquarters also exercised personnel functions within their jurisdictions that were comparable to those of the theater commander, subject, of course, to his authority, and they performed these functions through staff representatives similar to those of the theater commander. Adjustments of classification or assignment, although the responsibility of the theater commander, were to be decentralized as much as

[50] War Department Field Manual 101–5, "Staff Officers' Field Manual," 19 Aug. 1940.
[51] See footnote 32, p. 40.
[52] See footnote 50.

possible. This was especially the case with respect to enlisted personnel, in regard to which final authority usually was vested in regimental or separate unit commanders.

Medical Department Personnel Functions

As has been pointed out previously in this chapter, although the theater commanders were responsible for all matters pertaining to personnel, they delegated to the theater chief surgeons most of their authority for Medical Department personnel. The oversea department surgeons had been given responsibility for certain problems as early as 1942 when Army regulations had made it the responsibility of the department surgeon, as a staff officer of the oversea commander, to submit to the latter "such recommendations as to training, instruction, and utilization of Medical Department personnel belonging to the command, including those not under his personal orders, as he may (might) deem advisable * * *."[53] In December 1940, the preparation of estimates of personnel requirements that a theater technical service might develop was expressly stated to be the function of the chief of that service.

Within their own, more limited, spheres of jurisdiction, the surgeons on lower levels of command down to the lowest echelon possessed similar functions. In the European theater, the personnel functions of base section surgeons extended not only to medical personnel permanently assigned to the base section and to patients in base medical facilities, but also to that of units staging in the area so far as the balancing of their professional staffs was concerned.[54]

Medical Department authorities therefore might intervene in a great variety of matters affecting the personnel of their service, including assignment and rank, but the extent to which they could make their intervention effective varied, and depended, frequently, on the ability of the officer concerned to establish good working relations with those staffs of the theater or lower commands—including the air forces—that had the decisive authority in such matters.

Medical Department Personnel Offices

As the burden of duties increased for the various theater chief surgeons (fig. 16), they devolved some of their personnel functions, particularly the "paper work," on assistants by setting up personnel sections in their offices. Since the theater chief surgeon was also at times Services of Supply or Communications Zone surgeon, a single personnel section might serve him in both capacities. The War Department offered some guidance as to how a theater medical personnel section should be constituted by including such a unit in the table of organization for a headquarters, medical service, communications zone. The table provided for a personnel section headed by a major of the

[53] Army Regulations No. 40–10, 6 June 1924, par. 2b(5), and 17 Nov. 1940, par. 2b(5).

[54] Annual Report, Surgeon, Channel Base Section, Communications Zone, European Theater of Operations, U.S. Army, 22 Aug.–31 Dec. 1944, pp. 79–84.



FIGURE 16.—Representative theater chief surgeons. Upper left: Maj. Gen. Paul R. Hawley, MC, European Theater of Operations, U.S. Army. Upper right: Brig. Gen. Frederick A. Blesse, MC, North African Theater of Operations, U.S. Army. Lower left: Maj. Gen. Guy B. Denit, MC, Southwest Pacific Area. Lower right: Brig. Gen. Edgar King, MC, Pacific Ocean Areas.



FIGURE 16.—Continued. Upper left: Maj. Gen. Morrison C. Stayer, MC, Mediterranean Theater of Operations, U.S. Army. Upper right: Brig. Gen. Robert P. Williams, MC, China-Burma-India theater. Lower left: Col. George E. Armstrong, MC, China theater. Lower right: Brig. Gen. Crawford F. Sams, MC, U.S. Army Forces in the Middle East.

Medical Corps, with a first lieutenant, who might be an officer of the Medical Administrative Corps, and four enlisted men.[55]

The largest and most elaborate organization for the administration of matters pertaining to medical personnel in any oversea area was the Personnel Division in the Office of the Chief Surgeon of the European theater, who was also surgeon of the Services of Supply or Communications Zone. Its preeminence was natural in view of the strength of the Medical Department in that theater. The division originally consisted of but one second lieutenant of the Medical Administrative Corps, but grew from 3 officers and 9 enlisted men at the end of August 1942 to 9 officers, 29 enlisted men, and 2 British civilians in September 1944 when the office began to function in Paris.[56]

Generally speaking, however, Medical Department personnel offices at theater, army, or base section headquarters were staffed by relatively small numbers of officer and enlisted personnel. In the Southwest Pacific at the beginning of 1945, when the Services of Supply headquarters was located in Hollandia, New Guinea, the staff assigned to the Personnel Division of the Surgeon's Office comprised three officers and nine enlisted men. Heading the division was a lieutenant colonel of the Medical Corps; the Medical Administrative Corps provided the other two officers.[57] When the Medical Section of the Mediterranean theater was at its peak strength (April 1945), the personnel subsection consisted of one officer and two enlisted men. Similarly, during the combat operations of the Third U.S. Army in the European theater, its Headquarters Medical Section handled personnel matters through two Medical Administrative Corps officers and two enlisted men.[58]

In base sections and like jurisdictions, one officer ordinarily was assigned to personnel duties in the corresponding surgeon's office, often combining these with other functions. One or two enlisted men also were assigned to personnel activities.[59] As might be expected, the medical personnel officers in the base sections of the European Theater of Operations had somewhat larger staffs than were common elsewhere. In fact, the Personnel Division of the Surgeon's Office, United Kingdom Base, was a sizable organization. As of 1 January 1945, the staff comprised 6 officers and 13 enlisted men.[60]

---

[55] Table of Organization S–500–1, 1 Nov. 1940.

[56] (1) Administrative and Logistical History of the Medical Service, Communications Zone—European Theater of Operations (1945), ch. III, p. 63. [Official record.] (2) Annual Report, Chief Surgeon, European Theater of Operations, 1944, pp. 3–5. (3) History of Medical Service, Services of Supply, European Theater of Operations, U.S. Army, From Inception to 31 Dec. 1943 (1944).

[57] Annual Report, Surgeon, U.S. Army Forces, Western Pacific, 1945, pt. I—U.S. Army Services of Supply, p. 72.

[58] (1) Munden, Kenneth W.: Administration of the Medical Department in the Mediterranean Theater of Operations, U.S. Army, 1945, vol. I, chart p. 153. [Official record.] (2) Statement of Col. John Boyd Coates, Jr., MC, to the editor, 27 May 1961.

[59] (1) Annual Report, Surgeon, Base R, U.S. Army Forces, Western Pacific, 12 Feb.–30 June 1945, pp. 3–4. (2) Annual Report, Surgeon, Base K, U.S. Army Services of Supply, 1944–45. (3) Annual Report, Surgeon, Base K, U.S. Army Services of Supply, 1945, p. 2.

[60] Annual Report, Surgeon, Channel Base Section, Communications Zone, European Theater of Operations, August–December 1944, January–July 1945. (2) Annual Report, Surgeon, Seine Base Section, Communications Zone, European Theater of Operations, January–June 1945.

CHAPTER III

Requirements: 1939–41

STRENGTH OF MEDICAL DEPARTMENT COMPONENTS

Congressional Responsibilities

Although the Medical Department might estimate its personnel requirements for any fiscal year, the number it was allowed was fixed by Congress or by the War Department within congressional appropriation. Congress had set the quotas for officers of the Regular Army until 1939 and for enlisted men until 1940. Until 1916, the quotas were in terms of numbers of individuals. The National Defense Act of 1916 [1] and its amendments, which formed the National Defense Act of 1920,[2] based the number of officers and enlisted men on the total enlisted strength of the Army, the ratio varying for each corps. In time of actual or threatened hostilities, however, the Secretary of War was permitted to procure such additional numbers of enlisted men as might be required. Thus, in World War I, the maximum strength figure of the Medical Department—343,394—was 92.52 per 1,000 total Army strength or 98.52 per 1,000 Army enlisted strength.[3] In 1922, Congress abandoned the ratio system for officers and again authorized an absolute number for each corps.

The authorized officer strength of the Medical Department just prior to the emergency period was established by act of 3 April 1939 at 1,424 Medical, 316 Dental, 126 Veterinary, and 16 Medical Administrative Corps officers in the Regular Army, to be reached by 30 June 1949 through 10 approximately equal annual increments.[4] Officers appointed in the Medical Administrative Corps after the passage of this act were to be selected from candidates who were graduates of a 4-year course in pharmacy from an approved school. It was contemplated that the then current members of the corps would have left the military service by 30 June 1949. The Medical Administrative Corps was never reduced to 16 members. Normal attrition had brought the total down only to 58 by 1943, at which time the members were absorbed in the newly created Pharmacy Corps. No further changes occurred in authorizations for Medical Department Regular Army officers during the remainder of the emergency and the war period.

---

[1] 39 Stat. 171.

[2] 41 Stat. 766.

[3] For a detailed discussion of Medical Department strength in World War I, *see* The Medical Department of the United States Army in the World War. Washington: Government Printing Office, 1923, vol. I.

[4] 53 Stat. 559.

Until 1940, the enlisted strength of the Medical Department remained at 5 percent of the total Army strength, the ratio set by the National Defense Act of 1920.

Between 9 April and 22 June 1940, all of Western Europe except England fell under German control. These events in Europe had a tremendous effect on the U.S. military preparedness program. On 13 June, Congress appropriated sufficient funds to bring the Regular Army to its full statutory strength of 280,000 set by the National Defense Act of 1920. Before this could be accomplished, when the enlisted strength was still only 249,441, Congress passed a bill allowing the Army to be increased to 375,000.[5]

No further limitations were placed on the size of the Regular Army. The third supplemental appropriations act for fiscal year 1941 (approved on 8 October 1940) made it clear that the only limit on the Regular Army's strength was that which cash appropriations would impose.[6]

On 31 May 1940, the President asked Congress for authority to bring the National Guard into Federal service without the existing restriction which forbade use of the guard outside the United States. The request met with considerable opposition, and it was not until 27 August that the President was authorized to call up for a period of 12 months the National Guard and other Reserve components, which however were not to be employed "beyond the limits of the Western Hemisphere except in the territories and possessions of the United States, including the Philippine Islands." [7]

On 16 September 1940, Congress passed the first peacetime selective service act in the history of the United States. Like the National Guard-Reserve Act of 27 August of that year, the inductees were to serve for 12 months only, and the same limitation on oversea service was included.[8] In August 1941, the President was empowered to extend indefinitely the length of service for the National Guard, selective service trainees, and Reserve officers should Congress find our national interest to be imperiled.

WAR DEPARTMENT RESPONSIBILITIES

Army Nurse Corps

The strength of the Army Nurse Corps was never set by Congress but rather by the War Department within the limits of congressional appropriations. In June 1939, the strength was set at 675; a year later, 949. This was the Regular Army nurse component, the only one on active duty until September 1940, when Reserve nurses began to be appointed for that purpose. The authorization for Regular Army nurses continued to be raised, however, reach-

[5] Watson, Mark Skinner: Chief of Staff: Prewar Plans and Preparations. United States Army in World War II. The War Department. Washington: U.S. Government Printing Office, 1950.

[6] See footnote 5, above.

[7] S.J. Res. 286, 27 Aug. 1940, *in* 54 Stat. 858.

[8] S. 4164, 16 Sept. 1940, *in* 54 Stat. 885.

ing 1,875 in March 1945. Until 1941, the basis for the calculation of requirements was 1 nurse per 270 military personnel (3.7 per 1,000). In that year, the War Department General Staff, on recommendation of The Surgeon General, changed the formula to 120 nurses for each 1,000 hospital beds, or approximately 6 nurses per 1,000 of Army strength.[9]

Reserve Officers

During the emergency and war years, Congress placed no statutory limitations on the number of non-Regular Army officers of the Medical Department. Like the nurses, the number to be added became the responsibility of the War Department, acting within the limits of congressional appropriation. For example, an act of 3 April 1939 which permitted the calling of 300 Reserve officers of the Corps of Chaplains and of the Medical Department to extended active duty did not specify how many of each branch were to be called. The General Staff in making the decision allotted 255 of these officers to the Medical Department.[10] In December 1939, the General Staff, in anticipation of supplemental appropriations, authorized the corps area commanders to call up an additional 508 Medical Department Reserve officers. In the following September, it authorized the calling of 4,019 Reserve nurses to active duty, the first time such action was taken during the emergency. The number was increased by 1,000 in January 1941.

Besides setting quotas for personnel on active duty with the peacetime Army, the War Department provided for the establishment of a procurement objective for each section of the Officers Reserve Corps. No procurement objective was established for the Red Cross nurses' reserve; it might therefore recruit members without limit.

In 1939, the elements to be considered in establishing a procurement objective were reviewed and restated; according to a memorandum prepared in G–1 (8 June 1939), a number of misunderstandings about the objective had arisen, among others that it "should include all officers needed for a maximum effort. Actually, the peacetime procurement objective should be limited to the needs to fill early requirements during mobilization until such time as mobilization procurement can catch up with current needs."[11] A month later, the War Department published a set of figures giving the procurement objectives for Reserve personnel to be assigned to the corps areas. Comparison of these figures with the actual membership of the Medical Department Reserve Corps

---

[9] Annual Reports of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1940, p. 256; 1941, pp. 243–244.

[10] Letter, Secretary of War, to Daniel W. Bell, Acting Director, Bureau of the Budget, 27 May 1939.

[11] Memorandum for Record, signed "ESJ," and concurred in by The Adjutant General, Assistant Adjutant General, and Officer in Charge, Reserve Division, War Plans Office, 8 June 1939. (Compare with Army Regulations No. 105–5, 16 June 1936.)

TABLE 2.—*Procurement objectives (10 July 1939), and actual strengths (30 June 1939), of Medical Department Officers Reserve Corps*

Component	Procurement objectives	Actual strengths
Medical Corps	20, 870	15, 198
Dental Corps [1]	3, 585	5, 063
Veterinary Corps	668	1, 381
Medical Administrative Corps	1, 918	1, 243
Sanitary Corps	195	454

[1] The large excess of actual strength of the Dental Corps Reserve over the procurement objective is not easily reconciled with the later statement (see p. 57) that procurement was stopped when actual strength of that corps slightly exceeded the objective. Either the figures themselves are incorrect or, possibly, a larger procurement objective was in operation at the time the actual strength was computed. It also seems possible that authorities may have continued to appoint men in the Dental Corps Reserve even after the procurement objective had been exceeded.

Source: (1) Memorandum, The Adjutant General, for Commanding Generals of all Armies; Commanding Generals, all Corps Areas; Chiefs of all Arms and Services; Commandants, General Service Schools; Superintendent, U.S. Military Academy; Assistant Chiefs of Staff, War Department General Staff; and the Office of the Assistant Secretary of War. 10 July 1939, subject: Reserve Officers' Peacetime Procurement Objective for Mobilization, and Assignment and Promotion Procedures for Reserve Officers, of the Corps-Area Assignment Group—Current Instructions Supplementary to MR 1–3 (new number). (2) Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1939, pp. 174–175.

about the same time (30 June 1939) will give some idea of how adequate—in the opinion of the General Staff—the existing Reserves were to meet anticipated needs (table 2). The comparison is necessarily a rough one, as the figures for the procurement objective covered only allotments to the corps areas, not to other using agencies. The latter agencies, however, ordinarily received only a very small proportion of total personnel.

In September 1939, The Surgeon General estimated the requirements of a fully mobilized Army of 4 million, which was the maximum contemplated by the War Department's Protective Mobilization Plan with its several augmentations. Reduced to ratios (number of medical personnel per 1,000 of total Army strength), his estimates were as follows: For the Medical Corps, 7.5; for the Dental Corps, 1.875; for the Veterinary Corps, 0.375; for the Nurse Corps, 6.25; for the Sanitary and Medical Administrative Corps, 0.75; and for the enlisted complement, 75.00.[12] This estimate was based on World War I experience.

Although the total Medical Department strength of the Officers Reserve Corps (including members on duty and those not yet called) was below the procurement objective, The Surgeon General, as late as November 1939, expressed the opinion that the Reserves were sufficient for the basic force of

[12] Memorandum, Col. A. G. Love, for The Surgeon General, 28 Sept. 1939.



FIGURE 17.—Maj. Gen. Charles R. Reynolds, The Surgeon General, 1935–39.

1,150,000 contemplated in the War Department Protective Mobilization Plan. He was doubtful however that they contained enough of the right types of specialists.[13] Appointments in the Dental Corps Reserve had been suspended in 1938 with the consent of The Surgeon General, Maj. Gen. Charles R. Reynolds (fig. 17), when membership slightly exceeded the procurement objective.[14] In December 1939, the General Staff ordered a partial suspension of appointments to all sections of the Officers Reserve Corps, although neither the Medical Corps nor the Medical Administrative Corps had reached their authorized procurement objectives. However, the suspension order excepted the following categories: Graduates of the Reserve Officers Training Corps; applicants for the Air Corps Reserve; and recent graduates in medicine, dentistry, and veterinary medicine who were qualified for duty with the Regular Army.[15]

---

[13] Magee, James C.: The Medical Department, pp. 10–12 (a lecture delivered at the Army War College, 17 Nov. 1939).

[14] Medical Department, United States Army. Dental Service in World War II. Washington: U.S. Government Printing Office, 1955, p. 51.

[15] Letter, The Adjutant General, to Corps Area and Department Commanders and Commanders of Arms and Services, 8 Dec. 1939, subject: Suspension of Appointments in Officers Reserve Corps.

FACTORS AFFECTING DETERMINATION OF REQUIREMENTS

Medical Department Officer Shortages

After Congress enacted the legislation just discussed, the responsibility for its implementation fell on the War Department. With no statutory restrictions remaining on strength, outside those imposed by congressional appropriations, the Army increased from a total strength of 264,118 on 30 June 1940 to 1,455,565 on 30 June 1941.[16]

Naturally, this tremendous increase in such a short period of time created many problems. One of the biggest problems in the Medical Department was the shortage of officers. As early as August 1940, before actual augmentation took place, The Surgeon General reported to The Adjutant General and to the Assistant Chief of Staff, G–1, that an acute shortage of Medical Department officers has been the subject of "very grave concern" to his office for some time and that as of 25 July the deficits for the various corps were as follows (based on an authorized troops strength of 375,000): Medical Corps, 1,527; Dental Corps, 391; Veterinary Corps, 223. He predicted that if the National Guard were called into Federal service the shortages would rise to the following figures: Medical Corps, 5,295; Dental Corps, 1,259; Veterinary Corps, 657. Should "some form of Selective Service" increase the Army still further, the Surgeon General's Office estimated that in April 1941 the following shortages would obtain: Medical Corps, 8,455; Dental Corps, 2,044; Veterinary Corps, 1,049.[17]

Problems Created by National Guard Induction

At the time of induction into Federal service (27 August 1940), the National Guard brought with it a complement of Medical Department officers and enlisted men. National Guard officers had the same rights of resignation as members of the Officers Reserve Corps.[18] Many were also relieved from assignment because they were deemed necessary in an industry or occupation essential to the public interest. Upon mobilization, the medical service of the National Guard consisted of personnel assigned to tactical units only. In the middle of 1941, these units comprised 306 medical detachments, 20 medical regiments, and 1 medical battalion. The guard had no medical personnel of its own for fixed hospital service or for administrative overhead;[19] National

---

[16] Kreidberg, Marvin A., and Henry, Merton G.: History of Military Mobilization in the U.S. Army, 1775–1945. Washington: U.S. Government Printing Office, 1955, p. 581. (DA Pamphlet 20–212.)

[17] (1) Letter, The Surgeon General, to The Adjutant General, 6 Aug. 1940, subject: Shortage of Medical Department Personnel. (2) Memorandum, Office of The Surgeon General (Col. C. F. Lull), the Assistant Chief of Staff, G–1, 12 Aug. 1940, subject: Shortage of Medical Department Officer Personnel.

[18] Army Regulations No. 140–5, 16 June 1936, pars. 49, 53.

[19] (1) Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1941, p. 260. (2) Committee to Study the Medical Department, 1942, pp. 14–15.

Guard units, including medical units, were far below full strength when they were called into Federal service, so that personnel from Regular and Reserve components had to be assigned to them,[20] and National Guard officers could not be readily shifted to meet changing needs since certain restrictions on their reassignment were not removed until September 1941. These three factors considerably increased the demand on the Army for medical personnel at the time of the induction of more than 250,000 guardsmen.

Reserve Shortages

In September 1940, the Army had, aside from the medical units that were organic parts of existing divisions, only the following field medical units: Two surgical hospitals, two evacuation hospitals, two medical regiments, one medical supply depot, and one medical laboratory. In December, this was increased to 8 medical battalions, 8 medical regiments, 1 medical supply depot, 1 medical laboratory, 1 general dispensary, 15 evacuation hospitals, 6 surgical hospitals, 22 general hospitals, and 22 station hospitals. By the end of June 1941, all units had been activated.[21]

The next problem was the personnel to staff these units. In October 1940, The Surgeon General asked the War Department General Staff to remove the partial suspension of appointments to the Reserve imposed in December 1939, and to restore the situation that had existed before that date. This meant that appointments would be permitted in all corps of the Medical Department up to their procurement objectives, and the General Staff granted the request in December 1940 in that sense, with the proviso that applicants must agree to accept active duty when called upon.[22] Apparently, The Surgeon General had either disregarded the fact that the Dental, Veterinary, and Sanitary Corps had already passed these objectives or had felt at the time that their uncalled Reserves were sufficiently large and accessible for all purposes. Two months later, however, he pointed out that the authority granted did not permit commissioning additional dentists or veterinarians in the Reserves and urgently recommended that it be "expanded to cover" both of these corps. The recommendation was unfortunately worded; what he wanted was not an expansion of the authority to cover these corps—the authority already covered them—but permission to exceed their procurement objectives. He further recommended that in view of prospective needs during 1941 and 1942 the existing procurement objectives for all Medical Department corps be suspended "until

---

[20] Letter, The Adjutant General, to Commanding Generals all Corps Areas and Departments, 4 Sept. 1940, subject: Induction of the National Guard of the United States.

[21] 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.

[22] (1) Letter, Office of The Surgeon General, to The Adjutant General, 26 Oct. 1940, subject: Appointments in Medical, Dental, and Veterinary Reserve Corps. (2) Memorandum, Assistant Chief of Staff, G–1, for Chief of Staff, 1 Nov. 1940, subject: Appointments in Medical Department Reserve. (3) Letter, The Adjutant General, to each Corps Area Commander and The Surgeon General, 19 Dec. 1940, subject: Appointments in Medical Reserve.

in the opinion of The Surgeon General an adequate Reserve is available for the defense program with rapid expansion, if such should be required." [23] This did not mean that The Surgeon General was willing to accept unlimited numbers in the Reserves. If the surplus became larger than necessary to meet future needs, it might mean granting virtual deferment of service to a considerable group.[24]

Because of the difficulties in procuring officers for certain corps, some substitution of one type of officer for another was permitted in meeting requirements. As early as February 1940, the Medical Department received authority to substitute reservists of the Medical Administrative Corps and Sanitary Corps for members of the Medical Corps Reserve in meeting the quotas for active-duty assignments.[25] In 1941, after the Medical Replacement Training Centers for enlisted men at Camp Lee, Va., and Camp Grant, Ill., had been functioning for several months, the task of obtaining sufficient numbers of medical, dental, and medical administrative officers to staff them properly led The Surgeon General to suggest that "branch immaterial" [26] officers be used in battalion and center headquarters as well as in the companies. The recommendation was approved. At this time, The Surgeon General stated that each company could be adequately and properly staffed with six Reserve officers: Two medical, two dental, one medical administrative, and one branch immaterial.[27]

Enlisted Personnel

With the increased medical facilities, the Medical Department had an additional problem of securing an adequate supply of enlisted personnel. As early as February 1939, General Reynolds, declaring that the 5 percent maximum allowed by the National Defense Act of 1920 would be inadequate in an emergency, recommended that Congress be asked to amend the law so as to permit enlisting "in time of actual or threatened hostilities * * * such additional number of men as the service may require." Higher authority in the War Department, however, rejected the proposal on the ground that the reasons for giving priority to the Medical Department in this matter were not apparent. Several months later (May 1939), The Surgeon General repeated his request, but it was not until 1940 that he achieved his objective when Congress raised the Medical Department's quota to 7 percent and empowered the President

---

[23] Letter (not found), from Senator Pepper, which enclosed a protest from the American Dental Association on selection for training of dentists not commissioned in the Reserve, with 2d endorsement, The Surgeon General to The Adjutant General, 18 Feb. 1941.

[24] Compare the argument advanced by a spokesman of the Dental Division, Office of The Surgeon General, against a large increase in the size of the Dental Corps Reserve. (Letter, Office of The Surgeon General (Lt. Col. R. F. Craven), to The Adjutant General, 8 Oct. 1941.)

[25] Letter, The Adjutant General, to The Surgeon General, 19 Feb. 1940, subject: Added Reserves for Active Duty With Regular Army.

[26] "Branch immaterial" personnel were those whose training was in basic subjects without arm or service specialization.

[27] (1) Memorandum, Procurement Branch, Military Personnel Division, Office of The Surgeon General, for Director, Historical Division, Office of The Surgeon General, 20 Apr. 1944. (2) Memorandum, Office of The Surgeon General, for The Adjutant General, 18 Aug. 1941, subject: Utilization of Branch Immaterial Officers in Replacement Training Centers, with 1st endorsement thereto, 3 Sept. 1941.

(and hence the War Department) in the event of actual or threatened hostilities to authorize such additional enlistments as he considered necessary.[28] This did not insure that the General Staff would immediately raise the Medical Department's authorizations even to 7 percent, for as late as June 1941 these amounted to less than 6 percent, although by that time actual strength had apparently risen to a little more than 7 percent.

Nor did it settle the question as to what ratio of enlisted men should be allocated to tactical units on the one hand and to nontactical units and headquarters other than The Surgeon General's Office on the other. Differences of opinion arose, particularly on the latter point. Until the middle of 1939, The Surgeon General had been using enlisted men for nontactical assignments to the extent of a little more than 4 of the 5 percent authorized him at that time, leaving less than 1 percent for tactical use. At the existing strength of the Army (174,000 enlisted men), this permitted the maintenance in this country of no more than two medical regiments and a medical squadron—all at modified peace strength. Surgeon General Magee reported on 30 June 1939 that the following units were to be organized: Two additional medical regiments, one veterinary company, one ambulance battalion, and one medical squadron. Outside the country, there were two medical regiments, one of which was composed of Filipinos. General Magee did not propose to transfer any personnel from nontactical activities, having (as he asserted) already less than enough for those activities; nevertheless, he called attention to the dearth of medical personnel for tactical units.[29] Subsequent increases in the authorized strength of the Army to 227,000 during 1939 made possible the creation of more tactical medical units and detachments. General Magee welcomed this increment; in May and June 1940 when further enlargement of the Army to 375,000 was underway and Congress raised the Medical Department's ratio of enlisted men from 5 to 7 percent or more, he recommended the establishment of more tactical medical units, at least of certain types, than the General Staff was ready to approve—for example, four evacuation hospitals as against two, and four surgical hospitals as against two. No hospitals of either type had yet been activated, and up to this point, the Army was entirely lacking in field units to provide medical service above the division or corps level.[30] From then on, expansion of the Army proceeded even more rapidly—especially after the introduction of selective service in 1940—and with it the need for tactical medical units, including those at the divisional level.

A year or more before the outbreak of the war, planning for the number of units (and therefore of enlisted men as well as officers) which would be

---

[28] (1) Memorandum (excerpt), The Surgeon General, for The Adjutant General, 15 Feb. 1939, with endorsements thereto, 27 Apr. 1939 and 26 May 1939. (2) 54 Stat. 214.

[29] Annual Report of The Surgeon General, U.S. Army, Washington: U.S. Government Printing Office, 1939, pp. 173, 181.

[30] (1) Letter, The Surgeon General, to The Adjutant General, 20 Jan. 1940, subject: Enlisted Personnel, Medical Department. (2) Letter, The Surgeon General, to The Adjutant General, 19 June 1940, subject: Deficiencies in Corps and Army Medical Units. (3) Annual Report of the Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1940, p. 175. (4) See footnote 21, p. 59.

needed in the event of actual hostilities had produced disagreements between The Surgeon General and the General Staff. General Magee regarded the War Department's Protective Mobilization Plans for 1939 and 1940 as totally inadequate in the number of hospital centers and general and station hospitals projected for tactical use in wartime. The General Staff hesitated to increase this number, presumably because of the limited initial force contemplated in the mobilization plans and also because of a desire to emphasize in them combat units rather than service units. Eventually, however, in August 1940, the Staff modified its plans so as to include the number of general hospitals asked for by The Surgeon General—102—instead of the 32 originally specified. It was in connection with the mobilization plans and in order to create a reserve of officers to staff these hospitals that The Surgeon General obtained permission to revive affiliated units in various civilian medical schools and hospitals.[31]

The quota of enlisted men for nontactical units and headquarters was less easily agreed upon than the size of the Medical Department's tactical force, just discussed. In February 1940, General Magee declared that Medical Department enlisted strength for these purposes was below the 4.0715-percent ratio which had prevailed before 1 July 1939 and which, he said, was itself inadequate. In June 1940, he proposed 4.85 percent of total Army strength as the desirable ratio and continued to argue in terms of this figure until at least the middle of 1941. The argument was bound up with his objection to "displacing" enlisted men by civilian employees in nontactical hospitals to the extent of more than 20 percent. (His use of the word "displacement" may not have been quite apt. Little or no actual displacement of enlisted men had taken place—civilians had been employed mainly if not entirely to supplement them.) If a permanent displacement of 50 percent were accepted, where, he asked, would the Medical Department, whose hospitals were continually losing trained personnel to form cadres, get trained cadres for new nontactical hospitals and tactical units? He argued further that a displacement of more than 20 percent would seriously impair the training of tactical units then being activated, for personnel of the latter must receive their instruction as understudies in nontactical hospitals actually in operation and rendering patient care. Enlisted men of tactical units could not receive their training as understudies of civilian employees in nontactical hospitals when the civilians themselves had to be trained, and furthermore did not stay very long in their jobs. The Surgeon General's Office justified the 4.85-percent ratio on the ground that this figure was indicated conclusively by "the experience of the Medical Department extending over many years, both in peace and war." [32]

---

[31] See footnote 21, p. 59.

[32] (1) Memorandum, The Surgeon General, for Assistant Chief of Staff, G–3, 13 Feb. 1940. (2) Letter, The Surgeon General, to The Adjutant General, 3 Sept. 1940, subject: Employment of Civilians. (3) Memorandum, Acting Surgeon General, for Assistant Chief of Staff, G–1, 1 Apr. 1941, subject: I. Increase in Authorization for Medical Department Enlisted Men for Corps Area, Service Command, and War Department Overhead. (4) Letter, Maj. Gen. Norman T. Kirk, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 12 Dec. 1955. (5) Letter, Col. Paul A. Paden, MC, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 10 Dec. 1955.

In September 1940, when General Magee presented the 4.85-percent ratio as a formula for allocating newly inducted personnel of the National Guard and selective service to the Medical Department, the reaction of the General Staff was mixed. G–1 considered the ratio reasonable. G–3 (operations) thought it might be acceptable for planning purposes, but proposed that as no "studied determination" of medical personnel requirements for nontactical units and headquarters had apparently been made, the actual needs of each such entity should be determined; The Surgeon General should then meet part of their requirements by "affiliating" [33] with them the tactical units of a similar type—it seemed to G–3 that such affiliation would also facilitate the training of these units. Commenting that the allotments already tentatively made seemed generous, G–3 recommended that no change be made in them for the present. A notation in the file containing this correspondence dated 1 January 1941 states that General Magee's recommendations were "adjusted" in conference, and in a memorandum dated 16 April, G–1 promised that any further increases in Army strength would include a recommendation that Medical Department personnel be allocated in the ratio of 4.8 percent. The context of the latter document indicates that the 4.8 percent applied to nontactical units and headquarters and was therefore very close to General Magee's 4.85 percent for these purposes. But in May 1941,[34] and probably until the very end of this period (December 1941), actual authorizations ran far below the desired ratio.

Although the War Department General Staff allotted a much smaller number of enlisted men to nontactical units and headquarters than the Surgeon General's Office and G–1 thought proper, it authorized the employment of considerable numbers of civilians to make up the difference. In April 1941 when the enlisted allotment was only 2.2 percent, the civilian authorization amounted to 15,000 or 33 percent of the total allotment, military and civilian, This, according to G–1, still left a shortage of 22,000 enlisted men (on the basis of the 4.85-percent ratio). In terms of actual strength, comparable figures for which are lacking, the proportion of civilians may of course have been somewhat different. In December 1941, General Magee reported that it had been necessary to supplement the enlisted men allotted to hospitals by civilians to the extent of 50 percent, and by the temporary employment of tactical hospital units in nontactical hospitals.[35] He agreed that civilians might replace enlisted men in certain technical positions (those in which an enlisted man could not hope to attain proficiency without long education) and certain "scullery jobs" (which had no training value for him).[36] But he contended that the hiring of civilians itself presented problems; for example,

[33] G–3 did not explain what it meant by this term.

[34] Memorandum, Col. H. T. Wickert, for General Magee, 6 May 1941, subject: Enlisted Personnel, Medical Department.

[35] (1) Memorandum, G–1, for The Surgeon General, 16 Apr. 1941, subject: I. Increase in Authorization for Medical Department Enlisted Men for Corps Area, Service Command, and War Department Overhead. (2) Memorandum, The Surgeon General, for G–3, 11 Dec. 1941, subject: Personnel for Arms and Services With Army Air Forces.

[36] (1) See footnote 32 (2), p. 62. (2) Report, The Surgeon General's Conference With Corps Area Surgeons, 14–16 Oct. 1940.

their housing, messing, and the impermanence of their employment if they were later replaced by enlisted men. Such problems proved to be matters of some moment, although apparently they did not prevent the hospitals from rendering adequate service. Moreover, the use of new and relatively untrained enlisted men also presented some difficulties.

The War Department General Staff enabled nontactical installations and activities of the various services, including those of the Medical Department, to utilize personnel of the field forces. In October 1940, when the latter were placed under commands separate from those of the corps areas, their commanders were required to furnish the corps area commanders with such commissioned and enlisted personnel as they might request to operate their installations, pending procurement of the required personnel in the corps areas. In February 1941, announcement was made that field force personnel would be used to augment station complements whenever field forces were present on a post. This was part of a policy which aimed at restricting permanent station complements to the size necessary to maintain services when tactical forces were absent. It represented a departure from the former policy of providing station complements large enough for all contingencies so that tactical units could devote the proper amount of time to training. According to the General Staff, this expedient was necessary in order to prevent a material reduction of the number of troops assigned to field forces. Whether or not the policy resulted in a diminution of the allotments of Medical Department personnel to nontactical installations, it certainly enabled the latter to increase their complement of enlisted men, at least on a temporary basis.[37]

G–3's opinion that a study of the personnel needs of individual Medical Department installations would afford a firmer basis for allotments was probably not shared by the Surgeon General's Office; at any rate, no such studied determination seems to have been made. If it were not made, the reason may have been that the number of officers then available did not permit them to spend the time away from their day-to-day operations. Whether such a study would have enabled allotments to be calculated with complete accuracy may be doubted. To achieve that end in a period of rapid expansion, when the workload and other responsibilities of medical installations were constantly shifting, the study would have had to be continuous. Nevertheless, a thorough survey of the personnel situation at each hospital, for example, might have disclosed facts of considerable value to the policymakers. If it did not buttress General Magee's demand for an enlisted ratio of 4.85 percent, the survey might have enabled him to see a little more clearly how he could get along without it—as he actually had to do.

One substitute for such a detailed study was an estimate of needs according to the size of installations. For nontactical station hospitals, an estimate of this kind existed in the form of a table of organization showing the normal

[37] (1) Letter, The Adjutant General, to Commanders of Arms and Services, 3 Oct. 1940, subject: Organization, Training, and Administration of Army. (2) See footnote 21, p. 59.

personnel requirements for station hospitals of various bed capacities in the Zone of Interior in time of war.[38] Early in 1940, the War Department issued directions on the use of this table in responding to a request from a corps area commander for instructions concerning the employment of civilians in the event of mobilization. The table was to serve as a guide, the local situation determining actual need, pending issuance of a new table similar in purpose which would be included in Mobilization Regulations. The old table stated requirements only in terms of military personnel; the General Staff therefore at the same time publicized a list of "appropriate positions recommended by The Surgeon General that may be filled by civilians in Station and General Hospitals, Zone of Interior, during mobilization."[39] This list was reissued in June 1940.

Meanwhile, General Magee was asked for recommendations as to the form and content of a new table for converting bed requirements into personnel requirements. The General Staff probably expected that the new table would state requirements in terms of civilian personnel. General Magee, however, in December 1940 submitted a guide for determination of Medical Department personnel in Zone of Interior station hospitals, which followed the form of the old table of organization in specifying only military personnel, and merely stated that corps area commanders and chiefs of arms and services could "replace in part, decrease or augment the authorized enlisted men shown in the guide by qualified civilian employees." When G–4 (logistics) asked for a revision of the guide to show requirements for civilian as well as military personnel, General Magee's Office gave assurance that the substitution would be made on a man-to-man basis, an explanation which satisfied G–4.[40] The new guide also, however, raised the requirements for enlisted men above those of the old table of organization. This caused discussion within the General Staff as to whether if the guide was approved it might not compel larger allotments to the Medical Department than those already made, which had been based upon the old table. The final decision was that it would not, and the guide was published on 9 April 1941 with the understanding that it embodied requirements, not availabilities. Thus, the General Staff saved itself from sanctioning an increased allotment. On the other hand, General Magee avoided the necessity of again committing himself, except in vague terms, to the principle of substituting civilian employees for enlisted men. Nor did the Surgeon General's Office apparently use the guide as a new factor in estimating the general requirements for enlisted men in nontactical units and headquarters, for that Office continued to talk in terms of the 4.85-percent ratio. The Acting Surgeon

[38] Table of Organization 786, W, 1 July 1929.

[39] (1) Letter, Surgeon, Third Corps Area, to The Surgeon General, 22 Jan. 1940, subject: Civilian Employees for Station Hospitals, with endorsements thereto, 23 Feb. 1940 and 28 Mar. 1940. (2) Letter, The Adjutant General, to all Corps Area and Department Commanders, 28 Mar. 1940, subject: Use of Civilian Employees in Station Hospitals.

[40] Two months after this explanation was forthcoming (March 1941), the Surgeon General's Office informed the corps area surgeons that civilians should replace enlisted men on a three-for-two basis. (Minutes, The Surgeon General's Conference with Corps Area Surgeons, 10–12, Mar. 1941.)

General urged publication of the guide so that it could be used for planning purposes and for the assistance of corps area surgeons in procuring properly balanced staffs.

Civilians

No global figure or ratio was set during the emergency period to determine the number of civilians who could be employed by the Medical Department. The only formula affecting them which appears to have been discussed at this time was the proper percentage to be employed in nontactical hospitals—a proportion which, as we have seen, The Surgeon General held should not exceed 20 percent.

CHAPTER IV

Requirements: 1941–45

In May 1941, the War Plans Division of the General Staff was given the task of preparing a study on the ultimate munitions that the United States would have to produce to defeat the Axis Powers. At the request of President Roosevelt in July and again in August, the study was expanded to include an estimate of troop strength and total units necessary for the various theaters. This Victory Program submitted to the President on 25 September 1941 placed total strength at 8,795,658.[1] The production goals for munitions were immediately established on the basis of the Victory Program, but no action was taken on a troop basis until after the Japanese attack on Pearl Harbor. The Victory Program became the War Munitions Program at that time, and the preparation of intermediate troop bases became necessary. The 1943 troop basis was set at 8,208,000 (7,533,000 enlisted men, 675,000 officers); the 1944 troop basis reduced overall strength to 7,700,000.[2] In the spring of 1942, The Surgeon General estimated his requirements for the various corps of the Medical Department based on the strength estimates of the Victory Program and the 1943 troop basis, as yet unapproved.

MEDICAL CORPS

In April 1942, in compliance with a request from the Assistant Chief of Staff, G–1, War Department, General Magee estimated that the United States had a total of 176,000 physicians, and remarked that "while many are overage or have retired from practice * * * it will be assumed that the entire number is available for the period of national emergency." He doubted that the Federal services, including the Military Establishment, could obtain more than a third of these and declared that, if no more than 50,000 were available for the Army, the existing allotments and tables of organization would have to be reduced by one-third. He estimated that under these existing allotments and tables 75,000 physicians would be needed for a 7,500,000-man Army, or one for every 100 men. Initially, however, the ratio would be

[1] Watson, Mark Skinner: Chief of Staff: Prewar Plans and Preparations. United States Army in World War II. The War Department: Washington: U.S. Government Printing Office, 1950, pp. 338–349.

[2] Kreidberg, Marvin A., and Henry, Merton G.: History of Military Mobilization in the U.S. Army, 1775–1945. Washington: U.S. Government Printing Office, 1955, pp. 628–629. (DA Pamphlet 20–212.)

greater, decreasing as the troop basis rose.[3] In suggesting that he might be allowed 50,000, The Surgeon General at this early date had arrived at a figure very close to the 45,000 ultimately granted him.

In the course of the next few months, the question of the ratios of physicians to troops in foreign armies was injected into the discussion of the desirable strength of the Medical Corps. This point may have been raised at this time by the fact that in July plans for the first Allied assault landing (Operation TORCH) were being formulated. It was the President himself who raised the question by telling the Chief of Staff and the Chairman of the War Manpower Commission that he could not reconcile the British ratio of 3 physicians per 1,000 troops with the United States ratio of 8 per 1,000. At about the same time, a subcommittee of the Senate Committee on Labor and Education dealing with war manpower issued a preliminary report in which it stated, after noting that the ratio of doctors to military strength in the American Army appeared to be more than twice that maintained by the Allies of the United States, that British experience should be studied in order to work out a balanced plan for use of this scarce national resource.

Shortly after this recommendation was published, The Surgeon General took note of the President's comment in a communication to the General Staff. After stating a belief that the British ratio was 4.5 per 1,000 instead of 3, he said that the ratio of physicians to population in Great Britain was considerably lower than in the United States and that because of proximity to active operations "a large percentage" of British casualties were cared for in civilian hospitals. Moreover, not only were standards of medical care much higher in the United States than in Great Britain but the British themselves had recognized the inadequacy of their medical service by requesting "large numbers" of medical officers from the United States before we entered the war. Then, The Surgeon General, after reviewing the history of congressional action on ratios, pointed out that the act of 3 April 1939 in authorizing 1,424 Medical Corps officers had established a ratio of 6.33 per 1,000 of enlisted strength. He contended, however, that this figure provided Medical Corps officers only for administrative overhead and hospital care, not for combat units or for the organization and training of tactical medical units. He asserted that it had been demonstrated "through all the lean years prior to the present emergency" that this ratio would provide only for the necessary care of the sick "in accordance with the accepted standards of American medicine." [4] But during a war, he continued, it was necessary to man tactical units and to provide a relatively higher proportion of Medical Corps officers for the increased hospitalization incident to the care of battle casualties and troops living under adverse cli-

[3] Memorandum, The Surgeon General (Col. John A. Rogers, MC, Executive Officer), for Personnel Division, Services of Supply, 27 Apr. 1942.

[4] Memorandum, The Surgeon General (General Magee), for Chief of Staff, 23 Oct. 1942.

matic and general health conditions in various parts of the world. Small garrisons and task forces scattered throughout the world increased medical personnel requirements, although The Surgeon General said it was difficult to evaluate that factor accurately. He pointed out that he had reduced tables of organization and service command allotments sufficiently to save more than 8,600 doctors.

General Magee declared that he would be remiss in his duty if he "failed to emphatically protest any reduction of medical officers which would lower the standards of medical service * * * below that confidently expected by the American public. Should these standards be dangerously lowered future criticism would be mainly directed against the Army." "Any further material reduction," he said, "will lower medical efficiency to a dangerous level." He believed that 50,000 physicians for an army of 7.5 million men would enable his Department to perform its mission.

In concluding this strong statement of his position, The Surgeon General expressed his conviction that from the national point of view the problem was not so much one of reducing the number of physicians in the Army as it was one of redistributing available physicians to meet civil requirements.

The question of foreign ratios and also the proper ratio of doctors for the U.S. Army came before the Committee to Study the Medical Department of the Army. Those who testified on personnel matters included not only officers from the Surgeon General's Office and the Services of Supply, but also individuals from the Directing Board of the Procurement and Assignment Service, the Director of the War Manpower Commission, which in April 1942 had incorporated the Procurement and Assignment Service into its organization, officials of the American National Red Cross, and other civilians.

Shortly after General Magee's reply to President Roosevelt concerning the ratios of foreign and American doctors in army medical services throughout the world, the committee made its report. Among other comments, the committee stated, on what authority is unknown, that the ratios of Medical Corps officers to military personnel adopted by the Army was 6.5 per 1,000 troops in the United States and 10.5 per 1,000 in theaters of operations, but this ratio in foreign armies was not obtainable. Furthermore, the committee stated that it did not feel competent to express an opinion as to the adequacy of the American ratios." [5]

Meanwhile, the Deputy Chief of Staff in October 1942 asked The Surgeon General to submit a plan for the medical service of a fully expanded army (fig. 18). The plan, concurred in by the Air and Ground Surgeons and presented in December 1942, proposed 49,100 doctors for an army of 7,500,000—a ratio of about 6.5 per 1,000—and recommended a reduction of allotments to Zone of

[5] Report, Committee to Study the Medical Department, 1942.

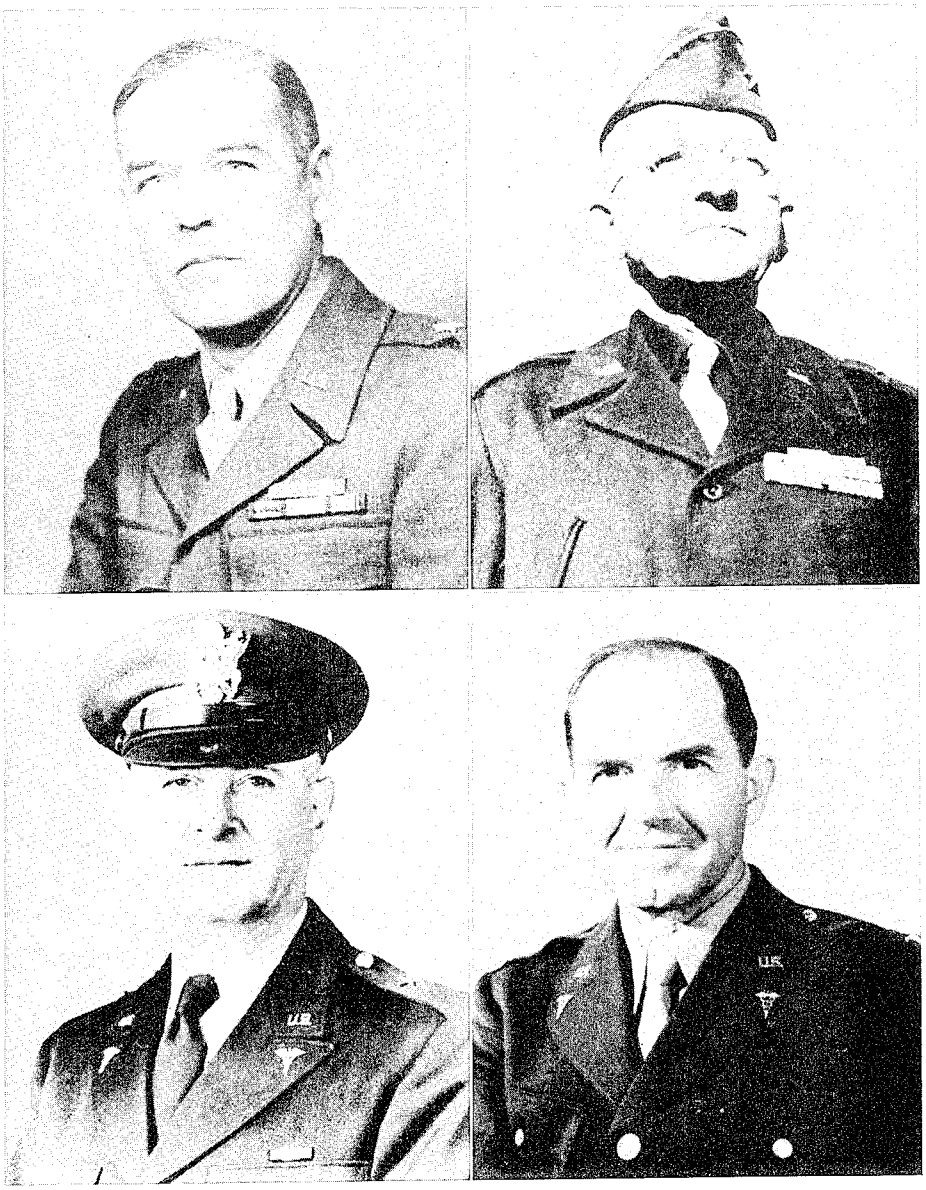


FIGURE 18.—Representative Army surgeons. Upper left: Brig. Gen. John A. Rogers, MC, First U.S. Army. Upper right: Brig. Gen. Thomas D. Hurley, MC, Third U.S. Army Lower left: Brig. Gen. Joseph I. Martin, MC, Fifth U.S. Army. Lower right: Col. (later Brig. Gen.) William A. Hagins, MC, Sixth U.S. Army.

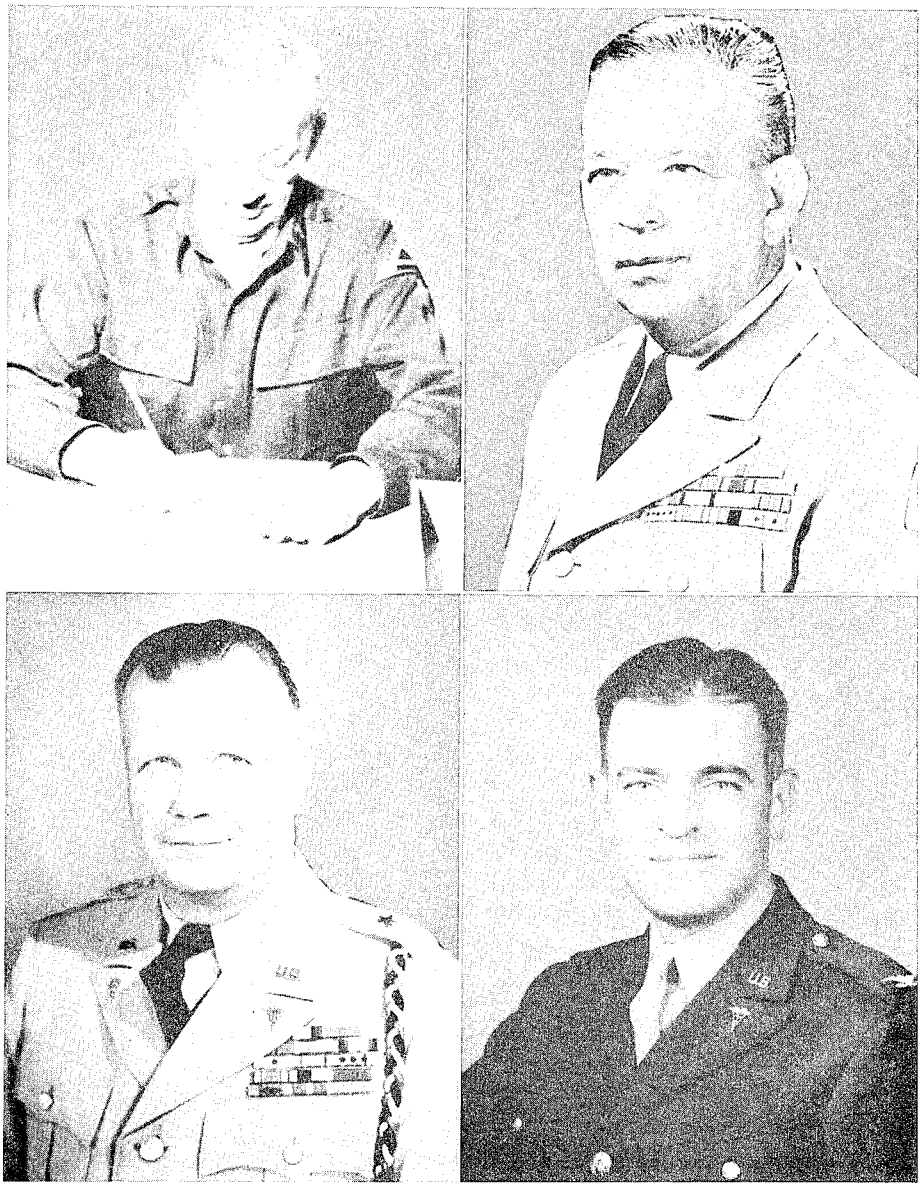


FIGURE 18.—Continued. Upper left: Col. Myron P. Rudolph, MC, Seventh U.S. Army. Upper right: Brig. Gen. George W. Rice, MC, Eighth U.S. Army. Lower left: Brig. Gen. William E. Shambora, MC, was colonel when Surgeon, Ninth U.S. Army. Lower right: Col. Frederic B. Westervelt, MC, Tenth U.S. Army.

663076°—63——7

Interior installations based on new personnel guides to be promulgated.[6] The proposed allotment to the three major forces were as follows:

	Allotment
Army Ground Forces:	
Units in the 1943 troop basis	[1] 13,222
Army Air Forces:	
Units in the 1943 troop basis	4,553
Zone of Interior (including station hospital staffs, schools, and so forth)	[2] 7,358
Services of Supply:	
Units in the 1943 troop basis for medical service (3 million overseas)	[3] 14,254
Zone of Interior (including station and general hospitals, technician schools, Medical Replacement Training Centers, laboratories, overhead and procurement and supply activities, except those provided by Army Air Forces)	[4] 8,809
Total	[5] 49,100

[1] After a reduction of 827.
[2] After a reduction of 262.
[3] After a reduction of 361.
[4] After a reduction of 2,805.
[5] Includes 904 allotted to War Department filler and loss replacement pool.

After discussion about the number of doctors, the Deputy Chief of Staff in March 1943 set the permissible number at 48,000 for an Army strength of 8,248,000 (the 1943 troop basis plus 40,000 Army nurses). Six months later, however, G–1 stated that in view of a reduction of the troop basis to 7,686,000 the War Department could not support the previous figure and ordered a restudy to reduce it, indicating that 45,000 would be about the right number. Shortly afterward, Army Service Forces headquarters directed The Surgeon General to modify his plan for the utilization of Medical Corps officers, using a basis of approximately 45,000 officers for an army of 7,686,000 as of 31 December 1943.[7]

At the end of September 1943, Medical Corps strength stood at 39,951 and total Army strength at 7,273,784, or a ratio of 5.49 doctors per 1,000 strength. Forty-five thousand doctors for an Army of 7,686,000 would have provided a ratio of slightly less than 6 per 1,000. In protesting against this reduction, The Surgeon General declared that 48,000 was an irreducible minimum. Although no action seems to have been taken on this rejoinder, The Surgeon General later noted that the reduction to 45,000 had been made while a draft of doctors was under discussion, and claimed that it was without prejudice to additional requirements after 1 January 1944.[8] At this time, there was no question of

[6] Memorandum, Acting Surgeon General, for Deputy Chief of Staff (through Military Personnel Division, Services of Supply), 14 Dec. 1942, subject: Availability of Physicians.

[7] (1) Memorandum, Deputy Chief of Staff, for Commanding General, Army Service Forces, 10 Mar. 1943, subject: Availability of Physicians. (2) Memorandum, G–1, for Commanding General, Army Service Forces, attention: Military Personnel Division, 18 Sept. 1943, subject: Officer Requirements. (3) Memorandum, Military Personnel Division, Army Service Forces, for The Surgeon General, 22 Sept. 1943, subject: Officer Requirements, Medical Corps.

[8] (1) Memorandum, Military Personnel Division, Army Service Forces, for The Surgeon General, 22 Sept. 1943, subject: Officer Requirements, Medical Corps, with 1st endorsement thereto, 2 Oct. 1943. (2) Memorandum, The Surgeon General, for Assistant Chief of Staff, G–1, 11 Sept. 1944, subject: Conference With Chairman, Procurement and Assignment Service.

exceeding an actual strength of 48,000 or even 45,000, since the total number of Medical Corps officers on duty was only about 40,000 as late as the end of December 1943 (table 1).

By the end of September 1944, however, the number on duty was approximately 45,000, and on 7 October, the War Department again established that figure as a ceiling; any excess was to be disposed of either by transferring officers to the Veterans' Administration or by separating them from the service. Two days later, The Surgeon General stated that 47,000 as of 31 December 1944 was a "firm requirement" and that further reduction of tables of organization was "out of the question." [9] On 7 November 1944, his appeal was rejected, but the War Department acknowledged that it was "impracticable to maintain an exact ceiling of 45,000" and that "some tolerance or leeway appears desirable on the long side." [10] In any event, the strength of the Medical Corps was permitted to exceed the ceiling; at the end of November 1944, it stood at 46,747 and reached its maximum—about 48,000—in July 1945 (table 1).

Procurement and Assignment Service

The Procurement and Assignment Service, which had been established shortly before Pearl Harbor as a coordinating agency for all Federal services for medical, dental, and veterinary personnel, in April 1942 created a Committee on Allocation of Medical Personnel, which was charged with determining a safe minimum standard of medical care for civilians. The minutes of the first meeting of this committee (26 April 1942) show that it entered on its task with the idea not only of allocating personnel to civilian and military service, but of trying to constrain the Army into what it considered an efficient use of physicians. Dr. Harold S. Diehl, Dean of Medical Sciences, University of Minnesota, the chairman, said that the committee had to plan to prevent medical personnel from being put into positions where their special qualifications were not utilized. Dr. Roscoe G. Leland, Director of the Bureau of Medical Economics of the American Medical Association, a member, expressed the opinion that it would be the committee's job to get the Army to change its position on requirements by reducing the ratio of physicians to Army strength and by replacing certain physicians with medical administrative personnel. Dr. Diehl then said that "if we have a case and can get the figures to prove it, we can get the Army to revise their demands."

This is one of the first indications that the members of the Procurement and Assignment Service actually meant to put a limit on the number of physicians the Army could have so as to keep civilian communities from being stripped of doctors. The sequel was that for the duration of World War II

[9] Memorandum, The Surgeon General, for the Assistant Chief of Staff, G–1, 9 Oct. 1944, subject: Medical Officer Requirements and Availabilities.

[10] Letter, The Adjutant General, to The Surgeon General, 7 Nov. 1944, subject: Medical Corps Officers—Procurement, Assignment, and Ceiling.

the Medical Department was governed in many aspects of its personnel procurement program by the wishes of a civilian agency.

On 7 November 1942, at a meeting attended among others by Surgeon General James C. Magee; Vice Adm. Ross T McIntire, his Navy counterpart; and Paul V. McNutt, Chairman of the War Manpower Commission, the Procurement and Assignment Service recommended a ratio of 1 physician to 1,500 of population as a minimum for civilian medical service in each State. This of course would indirectly set a limit on the procurement of doctors for the armed services. Admiral McIntire agreed that every possible effort should be made to maintain the proposed ratio and stated that the Navy could operate with "anywhere from 6 to 6.5 in this war." General Magee accepted the 1:1,500 ratio for civilian medical service, but objected to committing himself as to the precise number of doctors the Army would need. The Medical Department, he said, was reducing its figures "as far as our conscience and intelligence will let us," but "if it comes to a point of making immediate decisions, I am not in a position to do so at the present time." Mr. McNutt was obviously dissatisfied with The Surgeon General's position. He said that the Procurement and Assignment Service would give the Armed Forces all it possibly could, but that he knew "full well" that tables of organization had been too high. "If you want my candid appraisal of the situation," he said, "we cannot be dealing with any 8.2 or 8.3 per 1,000. We had better be talking about 6.4 or 6.5." The latter ratios would have given the Army about 48,000 doctors figured on a strength of 7.5 million, or in fact very nearly the 50,000 which The Surgeon General had earlier suggested. That suggestion had probably been made, however, with a view to giving the Army not as many doctors as would be considered ideal but simply enough to enable the Medical Department to fulfill its function.

The Procurement and Assignment Service adhered to the 1:1,500 ratio for civilian medical service throughout the war as a basis for authorizing the military services to procure doctors in the several States. Many States did not possess so high a ratio; some had higher. The Procurement and Assignment Service had small power to improve their positions by reallocating civilian doctors, and in fact, it achieved little in that respect.

In discussing the Procurement and Assignment Service's lack of power to relocate doctors, the vice chairman of that organization had stated:

> Our position would have been much easier, and some of our obvious failures might have been avoided, if we had possessed the same "power" over the relocation of civilian doctors to needy communities that we had to limit the commissioning of medical officers to those men considered "available." The fact that New York and Chicago, throughout the war, had an excess of doctors and dentists that we could not relocate, weakened our position and prevented the accomplishment of our obligations to the civilians. If another great war should break out, I personally think that a body with power over all professional people should be set up.[11]

[11] Letter, Harvey B. Stone, M.D., to Col. C. H. Goddard, MC, Office of The Surgeon General, 3 June 1952.



FIGURE 19.—Brig. Gen. Robert Mills, DC, wartime director of the Dental Division, Office of The Surgeon General.

DENTAL CORPS

By the start of World War II, experience had shown that any ratio of less than 1 dental officer for each 750 men would be grossly inadequate. Although formal requests for procurement objectives were generally brief, containing no discussion of the method of calculation, it is clear that the ultimate goal of the Surgeon General's Office was an overall ratio of 1 dentist for each 500 men. This ratio was agreed upon informally between the director of the Dental Division (fig. 19) and the chief of the Personnel Service, both in the Office of The Surgeon General.[12] Even though it was not "officially recognized," the July request for a procurement objective stated that it was based on a ratio of 2 dentists per 1,000, and permission was asked to appoint up to 9,000 Dental Corps officers for an Army of 4.5 million.[13] In November 1942, The Surgeon General estimated that in view of the planned increase in the size of the Army

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

[13] Letter, Office of The Surgeon General, to Commanding General, Services of Supply, 3 July 1942, subject: Procurement Objective, Dental Corps, Army of the United States.

he would need 17,248 dentists. This estimate was accepted by the War Department General Staff.[14]

The overall ratio of dental officers (1 to 500) which the Dental Service considered necessary was never reached during the entire war period except in September and October 1942. The problem of meeting the needs of new recruits for dental rehabilitation, which was particularly serious during the early part of the war, seems to have been partially met by deferring all but work of an emergency nature.

Early in 1943, the Procurement and Assignment Service determined that 1 dentist was required for each 2,500 civilians and that a total of 22,620 could be spared for the Army and Navy, thereby leaving 50,250 in civilian practice.[15] This standard and its application could be criticized on several grounds. In the first place, the standard was arbitrary, being based more on opinion than knowledge. Moreover, not all communities had as many as 1 dentist per 2,500 civilians—many had not above half that ratio—and there was no machinery to give them more or even to restrict recruiting to other areas. Finally, if the number of dentists that could be spared for the Armed Forces had been arrived at simply by counting as available all dentists in excess of the 1:2,500 ratio in communities possessing a higher ratio, the number would have been considerably larger than 22,620. The military authorities, however, did not raise these or other objections to the calculations of the Procurement and Assignment Service; they could hardly have effectively challenged a formula which gave them the right to solicit one-third of the Nation's dentists for 12 million men while two-thirds were reserved for 120 million civilians.

In late 1943, Army Service Forces set a ceiling of 15,200 for the Dental Corps. According to Col. George F. Jeffcott, DC:

> The manner in which the ceiling for the Dental Corps was established, and the exact date, are not entirely clear. In a memorandum to the Deputy Surgeon General, of 7 Sep 43, Lt Col D. G. Hall of the Personnel Service, SGO, stated that his office had "that day" been notified of a revised requirement based on changed plans in ASF * * *. Other incidental references [however] indicate that representatives of the Dental Division [SGO], the Military Personnel Division, SGO, and of G–1 attended conferences on the matter before a decision was reached. It is also probable that PAS [Procurement and Assignment Service] had a hand in the matter, but the extent to which its influence affected ASF is not known.[16]

VETERINARY CORPS

Unlike the Medical, Dental, and Army Nurse Corps, the size of the Veterinary Corps could not be calculated by a simple ratio of veterinarians to the overall strength of the Army. One factor that complicated the process of calculation was present to some degree before the United States entered

---

[14] Letter, The Adjutant General, to The Surgeon General, 27 Nov. 1942, subject: Increase in Procurement Objective for The Surgeon General (Dental Corps).

[15] Minutes, Committee on Dentistry, Procurement and Assignment Service, 20 Feb. 1943.

[16] See footnote 12, p. 75.

the war—the inspection of food by the Army Veterinary Service for other branches of the Military Establishment and even for certain nonmilitary agencies of Government. During the war, one of the most important tasks of Veterinary Corps officers was the procurement-inspection of food for the Navy and the Marine Corps; by the end of the war, Army veterinarians were inspecting about 90 percent of the Navy's food at the time of procurement.[17]

New and increased requests for veterinary officers throughout the war period therefore perplexed the General Staff, for no fixed basis, such as troop strength, could be used as a guide in making their decisions.[18] Army Regulations No. 40–2035, 18 December 1942, governing veterinarians, listed the number of assistants a station veterinarian could have (depending on animal strength) and stated further:

> A station having a human strength of approximately 1,000 will be allowed one or more veterinary officers, as circumstances warrant, for duty in connection with meat and dairy hygiene, the maintenance of instruction courses, or other duties pertaining to the veterinary service. At depots, ports of embarkation and debarkation, purchasing points, and other places where foods of animal origin are purchased, stored, or handled by the Army, the assignment of veterinary officers will be based on actual need as determined by The Surgeon General.

In practice, The Surgeon General from time to time requested new procurement objectives which would authorize the Medical Department to obtain additional veterinary officers as the occasion seemed to demand. Although the objectives granted were not as large as those he requested, they enabled the corps to be moderately enlarged. No ceiling appears to have been set for the Veterinary Corps until January 1945 and even this was more in the nature of a procurement objective, since the War Department General Staff not only set a figure (2,150) somewhat above the actual strength but authorized procurement of the necessary officers from certain specified, though restricted, sources.[19]

SANITARY CORPS

Throughout the war, no personnel ceiling was established for the Sanitary Corps, and no ratio was adopted as a means of computing the numbers required. The Surgeon General merely requested and justified successive procurement objectives which, if approved by the War Department General Staff, permitted him to add certain numbers to the corps. In February 1945, further commissioning in the corps was ordered stopped, the membership being considered large enough for the Army's needs.

---

[17] Annual Reports, Veterinary Division, Office of The Surgeon General, U.S. Army, 1942–46.

[18] Information from Maj. E. B. Miller, VC, U.S. Army Medical Service historian, 1950.

[19] Semiannual Report, Procurement Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1 Jan.–31 May 1945.

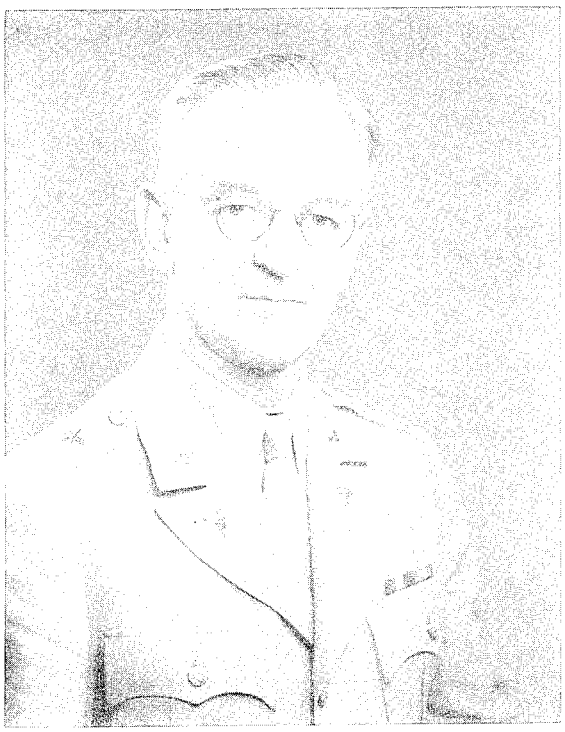


FIGURE 20.—Brig. Gen. Edward Reynolds, MAC, Chief, Medical Administrative Corps.

PHARMACY CORPS

The number of personnel required by the Pharmacy Corps was determined by The Surgeon General. Since most of the pharmaceutical work in the Army could be done by pharmacy technicians working under supervision, the 72 Pharmacy Corps officers permitted by the act of 1943 which created the corps proved to be more than sufficient throughout the war from The Surgeon General's point of view.

MEDICAL ADMINISTRATIVE CORPS

On 30 June 1940, the ratio of Medical Administrative Corps (fig. 20) officers on active duty to Medical Corps officers was a little more than 1: 25; 5 years later, the ratio had risen to 1: 2.4. This was due not to the establishment of a formal requirement for Medical Administrative Corps officers but rather to the transfer of administrative duties from Medical Corps officers to qualified nonprofessional personnel, thereby freeing the physicians for strictly professional work.

In April 1942 when, in reply to questions from G–1, The Surgeon General was discussing the substitution of Medical Administrative Corps for Medical Corps officers, he said that whereas 75,000 physicians would be needed according to existing tables of organization and allotments, probably 10 percent of that number, or 7,500, could be supplanted by Medical Administrative Corps officers. "It is doubtful that all of these or additional substitutions would prove of economic value," he explained.[20]

Apparently not until the Medical Department found itself limited by the ceiling on doctors did it envisage the great number and variety of assignments that members of the Medical Administrative Corps were qualified to fill. Nevertheless, in a report on the procurement and supply of Medical Corps officers, the Control Division, Services of Supply, stated in June 1942 that as a result of the serious shortage of Medical Corps officers the Medical Department had an obligation to release them from "all administrative procurement, and similar duties which can be assigned to nonmedical personnel." This report did not limit those to be substituted to members of the Medical Administrative Corps, but suggested the use of Sanitary Corps, branch immaterial, and Army Specialist Corps officers as well.[21] In July 1942, The Adjutant General issued a letter requiring the relief of Medical Corps officers from duties that did not demand professional training.

The Committee to Study the Medical Department reviewed the problem of replacement of Medical Corps officers and made the following recommendations:

1. The practice of assigning Medical Corps officers, even temporarily, to any type of work that could be performed by nonprofessional personnel should be discontinued.

2. Medical and dental officers should be utilized to the fullest extent in their professional fields.

3. All professional personnel engaged in administrative tasks except those who had lost the skills necessary for professional work should be replaced by Medical Administrative Corps personnel.

4. More nonmedical men who had proved competent in managing establishments providing medical care should be used in positions of greater responsibility in Army hospitals and even in the higher echelons of the Medical Department.

5. The Medical Department should take steps, "even at this late date," [1942] to increase greatly the number of Medical Administrative Corps trainees per month.

The committee believed that statements made by The Surgeon General's representatives that the supply of such officers would equal demand by 1 Jan-

[20] Memorandum, The Surgeon General (Col. John A. Rogers, MC, Executive Officer), for Personnel Division, Services of Supply, 27 Apr. 1942.

[21] The Army Specialist Corps was composed of administrative, professional, scientific, and technical specialists who were "civilians in uniform" functioning under civil service. The corps existed less than a year, being abolished in late 1942.

uary 1943 were far too optimistic.[22] As by that date only about 5,900 were on duty in contrast to the later peak strength of nearly 20,000, the committee's belief seems justified (table 1). Actually, the Department did not have enough Medical Administrative Corps officers until nearly a year after the committee met; even then, the sufficiency lasted but a few months.

Not all high ranking Medical Department officers agreed on the extent to which Medical Administrative Corps officers should replace those of the Medical Corps. The commanding officer of the Medical Replacement Training Center at Camp Pickett, Va., was reported in 1942 as insisting that he "could not possibly" run his center "on a sound basis" with fewer than two and one-half or three Medical Corps officers per training company; this would have required either 10 or 12 for each battalion. At the same time, it was reported that the training center at Camp Barkeley, Tex., was operating with only three Medical Corps officers per battalion.[23]

In 1943, the training center at Camp Grant, Ill., noted that young Medical Administrative Corps officers were rapidly replacing doctors and dentists, and that in most cases the replacement had proved very satisfactory. Whereas, on 30 June 1942, 37 percent of the 383 officers at the center had been Medical Corps, 25 percent Dental Corps, and 19 percent Medical Administrative Corps officers, a year later the percentage of medical and dental officers had fallen to 10 and 2, respectively, while that of Medical Administrative Corps officers had risen to 73 in a total officer group of 423.

In the fall of 1943—at a time when difficulties were foreseen in furnishing doctors to all the units and installations which The Surgeon General believed to be in need of them—General Kirk determined to effect a more widespread replacement. He decided to replace one of the two battalion surgeons with a specially trained Medical Administrative Corps officer to be known as battalion surgeon's assistant and to make other substitutions of a similar nature.[24] Although fear was expressed that such substitution in the battalion was a real source of danger since it was "unquestionable that many such untrained officers will assume unwarranted diagnostic powers and seriously endanger the health of the soldier under treatment," The Surgeon General disagreed with this belief, declaring flatly that the battalion surgeon's assistant was not given that assignment to make diagnoses or to treat the seriously injured. "He is put in there to do the administration of the detachment, command the litter bearers and *assist* the battalion surgeon * * *." General Kirk reasoned that since there had been no trouble in the hospitals with Medical Administrative Corps officers attempting to assume professional duties there was no reason to anticipate

[22] Report, Committee to Study the Medical Department, pp. 11, 38–39.

[23] Letter, 1st Lt. T. C. M. Robinson, Training Division, Office of The Surgeon General, to Col. Frank Wakeman, c/o Col. George M. Edwards, William Beaumont General Hospital, El Paso, Tex., 13 Dec. 1942.

[24] Annual Report, Operations Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1943–44.

trouble in the units.[25] Actually, although there may have been complaints against individual officers, the Office of the Surgeon, Army Ground Forces, was reported as stating that the work of the assistants had been very satisfactory.[26]

Fortunately, there were about 1,500 Medical Administrative Corps officers in replacement pools in the United States at the time The Surgeon General decided to use them in this way,[27] and beginning in January 1944, they were ordered to school in successive groups at Camp Barkeley to be trained as battalion surgeon's assistants. Ultimately (by May 1945), about 2,100 were graduated;[28] in the later stages of the training program, recently commissioned Medical Administrative Corps officers were sent to the school.

In addition to serving as battalion surgeon's assistants, Medical Administrative Corps officers came to be assigned to other positions formerly reserved for doctors. In November 1943, The Surgeon General proposed using them as registrars in hospitals. Some months later, the General Staff announced that they were to be preferred for assignment not only as registrars but as executive officers in station and general hospitals both at home and overseas.[29] The Surgeon General objected to making them executive officers of general hospitals on the ground that these officers must act for and in the absence of the commanding officer and must have a professional appreciation of the proposals presented in order that the personnel of the hospital might be properly utilized. As a consequence, the General Staff omitted reference to the use of Medical Administrative Corps (also Pharmacy and Sanitary Corps) officers as executive officers of general hospitals in the restatement of its policy in August 1944.[30]

There were other places in hospitals, however, where Medical Administrative Corps officers could relieve doctors. For example, in the later war years when the bed census in Army hospitals in the United States was running high, they were made ward property officers. In some hospitals, too, they came to serve as administrative assistants to the chiefs of the medical and surgical services.[31]

The extent to which Medical Administrative Corps officers were used in conjunction with Medical Corps officers in general hospitals of the Zone of Interior during the later war years is indicated by the table of suggested allotments published by the War Department in May 1944 (table 3). A similar situation came to prevail in other Medical Department installations as well; for example, in the replacement training centers, which late in the war were using large percentages of Medical Administrative Corps officers.

---

[25] Letter, Surgeon General Kirk, to Maj. Gen. Morrison C. Stayer, Surgeon, North African Theater of Operations, U.S. Army, 11 Sept. 1944, in reply to General Stayer's letter of 3 Sept. 1944, in which General Stayer had reported the comments of one of his subordinate officers.

[26] Semiannual History of Medical Administrative Corps and Sanitary Corps, 1 Jan.–31 May 1945.

[27] See footnote 24, p. 80.

[28] See footnote 26.

[29] War Department Circular No. 99, 9 Mar. 1944.

[30] War Department Circular No. 327, 8 Aug. 1944.

[31] Annual Reports, William Beaumont General Hospital, 1944; Ashburn General Hospital, 1944; and Fifth Service Command, 1945.



FIGURE 21.—Col. David E. Liston, MC, Deputy Chief Surgeon, European Theater of Operations, U.S. Army.

As late as 10 years after the war, there were differences of opinion among Medical Corps officers as to how completely Medical Administrative Corps officers had been able to perform certain duties previously performed by Medical Corps officers and noncommissioned officers. General Kirk stated that regardless of the number of Medical Administrative Corps officers employed "there were never enough doctors to do the job properly" until V–E Day. Several other medical officers also expressed opinions based on their wartime

TABLE 3.—*Numbers of Medical and Medical Administrative Corps officers suggested (1944) for Zone of Interior general hospitals of various sizes*

Number of beds	Medical Corps officers (number)	Medical Administrative Corps officers (number)	Number of beds	Medical Corps officers (number)	Medical Administrative Corps officers (number)
1,000	35	24	2,500	60	39
1,500	46	30	3,000	64	44
1,750	50	33	3,500	70	47
2,000	55	36	4,000	80	56

Source: War Department Circular No. 209, 26 May 1944.



FIGURE 22.—Col. Fred J. Fielding, MC, Office of The Surgeon General, U.S. Army.

experiences. Col. David E. Liston, MC (fig. 21), Deputy Chief Surgeon, European Theater of Operations, U.S. Army, stated his belief that "the increased number of Medical Administrative Corps officers did not materially affect the requirement for doctors and did affect [that is, reduce] the requirement for senior noncommissioned officers. Often the Medical Corps officer had to exercise an equal degree of supervision over the Medical Administrative officer to that exercised over his NCO previously." On the other hand, Col. Fred J. Fielding, MC (fig. 22), stated that in the later war years tables of organization and equipment "were culled to eliminate MC positions of administrative nature except for CO [commanding officer]." He went on to state that when in 1944 Medical Administrative Corps officers were trained as battalion surgeon's assistants "* * * this produced a direct replacement of many MC officers formerly required in a position not of administrative nature but related to the professional duty field." Lt. Col. Paul A. Paden, MC, also favored using Medical Administrative Corps Officers where possible to relieve Medical Corps officers. He went so far as to state: "Except for training, there was no reason why other than a few Medical Department officers should have been assigned to any type of unit until just before its *actual employment* in a theater of operations." He felt that even in combat the treatment should

have been minimal and that therefore a Medical Administrative Corps officer could easily have been a battalion surgeon's assistant.[32]

ARMY NURSE CORPS

During the first months of the war, the Surgeon General's Office made its estimates for nurse requirements and submitted them to the General Staff, which customarily accepted them. The ratio was approximately 6 nurses for 1,000 overall strength. In September 1942, when the troop basis was raised to 8,200,000, the Surgeon General's Office transmitted to the General Staff a figure of 51,177 as its estimate of the nurses required to serve a force of that size.[33] On this occasion, the General Staff did not approve the estimate. Some time during the first 2 months of 1943, G–3 notified the Surgeon General's Office that 51,177 was too high a figure and that the number was being held at 40,000 (including physical therapists and dietitians), which had been previously authorized for the fiscal year ending on 30 June 1944. The nurse requirement was verbally agreed to by the Assistant Chief, Operations Service, Office of The Surgeon General, but neither the Nursing Division nor the Personnel Division, Office of The Surgeon General, nor the nursing authorities of the War Manpower Commission, were informed that the authorized figure was to be retained.[34]

As a result, the Superintendent of the Army Nurse Corps (fig. 23) and various nursing organizations engaged in recruiting continued to assume for months that the War Department had authorized a quota of 51,000 nurses. Therefore, when the Superintendent heard that the budget contained provision for only 40,000 she refused to believe that the budget directive constituted a limitation and insisted that it would be impossible to operate with such a number. The nursing organizations also continued to use the goal of 51,000 to impress the nursing profession with the critical need for recruits.[35]

In a memorandum to the Commanding General, Army Service Forces, on 18 December 1943, General Kirk argued that the ceiling figure of 40,000, which actually included not only nurses but physical therapists and dietitians, was far too small to meet the requirements of the 1944 troop basis. In reaching

---

[32] (1) Letter, Maj. Gen. Norman T. Kirk (Ret.), to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 12 Dec. 1955. (2) Col. David E. Liston, MC, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 5 Jan. 1956. (3) Letter, Col. Fred J. Fielding, MC, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 12 Dec. 1955. (4) Lt. Col. Paul A. Paden, MC, to Col. C. H. Goddard, MC, Office of The Surgeon General, 9 June 1952.

[33] At 6 per 1,000 of troop strength, the estimate would have been 49,200. The higher figure may have been set in order to provide for losses.

[34] Blanchfield, Florence A., and Standlee, Mary W.: The Army Nurse Corps in World War II. [Official record.]

[35] (1) Haupt, A. C.: National War Nursing Program. Hospitals 17: 26–30, April 1943. (2) "Have You Thought It Through, Private Duty Nurse?" Am. J. Nursing 43: 522–523, June 1943. (Moreover, the Subcommittee on Nursing of the National Defense Council's Health and Medical Committee, unaware of the true situation, used the prospective depletion of civilian resources as a lever to secure an authoritative place for the Nursing Supply and Distribution Service in the Procurement and Assignment Service.)



FIGURE 23.—Col. Florence A. Blanchfield, ANC, Superintendent of the Army Nurse Corps.

this conclusion, he relied largely on the use of a ratio of 1 nurse to 10 fixed beds, the approximate ratio established for Zone of Interior hospitals and theater of operations fixed hospitals.[36]

G–1 of the War Department General Staff answered The Surgeon General's protest, but before doing so, it assembled further data on the subject. From the Inspector General, G–1 obtained a report by Maj. Gen. Howard McC. Snyder, MC, the medical representative on the Inspector General's staff. General Snyder cited a recent survey of 95 Zone of Interior hospitals which showed that they averaged 19 beds and 12.4 patients per nurse without consistently overworking the nurses; this was bolstered by a consideration of the facts which the War Department Manpower Board used to justify its estimate of Army nurse requirements for hospitals in the Zone of Interior; namely, 1 nurse per 12 beds in general hospitals and 1 nurse per 12 to 17½ beds in station hospitals. General Snyder pointed out that only 30.6 percent of the patients in the 95 hospitals surveyed were bed patients, which reduced the amount of nursing care required. Taking this into consideration, and allowing for the dispersion of beds necessitated in part by the care of patients having communi-

[36] War Department Circular No. 306, 22 Nov. 1943.

cable diseases, he estimated that a 750-bed "cantonment hospital" would require 40 nurses, or 1 nurse per 18¾ beds. His general conclusion was that The Surgeon General's estimate of 1 nurse per 10 beds was excessive and that the allotment of nurses for Zone of Interior hospitals should be reduced to 1 nurse per 17½ beds and for fixed-bed theater of operations hospitals to 1 nurse per 15 beds.

G–1 added some observations of its own, chiefly on the subject of how many fixed beds actually were required, and announced on 8 January 1944 that the ratio for Zone of Interior hospitals would be 1 nurse to 15 beds and for theater of operations fixed hospitals 1 nurse to 12 beds. The Surgeon General was to recommend reductions in allowances for Zone of Interior hospitals and in tables of organization to meet these ratios for the purpose of keeping within the 40,000 ceiling. G–1 concluded that "the present ceiling of 40,000 nurses will amply meet the overall requirements provided the ratio of nurses to beds is decreased, convalescent hospitals established, and maximum use made of semi-skilled aides, civilians, and corpsmen to replace nurses." The only concession The Surgeon General's Personnel Service was able to secure was that physical therapists and dietitians, of which the combined total at that time was approximately 1,700, would not be lumped with the nurses but would be in addition to the 40,000 limit.[37]

In response to this directive, The Surgeon General again entered a plea for the 1 to 10 ratio. He proposed, however, to retain the 40,000 ceiling "for the present" by filling all units in the troop basis with Army nurses at the existing table-of-organization figures—which would require 38,818 of the 40,000—and supplementing those who remained in the Zone of Interior by civilian nurses so as to provide a ratio of 1 nurse to 10 beds. G–1 rejected this proposal of 25 February 1944, "in view of the critical shortage of military and civilian nurses," and a few days later, the Deputy Chief of Staff enjoined compliance with the original directive of 8 January.[38]

In a little more than a month, on 5 April 1944, General Somervell was able to report that this directive was being carried out—in part. The Surgeon General had modified the tables of organization and also the allotments for Zone of Interior installations to provide the required ratios of nurses to fixed beds—1 to 12 and 1 to 15, respectively. As to maintaining the 40,000 ceiling, General Somervell referred to a study by The Surgeon General which showed that a total strength of 47,677 nurses was necessary to meet requirements for 1944, taking into account the new ratios but not allowing for potential requirements of 3,646 nurses "that can be foreseen at this time." The figure of 47,677 nurses required was arrived at as follows:

---

[37] (1) Memorandum, G–1, for Chief of Staff, 4 Jan. 1944, subject: Nurse Personnel Requirements. (2) Letter, G–1, to Military Personnel Division, Army Service Forces, to The Surgeon General, and to The Adjutant General, 8 Jan. 1944, subject: Nurse Personnel Requirements.

[38] (1) Disposition Form, G–1, to The Surgeon General, 25 Feb. 1944, subject: Nurse Personnel Requirements. (2) Memorandum, Deputy Chief of Staff, for Commanding General, Army Service Forces, 1 Mar. 1944, subject: Nurse Personnel Requirements.

	Number required
For general and station hospitals in Zone of Interior	[1] 13,867
For fixed-bed theater of operations hospitals	[2] 26,031
For other units, provided for in the 1944 troop basis:	
Hospital ships	1,309
Hospital trains	228
Auxiliary surgical groups	420
Composite units	390
Air evacuation squadrons	498
Evacuation hospitals	988
Evacuation hospitals, semimobile	2,200
Field hospitals	1,746
Total	47,677

[1] This number was calculated by applying the 1:15 ratio to 108,000 beds in station hospitals and 100,000 beds in general hospitals; total, 208,000 beds. Bed strength of station hospitals was arrived at by counting it as 4 percent of a 2,700,000 troop strength.

[2] This number was calculated by applying the 1:12 ratio to 312,375 beds, which were provided for in the War Department Operations Division troop unit basis.

General Somervell added that at his instance The Surgeon General was continuing his studies to produce the greatest possible economies in the use of nurses, but it seemed clear to General Somervell that the existing ceiling of 40,000 should be increased by at least 5,000. He therefore asked for a further authorization of 5,000 "to avoid interruption of the Nurse recruitment program." [39]

On 28 April 1944, G–1 more than met General Somervell's request by raising the authorization for nurses to 50,000 where it remained until almost the end of January 1945. Meanwhile, The Surgeon General's estimates of requirements ran considerably above that figure. In October 1944, his Strategic and Logistics Planning Unit forecast that by 31 December 1944 the need would rise to 45,869 and would remain at approximately that point until September 1945.[40] Early in January 1945, The Surgeon General raised the forecast to 59,401 for June 1945 (table 4).

The Surgeon General's estimate was considerably higher than a forecast made about 2 weeks later by the Military Personnel Division, Army Service Forces, which placed the requirement at 55,722 nurses by 30 June 1945. On 28 January 1945, the War Department General Staff virtually met this requirement by raising the ceiling to 55,000. A week afterward, it added 5,000 to make the total 60,000. These increases came in the midst of public agitation concerning the adequacy of the nursing force and the necessity of a draft of nurses. As many as 60,000 nurses might have been needed if Germany had continued in the war beyond May 1945. With her defeat in that month, however, the requirement for nurses rapidly diminished, and the problem became one of reduction rather than increase of the nursing force.

[39] Memorandum, Commanding General, Army Service Forces, for Deputy Chief of Staff, 5 Apr. 1944, subject: Nurse Personnel Requirements.

[40] Memorandum, Director, Strategic and Logistics Planning Unit, for The Surgeon General, 24 Oct. 1944, subject: Army Nurse Corps Requirements, Medical Department, U.S. Army.

TABLE 4.—*Proposed distribution of nurses, June 1945*

Units and installations	Authorized beds (number)	Bases for computation of requirements	Nurse requirements (number)
Table-of-organization units in troop basis:			
Overseas [1]	437, 500	table of organization	34, 657
Zone of Interior	6, 325	do	570
Non-table-of-organization in Zone of Interior:			
General hospitals	165, 000	1 nurse per 15 beds	11, 000
Convalescent hospitals	50, 000	1 nurse per 30 beds	1, 667
Regional and station hospitals	[2] 130, 000	1 nurse per 15 beds	8, 667
Miscellaneous			575
Miscellaneous:			
Theater of operations overhead			265
Pipeline; pools; sick			2, 000
Total			59, 401

[1] Includes fixed and mobile beds actually overseas. [2] Estimated strength V–E Day+90.

Source: Memorandum, The Surgeon General, for G–1, 4 Jan. 1945.

DIETITIANS AND PHYSICAL THERAPISTS

Early in 1943, after the dietitians and physical therapists had attained military status, Maj. Emma E. Vogel, WMSC, Superintendent of Physical Therapists (fig. 24), recommended a ratio of 1 physical therapist to 100 beds in Zone of Interior hospitals. She later was forced to lower the ratio when procurement failed to meet it.[41] The number of physical therapists specified in the manning guide for 10 April 1943 [42] reflected this lowered ratio. Seven months later, on 22 November, a further reduction, for the same reason, was put into effect.[43] The November reduction was drastic: for a 500-bed hospital, the number of physical therapists was cut from 4 to 2; for a 700-bed hospital, from 6 to 3; and for a 1,000-bed hospital, from 10 to 5. Dietitians, on the other hand, did not undergo comparable reductions. The guide issued in April 1943 allotted them to Zone of Interior hospitals at a considerably lower rate than physical therapists; for example, the 500-bed hospital was to have 3 dietitians, the 700-bed hospital 4, and the 1,000-bed hospital 5. The November guide, however reduced the allotment in only the larger sized hospitals—those of 2,000- to 3,000-bed capacity—which were to have 1 to 3 fewer dietitians than formerly. The result was that from November 1943 onward the guide for general, station, and eventually regional hospitals provided for the same, or nearly the same, number of physical therapists and dietitians in proportion to a hospital's bed capacity. This proportion was not changed, except for minor reductions in the largest hospitals,[44] during the remainder of the war. The

[41] Vogel, Emma E.: Physical Therapists of the Medical Department, United States Army. [Official record.]

[42] War Department Circular No. 99, 10 Apr. 1943.

[43] See footnotes 36, p. 85, and 41.

[44] War Department Circular No. 209, 26 May 1944.



FIGURE 24.—Maj. Emma E. Vogel, WMSC, Superintendent of Physical Therapists.

new Zone of Interior convalescent hospitals, however, were to have from two to six times as many physical therapists as dietitians, according to the guide issued in June 1945,[45] but the proportion of both was much smaller in relation to bed capacity than that allotted to other Zone of Interior hospitals.

The general and station hospitals for service overseas were provided by their tables of organization with fewer physical therapists and dietitians than were allotted to similar hospitals of like capacity in the Zone of Interior, and in 1943, even these few were reduced. Thus, in November 1943, the number of physical therapists in a 1,000-bed general hospital was cut from 5 to 3; in 750- to 900-bed station hospitals, from 4 to 2; and in 500- to 700-bed station hospitals, from 3 to 1. The numbers and reductions of dietitians were the same as for physical therapists. In July 1944, dietitians in the 1,000-bed general hospitals were reduced from 3 to 2, and 5 months later, physical therapists in 750- to 900-bed station hospitals were reduced from 2 to 1. Evacuation hospitals (750-bed) retained one physical therapist from April 1943 to the end of the war.[46]

[45] War Department Circular No. 170, 8 June 1945.

[46] (1) See footnotes 36, p. 85, and 42, p. 88. (2) T/O 8–550, General Hospital, 3 July 1944, and T/O 8–560, Station Hospital, 28 Oct. 1944.

Requests for authorizations of both physical therapists and dietitians were based mainly on the manning guides and tables of organization, but the authorizations granted by the War Department usually fell below those requested by the Surgeon General's Office. In September 1944, the latter asked for an increase in the ceiling for physical therapists from 1,000 to 1,464 and for dietitians from 1,500 to 2,000. In October, the War Department went no farther than 1,250 for physical therapists and 1,750 for dietitians. Next month, the Surgeon General's Office responded by asking for an increase from 1,250 to 1,700 in the authorization for physical therapists. This was disapproved in December, but at the end of January 1945, the War Department raised the ceiling for physical therapists to 1,500 and for dietitians to 2,000.[47]

A further increase was sought in April 1945. Based chiefly on manning guides and tables of organization, the total requirement for physical therapists was 1,779 and for dietitians, 2,303, made up as follows:[48]

	Dietitians	*Physical therapists*
Zone of Interior general hospitals	597	668
Zone of Interior regional hospitals:		
Army Service Forces	153	124
Army Air Forces	133	90
Zone of Interior station hospitals:		
Army Service Forces	233	121
Army Air Forces	185	19
Zone of Interior convalescent hospitals:		
Army Service Forces	40	101
Army Air Forces	20	20
Instructors	34	24
Surgeon General's Office	4	4
Table-of-organization units	862	557
U.S. Army Military Academy	2	1
Nonavailables:		
In transit and in personnel centers	25	18
Patients and personnel on terminal leave	15	12
Total	2,303	1,779

The Surgeon General requested ceilings a trifle lower than this computation called for; namely, 1,750 for physical therapists and 2,250 for dietitians. Six weeks later (30 May 1945), the War Department raised its total authorization for physical therapists to 1,700 and for dietitians to 2,150.[49] By that time, Germany was out of the war. Moreover, during the following months, recruit-

[47] (1) Letter, Chief, Personnel Service, Office of The Surgeon General, to Assistant Chief of Staff, G–1, War Department, 14 Sept. 1944, subject: Request for an Increase in the Procurement Objective for Dietitians and Physical Therapists, AUS. (2) Letter, The Adjutant General, to Commanding General, Army Service Forces, 30 Oct. 1944, subject: Procurement Objective for Appointment of Nurses, Physical Therapists, and Dietitians in the AUS. (3) Quarterly Report, Physical Therapy Branch, Office of The Surgeon General, U.S. Army, 1 Jan.–31 Mar. 1945. (4) Diary of Personnel Service, Office of The Surgeon General, for week ending 3 Feb. 1945.

[48] Memorandum, The Surgeon General, for Assistant Chief of Staff, G–1, 16 Apr. 1945, subject: Requirements for Dietitians and Physical Therapists.

[49] Letter, The Adjutant General, to Commanding General, Army Service Forces, 30 May 1945, subject: Requirements for Dietitians and Physical Therapists.

ment did not succeed in increasing actual strength above 1,580 for the dietitians and 1,300 for the physical therapists (table 1).

ENLISTED MEN

In 1940, the quota for the enlisted strength of the Medical Department was raised from the 5 percent of total Army strength, established by the National Defense Act of 1920, to 7 percent or more, at the discretion of the War Department, in case of emergency. This quota remained throughout the war. The lowest percentage in the period 1942–43 was 6.8; the highest, 7.5. After August 1944, it never rose above 7 percent; and between October 1944 and August 1945, it fell steadily from 6.9 to 6.1 (table 1).

At the end of December 1944, the Enlisted Branch of the Surgeon General's Office observed that for some time it "had acknowledged that there was sufficient enlisted personnel, such as it was." At this time, total Medical Department enlisted strength was 541,650 (table 1). By the end of March 1945, strength had decreased to 533,044, but the decline was not considered dangerous since it was caused "mainly by the deactivation of a number of T/O units." Two months afterward (31 May 1945), although Medical Department enlisted strength had fallen still further—to 524,332, of which 377,231 was overseas (table 5)—the enlisted personnel situation was described as "the best it has been for some time." [50]

Manning guides and tables of organization provided a basis for estimating the enlisted requirements, as they did in the case of other personnel. Guides for station hospitals in the Zone of Interior were issued in April 1941, December 1942, and May 1944. A comparison between the first and last of these will show the extent to which enlisted personnel were reduced in all except the 1,500- and 2,000-bed units: [51]

	Enlisted requirement	
Table-of-organization bed capacity:	*April 1941*	*May 1944*
250	150	131
300	175	157
350	200	180
400	225	198
450	250	222
500	275	239
600	325	292
700	370	341
750	390	368
800	410	383
900	455	422
1,000	500	458
1,500	700	706
2,000	900	912

[50] Quarterly Reports, Enlisted Personnel Branch, Personnel Service, Office of The Surgeon General, U.S. Army, for periods ending 31 Dec. 1944, and 31 Mar. 1945, and for 2 months ending 31 May 1945.

[51] (1) Mobilization Regulations No. 4–2, Change No. 1, 9 Apr. 1941. (2) See footnote 44, p. 88. (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.

TABLE 5.—*Medical Department enlisted strength, worldwide and overseas, 31 July 1941–30 September 1945*

Date and area	Army enlisted strength		Medical Department enlisted strength				
	Number [1]	Percentage of total Army strength [2]	Number [3]	Percentage of worldwide Medical Department enlisted strength	Rate per 1,000 troops [4]	Percentage of Army enlisted strength	Percentage of total Medical Department strength [5]
31 July 1941:							
Worldwide	1, 422, 158	92. 9	106, 662	100. 0		7. 5	83. 8
Overseas	128, 476	94. 7	4, 301	4. 0	31. 7	3. 3	81. 5
30 Nov. 1941:							
Worldwide	1, 523, 116	92. 6	108, 674	100. 0		7. 1	81. 6
Overseas	154, 938	93. 8	6, 580	6. 1	39. 8	4. 2	82. 3
31 Mar. 1942:							
Worldwide	2, 235, 113	93. 7	169, 627	100. 0		7. 6	84. 3
Overseas	306, 638	93. 5	15, 512	9. 1	47. 3	5. 1	77. 9
30 June 1942:							
Worldwide	2, 867, 762	93. 3	209, 952	100. 0		7. 3	82. 8
Overseas	565, 384	94. 0	35, 252	16. 8	58. 6	6. 2	82. 4
30 Sept. 1942:							
Worldwide	3, 670, 954	92. 4	283, 331	100. 0		7. 7	81. 1
Overseas	768, 165	93. 3	48, 547	17. 1	59. 0	6. 3	82. 5
31 Jan. 1943:							
Worldwide	5, 370, 755	92. 2	417, 307	100. 0		7. 8	83. 9
Overseas	1, 036, 329	92. 5	72, 263	17. 3	69. 7	7. 0	82. 1
30 Apr. 1943:							
Worldwide	6, 147, 248	91. 5	499, 657	100. 0		8. 1	84. 9
Overseas	1, 288, 913	92. 1	92, 446	18. 5	66. 1	7. 2	81. 7
31 July 1943:							
Worldwide	6, 467, 436	90. 7	529, 360	100. 0		8. 2	84. 3
Overseas	1, 634, 890	91. 9	114, 162	21. 6	64. 2	7. 0	81. 8
31 Oct. 1943:							
Worldwide	6, 625, 157	90. 3	507, 611	100. 0		7. 7	82. 5
Overseas	2, 054, 499	91. 7	146, 959	29. 0	65. 6	7. 2	81. 7
31 Jan. 1944:							
Worldwide	6, 792, 871	89. 9	515, 124	100. 0		7. 6	81. 9
Overseas	2, 580, 104	91. 7	196, 696	38. 2	69. 9	7. 6	82. 3
30 Apr. 1944:							
Worldwide	7, 042, 116	89. 7	532, 771	100. 0		6. 8	81. 8
Overseas	3, 251, 857	91. 5	248, 003	46. 5	69. 8	7. 6	82. 5
31 July 1944:							
Worldwide	7, 191, 703	89. 3	558, 828	100. 0		7. 8	82. 2
Overseas	3, 716, 742	90. 8	284, 791	51. 0	69. 9	7. 7	82. 8

See footnotes at end of table.

TABLE 5.—*Medical Department enlisted strength, worldwide and overseas, 31 July 1941–30 September 1945*—Continued

Date and area	Army enlisted strength		Medical Department enlisted strength				
	Number [1]	Percentage of total Army strength [2]	Number [3]	Percentage of worldwide Medical Department enlisted strength	Rate per 1,000 troops [4]	Percentage of Army enlisted strength	Percentage of total Medical Department strength [5]
31 Oct. 1944:							
Worldwide	7, 204, 580	88. 9	562, 796	100. 0		7. 8	81. 9
Overseas	4, 225, 564	91. 2	324, 711	57. 7	70. 0	7. 7	83. 0
31 Jan. 1945:							
Worldwide	7, 139, 700	88. 5	537, 303	100. 0		7. 5	80. 5
Overseas	4, 678, 043	91. 3	357, 567	66. 5	69. 8	7. 6	83. 2
30 Apr. 1945:							
Worldwide	7, 274, 779	88. 2	532, 029	100. 0		7. 3	79. 1
Overseas	4, 974, 051	91. 2	385, 296	72. 4	71. 9	7. 8	83. 1
31 May 1945:							
Worldwide	7, 305, 854	88. 1	524, 332	100. 0		7. 2	78. 6
Overseas	4, 925, 323	91. 1	377, 231	71. 9	69. 8	7. 7	82. 9
30 June 1945:							
Worldwide	7, 283, 930	88. 1	521, 282	100. 0		7. 2	78. 4
Overseas	4, 783, 503	91. 3	367, 844	70. 6	70. 2	7. 7	82. 9
31 July 1945:							
Worldwide	7, 200, 220	87. 9	514, 511	100. 0		7. 1	78. 0
Overseas	4, 491, 271	91. 2	350, 056	68. 0	71. 1	7. 8	83. 0
31 Aug. 1945:							
Worldwide	7, 040, 446	87. 7	493, 209	100. 0		7. 0	77. 3
Overseas	4, 214, 725	91. 2	311, 047	63. 0	67. 3	7. 4	82. 5
30 Sept. 1945:							
Worldwide	6, 598, 986	87. 2	454, 989	100. 0		7. 9	76. 0
Overseas	3, 788, 062	91. 1	273, 049	60. 0	65. 7	7. 2	82. 4

[1] Male personnel only. All data are from "Monthly Strength of the Army, Continental United States," and "Monthly Strength of the Army, Foreign and En Route," *in* "Strength of the Army," 1 Oct. 1945, pp. 58–59, with the following exceptions: Oversea data for 31 March 1942 are from sources of corresponding data listed in table 31, footnote 2 (see the cited footnote for the reasons for the substitution); worldwide data for 31 March 1942 are oversea strength as shown here plus male enlisted strength for the same date reported in "Monthly Strength of the Army, Continental United States," cited above; data for 31 July 1944 are from "Strength of the Army" for the same date and exclude personnel unaccounted for by commands (such personnel are included in the male enlisted strength for oversea areas (3,734,062) reported in "Monthly Strength of the Army, Foreign and En Route," cited above, but are excluded from this table since the number of medical personnel among them is unknown).

[2] For total Army strength, see table 31.

[3] Worldwide strength for July and November 1941 from "Strength of the Army" for corresponding dates; for other dates, from table 1 (SGO data). Oversea strength from sources shown in table 31, footnote 3, for period prior to September 1942 and for April 1944 in part, from "Strength of the Army" in all other instances.

[4] For troop strength, see table 31; for worldwide rates, see table 1 (SGO data).

[5] For total Medical Department strength, see table 31.

TABLE 6.—*Guide for utilization of personnel in named general hospitals, Zone of Interior*

Number of authorized beds	Officers																Enlisted men	Total personnel	Total personnel per 100 beds
	Medical Corps	Dental Corps	Medical Administrative Corps	Sanitary Corps	Veterinary Corps	Army Nurse Corps	Hospital dietitians	Physical therapists	Quartermaster Corps	Corps of Engineers	Signal Corps	Finance Department	Chaplain Corps	Corps of Military Police	Warrant officers	Total			
1,000	35	7	24	4	1	67	6	5	1	1	1	1	2	2	3	160	558	718	71.80
1,500	46	8	30	4	1	100	7	6	2	1	1	1	3	2	5	217	838	1,055	70.33
1,750	50	9	33	5	1	117	7	6	2	2	1	2	4	3	5	247	965	1,212	69.25
2,000	55	12	36	5	1	133	8	7	2	2	1	2	4	3	6	277	1,096	1,373	68.65
2,500	60	14	39	5	2	167	9	8	2	2	1	2	4	3	6	324	1,383	1,707	68.28
3,000	64	16	44	6	2	200	10	9	3	2	2	3	5	4	7	377	1,653	2,030	67.66
3,500	70	19	47	7	2	233	12	10	3	3	2	3	5	4	7	427	1,952	2,379	67.97
4,000	80	21	53	9	2	267	14	12	5	4	2	3	7	5	9	493	2,291	2,784	69.60

Source: War Department Circular No. 209, 26 May 1944. Substitution of civilians for enlisted men on a three-for-two basis was permitted. This obtained until War Department Circular No. 87, 19 Mar. 1945, required that substitution be made only on a one-for-one basis.

As for the Zone of Interior general hospitals, The Surgeon General in 1942 instructed them to use the table of organization for oversea general hospitals as their guide. This table provided for 500 enlisted men in a 1,000-bed hospital. A guide specifically for Zone of Interior general hospitals was issued at the end of 1942 and a new one in May 1944. The latter allotted from 558 enlisted men for a 1,000-bed hospital to 2,291 for a 4,000-bed hospital (table 6). The new guides for both general and station hospitals permitted the replacement of enlisted men "by similarly qualified civilians generally on a three-civilian for two-enlisted-men basis" because of the disparity in working hours. The guide for Zone of Interior convalescent hospitals, issued in June 1945, also permitted the replacement of enlisted men by civilians, but made no reference to ratios. It allotted from 200 enlisted men for the 500-bed hospital to 1,400 for the 6,000-bed hospital (table 7). It will be noted that in these guides the ratio of enlisted men to bed capacity was much lower in convalescent hospitals than in station hospitals, and lower in the latter than in general hospitals.

Successive tables of organization for oversea units, like the manning guides for Zone of Interior installations, showed reductions in the number of enlisted men during the war period, as is illustrated in the tables for various types of hospitals and for the medical detachment of the infantry regiment (tables 8 and 9).

The total requirement for personnel in table-of-organization units of all types appeared in the troop basis issued from time to time by the War Department. An analysis of the troop basis for 1 October 1944, prepared by the Surgeon General's Office, showed the distribution of Medical Department personnel among table-of-organization units of the ground, air, and service forces at the actual strength on 30 September 1944 and at the strength planned on 1 October 1944 for 31 December 1944 and 30 June 1945. The distribution

TABLE 7.—*Guide for utilization of personnel in convalescent hospitals, Zone of Interior*

Number of authorized beds	Officers									Enlisted men	Total personnel	Total personnel per 100 beds
	Medical Corps	Dental Corps	Medical Administrative Corps	Sanitary Corps	Hospital dietitians	Physical therapists	Chaplain Corps	Warrant officers	Total			
500	13	3	30	1	1	2	1	1	52	200	252	50.4
1,000	20	5	50	1	1	4	1	1	83	323	406	40.6
1,500	24	6	60	1	1	5	2	1	100	428	528	35.2
2,000	28	8	68	1	1	6	2	1	115	529	644	32.2
2,500	34	10	80	1	2	7	3	1	138	649	787	31.5
3,000	40	12	91	1	2	7	3	2	158	768	926	30.9
4,000	50	16	109	1	2	8	3	2	191	958	1,149	28.7
5,000	63	20	130	1	3	10	4	3	234	1,203	1,437	28.7
6,000	74	24	146	1	3	12	4	3	267	1,400	1,667	27.8

TABLE 8.—*Table-of-organization changes in certain types of hospitals, 1940–44*

Type of hospital and authority	Officers											Total enlisted men	Aggregate
	Medical Corps	Medical Administrative Corps	Dental Corps	Sanitary Corps	Chaplain Corps	Quartermaster Corps	Warrant officers	Army Nurse Corps	Hospital dietitians	Physical therapists	Total		
General (1,000-bed):													
T/O 683, 6 July 1932	30	6	4		1	1		120			162	400	562
T/O 8–507, 25 July 1940	55	6	7	1	2	2		120			193	500	693
T/O 8–550, 1 Apr. 1942	38	7	5	2	2	2	1	105			162	500	662
T/O 8–550 (Ch 2), 5 Oct. 1942	37	8	5	2	2	2	1	105			162	500	662
WD Cir. 306, 22 Nov. 1943	37	8	5	2	2	2	1	100	3	3	163	500	663
T/O 8–550 (Ch 3), 4 Mar. 1944	37	8	5	2	2	2	1	83	3	3	146	500	646
T/O 8–550, 3 July 1944	32	[1] 10	6	2	3		1	83	3	2	142	450	[2] 594
Station (250-bed):													
T/O 684–W, 1 July 1929	11	2	2					35			50	150	200
T/O 8–508, 25 July 1940	15	3	2					30			50	150	200
T/O 8–560, 22 July 1942	13	5	2		1			30			51	150	201
WD Cir. 306, 22 Nov. 1943	13	5	2		1			25			46	150	196
T/O 8–560 (Ch 3), 4 Mar. 1944	13	5	2		1			21			42	150	192
T/O 8–560, 28 Oct. 1944	10	5	2		1			21			39	138	[2] 179
Station (500-bed):													
T/O 8–508, 25 July 1940	23	8	4					60			95	275	370
T/O 8–560, 22 July 1942	19	8	3	1	2		1	55			89	275	364
WD Cir. 306, 22 Nov. 1943	19	8	3	1	2		1	50	1	1	86	275	361
T/O 8–560 (Ch 3), 4 Mar. 1944	19	8	3	1	2		1	42	1	1	78	275	353
WD Cir. 99,[3] 9 Mar. 1944	16	11	3	1	2		1	42	1	1	78	275	353
T/O 8–560, 28 Oct. 1944	16	[4] 11	3	1	1		1	42	1	1	77	253	330

Station (750-bed):													
T/O 8–508, 25 July 1940	37	8	4					90			139	390	529
T/O 8–560, 22 July 1942	24	9	4	1	2		1	75			116	392	508
WD Cir. 306, 22 Nov. 1943	24	9	4	1	2		1	75	2	2	120	392	512
T/O 8–560 (Ch 3), 4 Mar. 1944	24	9	4	1	2		1	63	2	2	108	392	500
WD Cir. 99,[3] 9 Mar. 1944	21	12	4	1	2		1	63	2	2	108	392	500
T/O 8–560, 28 Oct. 1944	20	[4] 12	4	1	2		1	63	2	1	106	351	457
Evacuation (750-bed):													
T/O 283–W, 1 July 1929	32	4	2		1	1		60			100	300	400
T/O 8–232, 1 Oct. 1940	37	5	3		1	1		52			99	318	417
T/O 8–580, 2 July 1942	34	8	3		1	1		52			99	318	417
T/O 8–580, 23 Apr. 1943	37	5	3		2		1	52	1		101	308	409
WD Cir. 306, 22 Nov. 1943	37	5	3		2		1	53	1		102	308	410
T/O 8–580, 31 Jan. 1945	37	5	3		2		1	53	1		102	303	405
Evacuation (400-bed):													
T/O 8–581, 2 July 1942	29	7	2		1		1	48			88	248	336
T/O 8–581, 26 July 1943	29	6	2		1		1	40			79	217	296
T/O 8–581, 25 Mar. 1944	28	7	2		1		1	40			79	217	296

[1] Five of these might be members of the Pharmacy Corps. Since none of the tables of organization or circulars cited in the table stipulated that a Pharmacy Corps officer had necessarily to be placed in any of these hospitals, no column has been shown for them. See also footnote 4.

[2] Includes one engineer officer and one officer, branch immaterial.

[3] In order to conserve Medical Corps officers, this circular stated that "executive officers and registrars of numbered or fixed general or station hospitals should preferably be Medical Administrative Corps officers commissioned because of prior training or experience as civilian hospital administrators or Medical Department noncommissioned officers." War Department Circular No. 152, 17 April 1944, allowed officers of other corps than the Medical Administrative Corps to be substituted in these jobs, stating that executive officers "of all numbered or fixed station hospitals and registrars of all numbered or fixed general or station hospitals" should preferably be either Medical Administrative Corps, Pharmacy Corps, or Sanitary Corps officers, "commissioned because of prior training or experience as civilian hospital administrators or Medical Department noncommissioned officers." Permission to use other than Medical Corps officers as executive officers of general hospitals was later withdrawn (War Department Circular No. 327, 8 Aug. 1944).

[4] These officers might be in the Pharmacy Corps.

of Medical Department enlisted personnel presented in this analysis was as follows:[52]

	Actual strength, 30 Sept. 1944	*Planned strength, for 31 Dec. 1944 and 30 June 1945*
Army Ground Forces:		
Combat and communications zones	166,935	164,664
Zone of Interior	807	943
Total	167,742	165,607
Army Air Forces:		
Combat and communications zones	24,709	25,011
Zone of Interior	117	193
Total	24,826	25,204
Army Service Forces:		
Combat and communications zones	180,250	217,904
Zone of Interior	1,656	816
Total	181,906	218,720
Grand total	374,474	409,531

TABLE 9.—*Table-of-organization changes in the medical detachment of the infantry regiment (T/O 7–11), 1938–45*

Date	War strength of regiment	Medical Corps	Dental Corps	Medical Administrative Corps	Enlisted men in medical detachment
6 Dec. 1938	2,542	8	2		96
1 Mar. 1940	2,776	8	2		96
1 Oct. 1940	3,449	8	2		96
1 Apr. 1942	3,472	8	2		126
1 Mar. 1943	3,088	7	2		103
26 Feb. 1944	3,257	7	2		126
30 June 1944	3,207	5	2	3	126
1 June 1945	3,697	5	2	3	126
5 Sept. 1945	3,697	5	2	3	136

[52] Letter, Military Personnel Planning and Placement Branch, Military Personnel Division, Office of The Surgeon General (Lt. Col. Fred J. Fielding), to Director, Military Personnel Division, Office of The Surgeon General, 1 Dec. 1944, subject: War Department Troop Basis as of 1 October 1944.

ENLISTED WOMEN

The establishment of a requirement for enlisted women—members of the Women's Army Corps (usually called Wacs) [53]—evolved during the course of 1942. The Surgeon General rejected the idea of adding them to the hospital complements when it was first broached in the spring of 1942. His objection to taking them was that it would interfere with the employment of civilians and the training of enlisted men and would cause difficulties in the way of housing and recreation. His opinion changed as a result of pressure from various sources before the end of 1942—the insistence of the General Staff and Services of Supply headquarters that all services should make use of Wacs in order to release more men for combat duty, the recommendations of the Committee to Study the Medical Department that Wacs could supplement the supply of nurses, the difficulty of enlarging or even maintaining the civilian staffs, and the trend of thought in his own Office and among hospital commanders. Accordingly, after proposing a test at two hospitals, which could not be carried out because WAC personnel were not available, he appointed a board in January 1943 to consider the matter and asked for reports from the service commands, the Air Forces, the Transportation Corps, the Military District of Washington, and the Army Medical Center on the possibilities involved. While not all hospital commanders were favorable to the use of Wacs, Services of Supply hospitals of 600 beds or more estimated that Wacs could replace from 30 to 50 percent of their enlisted men; the Air Forces planned to make use of Wacs in hospitals having a capacity of as few as 200 beds. On this basis, The Surgeon General's board calculated that more than 10,000 Wacs would be needed in the hospitals. The Surgeon General sent the service commands tabulations of WAC personnel for hospitals to be used in making up anticipated requisitions. Before the matter could be carried further, a falling off in WAC recruitment caused WAC headquarters to notify The Surgeon General in June 1943 that he could expect only 150 to 175 women a month for training, beginning in September. The use of large numbers of Wacs in hospitals therefore had to be postponed.

Late in 1943, when medical installations were requisitioning these women, the Deputy Surgeon General wrote that the Medical Department could employ all of them who could be made available, "in fact," he declared, "the entire WAC organization could be utilized in order to release male military operating personnel." [54] Several campaigns to recruit members of the Women's Army Corps for employment as Medical Department technicians (fig. 25) ensued during 1944 and 1945, one setting its quota as high as 7,000. This quota was met.

---

[53] For convenience, the later title of this organization will be used here. Its earlier title (until 1 July 1943) was "Women's Auxiliary Army Corps."

[54] Memorandum, General Lull, for Commanding General, Army Service Forces, 27 Dec. 1943, subject: Reduction of Military Operating Personnel, Army Service Forces.



FIGURE 25.—Members of the Women's Army Corps learning from Army nurse how to change surgical dressing.

CIVILIANS

No formula was established for computing the total number of civilians required for Army medical service in the Zone of Interior until the establishment of bulk authorizations in June 1943.[55] Before then, the number of civilians who could be employed was unrestricted except through the allotment of funds. Under the new system, the permitted number varied inversely with the number of military personnel authorized.

Large numbers of civilians were used throughout the war as substitutes for military personnel in many kinds of work. The process of substitution was intensified during the later war years when the Medical Department had to move large numbers of officers and enlisted men out of its installations in the United States for service overseas. As the number of enlisted men remaining was more than ever inadequate to meet all demands, Medical Department authorities could hardly repeat their earlier protests against the free substitution of civilians in their installations with any prospect of being heeded. At one time (May 1944), the General Staff permitted the substitution of civilians in hospitals for enlisted personnel on a three-for-two basis (taking account of the civilians' work day of only 8 hours as against that of 12 for enlisted personnel); in 1945, however, the General Staff ordered that substitutions be

[55] This section deals only with developments in the Zone of Interior. Of necessity, there was no requirement for civilians in oversea theaters. They were used if they were available but could not be counted on in advance. Oversea use of civilians is therefore treated under "Procurement" in chapter VIII.



FIGURE 26.—Nurses' aides, Camp Fannin, Tex.

made on a one-for-one basis.[56] This one-for-one rule handicapped commanders of hospitals and other installations which operated for more than 8 hours a day.

Civilians employed in Medical Department installations represented all grades of skill, from the janitor who kept the floors of a hospital tidy to the highly specialized medical or surgical consultant. Technical positions, including those of dental hygienists and laboratory technicians, were more difficult to fill than those demanding less skill. As male help became scarcer, large numbers of women were employed. For example, in 1943, when many enlisted men were withdrawn from installations for shipment overseas, the commander of Percy Jones General Hospital, Mich., reported that he had elicited the help of the families of military personnel.[57]

In the nursing field, Army nurses were supplemented by civilian nurses' aides (fig. 26), both paid and volunteer; by cadet nurses, who were students receiving part of their training in Government hospitals, in the course of which they rendered nursing service and on graduation accepted employment as full-fledged nurses in one branch or another of the Federal hospital system; and finally, graduate nurses who for one reason or another could not meet the qualifications of the Army Nurse Corps but who could meet the qualifications of the Civil Service Commission.[58]

[56] (1) See footnote 55, p. 100. (2) War Department Circular No. 87, 19 Mar. 1945.
[57] Annual Report, Percy Jones General Hospital, 1942.
[58] See footnote 34, p. 84.

Occupational therapists also were employed as civilians throughout the war by the Medical Department.

The Army Specialist Corps, as already mentioned, during 1942 furnished a limited number, possibly about a hundred, of administrative, professional, scientific, and technical specialists. In late 1942, the Secretary of War decided that it was not feasible to have two uniformed services and abolished the corps, permitting its members to the extent practicable to apply for commissions in the Army of the United States.[59]

Although some difficulties and complaints arose concerning the use and performance of civilian employees in the Medical Department, certainly thousands of intelligent, hard-working, and responsible civilian employees were to be found in its establishments. It is even more obvious that whatever drawbacks the use of civilians involved, the Medical Department would have been quite unable to carry its load without their assistance.

While Red Cross workers in Army hospitals were not regarded as making up deficiencies in the supply of military personnel, at least not in the same sense as were civilians hired for that purpose, they performed a variety of services in connection with the care of patients, for which they received no pay from the Government. The Medical Department had reason to be grateful for the contributions these workers made to the well-being of its patients.

ADDITIONAL UNIT REQUIREMENTS OVERSEAS

Additional requirements overseas[60] were based on four factors: (1) Losses, both physical or administrative; (2) additions to non-table-of-organization personnel; (3) reorganizations of table-of-organization units; and (4) shortages.

Losses

An individual was officially recognized as a physical "loss" to his unit when the unit was notified of his death, capture, internment in a neutral country, absence without leave for an appreciable period, or hospitalization. The unit could then request a replacement. The question as to whether a hospitalized soldier should remain on the rolls of his unit was resolved in the light of the amount of time it was believed that the unit could operate efficiently without the services appropriate to his position. A difference necessarily existed between units functioning in forward areas and those operating in the rear. Under combat conditions, a unit could not afford to wait any appreciable period for the return of an individual, and its right to replace him arose simultane-

[59] Memorandum, Secretary of War, for Director, Army Specialist Corps, 31 Oct. 1942, subject: Disposition of the Army Specialist Corps.

[60] Unless otherwise indicated, this section is based on (1) Annual Reports, Surgeon, European Theater of Operations, U.S. Army, 1943 and 1944, and (2) Administrative and Logistical History of Medical Service, Communications Zone, European Theater of Operations, U.S. Army, chs. IV and X. [Official record.]

ously with his hospitalization.[61] In July 1944, this situation was given official recognition when the War Department in effect directed that troops in combat areas officially designated by the theater commander be dropped from the rolls of their units immediately upon hospitalization. For most personnel whose hospitalization originated in locations not designated as combat areas, the assignment to the original unit was to be severed only after completion of 60 days' total hospitalization.[62]

Administrative losses occurred when table-of-organization positions were vacated by the transfer of individuals to other assignments within the unit or in other units or when they were separated from the military service altogether for reasons wholly within the control of the Army. From the middle of 1943 on, rotation was still another cause. Even if the vacancy were filled by reassignment or promotion, another vacancy was thus created.

Non-Table-of-Organization Allotments

The War Department recognized the need for oversea personnel beyond that shipped in units from the Zone of Interior and therefore established a "non T/O allotment" for each theater. In the European theater, the amount of personnel authorized for the medical service out of the non-table-of-organization allotment during 1943 and 1944 was as follows:

1 April 1943:	
Total	1,143
Officers (including warrant officers)	281
Enlisted	862
1 September 1943:	
Total	1,275
Officers (including warrant officers)	390
Enlisted	885
1 April 1944:	
Total	1,710
Officers (including warrant officers)	362
Enlisted	1,348
6 September 1944:[1]	
Total	1,403
Officers (including warrant officers)	416
Enlisted	987

[1] This date is only approximate, the authorization being fixed about the time Headquarters, European Theater of Operations, U.S. Army, was established in Paris.

In relation to theater medical strength, the authorization for 1 April 1943 amounted to 10.86 percent; that for 1 September 1943, to 6.05 percent; 1 April 1944, to 1.54 percent; and 6 September 1944, 0.83 percent. During 1944, the

[61] In the European theater, units engaged in combat were authorized in November 1944 to include in their daily replacement requisitions a statement of anticipated losses for a period of 48 hours after the requisition was made as a basis for provision of replacements.

[62] War Department Circular No. 280, 6 July 1944.

number of Medical Department personnel actually assigned to non-table-of-organization establishments, including, besides the offices of the Theater Chief Surgeon and base section surgeons, two central dental laboratories, the supply depots, and other installations, declined from about 4 percent of the total number of medical personnel in the theater to less than 1 percent.

Additional and Reorganized Table-of-Organization Units

In some cases, the Zone of Interior failed to provide the oversea theaters with a sufficient number of table-of-organization units to meet the requirements. It was therefore necessary to set up such units locally and to provide them with personnel. In the early part of 1945, for example, the War Department authorized the European theater to activate 11 medical teams, each with a strength of 10 men; 34 mess teams, each with 4 men; 23 dental prosthetic teams, each with a similar strength; and 2 optical repair teams which required an aggregate of 9 men.[63] The establishment of newly activated table-of-organization units in the Southwest Pacific Area in late 1944 was one of the factors which created a large number of vacancies for dental officers in that region.[64]

An increase in the authorized size of a unit after it had arrived in a theater of operations also made it necessary for authorities within the theater to provide it with additional personnel. In 1943, several small station and general hospitals arriving in the United Kingdom were rerated as larger units. This required additional personnel. Additional personnel also were required in certain units in the North African theater through augmentation in size of all 1,000-bed general hospitals by 50 to 100 percent.[65] For example, the 6th General Hospital, by an increase of its authorized bed capacity from 1,000 to 1,500 beds in mid-1944, witnessed an expansion of its authorized enlisted strength from 500 to 562 men.[66] When patients in excess of the table-of-organization bed capacity of certain hospitals in the Seine Section were hospitalized in these installations during January–March 1945, augmentation of the nursing personnel became necessary wherever this took place. Revisions of tables of organization that established additional authorizations for personnel, such as dental and medical administrative officers, likewise compelled theater medical authorities to look for the personnel with which to fill these slots. As one example, the revision of Table of Organization 8–560 on 28 October 1944 created 326 new medical administrative officer posts in oversea station hospitals.

---

[63] For the table-of-organization strength of the units mentioned see "Medical Department Service Organization." T/O&E 8–500, 23 Apr. 1944.

[64] Essential Technical Medical Data, U.S. Army Forces, Far East, for December 1944, dated 15 Feb. 1945.

[65] Logistical History of North African-Mediterranean Theater of Operations, U.S. Army, pp. 291–294. [Official record.]

[66] Historical Report, 6th General Hospital, Mediterranean Theater of Operations, 22 Oct. 1944. [Official record.]

Shortages

Another factor which created a need for personnel to fill vacancies overseas was the practice dating from the spring of 1944 of sending table-of-organization units abroad short of their full complements of medical personnel. In the latter part of that year, many general hospitals were sent to the European theater with only 16 Medical Corps officers in each; field units likewise were dispatched without their full complement of such officers. One justification for this procedure was that by this time the theater already boasted an ample supply of specialist personnel who could be assigned to these understaffed units, but there continued to be shortages outside the specialties. During June and July 1944, the European theater received 12 general hospitals, each of 1,000-bed capacity, without their nurse complements (table 10).

TABLE 10.—*Medical Department overstrengths and understrengths in various oversea theaters or areas, 30 November 1943*

Theater or area	Authorized strength [1]	Overstrength		Understrength	
		Number [2]	Percent	Number [2]	Percent
	Medical Corps				
Europe	3,812	2	0.05	0	0
North Africa	3,434	102	2.97	0	0
China-Burma-India	671	0	0	0	0
Central Pacific	740	70	9.46	0	0
South Pacific	1,131	0	0	157	13.88
	Dental Corps				
Europe	729	0	0	0	0
North Africa	650	11	1.69	0	0
China-Burma-India	106	0	0	0	0
Central Pacific	195	0	0	26	13.33
South Pacific	207	0	0	21	10.14
	Veterinary Corps				
Europe	51	0	0	0	0
North Africa	30	7	23.33	0	0
China-Burma-India	85	0	0	0	0
Central Pacific	22	2	9.09	0	0
South Pacific	19	0	0	1	5.26

See footnotes at end of table.

TABLE 19.—*Medical Department overstrengths and understrengths in various oversea theaters or areas, 30 November 1943*—Continued

Theater or area	Authorized strength [1]	Overstrength		Understrength	
		Number [2]	Percent	Number [2]	Percent
	Sanitary Corps				
Europe	91	0	0	0	0
North Africa	118	2	1. 69	0	0
China-Burma-India	20	0	0	0	0
Central Pacific	17	0	0	0	0
South Pacific	61	0	0	19	31. 15
	Medical Administrative Corps				
Europe	835	0	0	0	0
North Africa	786	33	4. 20	0	0
China-Burma-India	125	0	0	0	0
Central Pacific	201	0	0	29	14. 43
South Pacific	239	0	0	56	23. 43
	Army Nurse Corps				
Europe	4, 142	0	0	0	0
North Africa	4, 120	5	. 12	0	0
China-Burma-India	633	0	0	0	0
Central Pacific	1, 054	0	0	157	14. 90
South Pacific	1, 117	0	0	290	25. 96
	Enlisted men				
Europe	41, 972	439	1. 05	0	0
North Africa	39, 349	924	2. 35	0	0
China-Burma-India	6, 200	3	. 05	0	0
Central Pacific	14, 056	0	0	1, 521	10. 82
South Pacific	13, 593	0	0	1, 105	8. 15

[1] The exact authorized strength used in determining overstrength or understrength is unknown. For the purposes of this table, it is assumed that the authorized strength is the actual strength on 30 November 1943 as reported in "Strength of the Army" for that date minus the overstrength or plus the understrength.

[2] Memorandum, Acting Adjutant General, for Assistant Chief of Staff, G-3, subject: Monthly Reports of Replacements Available in Overseas Theaters, 27 Dec. 1943. (Overstrengths appear to be strength above T/O strength and non-T/O allotments plus permanent overstrength as authorized by the War Department.)

In some instances, the overall strength was up to the table-of-organization requirement, but the personnel were not professionally suitable. For example, the 5th Auxiliary Surgical Group, after repeated depletions of its well-qualified professional personnel in order to fill other units, was finally shipped to the European theater in the summer of 1944 with whatever medical officers were available, regardless of their suitability to the organization's functions.[67]

During 1944, the European theater was almost consistently below authorized strength in Medical Corps officers. Even on D-day, there was a shortage of 35 Medical Corps officers in the theater. A persistent shortage of Dental Corps officers existed during the same year, which was aggravated by increases in table-of-organization authorizations; in November, the shortage amounted to 238. With regard to nurses, the situation was similar to that pertaining to Medical Corps officers. Consistent shortages began to appear in April and continued into June. From the end of July, the shortages reappeared and steadily increased so that by the end of the year the theater lacked 345 of its proper table-of-organization strength in nurses. Until October, there was a critical shortage of physical therapy aides. A severe shortage of dietitians also existed throughout the year. From November, there was a steady increase in the deficit in enlisted men, particularly in ground force units. Because of the losses occasioned by the Battle of the Bulge, a shortage of approximately 500 medical enlisted men appeared in each of the four field armies engaged in the theater.

The shortages persisted to the end of the war. In mid-March 1945, the medical service of the communications zone of the European theater was reported to be at 94.1 percent of its table-of-organization strength. In this respect, it was worse off than every other service except the Signal Corps. For all arms and services, the corresponding figure was 96.2 percent. As regards Medical Department officers, the shortage in table-of-organization strength was 9.9 percent and in this category of personnel, too, only the Signal Corps was at a greater disadvantage. The shortage of Army officers as a whole was 7.7 percent.

In other theaters, there were similar shortages in 1944. For example, as of 31 December 1944, the Southwest Pacific Area needed approximately 124 officers to reach the dental strength required under tables of organization.[68] With regard to nurses, the shortage was in excess of 1,300.[69]

As of 31 May 1945, the Eighth U.S. Army, operating in the Pacific, had shortages of medical officers and nurses which were, respectively, in excess of 10 and 25 percent of authorized strengths (table 11). In July 1945, the shortage of medical officers in the entire Pacific was at least 300.[70]

---

[67] Annual Report, 5th Auxiliary Surgical Group, 1944, pp. 98, 144–145.

[68] See footnote 64, p. 104.

[69] Annual Report, Surgeon, U.S. Army Services of Supply, Southwest Pacific Area, 1944, p. 47.

[70] Memorandum, Eli Ginzberg, Director, Resources Analysis Division, Office of The Surgeon General, for Lieutenant Colonel Lueth, 26 July 1945, subject: Notes on 10 July Conference With AFPAC.

TABLE 11.—*Authorized and actual strengths of medical personnel, Eighth U.S. Army, 31 May 1945*

Group	Strength		Percent short
	Authorized	Actual	
Medical Corps	786	703	10. 6
Medical Administrative Corps	354	330	6. 8
Veterinary Corps	3	4	0
Dental Corps	172	160	7. 0
Sanitary Corps	41	42	0
Army Nurse Corps	372	278	25. 3
Enlisted men	11, 973	11, 148	6. 9

Source: Quarterly Report, Surgeon, Eighth U.S. Army, 1945 (2d quarter), p. 2.

In the Middle Pacific Area, although there was no shortage of Medical Corps officers in July 1945, there were inadequate numbers of medical and surgical specialists. After V–E Day, certain units designed for the European theater had been diverted to the Pacific and arrived in that area short of such specialists.[71]

In the period 7 December 1941–31 August 1945, Medical Corps officers in the Central Pacific attained their authorized strength only during the month of January 1945.[72] In late 1943, reports to the War Department indicated that in terms of table-of-organization and table-of-allotment strength plus authorized overhead there was a surplus in the North African theater among all, or virtually all, Medical Department elements. At that time, there were also some surpluses in the European theater and the Central Pacific. The Central Pacific, however, had substantial shortages in dental and medical administrative officers as well as in enlisted men, the shortages apparently being greater than 10 percent of the authorized strength in each case. The situation was even worse in the South Pacific, every element reported being understrength. In some elements, the understrength was over 25 percent.

Both line officers and Medical Department authorities were sometimes extremely reluctant to use nurses in forward areas, particularly during the earlier phases of combat operations. Units sometimes were given additional enlisted personnel instead of nurses.[73] In at least one case, after a unit had been transferred from Alaska to Europe, it was considered necessary or advisable to replace the extra enlisted technicians by nurses.[74]

[71] Col. Fred J. Fielding, formerly of the Military Personnel Division, Office of The Surgeon General, minimizes the extent to which units arrived in the Pacific short of specialists. Commenting on the statement in the text, he remarks (Letter to Col. J. B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 12 Dec. 1955): "This was not the policy, however, and only one or two units were diverted while on high seas or before landing in ETO. Units from ETO were reorganized with balanced staff and shipped to Pacific after V–E Day."

[72] Whitehill, Buell: Administrative History of Medical Activities in the Middle Pacific, 1946, p. 12. [Official record.]

[73] This was authorized for certain evacuation hospitals by T/O&E 8–581 (25 Mar. 1944).

[74] Annual Report, 28th Field Hospital, European Theater of Operations, U.S. Army, 1944, p. 11.

Shortages of enlisted specialists also existed although it is difficult to assess their prevalence. For example, the 3d General Hospital, through the operation of the 38-year draft limitation, lost 140 enlisted men in the 2 months before its departure for the North African theater on 12 May 1943. This created a shortage which was manifested overseas primarily in the clerical field since the unit had not obtained adequately trained replacements before leaving the United States.[75]

[75] Annual Report, 3d General Hospital, 1944.

CHAPTER V

Procurement During the Emergency Period

During the period 1939–41, the problems of procurement were apparently of greater moment to The Surgeon General than those of requirements. Especially difficult was the procurement of Medical Corps officers although in no category of Medical Department personnel was the supply always equal to the demand. Shortages varied, of course, and according to Lt. Col. Paul A. Paden, MC, a former chief of The Surgeon General's Personnel Division: "Army-wide shortages were never so acute as local shortages." [1]

PREEMERGENCY PROCEDURES

The National Defense Act of 1920 stated that the Army of the United States should consist of the Regular Army, the National Guard, and the Organized Reserves. Thus, there were three means of entering the medical service of the Army:

1. Regular Army.—Individuals interested in securing an appointment in the Regular Army could apply to The Adjutant General. Applicants having the necessary educational qualifications had to pass a competitive examination prepared by The Surgeon General and conducted by an examining board which also considered the candidate's physical condition, moral character, and general fitness.[2] The board's report went to the Central Medical Department Examining Board for review and the necessary grading of papers. If the candidate was found qualified by this board and was recommended by The Surgeon General, and if the recommendation was approved by the Secretary of War, he was appointed to the appropriate Medical Department corps as a Regular Army officer.[3]

2. Officers' Aeserve Corps.—Persons interested in obtaining Reserve commissions applied to the corps area commander. The latter, acting on the recommendation of a board which examined the candidates' qualifications (educational and otherwise), transmitted the names of successful applicants

[1] Letter, Lt. Col. Paul A. Paden, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 10 Dec. 1955.

[2] Beginning at least as early as 1921, the competitive examination was dispensed with in the case of medical and dental interns who had completed a year's internship in an Army hospital, and who were found qualified by a board of officers, and were recommended by the commanding officer of the hospital wherein their internship was served. Examinations for such interns were apparently in effect, however, from August 1939 to November 1941. (AR 605–10, 24 Feb. 1921; AR 605–20, 16 Aug. 1939 and C 1, 14 Nov. 1941.)

[3] Army Regulations No. 605–20, 16 Aug. 1939.

663076°—63——10

to The Adjutant General for issuance of letters of appointment to the appropriate Medical Department Reserve Corps.[4]

3. National Guard.—Any officer of a State National Guard Unit might be commissioned in the National Guard of the United States upon passing "such tests as to his physical, moral, and professional fitness as the President may prescribe." [5] Most State National Guard officers obtained such commissions.[6] In peacetime, this made them eligible for active duty with the Guard at the order of the State Governor, and in time of national emergency declared by Congress, it enabled the President to call them into the active service of the United States. Enlisted men of the National Guard also might hold commissions in the National Guard of the United States, which would give them officer status whenever the latter was called into active service.

EARLY RESERVE MEASURES

The Situation at the Beginning of the Emergency

The most important function of the procurement system during the early emergency period—at least from the standpoint of the Medical Department—was to provide additional officers and nurses, by way of the Reserves, for the medical service of the active forces. These forces were constantly expanding, and their needs were immediate. On 30 June 1939, the Nurse Corps and all officer corps except the Veterinary Corps were below their authorized active-duty strength, and authorizations of medical, dental, and veterinary officers, as well as nurses, increased considerably during the following year. The National Guard and the Regular Army could not furnish the additional strength that would be needed under conditions of rapid expansion. The National Guard was called in August 1940, but Congress did not authorize officer appointment to the Regular Army in sufficient numbers to correspond with the 1939–40 increases in enlisted strength. Even the small Regular Army additions which Congress permitted were not realized in full. Thus, at the end of June 1940, there were 46 vacancies in the Regular Army Medical Corps, 11 in the Dental Corps, and 10 in the Medical Administrative Corps; only the Veterinary Corps had filled its quota.[7] The backlog of reservists, however, looked more than adequate on paper. On 30 June 1939, the Reserves of three of the five officer corps were above their procurement objectives (table 12), while Reserve nurses registered with the Red Cross were many times the number of the nurses on active duty with the Army.[8] Changes in the Officers' Reserve Corps as of June 1940 and June 1941 are shown in table 13. Comparable figures for the National Guard are in table 14.

---

[4] Army Regulations No. 140–33, 30 July 1936.

[5] 48 Stat. 53.

[6] Annual Report of the Chief, National Guard Bureau, 1940, p. 9.

[7] Annual Report of The Surgeon General, U.S. Army, Washington: U.S. Government Printing Office, 1940, p. 162.

[8] The active duty strength was 672; the Red Cross Reserve amounted to 15,761.

TABLE 12.—*Active-duty strength of Medical Department groups, by Army components, 30 June 1939–30 November 1941* [1]

Component	30 June 1939	30 June 1940	30 June 1941	30 November 1941 [2]
Regular Army: [3]				
Medical Corps	1,094	1,160	1,206	1,271
Dental Corps	220	252	266	270
Veterinary Corps	126	126	126	126
Medical Administrative Corps	64	62	61	68
Army Nurse Corps	672	942	1,280	1,402
Total officers and nurses	2,176	2,542	[4] 2,939	[5] 3,137
Enlisted men [6]	9,359	14,974	[7] 31,343	[8] 31,872
Grand total	11,535	17,516	34,282	35,009
Reserves: [9]				
Medical Corps	706	414	8,025	8,984
Dental Corps	157	101	[10] 2,090	2,531
Veterinary Corps	96	45	[10] 404	541
Sanitary Corps	----------	8	186	226
Medical Administrative Corps	[11] 17	4	772	933
Army Nurse Corps	----------	----------	4,153	5,409
Total officers and nurses	976	[12] 572	15,630	18,624
Enlisted men [13]	----------	----------	1	10
Grand total	976	572	15,631	18,634
National Guard:				
Medical Corps	----------	----------	1,080	1,072
Dental Corps	----------	----------	280	280
Veterinary Corps	----------	----------	33	28
Sanitary Corps	----------	----------	1	1
Medical Administrative Corps	----------	----------	275	266
Total officers	----------	----------	[14] 1,669	[15] 1,647
Enlisted men	----------	----------	[16] 14,715	12,075
Grand total	----------	----------	16,384	13,722
Army of the United States:				
Medical Corps	----------	----------	----------	----------
Dental Corps	----------	----------	----------	----------
Veterinary Corps	----------	----------	----------	----------
Medical Administrative Corps	----------	----------	----------	76
Total officers [17]	----------	----------	----------	76
Enlisted men [18]	----------	----------	755	794
Grand total	----------	----------	755	870
Selectees, enlisted men [19]	----------	----------	[20] 51,255	63,351

See footnotes on pages 114 and 115.

[1] Unless otherwise specified, data on officers and nurses from 30 June 1939 to 30 June 1941, inclusive, are from corresponding "Annual Reports of The Surgeon General, U.S. Army"; and data on enlisted men are from equivalent "Annual Reports of The Secretary of War."

[2] Data for male officers, with the exceptions mentioned in other footnotes, are from Memorandum, F. M. Fitts, to Colonel Lull, 29 Oct. 1942, subject: Status of Medical Department Officers as of 7 Dec. 1941, addendum to "History of Military Personnel Division, Personnel Service, 1939–April 1944." The figures represent strength on 5 December 1941.

[3] Authorized Regular Army strengths were: (1) For 30 June 1939: MC, 1,133; DC, 233; VC, 126; MAC, 72; ANC, 675; and enlisted men, 8,643. (2) For 30 June 1940: MC, 1,210; DC, 264; VC, 126; MAC, 72; ANC, 949; and enlisted men, 13,628. (3) For 30 June 1941: MC, 1,230; DC, 267; VC, 126; MAC, 72; ANC, 1,875; (no figures for enlisted men). (Data are from "Annual Reports of The Surgeon General, U.S. Army" for dates corresponding to those shown except authorization for enlisted men in 1939 which is from the report for 1940, p. 170.)

[4] Probably includes retired officers on active duty as follows: MC, 18; VC, 2; and MAC, 3. (Figures pertaining to the Medical and Medical Administrative Corps are for the week ending on 4 July 1941 and were provided by the Military Personnel Division, Office of The Surgeon General, on 30 August 1949.)

[5] Includes the following retired officers on active duty: MC, 38; DC, 2; VC, 2; and MAC, 7. (Data from source of Regular Army strength figures on the same date, see footnote 2, above.)

[6] Includes Philippine Scouts.

[7] Includes an estimated 608 members of the Regular Army Reserve. The number of Regular Army Enlisted Reserves who, regardless of branch, were called into active service was 12,190; all of these went on duty in February 1941. Of the total, 672 or somewhat more than 5 percent were Medical Department personnel. By 30 June 1941, the Regular Army Enlisted Reserves on active duty had declined to 10,919. Assuming that 5 percent of the decline had occurred in the Medical Department, the loss to the medical service amounted to 64, leaving a balance of 608.

[8] Figure supplied by Statistics and Accounting Branch, Statistics Section, Office of The Adjutant General, 24 October 1957. Includes an estimated 548 members of the Regular Army Reserves. This estimate is based on the rate of decline of the Regular Army Reserves without distinction of branch between February and 30 June. As shown in footnote 7, above, this rate when applied to the Medical Department left a balance of 608 on 30 June. If the rate of decline, approximately 12 per month, is assumed to have continued, the loss between this date and 30 November 1941 amounts to 60, and the strength on the latter date is reduced to the figure stated at the beginning of this note.

[9] Authorized active-duty strengths for the Reserves are known only for 30 June 1940. At that time they were: MC, 1,271; DC, 219; VC, 76; and MAC, 4. The number authorized for the Medical Corps was 1,283 minus the number of Medical Administrative and Sanitary Corps Reserve officers on active duty.

[10] Divisional reports in the source for these figures (Annual Report of The Surgeon General, 1941) show 1,745 dental Reserve officers and 435 veterinary Reserve officers on extended active duty (pp. 183, 190). The explanation for the discrepancy in the case of the dental officers may be similar to that mentioned in footnote 12 (that is, the figure stated in the table may include individuals for whom active-duty orders had been requested), but it does not explain the difference in the Veterinary Corps figures.

[11] Includes Sanitary Corps.

[12] Data are described in the source as "on duty or duty orders requested as of June 30, 1940." Except in the case of the Sanitary Corps, where the strength is reduced to 6, the same figures are reproduced in the report for 1941 (p. 142) under the simple heading of "on duty June 30, 1940." The report for 1940 also states (p. 209) that 25 Veterinary Corps reservists were on active duty on 30 June; failure to include those who had not yet come on active duty may account for the discrepancy.

[13] Does not include Regular Army Reserve (see footnotes 7 and 8, above). The figure for 30 November 1941 was provided by the Statistics and Accounting Branch (see footnote 8, above) on 24 October 1957.

[14] Commissioned personnel of the Medical Department in the National Guard of the United States, as reported by the Chief of the National Guard Bureau in his annual report for fiscal year 1941.

The Annual Report of The Surgeon General, U.S. Army, for the same date (p. 260), gives the following figures instead of those shown: For MC, 1,120; DC, 243; VC, 60; MAC, 153; total, 1,576.

No strength is shown for the Sanitary Corps, but 16 warrant officers are credited to the Medical Department; presumably, these were men serving in medical units.

Elsewhere in the 1941 Annual Report of The Surgeon General, the number of Veterinary Corps officers of the National Guard is stated to be 34 (p. 190), and the number of Dental Corps officers, 282 (p. 183). These figures, which approximate those shown in the body of this table, undoubtedly are more accurate than the corresponding personnel figures stated. It also is unlikely that the strength of the Medical Corps personnel, like that of the Veterinary Corps personnel, could have exceeded the strength shown for the National Guard of the United States, which consisted of all individuals who had been inducted since the federalization of the National Guard minus those who had been completely separated from the Federal service and also had been dropped from their

National Guard status. On the other hand, the figure for the Medical Administrative Corps probably is very low in view of the much higher strength shown for the group at later periods and the fact that few if any members of the corps could have been inducted after 30 June 1941. (See footnote 15.) As late as 30 June 1943, the active-duty strength of the Medical Administrative Corps in the National Guard was shown to be 277. (Annual Report, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1943.) Similar considerations govern the strength of the Dental Corps personnel, which at the same date was reported to be 273.

The Annual Report of the Secretary of War for the fiscal year 1941 shows no breakdown for the Medical Department corps in the National Guard but reports the aggregate strength of these groups on 30 June 1941 as 1,491.

[15] Adjustment of strengths shown for 1 November 1941, in memorandum cited in footnote 2, p. 114, for MC is 1,072; for DC, 300; for VC, 28; and for MAC, 266.

In view of the considerations mentioned in footnote 14, it is unlikely that the Dental Corps personnel of the National Guard numbered 300, since at the end of June it had been only 280. At that time, the total number of Medical Department officers of the National Guard remaining to be inducted had been six. (*In* Annual Report of Chief of National Guard Bureau for the fiscal year 1941, pp. 117–118.) For that reason, the number of Dental Corps officers of the National Guard on active duty on 1 November 1941 has been reduced to 280. In view of the fact that the Active National Guard as late as 30 June 1942 is credited with one Sanitary Corps officer, one such officer is credited to the active duty strength on 1 November 1941. A breakdown of the National Guard strength of Medical Department officers on 30 November 1941 is not available, but it is assumed that it did not differ greatly from the same strength at the beginning of the month. However, according to information supplied by the Statistics and Accounting Branch, Statistics Section, Office of The Adjutant General, on 24 October 1957, the aggregate of the strength on 30 November 1941 was 1,590, but for purposes of consistency, the total of 1,647 as of 1 November 1941 is stated in the body of this table.

[16] Strength for 30 June 1941 is based on Annual Report of Secretary of War for 1941, which shows medical enlisted strength of National Guard on that date to be 15,470. Since 755 of these are estimated to be Army of the United States personnel (see footnote 18), the strength of the National Guard personnel proper is deemed to be 14,715. Strength of 30 November 1941 is based on data supplied by Statistics and Accounting Branch, 24 October 1957, showing medical enlisted strength of the National Guard on the former date to be 12,869. Since no separate strength figures for AUS enlisted personnel are shown in these data, it is assumed that the estimated 794 medical enlisted men in that category (see footnote 18) must be subtracted from 12,869 in order to arrive at approximately the true National Guard strength, that is, 12,075.

[17] Personnel who entered the Army of the United States directly, without previous service as members of the Regular Army, the Reserves, or the National Guard. Strength information from Statistics and Accounting Branch (see footnote 8), 24 October 1957. This information is not broken down by corps, but the number 76 corresponds closely to the strength (77) of the first class for MAC's at Carlisle Barracks, Pa., which graduated in September 1941. The entire 76 therefore have been attributed to the Medical Administrative Corps. According to "Officers Appointed in the MC, DC, VC, MAC, and PhC. From 1 January 1939 through 1946. Month of Occurrence. OTN 337," (prepared by the Adjutant General's Office, Strength Accounting Branch, 8 July 1946), 161 Medical Department officers classified as AUS had come on duty by 30 November 1941. They included the following: MC, 28; DC, 38; VC, 10; MAC, 85. However, some of these are shown as having come on active duty as early as January 1941, and it is possible that many of those comprehended in the data entered upon active duty at the time stated but as members of the Reserves or the National Guard, acquiring AUS status later.

[18] Comprises volunteers on 1-year enlistments. According to the Annual Report of the Secretary of War, 1941, a total of 767 enlisted volunteers had come on duty with the Medical Department from September 1940 to the end of June 1941. The corresponding number for the Army as a whole was 22,390. Of these, 22,060 remained on duty on 30 June 1941, for a loss of 1.5 percent. Applying the same percentage to the enlisted volunteers of the Medical Department, the balance remaining on 30 June 1941 was 755. The number of such personnel on duty on 30 November 1941 is unknown, but on 31 December 1941, it was 802. (Information from Statistics and Accounting Branch, 24 October 1957.) By prorating the difference between the numbers present on 30 June and 31 December on a monthly basis, the estimated strength of Medical Department enlisted personnel classified as "AUS" is found to be 794.

[19] The figure for 30 November was prorated by the Statistics and Accounting Branch (see footnote 8), 24 October 1957.

[20] Of these, 38,756 were serving in Regular Army units and 12,799 in National Guard units. (Annual Report of Secretary of War, 1941.)

At this time, the total authorized strength of Medical Department enlisted personnel, both selectees and others, was approximately 82,150. Of these, about 20,437 were allotted to National Guard units, 1,387 to the veterinary service, and 60,326 to the remainder of the Medical Department establishment. (Annual Report of The Surgeon General, 1941, p. 148.)

TABLE 13.—*Strength of Medical Department Reserves (Regular Army Reserve and Reserve Corps), 1939–41*

Personnel	Strength, 30 June 1939	Changes, 1 July 1939–30 June 1940		Strength, 30 June 1940	Net change since 30 June 1939 (percent)	Changes, 1 July 1940–30 June 1941		Strength, 30 June 1941	Net change since 30 June 1940 (percent)	Changes, 1 July–30 Nov. 1941		Strength, 30 Nov. 1941	Net change since 30 June 1941 (percent)
		Procured	Lost			Procured	Lost			Procured	Lost		
Regular Army Reserve													
Enlisted men:[1]													
All branches	19, 301			28, 020	+45			10, 919	−61				
Medical Department	1, 028			1, 475	+43								
Reserve Corps													
Total officers:													
All branches[2]	131, 726			132, 652	+0. 6								
Male only[3]	115, 965	[4] 11, 008	[5] 10, 120	[3] 116, 853	+0. 8	[4] 17, 541	[5] 11, 647	[3] 122, 747	+5				
Medical Department	39, 100			39, 918	−0. 5								
Male only[6]	23, 339	501	701	23, 139	−0. 9	4, 903	6, 740	21, 302	−8			20, 609	−3
Medical Corps	15, 198	308	207	15, 299	+0. 7	3, 919	5, 244	13, 974	−9			13, 745	−1
Dental Corps	5, 063	0	398	4, 665	−8	722	959	4, 428	−5			4, 060	−8
Veterinary Corps	1, 381	163	7	1, 537	+11	74	218	1, 393	−9			1, 346	−3
Sanitary Corps	454	0	9	475	+5	47	63	459	−3			415	−10
Medical Administrative Corps	1, 243	0	80	1, 163	−6	141	256	1, 048	−10			1, 043	−0. 5
Army Nurse Corps (Red Cross Reserve)[7]	15, 761			15, 779	+0. 01								
Enlisted men:[8]													
All branches	3, 054			3, 233	+6			2, 149	−34			157, 000	+720
Medical Department	16			49	+206							13, 020	

Affiliated units, officers:													
All branches													
Male only													
Medical Department, male only								[9] 1,639					
Medical Corps								[9] 1,414					
Dental Corps								[9] 176					
Medical Administrative Corps								[9] 49					
Affiliated Reserve Officers: [10]													
All branches													
Male only								[11] 1,561					
Medical Department, male only [12]								1,410				1,405	−0.4
Medical Corps								1,257				1,264	+0.6
Dental Corps								122				120	−2
Medical Administrative Corps								31				21	−32

[1] Figures for 1939 and 1940 are, respectively, from "Annual Report of the Secretary of War" (1939) p. 85, and (1940) p. 61. Figure for 1941 is number of members of the Regular Army Reserve on active duty on 30 June 1941. (See table 12.) Since the entire membership of the Regular Army Reserve was required to be called to active duty by 15 February 1941, it is assumed that those on active duty on 30 June 1941 constituted the entire strength of this Reserve. The corresponding figure for the Medical Department is estimated to be 608 (table 12, footnote 7) which is 59 percent less than the strength for Medical Department members of the Regular Army Reserve on 30 June 1940.

[2] Aggregate of strengths, as shown in this table, of male officers in all branches and nurses.

[3] Adjustments of strengths shown in "Annual Reports of the Secretary of War" for corresponding dates; that is, for 1939—116,719; for 1940—116,636; for 1941—122,020, by subtracting from these strengths the amounts attributed in the same sources to the Medical Department; namely,

	1939	*1940*	*1941*
Medical Corps	15,956	15,187	14,497
Dental Corps	4,979	4,627	4,630
Veterinary Corps	1,509	1,525	1,319
Sanitary Corps	432	451	498
Medical Administrative Corps	1,217	1,132	1,631
Total	24,093	22,922	22,575

and adding the aggregate strength of the corps listed as shown in the body of this table.

Footnotes continued on page 118.

[4] Computed by substracting from total accessions for Officer Reserve Corps as shown in "Annual Reports of the Secretary of War" for 1940 and 1941; that is, for 1939–40—12,300, for 1940–41—16,189, accessions of Medical Department officers reported in the same sources as follows:

	1939–40	*1940–41*
Medical Corps	1,518	2,686
Dental Corps	35	649
Veterinary Corps	143	57
Sanitary Corps	47	35
Medical Administrative Corps	50	124
Total	1,793	3,551

and adding aggregate accessions of the same groups as stated in this table.

[5] Computed by adding number procured to strength at beginning of the period and subtracting the strength at the close of the period from the total.

[6] Basic data through June 1941 from "Annual Reports of The Surgeon General, 1939–41." Basic data for November 1941 from Memorandum, F. H. Fitts to Colonel Lull, 29 Oct. 1942, subject: Status of Medical Department Officers as of 7 Dec. 1941, addendum to History of Military Personnel Division, Personnel Service—1939–April 1944.

[7] Basic data from Memorandum, Superintendent, Army Nurse Corps, for The Surgeon General, 2 Dec. 1941, in Miss Byers' Book Data on Army Nurses, 1941.

[8] Basic data through June 1941 from "Annual Reports of the Secretary of War" for dates corresponding to those shown. Strength on 30 November 1941 is unknown, but is estimated to have been 157,000 for the Army in general. The vast increase in the strength of the Enlisted Reserve Corps which this figure signifies is the result of amendments to the basic Selective Service law in August 1941 authorizing release from active duty of men inducted under the act who were over 28 years of age upon their own request and release of men below this age upon showing that their retention in the Army would subject them or their wives and dependents to undue hardship. Under these provisions over 155,000 men were released between 1 September 1941 and Pearl Harbor, but all of them were retained in the Enlisted Reserve Corps ("Selective Service in Peacetime," First Report of Director of Selective Service, 1940–41, pp. 267–268). Since more than 2,000 were in the corps on 30 June 1941, this figure has been added to 155,000 to determine the estimated strength of the corps on 30 November. Medical Department enlisted strength during the period July–November 1941 was in the vicinity of 8.4 percent of the total draftee strength of the Army. (According to "Annual Report of the Secretary of War" for 1941), the total number of drafted enlisted men on active duty was 606, 915 on 30 June 1941. Of these, 8.5 percent (see table 12) were Medical Department personnel. On 30 November 1941, in accordance with data supplied by the Statistics and Accounting Branch, Statistics Section, Office of The Adjutant General, on 7 May 1958, the total number of selectees on active duty was 756,747. The proportion of those assigned to the Medical Department was 8.4 percent (table 12). Assuming that the same percentage of the 155,000 released men comprised Medical Department personnel, the number of such personnel placed in the Enlisted Reserve Corps was 13,020. The number of Medical Department enlisted men who were in the Enlisted Reserve Corps after 30 June 1940 and before 1 September 1941 is unknown, but in view of the earlier figures on the same topic, it must have been negligible. Consequently, 13,020 is taken as an approximation of the Medical Department membership in the Enlisted Reserve Corps on 30 November 1941.

[9] From "Annual Report of The Surgeon General" for 1941. Includes members of the Affiliated Reserve (footnote 10) and members of the Officers Reserve Corps who were not members of the Affiliated Reserve although members of the affiliated units.

[10] Members of the Officers Reserve Corps who possessed Reserve Status only through assignment to an affiliated unit.

[11] Adjustment of strength of all branches as shown in "Annual Report of the Secretary of War" for 1941; that is, 1,659, by subtracting strengths reported therein for the Medical Department (Medical Corps, 1,326; Dental Corps, 137; and Medical Administrative Corps, 45) and adding the strength of the Affiliated Reserves in these corps as stated in the body of this table.

[12] Basic data for June 1941 from "Annual Report of the Surgeon General," 1941, pp. 145–146. Slightly different figures are also given in the same source (pp. 146–147); namely, Medical Corps, 1,264; Dental Corps, 120; and Medical Administrative Corps, 31. (The source states that these figures represent the strength of the affiliated units, but their size indicates that they really apply to the Affiliated Reserve.) Basic data for November are from Memorandum, F. H. Fitts, to Colonel Lull, cited in footnote 6. This source reports the total number of Medical Administrative Corps officers in the Affiliated Reserve to be 31, but the distribution of the same group by rank results in a total of 21. However, since 31 is the strength which the group possessed on 30 June 1941, it is possible that the figure 31 is correct for 30 November.

TABLE 14.—*Strength of Medical Department Reserves (National Guard), 1939–41*

Component	Strength, 30 June 1939	Changes, 1 July 1939–30 June 1940		Strength, 30 June 1940	Net change since 30 June 1939 (percent)	Changes, 1 July 1940–30 June 1941		Strength, 30 June 1941	Net change since 30 June 1940 (percent)	Changes, 30 June–30 Nov. 1941		Strength, 30 Nov. 1941	Net change since 30 June 1941 (percent)
		Procured	Lost			Procured	Lost			Procured	Lost		
National Guard of United States: [1]													
Officers: [2]													
All branches	16,341			16,415	+0.5			19,069	+16			15,926	−16
Medical Department	1,592			1,509	−5			1,669	+11			1,557	−7
Medical Corps	1,078			1,022	−5			1,080	+6			1,081	+0.9
Dental Corps	245			228	−7			280	+23			260	−7
Veterinary Corps	73			65	−11			33	−49			29	−12
Sanitary Corps	2			1	−50			1	0			1	0
Medical Administrative Corps	195			193	−1			275	+42			186	−32
Warrant officers [3]	212	31	28	215	+1	73	87	201	−7			196	−2
Enlisted men [4]													
All branches	183,233			224,882	+23			243,057	+8			213,449	−12
Medical Department	12,144			14,745	+21			14,735	−.07			12,075	−18
Sources of National Guard of United States: [5]													
Active National Guard officers: [6]													
All branches	14,465	1,523	1,426	14,562	+0.7	5,125	3,471	16,216	+11			15,926	−2
Medical Department	1,537	309	274	1,572	+2	808	767	1,613	+3			1,557	−3
Medical Corps	1,089	242	216	1,115	+2	593	587	1,121	+0.5			1,081	−3
Dental Corps	235	48	40	243	+3	138	111	270	+11			260	−4
Veterinary Corps	67	1	8	60	−10	14	40	34	−43			29	−17
Sanitary Corps	1	0	0	1	0	0	0	1	0			1	0
Medical Administrative Corps	145	18	10	153	+6	63	29	187	−22			186	−0.5

See footnotes at end of table, p. 121.

TABLE 14.—*Strength of Medical Department Reserves (National Guard), 1939–41*—Continued

Component	Strength, 30 June 1939	Changes, 1 July 1939–30 June 1940		Strength, 30 June 1940	Net change since 30 June 1939 (percent)	Changes, 1 July 1940–30 June 1941		Strength, 30 June 1941	Net change since 30 June 1940 (percent)	Changes, 30 June–30 Nov. 1941		Strength, 30 Nov. 1941	Net change since 30 June 1941 (percent)
		Procured	Lost			Procured	Lost			Procured	Lost		
Warrant officers [7]	212	31	28	215	+1	73	87	201	−7			196	−2
Enlisted men [8]													
All branches	184, 825			226, 837	+23			243, 057	+6			213, 449	−12
Medical Department	12, 197			14, 799	+22			14, 735	−0. 4			12, 075	−18
Inactive National Guard officers:													
All branches	674			739	+10			533	−28			343	−36
Medical Department	42			47	+12			24	−49			15	−38
Medical Corps	30			33	+10			14	−58			9	−36
Dental Corps	4			4	0			6	+50			3	−50
Veterinary Corps	7			8	+14			3	−63			2	−33
Sanitary Corps	0			0	0			0	0			0	0
Medical Administrative Corps	1			2	+100			1	−50			1	0
Warrant officers [9]													
Enlisted men [9]													
Holding commissions in National Guard of United States: [10]													
All branches	1, 602			1, 955	+22			3, 081	+57			3, 001	−3
Medical Department	53			54	+2			115	+113			120	+4
Medical Corps	0			1				7	+600			7	0
Dental Corps	4			0	−100			20				20	0
Veterinary Corps	0			0	0			0	0			0	0
Sanitary Corps	1			1	0			0	−100			0	0
Medical Administrative Corps	48			51	+6			88	+73			93	+6

[1] Members of the National Guard who had taken an oath and had been appointed for Federal service whenever it became necessary (Dictionary of United States Army Terms, TM 20-205, 18 Jan. 1944).

[2] Basic data through June 1941 from "Annual Reports of Chief of National Guard Bureau" for corresponding dates. Strength on 30 November 1941 computed by prorating on a monthly basis the difference between the strength on 30 June 1941 and the strength of the Active National Guard on 30 June 1942 (see footnote 5). Membership in the Active National Guard of the United States and the difference prior to completion of the induction of the Guard into the Federal service between the commissioned strength of the Active National Guard and that of the National Guard of the United States (exclusive of enlisted men holding commissions) was the result almost entirely of the timelag between appointment in the Active National Guard and recognition of the appointee by the Chief of the National Guard Bureau. (See "Annual Reports of Chief of National Guard Bureau" for 1939 and 1941.) With the induction of the Guard and termination of appointments therein, the difference disappeared. (In the Annual Report of the Chief of the Bureau for 1942, only the strength of the Active National Guard was reported.)

[3] Comprises individuals with the status of warrant officers in the Active National Guard.

[4] Enlisted men in the Active National Guard did not have a separate status in the National Guard of the United States. Figures shown are therefore the same as those stated under Active National Guard except those for 1939 and 1940 which are the difference between the number of enlisted men in the Active National Guard at those times and the number of enlisted men of the National Guard holding commissions in the National Guard of the United States. The numbers of enlisted men actually inducted with the National Guard were substantially in excess of the strengths shown here; by 30 June 1941, according to the National Guard Bureau, the number in all branches had reached 278,526 and those in the Medical Department had grown to 17,238. (Annual Report of Chief of National Guard Bureau, 1941.) The number further increased slightly so that on 30 November 1941 the total inducted for all branches reached 279,358. The number inducted in the Medical Department is unknown but could scarcely have been more than 100 greater than it had been on 30 June. (Annual Report of Chief of National Guard Bureau, 1942.) Figures provided by the Secretary of War relative to 30 June 1941 are considerably less than those reported by the National Guard Bureau: 272,559 in all branches and 15,011 in the Medical Department. (Annual Report of the Secretary of War, 1941.)

[5] All basic data pertaining to officers and warrant officers through 30 June 1941 come from the "Annual Reports of the Chief of the National Guard Bureau" corresponding to the dates shown. Figures for 30 November 1941 were computed by prorating on a monthly basis the differences between the strengths on 30 June 1941 and the corresponding strengths on 30 June 1942. According to the "Annual Report of the Chief of the National Guard Bureau" for 1942, the strengths on the latter date were as follows:

	Active National Guard	*Inactive National Guard*	*Enlisted men holding commissions*
All branches	15,524	75	3,001
Medical Department:			
Medical Corps	1,043	4	7
Dental Corps	251	1	20
Veterinary Corps	27	0	0
Sanitary Corps	1	0	0
Medical Administrative Corps	184	0	99
Total	1,506	5	126
Warrant officers	189	1	----------

[6] Basic data on losses are from the sources of the accompanying strength data. (See footnote 5.) Figures on procurement were computed by adding losses to the strength at the end of the period and subtracting the strength at the beginning of the period from the resulting sums.

[7] Strengths for 1939 and 1940 include 1 cornet.

[8] Basic data for 1939 and 1940 from the corresponding "Annual Reports of the Chief of the National Guard Bureau." Basic data for June and November 1941 are active-duty strength of National Guard enlisted men at these times (see table 12).

[9] Information not available.

[10] Basic data through June 1941 from corresponding "Annual Reports of the Chief of the National Guard Bureau." Figures for 30 November 1941 were computed by prorating on a monthly basis the difference between the strengths on 30 June 1941 and 30 June 1942. In addition to enlisted men, the following held commissions in the National Guard of the United States: 1939 and 1940, warrant officers, 2; cornets, 1; June 1941, warrant officers, 1. None of these held commissions in a Medical Department component. All data from "Annual Reports of the Chief of the National Guard Bureau," 1939 to 1941, inclusive.

Since no means existed at this time by which persons could be compelled to accept appointments in the Regular Army or the Reserves, or even (if reservists) to accept a call to active duty, Army authorities had to depend on appeals to the patriotism or self-interest of those they wished to reach; in the case of nurses, the Red Cross joined in the appeal. During the spring and summer of 1940, publicity campaigns were undertaken to speed the entry of medical reservists into active service. The Surgeon General requested medical journals to print informational letters, and prominent civilian members of the Reserve Corps as well as Reserve Officers' Training Corps instructors in medical schools were utilized to encourage recruitment.

The procedure for bringing Reserve officers and nurses on active duty began with a summons from the chief of the reservists assignment group (the corps area commander or The Surgeon General). The reservist had the right to either accept or refuse the call as he wished. If he accepted, the next step was a physical examination. If that was satisfactory, the necessary papers were forwarded to The Adjutant General, who issued duty orders.

Act of 3 April 1939

But the problem of applying the officer Reserves to actual needs proved to be acute. The first move of any importance to draw on the Medical Department Officers Reserve Corps for the benefit of the active forces was made in the act of 3 April 1939—the same act that fixed the authorized strength of the Regular Army officer corps. Under this act, the President was empowered to call up 255 male Reserve lieutenants and captains of the Medical Department for not more than 1 year of voluntary active duty with an extension, at the discretion of the Secretary of War, to as long as 2 years. Only during an emergency declared by Congress could Reserve officers be ordered to duty without their consent; virtually no means existed by which, in time of peace, they could be compelled to serve even their 2-week tour of active duty when called upon. They could resign, or if they persisted in ignoring the call, one of two courses was open to the Army: It might place them on the ineligible list for the remainder of their 5-year term of appointment, or if they had had 15 years of satisfactory service to their credit, it could transfer them to the Inactive Reserve. In either case, they lost certain privileges, such as right of promotion.[9] Like all previous legislation pertaining to reservists, the new act imposed no penalties whatever on those who declined to serve for the 1 or 2 years specified; in fact, it was only on their application that the duty orders could be issued. This concession was necessary as a matter of good faith, since reservists had accepted their commissions under no obligations of lengthy peacetime service.

The act of 3 April 1939 was the last occasion, until the later emergency period, that Congress itself laid down the conditions under which new incre-

[9] Army Regulations No. 140–5, 16 June 1963.

ments of Reserve officers were to be called to active duty.[10] Thereafter, the War Department assumed that function.

Modification of the act

In making allotments to the Medical Department for the purpose of bringing Reserve officers on duty, the General Staff did not always prescribe the same conditions of service as were laid down in the act of 3 April 1939. With only 139 of the 255 medical officers allotted under this act procured and placed under orders by the end of November, the General Staff modified the rules. A proposed further enlargement of the Army would give the Medical Department an additional 508 officers, whenever the necessary legislation should be passed. In anticipation of such legislation, corps area commanders were instructed to recruit only captains and lieutenants who were less than 35 years old. These men could be placed on active duty for 1 year only.[11] The Surgeon General, foreseeing administrative difficulties arising from these differences, recommended to The Adjutant General (1) that procurement of officers over 35 years of age for active duty be permitted, and (2) that the allowable tour of duty be extended beyond 1 year. The latter step would reduce the annual turnover to a number "considered more within reason."[12] A few months later, the War Department granted authority to extend the tour of all Medical Department officers to 2 years, but there is no indication that, for the time being, the age limit was raised above 35.[13] The restriction was lifted only after the enactment of compulsory service for the Reserves in August 1940.

Since the bulk of the new officer and nurse strength added during this period was to come from the Reserves, anything that limited the number of reservists subject to call, that interfered with summoning them to active duty, or that prevented the Medical Department from using them as long as necessary might mean that requirements could not be fully met. Late in December 1939, therefore, the War Department authorized new appointments in the Reserve if the existing members would not accept active duty voluntarily and if the new appointees would agree to serve immediately. This authority seems to have had a rather limited application and to have resulted in the appoint-

---

[10] Letter, Secretary of War, to Hon. Daniel W. Bell, Acting Director, Bureau of the Budget, 27 May 1939.

[11] (1) Letter, The Adjutant General, to each Corps Area Commander, 23 Oct. 1939, subject: Additional Reserve Officers To Be Placed on Duty With the Regular Army. (2) Letter, The Adjutant General, to each Corps Area Commander, 8 Dec. 1939, subject: Age Limit, Reserve Officers, Medical Department. (The policy was laid down in October 1939, in anticipation of the appropriation act of February 1940 which made the procurement possible.)

[12] Letter, The Surgeon General, to The Adjutant General, 18 Jan. 1940, subject: Removal of Certain Restrictions Governing Selection of Additional Medical Department Reserve Officers.

[13] Memorandum, Brig. Gen. William E. Shedd, Assistant Chief of Staff, G–1, for Chief of Staff, War Department General Staff, 27 May 1940, subject: Medical Department Reserve Officer Personnel, with 1st endorsement thereto, 4 June 1940.

ment of no more than 125 Medical Department officers between June and August 1940.[14]

Emergency Measures

An indication of the scarcity of officers is the fact that, in January 1940, The Surgeon General was forced to recommend the summoning of Reserve officers to active duty for periods of 28 days as a provision for the year's maneuvers. The General Staff approved the use of 138 Medical Department Reserve officers on this basis for service in tactical units.[15]

At almost the same time, the General Staff announced two measures of more permanent relief. One was a program recalling retired Regular Army officers to active duty for utilization with Reserve Officers' Training Corps units and the recruiting service. This was of small importance numerically, and it was not until 6 months later that The Surgeon General substituted retired officers for some of the 23 Regular Army Medical Corps officers on Reserve Officers' Training Corps duty.[16] Much more significant from the standpoint of policy was the grant of authority to substitute reservists of the Medical Administrative and Sanitary Corps for members of the Medical Corps Reserve in meeting the quotas for active-duty assignments.

THE BEGINNING OF MOBILIZATION

The Change From Voluntary to Involuntary Service

Full mobilization began with the calling of the National Guard into Federal service (27 August 1940) and the enactment of the Selective Training and Service Act less than a month later (16 September). More or less concurrently with these measures, a number of steps were taken to increase the supply of Medical Department officers and nurses. The law ordering the induction of the National Guard was itself perhaps the most important in this respect. This law also made active duty compulsory for all reservists, including those of the Medical Department. It authorized the President during the

---

[14] (1) Letter, The Adjutant General, to each Corps Area Commander, 22 Dec. 1939, subject: Procurement of Medical Department Reserve Officers. (2) Letter, The Surgeon General, to The Adjutant General, 15 Aug. 1940, subject: Reserve Officer Personnel. (3) Letter, The Surgeon General, to The Adjutant General, 24 Aug. 1940, subject: Appointments in Medical Department Reserve. (4) Memorandum, Assistant Chief of Staff, G–1, for Chief of Staff, 30 Dec. 1940, subject: Cancellation of Authority to Appoint in the Medical Department Reserve.

[15] (1) Letter, The Surgeon General (Executive Officer), to The Adjutant General, 18 Jan. 1940, subject: Additional Medical Department Reserve Officers Required for Temporary Duty With Regular Army. (2) Memorandum, War Department General Staff (Personnel Division, G–1), for Chief of Staff, 3 Feb. 1940, subject: Additional Medical Department Reserve Officers Required for Temporary Duty With Regular Army, with 2d endorsement thereto, 6 Mar. 1940.

[16] (1) Letter, The Adjutant General, to Corps Area and Department Commanders, 22 Jan. 1940, subject: Assignment of Retired Officers to Active Duty. (2) Letter, The Surgeon General, to The Adjutant General, 3 July 1940, subject: Utilization of Retired Officers (cited in Memorandum, Lt. Col. D. G. Hall, Office of The Surgeon General, for Director, Historical Division, Office of The Surgeon General, 20 Apr. 1944, subject: History of Procurement Branch, Military Personnel Division, Personnel Service, Office of The Surgeon General.)

period ending on 30 June 1942 to call to active duty for a period of 12 months, with or without their consent, members and units of the Reserve components of the Army of the United States (Officers' Reserve Corps, National Guard, and Enlisted Reserve Corps) and retired members of the Regular Army. There were important restrictions, however. Reserve components could not be employed beyond the limits of the Western Hemisphere, except in territories and possessions of the United States. The law also stipulated that any reservist called to duty, if below the rank of captain and having no income beyond what he himself earned to support dependents, could resign and be discharged upon his own request if made within 20 days of his entry upon duty.[17]

Signalizing as it did the passing from voluntary to involuntary military service, this law constituted an important step toward placing the United States on a preparedness basis as far as personnel was concerned. Physically qualified Reserve and National Guard officers holding the rank of captain or above were for the first time compelled to serve. Previously, too, Congress had in one way or another limited the numbers of Reserve officers to be placed on active duty; this law, carrying no such limitations, opened the way for mobilization on a much wider scale. The effect of granting individual officers below the grade of captain the right to resign, however, reduced the benefit of the law, for hundreds of Medical Department Reserve officers exercised this right before it was canceled on 13 December 1941, shortly after entry of the United States into the war. Desirable as it was from the standpoint of the Army to prohibit resignations entirely, Congress may have felt that public opinion demanded some concessions to officers in the lower ranks; it is worth noting that these concessions were similar to the exemptions granted draftees when selective service legislation was enacted shortly afterward.

Further Emergency Reserve Measures

Immediately following the enactment of the Selective Service Act, two measures were introduced to increase the supply of officers for the Army as a whole and therefore for the Medical Department. On 27 September 1940, the War Department called Reserve officers employed with the Civilian Conservation Corps to active duty for assignment within Army installations.[18] The second measure came in October when the system of corps area debits and credits was initiated. If the number of Reserve officers available to a corps area commander was insufficient for his needs, he was ordered to report the shortage to the War Department, which would then start action to supply additional officers from other corps areas. Such a system was necessary because the distribution of men in training by corps areas did not correspond to the distribution

[17] 54 Stat. 858.

[18] Letter, The Adjutant General, to each Corps Area Commander and Commanders of Arms or Services, 13 Sept. 1940, subject: Placing on Active Duty of Reserve Officers Who are Employees of the Civilian Conservation Corps.

of Reserve officers.[19] A similar system had already been applied to nurse procurement.[20]

Medical Administrative Corps

Members of the Medical Administrative Corps Reserve responded to the call to active duty in larger proportion than did Medical Corps reservists (tables 12 and 13). A possible reason is that some of those holding Reserve commissions in the Medical Administrative Corps were enlisted men of the Regular Army who for reasons of pay and prestige would accept active duty as officers more readily than would civilian doctors in the Medical Corps Reserve. Yet the number responding fell far short of the demand for qualified personnel who could act as instructors in medical training centers or serve in hospital administration. Men therefore had to be trained for commissioning in the corps. It was not until July 1941, however, that the first officer candidate school, at Carlisle Barracks, Pa., opened for Medical Administrative Corps training. In April, The Surgeon General had asked for the establishment of such a school, to accommodate 100 candidates with eventual expansion to a capacity of 200. As part of a general enlargement of the officer candidate school program (planned but not yet put into effect), the Chief of Staff authorized a school for 100 Medical Administrative Corps candidates, to be opened on 1 July instead of on 1 August 1941, although The Surgeon General had recommended the latter date. One class of 77 second lieutenants graduated before Pearl Harbor.[21]

Sanitary Corps

The procurement of Sanitary Corps officers presented no great problem, from the standpoint of actual numbers, during this period. Members on active duty increased from 6 on 30 June 1940 to 186 a year later; the shortage on 30 June 1941 was only 22. The Sanitary Corps in the prewar period consisted of professional men, such as entomologists, bacteriologists, and sanitary engineers. As such, its members required long periods of civilian training. No officer candidate school, therefore, was established for the corps at this time—or even later when the practice of commissioning nonprofessional men in the corps began.

---

[19] (1) Letter, The Adjutant General, to Commanding General, each Corps Area, 2 Oct. 1940, subject: Additional Reserve Officers for Extended Active Duty with Corps Areas. (2) Memorandum, Lt. Col. D. G. Hall, Office of The Surgeon General, for Director, Historical Division, Office of The Surgeon General, 20 Apr. 1944, subject: History of Procurement Branch Military Personnel Division, Personnel Service, Office of The Surgeon General.

[20] Letter, The Adjutant General, to each Corps Area Commander and The Surgeon General, 24 Sept. 1940, subject: Procurement of Reserve Nurses.

[21] (1) Letter, The Surgeon General, to The Adjutant General, 3 Apr. 1941, subject: Officer Candidate School. (2) Memorandum, Operations and Training Division, War Department General Staff, for Chief of Staff, 9 Apr. 1941, subject: Officer Candidate School. (3) Memorandum, Reserve Division, Office of The Adjutant General (Col. H. N. Sumner), for Major West, G–3, 15 Oct. 1941, with enclosure thereto.

DEFERMENT OF SERVICE FOR RESERVE OFFICERS

While The Surgeon General was anxious to place many reservists on active duty as possible, he recognized that in some cases they might, at least temporarily, be employed to greater advantage in a civilian capacity. Reserve officers on inactive status were exempt from the draft, and the process of granting them deferment of service differed from that employed with respect to potential draftees. On his own authority, The Surgeon General could defer the service of Medical Department Reserve officers in the Arm and Service Assignment Group only. Appeals for deferment by officers in the Corps Area Assignment Group (which contained much the larger portion of the Reserve) could be acted upon only by the corps area commanders. At times, in order to protect civilian interests, The Surgeon General recommended the transfer of officers from the latter to the former group.[22] In September 1940, he recommended to the Office of the Secretary of War that Reserve officers who held key positions as public health officers or as teachers at medical institutions be transferred to the War Department Reserve Pool for assignment and retention in their civilian jobs. That office disapproved the proposal, stating that they must be available for active duty if their services were needed, but agreed that the military service of State public health officers and teachers at medical institutions would be deferred as long as possible.[23] Throughout the emergency and war periods, deferment continued to be granted to certain members of faculties (either reservists or civilians) who were declared by the respective deans to be essential.

U.S. Public Health Service and Veterans' Administration Reserves

The U.S. Public Health Service and the Veterans' Administration cooperated with The Surgeon General in keeping to a minimum the deferments of members of their staffs who were also Reserve officers in the Medical Department. The Surgeon General of the U.S. Public Health Service stated in a circular addressed to members of his organization that except in cases of emergency or in unusual situations, where the services of the men who happened to be Reserve officers were most essential to the conduct of Public Health Service work, no effort would be made to delay or prevent such officers from being ordered to active duty. When called, they were to be released immediately from employment by the Public Health Service.[24]

---

[22] Letter, The Surgeon General, to Dean, School of Medicine, Creighton University, Omaha, 7 Feb. 1941.

[23] Memorandum, The Surgeon General, for Maj. F. H. Kohloss, Office of Assistant Secretary of War, 2 Dec. 1940, subject: Deferment of Extended Active Duty of Certain Categories of Officers of the Medical Department Reserve.

[24] Circular (unnumbered), Surgeon General, U.S. Public Health Service, to Commissioned Officers in Charge, U.S. Public Health Service, and Others Concerned, 9 Oct. 1940, subject: Commissions in Reserve Corps of Army, Navy, or Marine Corps.

The Veterans' Administration and the War Department, beginning in August 1940, worked out a plan by which the Medical Department when necessary could obtain the services of the Medical and Dental Corps Reserve officers employed as civilians by the Veterans' Administration without disrupting the medical service of the latter. The Veterans' Administration employed about 400 such Reserve officers, and to call to duty any appreciable number at one time would obviously have disorganized the work of that agency. The plan agreed upon provided that the War Department would defer the military service of key employees as long as possible; it would submit names of officers desired but would not order anyone to active duty until the Veterans' Administration had an opportunity to secure a replacement.[25] The War Department would ascertain from the Veterans' Administration the earliest date on which an officer could be made available. If that date was more than 60 days ahead, the officer would be transferred to the War Department Reserve Pool and not called to active duty. A similar plan was adopted for Reserve nurses who were in the employ of the Veterans' Administration.[26] Later, this plan was modified, at the request of The Surgeon General, by a provision that the headquarters having assignment jurisdiction was to make every reasonable effort to determine the officer's physical fitness before requesting his release from the Veterans' Administration.[27] Obviously, an officer found physically unfit for duty was not requested, and the Veterans' Administration therefore was spared the trouble and expense of obtaining a replacement for a man who later was returned to it after being rejected for Army service.

Establishment of Rosters for Reserve Officers

In November 1940, the Secretary of War directed each assignment authority (corps area, departmental, and arm or service headquarters) to prepare and maintain rosters for the purpose of establishing priority in which Reserve officers would be ordered to active duty. These headquarters were to maintain separate rosters for Medical Department Reserve officers, general provisions and restrictions on selection of Reserve officers being clearly defined. The position of an officer on a roster was to depend on the following factors: Extent of deferment proposed by the officer and reasons therefor, personal obligation as to dependents, professional attainments and value to the service (in this connection age and physical aptitude were to be considered), and the need for the officer's services to the community in his civilian status. In the

[25] (1) Letter, The Secretary of War, to the Administrator of Veterans Affairs, 18 Oct. 1940. (2) Letter, The Surgeon General, to Senator Chan Gurney (South Dakota), 22 Oct. 1940.

[26] (1) See footnote 25(1), above. (2) Letter, Col. Florence A. Blanchfield, USA (Ret.), to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 21 Feb. 1956, with enclosure thereto.

[27] (1) Letter, The Surgeon General, to The Adjutant General, 25 Aug. 1941, subject: Release of Medical Department Reserve Officers by Veterans' Administration for Extended Active Duty. (2) Letter, The Adjutant General, to Commanding General, First Corps Area [and other corps areas], 11 Sept. 1941, subject: Release of Medical Department Reserve Officers by Veterans' Administration for Extended Active Duty.

preparation of these rosters, assignment authorities were directed to use the supplementary classification questionnaires for Medical Department Reserve officers (W.D., A.G.O. Form No. 178–2).[28] Such a system of rosters became necessary after the Chief of Staff stated that as individuals had accepted commissions in the Officers' Reserve Corps with the understanding that a national emergency meant war, they would be consulted as to their availability before being arbitrarily called to duty for training during peacetime.[29]

EXTENSION OF RESERVISTS' TOUR OF DUTY

As early as January 1939, even before the augmentation of the Army began, The Surgeon General stated that the tours of duty of Medical Department Reserve officers might have to be extended beyond 1 year. As voluntary procurement measures failed to secure the desired number of officers, it became more evident that an extension of the 1-year tour was necessary.[30] In 1939 and 1940, Medical Department Reserve officers were brought on duty for 1 year, with a possible extension of service to 2 years.

Extension by Interpretation

After Congress made active duty compulsory (or partially so) for both Reserve and National Guard officers (August 1940), the Judge Advocate General ruled that officers who had entered on active duty before passage of this legislation could be compelled to serve an extra year without their consent. He ruled further that officers called to duty under the new law without their consent were exempt from the extra duty unless they agreed to it.[31] In other words, those who had volunteered prior to August 1940 for 1 year's service were now forced to stay in for 2; those who had been brought on duty involuntarily after August 1940 did not have to stay in for the second year unless they so requested.

At first, The Surgeon General favored retaining Medical Reserve Corps officers on duty for the second year.[32] Two months later, however, he conceded that since few officers were concerned, the number thus made available for military service would be negligible, and the psychological reaction of the individual and the profession at large would be unfavorable. The Secretary of War adopted The Surgeon General's point of view and announced that, with

---

[28] Letter, The Adjutant General, to Commanding Generals, all Corps Areas, and Commanders of War Department Arms and Services, 20 Nov. 1940, subject: Reserve Officers for Extended Active Duty Under Public Resolution 96, 76th Congress.

[29] Letter, Lt. Col. F. M. Fitts, to Col. Calvin H. Goddard, Director, Historical Unit, Office of The Surgeon General, 21 Jan. 1952.

[30] Letter, General Magee, to Colonel McCornack, 24 Jan. 1939.

[31] (1) Letter, The Adjutant General, to each Corps Area and Department Commander, 19 Sept. 1940, subject: Reserve Officers Ordered to Active Duty Without Their Consent. (2) Letter, The Adjutant General, to Chiefs of all War Department Arms and Services, 10 Oct. 1940, subject: Continuation of Active Duty, Without Their Consent, of Reserve Officers Now on Extended Active Duty.

[32] Letter, The Surgeon General, to The Adjutant General, 15 Jan. 1941, subject: Extensions of Tours of Active Duty for Medical Corps Reserve Officers.

the exception of officers whose current tours of active duty were based on agreement for extension of tour, the policy of the War Department was that Reserve officers of the Medical Department be not continued on active duty for a period longer than 1 year without their consent. With minor exceptions, Reserve officers of the Medical Department whose tours had been extended without their consent under the law of August 1940 would upon application be relieved from active duty.[33]

Service Extension Act, 1941

The Service Extension Act of August 1941 permitted the President to extend for 18 months the service of members of the Reserves and National Guard. The act also provided for the release of officers whose retention would cause them undue hardship. The War Department announced that so far as practicable it would release all Reserve officers (other than officers of the Air Forces) having 12 months' service if they did not wish to extend their tours beyond that period. The Surgeon General, under pressure to obtain more officers, recommended and the War Department in response directed that the tours of all Medical Reserve Corps officers be extended where it had been determined that replacements were not available.[34]

Establishment of the Army of the United States

On 22 September 1941, a joint resolution of Congress permitted the President to commission newly appointed officers in the Army of the United States as an alternative to one of its several components (including the Reserves). Persons so appointed might be ordered to active duty for any period the President prescribed, and the appointment might continue "during the period of the emergency and six months thereafter." [35] On this basis, the Secretary of War declared that, with exceptions that would not include many officers, all persons commissioned thereafter during the emergency were to be appointed in the Army of the United States. Applications for appointment in the Officers' Reserve Corps then being processed would, with the exceptions mentioned above, be considered as applications for appointment in the Army of the United States.[36] Shortly after Pearl Harbor, the problem of extending the term of active duty for National Guard and Reserve officers was solved by an act of 13 December 1941 which obliged all members of the Army to serve for the duration of the war and 6 months thereafter.

---

[33] Letter, The Adjutant General, to Commanding Generals of all Armies, Army Corps, and others, 1 May 1941, subject: Extension of Tours of Active Duty, Reserve Officers.

[34] Letter, Office of The Surgeon General, to Office of The Adjutant General, 3 Sept. 1941, subject: Extension of Tours of Active Duty, Reserve Officers, with 1st endorsement thereto, 20 Sept. 1941. (It must be assumed that National Guard officers, although they were not specifically mentioned in this correspondence, were covered by the same policy.)

[35] 55 Stat. 728.

[36] Letter, The Adjutant General, to Commanding Generals of all Armies, Corps Areas, Departments, and others, 7 Nov. 1941, subject: Policies Relating to Appointments in the Army of the United States Under the Provisions of Public Law 252, 77th Congress.



FIGURE 27.—Col. Richard H. Eanes, MC, Chief Medical Officer, Selective Service System.

EFFECT OF SELECTIVE SERVICE LEGISLATION

When the Selective Training and Service Act was passed on 16 September 1940, no occupational group, as such, was excluded except ordained ministers of religion and students preparing for the ministry. Therefore doctors, dentists, veterinarians, and other professional people of value to the Medical Department would be drafted as needed and duly commissioned in any of the corps except the Nurse Corps (women were exempt from the draft). In addition, age limits were originally broad enough (21 to 35, inclusive) to cover a large number of the physicians and a much larger proportion of the dentists in the country.

The prospect of drafting professional men in both the numbers and types needed was dimmed by the action of the Selective Service boards. These boards, in whom sole authority for the selection lay, may not have been technically qualified to pass upon the essentiality of professional personnel either to the Army or to the local community; their decision as to whether a doctor or dentist was or was not to be deferred might depend somewhat on his local popularity. On the other hand, Col. Richard H. Eanes, MC (fig. 27), who was on duty with Selective Service headquarters during the war, stated later

that while it was "technically correct" that local boards were not technically qualified to make decisions concerning the absolute essentiality of the individual for the medical needs of the community, "sound judgment on the part of many local boards generally resulted in decisions that were proper." [37] It was quite reasonable to expect, however, that since the boards had to consider the health needs of their local communities they would consider these needs first before taking into account those of the Army.

On the other hand, however lenient the draft boards might be toward doctors and dentists, individual members of those professions could not be certain of escaping the draft. That fact undoubtedly caused some to apply for commissions before the blow fell. In that way, they avoided the indignities—as some considered them—of being compelled to enter the Army and serve as enlisted men until accepted for a commission, as all draftees must do. Such a prospect was rather remote, especially for physicians, but it remained a possibility.

The Medical Department, partly at the request of the professional organizations, desired to remove that possibility completely. The Army felt that it would be the target for widespread criticism if the services of professional men were wasted in relatively minor, nonprofessional activities. On the day the Selective Training and Service Act was passed (16 September 1940), therefore, The Surgeon General recommended to the War Department that appointments in the Reserves be opened to persons who might be drafted. Since no action was taken, substantially the same request was repeated on 26 October, again with no immediate result.[38] About the same time, The Surgeon General reminded the corps area surgeons that they could make appointments in the Reserve Corps if vacancies existed and when an applicant was desired for active duty.[39] Meanwhile, the heads of selective service and the local draft boards, foreseeing no shortage of civilian dentists, did not hesitate to induct as an enlisted man any dentist who was not needed at the moment in his own community. The American dental profession, supported by The Surgeon General, voiced its concern, claiming that serious difficulties might ensue if dentists were not used in their professional capacity.[40] In January 1941, the chief of the Dental Division, Office of The Surgeon General, suggested to the Assistant Chief of Staff, G–1, that qualified physicians, dentists, and veterinarians who stood high on the list for induction should be granted commissions in the Reserve Corps "without reference to procurement objectives." He also advised that such persons be "assigned to active duty as soon as commissioned." This suggestion was no doubt vitiated from the War Department General Staff's point of view by a further and apparently

[37] Letter, Col. Richard H. Eanes (Ret.), Chief Medical Officer, Selective Service System, to Col. C. H. Goddard, Office of The Surgeon General, 5 Sept. 1953.

[38] Letters, The Surgeon General, to The Adjutant General, 16 Sept. 1940, and 26 Oct. 1940, subject: Appointment in Medical, Dental, and Veterinary Corps Reserve.

[39] Letter, Office of The Surgeon General (Executive Officer), to each Corps Area Surgeon, 29 Oct. 1940, subject: Extended Active Duty Vacancy Required for Approval of Applicant for Commission.

[40] Memorandum, Office of The Surgeon General (Brig. Gen. Albert G. Love), for G–1, 25 Mar. 1941.

conflicting proposal that a person so commissioned should be called to active duty "as soon as his services can be properly utilized."[41] No action was taken on these proposals.

Congressional Action

In the meantime, several bills were introduced in Congress to commission licensed physicians and dentists in lieu of induction, and also to defer students and teachers in medical and dental schools. The Army disapproved all these bills on the grounds that no one group should get preferential treatment. In addition, The Surgeon General did not want to be placed in the position of commissioning all doctors and dentists.[42]

War Department Action

At this same time, The Surgeon General desired to add to the numbers in the Dental, Veterinary, and Sanitary Corps Reserve, but he wished to retain the power to determine just which officers were to be commissioned. The publicity surrounding the induction of dentists for service as enlisted men continued to embarrass him; communities and professional societies persisted in demanding that dentists be commissioned rather than be allowed to serve as enlisted men. On 5 May 1941, the War Department finally stated that inducted individuals who qualified for appointment in the Dental or Veterinary Corps Reserve should be encouraged to apply for appointment in the Reserve so that they could serve in a professional capacity. Those qualified would be discharged as enlisted men and ordered to active duty as commissioned officers for a period of 12 months,[43] after which they would, presumably, return to inactive status in the Reserve. Although this order undoubtedly accommodated many inducted men, it did not prevent the induction of dentists or veterinarians. Agitation continued both to commission inducted men and to open the Reserve Corps to permit further commissioning,[44] thereby preventing the induction of additional dentists. The Office of The Surgeon General, however, held that the Army could not justify commissioning unlimited numbers in the Reserve without reference to its needs, as this would be tantamount to granting a deferment denied to persons outside the medical profession.[45]

---

[41] Letter, Brig. Gen. Leigh C. Fairbank, to Brig. Gen. William E. Shedd, G-1, 22 Jan. 1941, subject: Reserve Commissions for Physicians, Dentists, and Veterinarians Subject to Induction.

[42] (1) S. 783 and 197, 77th Cong. (2) Senate Committee on Military Affairs, 77th Cong., 1st sess., hearings on S. 783, "Doctors and Medical Students Under the Selective Service," pp. 155, 159, 163–164.

[43] Letter, The Adjutant General, to each Commander of Army or Service, 5 May 1941, subject: Appointment in the Dental and Veterinary Corps Reserve of Inducted Individuals.

[44] Letter, C. Willard Camalier, Chairman, Dental Preparedness Committee, American Dental Association, to James Rowe, Jr., Administrative Assistant to the President, 17 Sept. 1941.

[45] Memorandum, Office of The Surgeon General (Col. Robert C. Craven), for The Adjutant General, 8 Oct. 1941.

By the spring of 1941, the selective service authorities were beginning to show some alarm over the professional personnel situation, and on 22 April they cautioned local boards that a shortage of dentists might impend. This warning was strengthened on 12 May.[46] At that time, local boards were reminded that (1) they still had full responsibilty for determining whether a dentist was indispensable to his community; (2) the Army did not need dentists for the time being; and (3) if a board felt that a dentist should nevertheless be inducted, he should be advised that he might apply for a commission as soon as he went on active duty. This directive must have discouraged the draft of dentists, but it did not positively prohibit it. Although the Selective Service System maintained that group deferments should not be granted, it can be seen from these memorandums that the authorities of that agency moved closer to sanctioning the deferment of at least one group. There were no major changes of policy on the subject during the remainder of 1941, and with the creation of the Procurement and Assignment Service in the fall of that year, a new agency was to determine whether doctors, dentists, and veterinarians were available for military service or should be kept in their communities.

ARMY NURSE CORPS

Applicants for appointment to the Army Nurse Corps underwent a somewhat different routine from the other Medical Department corps. To enter the Regular Army component of the corps, they applied directly to The Surgeon General, and did not ordinarily have to take a professional examination, although The Surgeon General might prescribe one if he chose. An applicant must, however, present a certificate from the superintendent of the nursing school attended, and if she was qualified professionally, morally, and physically, according to Army standards, and was registered in the State in which she had graduated or in which she was practicing nursing, she became eligible for appointment. Entrance to the Reserve could be gained primarily but not exclusively by enrollment with the Red Cross Nursing Service which furnished The Surgeon General a list of available nurses who could be called upon in time of emergency. While Reserve nurses must be obtained from the Red Cross "so far as practicable," they could also be recruited "from any other acceptable source."[47]

The law calling up the Reserves did not affect Reserve nurses, since the latter were not part of the Army Reserves. Two weeks after the law was enacted, however, the General Staff authorized the assignment of 4,019 Reserve nurses to active duty on a voluntary basis. Previously, all nurses procured for active duty had to be appointed to the Regular Army. They could now also

[46] Memorandums I–62 and I–99, Selective Service Headquarters, 22 Apr. 1941 and 12 May 1941, respectively, for State Directors.

[47] Army Regulations No. 40–20, 31 Dec. 1934.

be brought in with the status of reservists serving for 1 year, but under suitable conditions, the period could be extended.[48]

The recruitment of nurses proved to be much less simple than The Surgeon General had expected. With over 15,000 enrolled in the First Reserve of the Red Cross, he anticipated little difficulty in meeting the first requirements for Reserve nurses, amounting to 5,019, by January 1941. At first, however, relatively few accepted active duty, and only 607 had been assigned by 1 February 1941. The Red Cross sometimes found it necessary to canvass as many as 10 Reserve nurses before discovering one willing to accept active duty.[49]

The meagerness of the response impelled The Surgeon General to recommend invoking the more liberal terms of Army regulations, and corps area commanders were accordingly authorized to procure Reserve nurses not only from the Red Cross but from "any acceptable source." [50] The Red Cross was thus prodded to more vigorous action. A publicity campaign was undertaken, using the radio, newspapers, and magazines, to promote recruitment. These measures apparently had their effect—between the first of February and the middle of March 1941, 1,000 nurses were placed on active duty. By 30 June 1941, 1,280 Regular Army and 4,153 Reserve nurses were in service, 500 of the Regulars having been brought in within the past 12 months, and all the Reserves since September 1940. This represented 595 and 866 fewer than the respective authorizations as they existed on 30 June 1941.[51]

Procurement for the Army Nurse Corps, unlike that for other Medical Department Corps, was hampered by the fact that its Reserve, built up by the Red Cross, was never under legal compulsion to accept active duty. On the other hand, no limit was ever placed on the number who could be recruited for the Red Cross Reserve. The War Department could restrict only the number of nurses who were placed on active duty as Reserve appointees; it could not—as in the case of other components—impose procurement objectives which limited the inactive as well as the active membership to a certain figure. Adherence to these procurement objectives for other corps sometimes reduced the number of transfers from inactive to active status by preventing the recruitment of new reservists who might be more amenable to accepting active duty or more available for performing it than the existing members. The Red Cross, however, could go on enlarging its backlog of Reserve nurses indefinitely, with the prospect that among the larger number more would be found to volunteer for active service.

---

[48] (1) Letter, Office of The Surgeon General (Executive Officer), to The Adjutant General, 10 Sept. 1940, subject: Procurement of Reserve Nurses. (2) Letter, The Adjutant General, to each Corps Area Commander and The Surgeon General, 24 Sept. 1940, subject: Procurement of Reserve Nurses.

[49] (1) Annual Report of The Surgeon General, U.S. Army, Washington: U.S. Government Printing Office, 1941. (2) Statement of Medical Department Activities by Maj. Gen. James C. Magee, The Surgeon General, for the Sub-Committee of the Committee on Appropriations, House of Representatives, 77th Cong., 1941, p. 10. (3) Blanchfield, Florence A., and Standlee, Mary W.: The Army Nurse Corps in World War II. [Official record.]

[50] (1) Letter, The Surgeon General, to The Adjutant General, 16 Dec. 1941, subject: Reserve Nurses. (2) Letter, The Adjutant General, to each Corps Area Commander and The Surgeon General, 4 Jan. 1941, subject: Procurement of Reserve Nurses.

[51] See footnote 49 (1).

STUDENTS IN PROFESSIONAL SCHOOLS

Only one phase of the problem of obtaining professional personnel has so far been discussed—that which concerned fully trained doctors, dentists, veterinarians, and sanitarians. This aspect overlaps the second phase of the problem, which concerned students in professional schools. Recent graduates were a highly regarded source of officer personnel. For them and for the community at large, the transition to military service was easier than for men already established in civilian practice. As a group, these young men were also physically best able to perform arduous military duties. The Medical Department was therefore anxious to obtain their services as soon as they had finished their education. But to do this, it was desirable to place a claim on them some time in advance—while they were still students. They also had to be permitted to complete their studies, which meant protecting them against the draft and against a premature call to duty as officers. Thus, the phase of procurement having to do with fully trained doctors (and other professional personnel) merged with that of maintaining the source of future supply—students in professional schools. The civilian community was also interested in maintaining such a supply for its own needs, and the Medical Department could therefore cooperate with leaders of the civilian profession in protecting the student group.

Although at the beginning of mobilization the Officers' Reserve Corps seemed to contain ample numbers of dentists and veterinarians for immediate needs, it was early recognized that a continuing supply of men in those fields as well as in medicine could come only from the group of graduating students, interns, and residents if civilians as well as military needs were to be met.

Medical Students

In 1939, medical educators raised the question of how the Army would utilize its young Reserve officers who, upon the declaration of a national emergency, might be engaged in the study of medicine. Among those in process of receiving their medical education, the Army had some claim on those holding commissions in either medical or nonmedical sections of the Officers' Reserve Corps, or enrolled in either of the corresponding sections of the Reserve Officers' Training Corps.

In February 1940, the War Department announced that Medical Corps Reserve officers would not be called up until they had completed one year of hospital internship.[52] A considerable number of medical students, however, held commissions in nonmedical sections of the Officers' Reserve Corps, commissions which they had received on completing a course in the Reserve Officers' Training Corps undertaken during their premedical years. Retention of these commissions would have eliminated them as future officers in the Medical

[52] Letter, The Adjutant General, to all Corps Area and Department Commanders and The Surgeon General, 19 Feb. 1940, subject: Extended Active Duty for Medical Reserve Officers.

Corps. The growing possibility of war caused their status to receive careful study within the War Department. As a result, the Department in April 1940 authorized the transfer of these nonmedical Reserve officers to the Medical Administrative Corps section of the Officers' Reserve Corps if they were full-time students in approved medical, dental, or veterinary schools. The transfer was to be effective only at the direction of the War Department during mobilization, and the call to active duty was made a function of The Surgeon General. The War Department ordered the transfer in August 1940. By June 1941, 529 medical, 48 dental, and 32 veterinary students had been transferred to the Medical Administrative Corps Reserve.[53]

Students in the medical units of the Reserve Officers' Training Corps were few; only 23 medical schools and colleges had such units and only a small percentage of their students were enrolled. No similar units existed in dental or veterinary schools. There were many more nonmedical Reserve Officers' Training Corps units in the educational institutions of the country, but how many premedical students belonged to them is unknown. In September 1940, the Selective Service Act granted deferment of service to third- and fourth-year students in all sections of the Reserve Officers' Training Corps.[54]

But the vast majority of medical students, interns, and residents had assumed no military obligations whatever. At first, The Surgeon General attempted to obtain for immediate service in the Medical Department some of those who had just completed their studies as interns or residents. Later on, as selective service became imminent, he tried to protect others of the unobligated group—veterinary and dental as well as medical students—from calls to service until they had finished their schooling. In the early months of 1940, The Surgeon General appealed to residents and interns (the latter after they had finished a year's internship) to take commissions in the Officers' Reserve Corps with the obligation of accepting active duty for 1 year beginning about 1 July 1940. He appealed to them because he thought they might be more willing than others to accept such duty since they had not committed themselves to practice. As their acceptance had to be voluntary, The Surgeon General was limited to publicity and persuasion in his efforts to commission these young physicians.

When it seemed probable in the summer of 1940 that selective service would be introduced, the situation of students, interns, and residents changed considerably. The vast majority of them, not being members of the Officers' Reserve Corps or Reserve Officers' Training Corps, could lay no claim to exemption or deferment. The War Department made no plans to exempt them, and it was assumed that they would be faced with the choice of accepting commissions in the Medical Department Reserve or being inducted into the Army, in which case they would serve as privates. At the same time, the leaders of medi-

[53] (1) Letters, The Adjutant General, to Corps Area and Department Commanders and each Chief of Arm or Service, 17 Apr. 1940, and 25 Aug. 1940, subject: Special Mobilization Procedures for Procurement of Medical Department Reserve Officers Who are Students in Approved Schools. (2) See footnote 49 (1), p. 135.

[54] 54 Stat. 858.

cine, dentistry, and veterinary medicine expressed their concern over the harm these professions might suffer if the supply were cut off by an interruption of training. In this matter, Army authorities, including The Surgeon General and his assistants, had a dual responsibility. They must first of all provide the necessary medical service for an expanding Army. At the same time, they had to take into account the problems of civilian medicine during periods of mobilization and war.

Commissioning of Interns

The Surgeon General had followed the policy of approving interns' applications for commissions with the understanding that they would not be called to active duty before the completion of training. [55] In May 1941, the War Department authorized the commissioning of interns in the Medical Corps Reserve "with the understanding that they will be ordered to one year's active duty immediately upon completion of their internship." [56] On 19 December 1940, the War Department had issued an order authorizing appointment of a sufficient number of applicants to fill any vacancies in the procurement objectives of the Medical Department Officers' Reserve Corps. Men accepting commissions under the terms laid down in this order had to agree that they did not come within the category of those entitled to resign (granted by the law of August 1940 making active duty for reservists compulsory) and that they would not exercise the right if ordered to active duty. [57]

Deferment Under Selective Service

The Selective Training and Service Act deferred the service of all college and university students until July 1941. Otherwise, local draft boards were to grant deferments for persons whose employment or activity was necessary to the maintenance of the national health, safety, or interest. Spokesmen for the medical profession objected to leaving the decision on interns and residents to the "wisdom or lack of wisdom" of the local draft boards, demanding that medical men should have a voice in deciding "what is important to protect in medical training and in the maintenance of American medical institutions." [58] A full-scale controversy was soon in progress, as the War Department attempted to persuade a large number of students who would graduate in June 1941 to apply for commissions in the Medical Corps Reserve. The procedure for granting such commissions was simplified in February 1941, and, as the end of the school year approached, considerable publicity was given to the plan among military authorities and deans of medical schools. The

[55] Statement of Brig. Gen. A. G. Love, Office of The Surgeon General, at Conference, Committee on Medical Preparedness, Chicago, 23 Nov. 1940, reported in the *Journal of the American Medical Association*, 7 Dec. 1940, p. 2008.

[56] Letter, The Adjutant General, to all Corps Area and Department Commanders and The Surgeon General, 26 May 1941, subject: Deferment of Medical Students.

[57] Letter, The Adjutant General, to each Corps Area and Department Commander and The Surgeon General, 19 Dec. 1940, subject: Appointment in the Medical Department Reserve.

[58] Wilbur, R. L.: Some War Aspects of Medicine. J.A.M.A. 116: 661–663, 22 Feb. 1941.

response was not satisfactory. Of the 5,000 male students who graduated in medicine in 1941, only 1,500 made application for commissions in the Medical Corps Reserve.[59] Many interns and residents preferred to take their chance with the draft, knowing the reluctance of local boards to induct physicians as enlisted men. If actually drafted, that would be time enough to apply for a commission.

The policy of the Selective Service authorities toward students was an important factor in the situation. Although at first this agency stood firmly against group deferments, it stated in February 1941 that it was of great importance that the supply of physicians "be not only maintained but encouraged to grow" and that no medical student or intern who gave promise of becoming an acceptable physician should be called for military duty prior to his becoming one. A short time later (May 1941), the Selective Service office made the same statement apropos of dental students.[60] There is no doubt that local boards placed vast numbers of students—medical, dental, and veterinary, as well as other—in class II and deferred them for occupational reasons. A compilation prepared by the Selective Service Administration covering the period from the passage of the Selective Service Act to Pearl Harbor shows the percentage of deferred students in several fields of study: [61]

Field of study	*Percentage in class II*
Dentistry	81
Medicine	80
Veterinary medicine	72
Engineering	71
Chemistry	69
Pharmacy	66
Physics	59
Geology	56
Biology	46

Medical Administrative Corps Reserve Commissions

In February 1941, The Surgeon General, linking a desire to build up the strength of the Reserve Corps with his wish to permit the continuance of training in civilian schools, submitted to the War Department a detailed analysis of the problem with a recommendation that provision be made for the granting of commissions in the Medical Administrative Corps Reserve to junior and senior students not only in approved medical schools but in approved dental

[59] (1) Letter, The Adjutant General, to all Corps Area Commanders, 18 Feb. 1941, subject: Appointment in Medical Corps Reserve of Graduates of Approved Medical Schools. (2) See footnote 49(1), p. 135.

[60] (1) Memorandum I–91, National Headquarters, Selective Service System, for all State Directors, 22 Apr. 1941, subject: Supplement to Memorandum I–62: Occupational Deferment of Doctors, Internees, and Medical Students (III). (2) Memorandum I–99, National Headquarters, Selective Service System, for all State Directors, 12 May 1941, subject: Supplement to Memorandum I–62: Occupational Deferment of Dentists and Dental Students (III).

[61] Selective Service in Peacetime, First Report of the Director of Selective Service, 1940–41, p. 172.

and veterinary schools. This would have extended the practice already adopted to the case of interns but not yet formally approved by the War Department. In rejecting this new proposal, the General Staff expressed the view that "such action would constitute special treatment for a particular class of students which would result in exempting them from Selective Service"; exemptions from selective service could not be granted for any particular group unless it could be clearly demonstrated that personnel in that group would be required in key positions in industries essential to the national defense.[62]

Under pressure from various medical and dental societies and backed by the knowledge that the Under Secretary of War, Robert P. Patterson, was keenly interested in the problem, on 10 May 1941 The Surgeon General again recommended to the War Department that either of the following actions be taken: To commission a medical student in the Medical Administrative Corps Reserve as soon as he was enrolled in a grade A medical school or to enroll him at that time in the Enlisted Reserve Corps for a period of 3 years and then commission him in the Medical Administrative Corps Reserve until graduation, when he would be commissioned in the Medical Corps Reserve and called to duty on completing his internship.[63]

On 26 May 1941, the War Department went part of the way by granting authority to commission as second lieutenants in the Medical Administrative Corps Reserve, after 1 July 1941, male junior and senior students in approved medical schools in the United States who were fit for military service. Under regulations published several weeks later, students so commissioned were transferred to and retained in the War Department Reserve Pool [64] until eligible for appointment in the Medical Corps Reserve (at the end of their 4-year course). No examination except the physical was necessary. Appointments were to be made without reference to the procurement objective for the Medical Administrative Corps Reserve. Officers were to be discharged from the Reserve if they discontinued their medical education, dropped out of school entirely, matriculated in an unapproved school of medicine, or failed to secure appointment in the Medical Corps Reserve within a year of the completion of the 4-year course in medical school.[65] Discharge from the Medical Administrative Corps Reserve placed the individual again within the purview of selective service. It will be noted that this grant of authority took no account of dental and veterinary students or of first- and second-year medical students. No further concessions, however, were made until after the outbreak of war.

---

[62] Memorandum, The Surgeon General, for The Adjutant General, 18 Feb. 1941, subject: Commissioning of Junior and Senior Students in the Medical Department Reserve Corps, with 1st endorsement thereto, 18 Mar. 1941.

[63] (1) Memorandum, Under Secretary of War, for General Marshall, 1 May 1941. (2) Memorandum, The Surgeon General, for Assistant Chief of Staff, G–1, 10 May 1941.

[64] Officers in this pool could be ordered to active duty only with the approval of the War Department.

[65] Letter, The Adjutant General, to The Surgeon General (and others), 26 May 1941, subject: Deferment of Medical Students.

RESERVE UNITS

Revival of Affiliated Units

The affiliated Reserve units constituted a special type of Reserve, and, from the personnel viewpoint, they possessed a character in many respects different from that of other medical units. They had their own quotas and their own system of procurement, and their development affected the general personnel situation in a number of special ways.

The Protective Mobilization Plan

As the threat of war increased, the value of an affiliated Reserve such as that so successfully used in World War I again became evident. The Protective Mobilization Plan of 1939 called for a number of tactical hospitals to be brought into service during the first months of an emergency. A reserve of personnel for these hospitals composed of men and women highly skilled and already trained to work together as a unit would make them quickly available if the need arose. It was for this purpose that The Surgeon General, Maj. Gen. Charles R. Reynolds, in March 1939 proposed the revival of affiliated units.

He had made the suggestion several times before without effect. This time, he submitted a formal and detailed request, beginning with a statement of the case for affiliated units. Hospitals called for by the Protective Mobilization Plan, he argued, must be completely integrated units with harmonious staffs of competent and qualified physicians and surgeons, which would be sufficiently coordinated and organized to be able to function in a theater of operations with a minimum of delay. General Reynolds stated it to be his firm conviction that such units would be forthcoming only if they were affiliated in peacetime with large and well-staffed civilian hospitals. An obstacle to the provision of a superior medical service for mobilization, in any case, was the fact that the necessary specialists could not be recruited under existing Reserve regulations. These regulations provided that appointees to the Officers Reserve Corps must be less than 35 years of age and must enter the corps as first lieutenants. Few of the outstanding specialists who would be needed in case of mobilization or war were under 35, for very few physicians acquired the desired proficiency before reaching that age. Those who were qualified could not be expected to accept commissions as first lieutenants and thus find themselves in the same grade with recent graduates of medical schools.

On the basis of the facts just outlined, General Reynolds made a series of recommendations, the most important of which was that selected hospitals and medical schools rated as satisfactory by the American College of Surgeons and the American Medical Association be invited to organize hospital units. He also recommended that selected individuals in participating institutions, above the age of 35 years, be commissioned in the Reserve with grades (and oppor-

tunities for promotion) which were commensurate with their professional qualifications.

During succeeding months, the War Department General Staff studied this proposal; it opposed the recommendation that officers be commissioned above the rank of first lieutenant as contravening current policy, but, on 3 August 1939, the proposal was approved, subject to the determination of certain details.[66] These details concerned the proposed waiving of restrictions on the appointment, promotion, and training of Medical Department Reserve officers for these units. The Surgeon General was requested to submit recommendations on these points, and also on the allocation of units and other administrative details.

In reply, General Magee, who had succeeded General Reynolds in June 1939, advised that, as a beginning, all theater of operations hospitals provided for in the Protective Mobilization Plan—32 general, 17 evacuation, 13 surgical, and 4 station hospitals—be affiliated units. He proposed to allocate these, as far as possible, to institutions that had sponsored similar units in World War I. The commanding officer of each unit was to be a member of the Regular Army, as was the executive officer in general and evacuation hospitals; these two officers would join the unit when it was activated. It was recommended that all other officers be members of the Reserve. The unit director was to be the senior staff member, and he would be the responsible peacetime head of the organization. General Magee outlined a detailed procedure for the appointment and promotion of Reserve officers which included authority to appoint officers between the ages of 23 and 55 to any grade for which there existed an appropriate vacancy. Promotion in the unit was to be by virtue of appointment to a position which carried a higher grade. Withdrawal from the staff of the sponsoring institution would automatically operate to terminate the Reserve appointment. Active- and inactive-duty training requirements were also listed.[67]

On 19 October 1939, General Magee submitted a revised list of sponsoring institutions, including all of the proposed units except the four station hospitals.[68] War Department approval followed a month later. At the same time, The Surgeon General was given assignment jurisdiction over officer personnel prior to mobilization and was authorized to proceed with the organization of these affiliated units upon issuance of the necessary War Department directive. Details of the plan were approved early in 1940.[69]

---

[66] Letter, The Adjutant General, to The Surgeon General, 3 Aug. 1939, subject: System of Affiliating Medical Department Units With Civilian Institutions, and Appointment and Promotion in the Medical Reserve Corps.

[67] Letter, The Surgeon General, to The Adjutant General, 22 Sept. 1939, subject: Affiliation of Medical Department Units With Civilian Institutions.

[68] Letter, The Surgeon General, to The Adjutant General, 19 Oct. 1939, subject: Affiliation of Medical Department Units With Civilian Institutions.

[69] (1) Letter, The Adjutant General, to The Surgeon General, 22 Nov. 1939, subject: Affiliated Medical Units—Allocation, Organization, and Mobilization. (2) Letter, The Adjutant General, to The Surgeon General, 26 Jan. 1940, subject: Officers of Affiliated Medical Units—Appointment, Reappointment, Promotion, and Separation. (3) Letter, The Adjutant General, to The Surgeon General, 11 May 1940, subject: Officers of Affiliated Medical Units—Appointment, Promotion, and Separation.

Organization of the units

Meanwhile, the Office of The Surgeon General had been actively engaged in implementing this project. Once the sponsoring institutions had been chosen and approved, The Surgeon General notified these institutions, outlined the plan, asked their acceptance of it, and requested them to begin the necessary work of establishing and training the proposed units. Upon receipt of concurrence, the Office of The Surgeon General advised The Adjutant General, and thus affiliation was formally established.[70]

The response during the spring and summer of 1940 was enthusiastic. Since the project had been first proposed, Germany had overrun Norway, France, and the Low Countries, and involvement of the United States seemed imminent to many. The resulting patriotic appeal was reinforced by the fact that most of the proposed sponsors had organized similar units in the First World War, and the old numerical designations were revived for the new units. Not only did the listed institutions respond to the appeal, but many others applied to General Magee during 1940 and 1941 for inclusion in the project. He rejected these offers, stating that the program might later be broadened to include additional smaller hospitals.

The actual organization of the units through the commissioning and assignment of officers was a long and tedious process, requiring many months to complete. Detailed instructions were distributed.[71] With rare exceptions, officer appointments made by the institution were not questioned by The Surgeon General. The Office of The Surgeon General maintained contact with the sponsoring institutions through its Reserve Subdivision and during the organization period established rosters of unit personnel. At the time, there was no definite provision for furnishing these hospitals with enlisted men. It turned out, however, that when the hospitals were activated—in 1942–43—a large part of this personnel was drawn from existing theater of operations hospital units. Another part came from the reception or training centers. Special arrangements were also made whereby men from the sponsoring institution could be voluntarily inducted into the service and earmarked for assignment to the affiliated unit when it was activated.[72]

The original list of hospitals proposed by The Surgeon General and approved by the General Staff provided for the necessary theater of operations hospitalization envisaged by the Protective Mobilization Plan for the first 120 days of mobilization. There still remained the problem of insuring the additional hospitalization required for the four successive augmentations of the basic plan. It had been The Surgeon General's intention to create additional affiliated units for this purpose, once the organization of the first group of

[70] Memorandum, Lt. Col. Paul A. Paden, Director, Medical Personnel Division, Office of The Surgeon General, for Colonel Love, Historical Division, Office of The Surgeon General, 15 Apr. 1944.

[71] Letter (mimeographed), The Surgeon General, to each affiliating institution, 16 May 1940, subject: Affiliated Units, Medical Department, U.S. Army.

[72] (1) Smith, Clarence McKittrick: The Medical Department: Hospitalization and Evacuation, Zone of Interior. United States Army in World War II. The Technical Services. Washington: U.S. Government Printing Office, 1956. (2) See footnote 70.

hospitals had been accomplished. By June 1940, the preparation of the approved hospitals had proceeded sufficiently to make the organization of additional affiliated units feasible. The widespread publicity given to the program had resulted, as already mentioned, in a large number of requests for affiliation from institutions not on the first list, including some that had sponsored units in 1917. It seemed the proper time therefore to expand the program. On 26 June 1940, General Magee requested permission to organize additional hospitals. He proposed that neither the exact number of units nor their distribution be determined at that time. On 22 July 1940, the War Department approved the organization, as affiliated units, of an additional 36 general hospitals, 13 evacuation hospitals, and 10 surgical hospitals as part of the first augmentation of the Protective Mobilization Plan.[73] This authorization almost doubled the number of affiliated hospitals to be made available.

The original plan had been to provide, at the time of activation, Regular Army officers as commanding officers of these affiliated units who would replace the directors when the units were called into service. As the organization proceeded, however, it became apparent that in certain instances it would be desirable to continue unit directors as commanding officers during mobilization. Four unit directors, each of whom had had experience and training during World War I and who had maintained an unusually active interest in the Organized Reserve since that time, were considered qualified to command their units. General Magee recommended that these men receive mobilization assignments as commanding officers, and that officers of the Regular Army Medical Corps be assigned as executive officers. He further proposed that if similarly qualified directors were appointed in other units he should be authorized to make similar assignments. The request for the assignment of the four officers (fig. 28) was approved: Col. Thomas R. Goethals, MC, to the 6th General Hospital, Lt. Col. (later Col.) Henry R. Carstens, MC, to the 17th General Hospital, Col. E. T. Wentworth, MC, to the 19th General Hospital, and Col. J. G. Strohm, MC, to the 46th General Hospital; but The Surgeon General was required to make separate requests for future assignments, as these would involve changes in the approved allotments of officers.[74]

By October 1941, the organization of affiliated units had reached an advanced stage, and 41 general hospitals, 11 evacuation hospitals, and 4 surgical hospitals actually had been organized. A certain number of institutions had not shown interest in the project, and no personnel were assigned to those units; a number of additional units also were contemplated, but the Secretary of War had not yet authorized them.[75]

---

[73] Letter, The Surgeon General, to The Adjutant General, 26 June 1940, subject: Affiliated Units, Medical Department, with 1st endorsements thereto, 22 July 1940.

[74] Letter, The Surgeon General, to The Adjutant General, 18 June 1940, subject: Affiliated Units, Medical Department, with 1st endorsement thereto, 8 July 1940.

[75] (1) Memorandum, Lt. Col. Francis M. Fitts, Office of The Surgeon General, 7 Oct. 1941, subject: Status Report, Affiliated Units. (2) The publication cited in footnote 72(1), p. 143, contains lists (tables 6 and 7) of the affiliated general and evacuation hospitals, showing Army number, institution with which affiliated, dates of activation and embarkation, and initial destination.

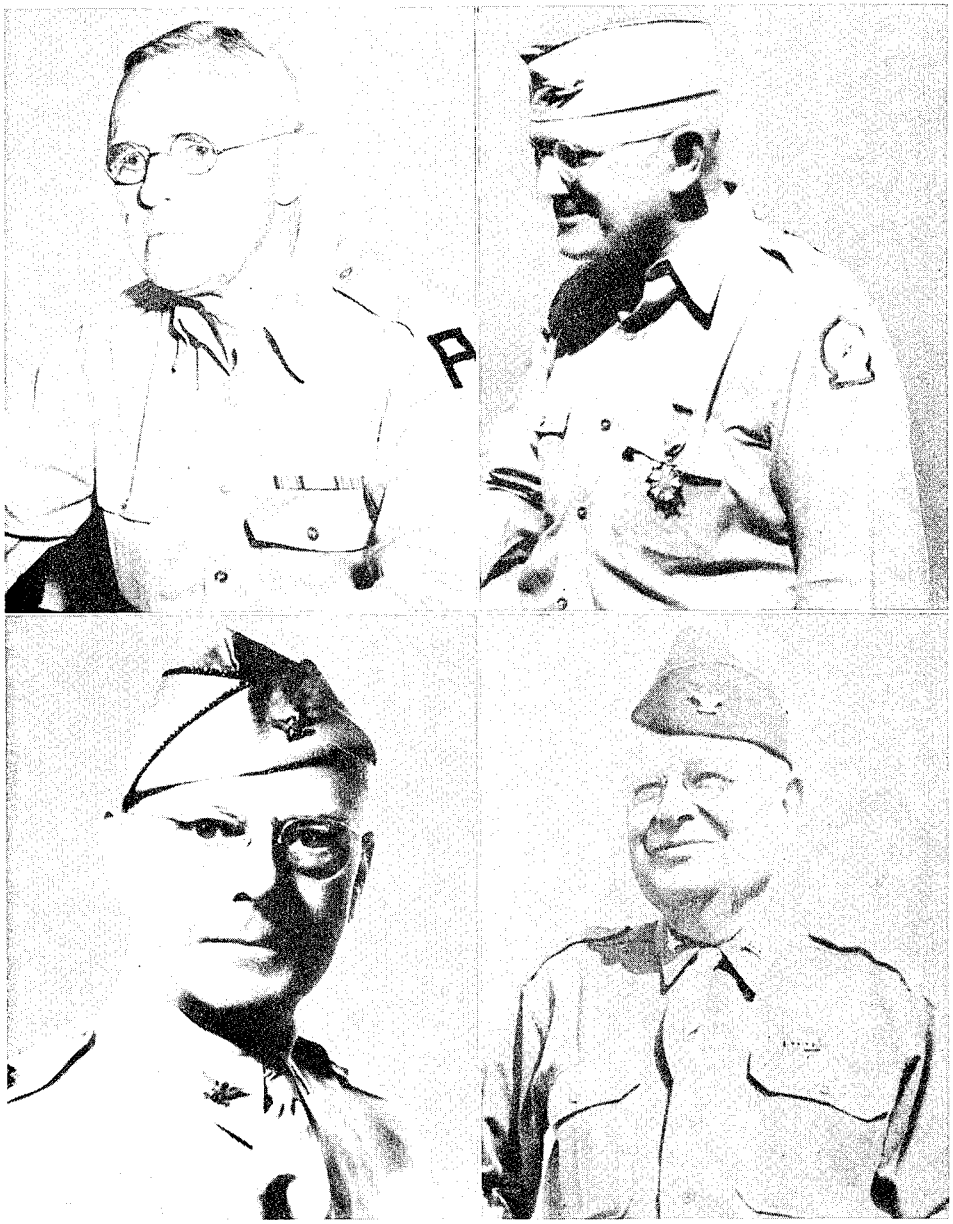


FIGURE 28.—Early appointments as commanders of affiliated units. Upper left: Col. Thomas R. Goethals, MC, to the 6th General Hospital. Upper right: Col. Henry R. Carstens, MC, to the 17th General Hospital. Lower left: Col. E. T. Wentworth, MC, to the 19th General Hospital. Lower right: Col. J. G. Strohm, MC, to the 46th General Hospital.

Deferment of Active Duty for Members of Affiliated Units

While affiliated units awaited activation, the Reserve officers in them enjoyed what amounted to a deferment of service. The possibility of calling the officers of these units to active duty received consideration in September and October 1940. During the spring and summer of that year when large numbers of Reserve officers in other categories were being called to duty, the directors of affiliated units were recruiting for their organizations on the understanding that appointees would remain on inactive status until the units themselves were called up. Following mobilization of the National Guard and the advent of selective service in the autumn of 1940, however, a number of persons suggested calling the officers of affiliated units individually to active duty. The Surgeon General not only rejected these proposals but attempted to get assurances from the War Department that neither individual reservists nor the affiliated units in which they served would be called to active duty before war came. While the General Staff would make no clear-cut declaration of policy to that effect, it followed (for the time being) The Surgeon General's recommendation in practice.[76] No affiliated unit was activated until after Pearl Harbor, and no steps were taken to call up individual members until still later (table 15).

The urgent demand for additional Medical Corps officers throughout 1941 drew attention once more to the affiliated units as a source of supply, and particularly to the more than two hundred Medical Corps Reserve officers in these units who were of draft age. In May 1941, The Surgeon General submitted a recommendation to The Adjutant General that these officers be discharged from their special commissions and that upon application they then be appointed in the Reserve in the grade of first lieutenant and ordered to active duty as soon as their services were required; they were also to be instructed that if their units were called they would be assigned for duty with them. Apparently, the heavy demand for additional officers prompted The Surgeon General to recommend a measure which would in effect have abrogated

TABLE 15.—*Medical Department officers of affiliated Reserve in affiliated medical units, February 1941*

Status	Medical Corps	Dental Corps	Medical Administrative Corps	Total officers
Original appointments in the affiliated Reserve	547	53	13	613
Transfers from nonaffiliated to affiliated Reserve	239	19	6	264
Total	786	72	19	877

Source: Report, Operations Service, Office of The Surgeon General, subject: Officers in Affiliated Units, as of February 26th, 1941.

[76] (1) Memorandum, The Surgeon General, for Assistant Chief of Staff, G–1, 28 Sept. 1940. (2) Memorandum, The Adjutant General, for The Surgeon General, 29 Oct. 1940, subject: Mobilization of Affiliated Units.

the original understanding with some of the officers in the sponsoring institutions. To this recommendation, the War Department replied that a program to discharge affiliated Medical Corps Reserve officers from their commissions and permit them then to volunteer for appointment in the nonaffiliated Reserve as first lieutenants would probably result in the loss of many officers. It was pointed out that many of these officers would not accept reappointment in that grade. However, the War Department authorized the discharge of affiliated officers above the rank of first lieutenant who, prior to discharge, volunteered to accept an immediate appointment in the nonaffiliated Reserve in the lower rank. The number of affiliated Reserve officers who accepted active duty on these terms is unknown, but past experience indicates that it was probably approximately 2 percent.[77]

While The Surgeon General was suggesting means of placing on active duty some of the officers in affiliated units already formed, he was also sanctioning the formation of additional units for use in case of war. In June 1941, the general regulations for affiliated units were modified, providing for some amelioration of the condition mentioned above.[78] The Surgeon General announced that no additional appointments would be made to affiliated units in the age group eligible for induction under selective service. Officers of the nonaffiliated Reserve who had been assigned without change of grade to affiliated units were to be considered as available for active duty. But officers of the affiliated Medical Corps Reserve could be brought on active duty only when they requested appointment in the nonaffiliated Reserve in the grade of first lieutenant.

The number of personnel assigned to affiliated units on 30 June 1941 is given in table 16. Of those shown, 1,257 Medical Corps, 122 Dental Corps, and 31 Medical Administrative Corps officers were said to belong to the affiliated Reserve and the remainder to the nonaffiliated Reserve. In October

TABLE 16.—*Medical Department officers in affiliated units, 30 June 1941*

Type of hospital	Medical Corps	Dental Corps	Medical Administrative Corps
General	1,144	157	44
Evacuation	233	15	3
Surgical	37	4	2
Total	1,414	176	49

Source: Annual Report of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1941, pp. 145-146.

[77] (1) Letter, Office of The Surgeon General (Executive Officer), to The Adjutant General, 5 May 1941, subject: Physicians of Draft Age Holding Commissions in Affiliated Units, with 1st endorsement thereto, 26 May 1941. (2) Letter, The Surgeon General, to The Adjutant General, 5 Aug. 1941, subject: Active Duty Orders for Medical Officers (Affiliated).

[78] Letter, Office of The Surgeon General, to each affiliating institution, 2 June 1941.

1941, 158 Medical Corps, 3 Dental Corps, and 1 Medical Administrative Corps officers from affiliated units were on active duty.[79] Thus, the basic problem of obtaining the services of medical personnel in affiliated units for the rapidly expanding Army remained unsolved right up to the outbreak of war—and even afterward.

OTHER SOURCES OF OFFICER PERSONNEL

Additional sources of professional personnel for the Medical Department in the prewar years existed, but for a variety of reasons were still looked upon as "off limits." These included graduates of foreign and of substandard American medical schools, Japanese-Americans, female doctors and dentists, and certain other professional minorities.

Graduates of Foreign and Substandard American Medical Schools

Foreign graduates

As early as 1933, the National Board of Medical Examiners, while not raising a general bar against graduates of foreign schools, stipulated that a student matriculating in a European medical school after the school year 1933 would have to submit evidence of the following in order to be admitted to the board's examination: (1) A premedical education equivalent to the requirements of the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association; (2) graduation from a European medical school after a course of at least 4 academic years; and (3) a license to practice medicine in the country in which that school was located. In 1939, the same board barred from its examinations the graduates of "extramural" (that is, not university connected) British medical schools.[80]

Army Regulations No. 140–33, issued on 30 July 1936, required a candidate for the Medical Corps Reserve to possess a license to practice in a State, Territory, or the District of Columbia, or a diploma from the National Board of Medical Examiners; he must also hold the degree of Doctor of Medicine from a class A medical school—that is, one approved by the American Medical Association. Although in the fall of 1940 The Surgeon General received many protests, both from individuals and from organizations such as the American Jewish Congress,[81] protesting the exclusion of foreign graduates from the Medical Corps, a revision of AR 140–33 on 15 December 1940 did not change essentially the previous conditions for admission to the Medical Corps.

---

[79] See footnotes 49(1), p. 135, and 75(1), p. 144.

[80] Letter, Office of The Surgeon General (Colonel Lull), to George L. Cassidy, Associate Editor, New York Post, 14 Nov. 1940, with enclosure thereto.

[81] Letter, Carl Sherman, Chairman, Administrative Committee, American Jewish Congress, to Assistant Secretary of War, 28 Nov. 1940.

At that time, The Surgeon General stated that he himself had no means of classifying foreign medical schools definitively. While some were undoubtedly satisfactory, there was considerable evidence that many did not have acceptable standards, and he did not desire to have the American soldier treated by physicians not fully qualified in accordance with the standards of approved American schools.[82] Several officers who were in the Surgeon General's Office at the time have restated and enlarged upon these points. Brig. Gen. Albert G. Love (Ret.) has pointed out that "in the years prior to World War II, the American Medical Association had done * * * a tremendous job in classifying medical schools, raising the standard of medical education, and forcing substandard schools to raise their standards or close their doors." A former staff member of The Surgeon General's Personnel Division, who dealt with hundreds of graduates of foreign medical schools, wrote that "some were unquestionably well qualified professionally, mentally, physically and socially. Others, were, however, very undesirable as Medical Corps officers * * * many had failed in American medical schools before entering foreign schools. Others had Arts school academic averages so low that their admission to an approved [medical] school was not justified. It was also known that many European medical schools, particularly German, had deteriorated rapidly in the late twenties and in the thirties.[83]

Also in December, 1940, Dr. J. John Kristal, Chairman of the Executive Committee of the American Alumni of British Medical Schools, wrote to Dr. Irvin Abell, Chairman of the Committee on Medical Preparedness of the American Medical Association, listing six "quite stringent" requirements that might be established for graduates of the British medical schools in order to obtain commissions in the U.S. Army Medical Corps Reserve. His proposal was approved by The Surgeon General who on 30 December 1940 forwarded it to the War Department General Staff, substituting, however, the word "foreign" where Dr. Kristal had used "British," and including a stipulation of citizenship. The six requirements were as follows:

1. They shall be citizens of the United States. They shall present satisfactory evidence of premedical education equivalent to the requirements of the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association.

2. They shall have completed a medical course of at least four academic years.

3. They shall have obtained a license to practice in the country in which the medical school from which they graduated is located.

4. They shall have evidence of a year's internship or more in a hospital acceptable to the Council on Medical Education and the Committee on Hospitals of the American Medical Association.

5. They shall be eligible to take the examination given by the National Board of Examiners.

6. They shall have a license to practice medicine in some state or territory of the United States.

[82] Letter, Office of The Surgeon General (Colonel Lull), to The Adjutant General, 23 Nov. 1940.

[83] (1) Letter, Brig. Gen. Albert G. Love (Ret.) to Col. John B. Coates, Jr., Director, Historical Unit, U.S. Army Medical Service, 29 Nov. 1955. (2) Letter, Col. Paul A. Paden, to Col. C. H. Goddard, Office of The Surgeon General, 21 Jan. 1952.

Two months later (5 February 1941), the War Department General Staff approved these recommendations.[84]

Graduates of unapproved American schools

As to graduates of unapproved schools in the United States, The Surgeon General continued to hold that they should be rejected, urging that as soldiers had to take what the Army offered in the way of doctors they should be afforded at least the protection which most States accorded them as civilians. Therefore, only doctors who could be licensed to practice in a majority of the States should be granted commissions in the Medical Corps.[85] (The graduates of these unapproved schools could receive licenses in only one or two States.)

Again, as in the case of graduates of foreign schools, objections were raised to the existing policy. This time, however, it was felt that considering the shortage both in the Armed Forces and in civilian life the policy not only subjected doctors to the chance of being drafted, after which they would serve not as doctors but as enlisted men,[86] but also that it worked to the economic disadvantage of doctors already in the service. "When these men get out of the Army," the president of a State medical society wrote to The Surgeon General, "they will find that [graduates of unapproved schools] have adopted [that is, taken over] their practices." He considered this an unfair advantage to take of any doctor and asked if it was possible to commission graduates of unapproved schools as second lieutenants "or some lower commission" and allow them to serve as mess or sanitary officers. The Surgeon General replied that the advantage given to graduates of unapproved schools was more apparent than real. However, he held out a promise: "If the general thought of the medical profession should be that these men should be accepted on the same footing as graduates of Grade A schools, thought can be given to a modification of our present practice." [87]

Soon, thereafter, the Directing Board of the Procurement and Assignment Service suggested terms on which graduates of unapproved medical schools might be accepted for commissions. In April 1942, accordingly, The Surgeon General announced that such graduates would be commissioned in the Medical

---

[84] (1) Letter, Office of The Surgeon General (Col. G. F. Lull), to The Adjutant General, 30 Dec. 1940, subject: Appointment of Graduates of Foreign Medical Schools. (2) Letter, The Adjutant General, to The Surgeon General, 5 Feb. 1941, subject: Appointments of Graduates of Foreign Medical Schools in Medical Department Reserve. (3) Letter, The Adjutant General, to Corps Area and Department Commanders and The Surgeon General, 5 Feb. 1941, subject: Appointments of Graduates of Foreign Medical Schools in Medical Department Reserve.

[85] Letter, The Adjutant General, to President, Association of Medical Students, Middlesex Hospital, Cambridge, Mass., 22 Dec. 1941. (The Surgeon General had sent this reply to The Adjutant General for forwarding to the president of the Association of Medical Students, 16 Dec. 1941.)

[86] (1) Letter, Dr. John F. McGuinness, Woburn, Mass., to President Roosevelt, 7 Jan. 1942. (2) Letter, Senator C. Wayland Brooks (III), to The Surgeon General, 13 Feb. 1942. (3) Letter, Joseph H. Dorfman, Detachment Commander, Headquarters Detachment, Detachment of Illinois, Sons of American Legion, to The Surgeon General, 10 Feb. 1942.

[87] (1) Letter, President, Massachusetts Medical Society, to Surgeon General Magee, 31 Jan. 1942. (2) Letter, Surgeon General Magee, to Dr. Frank R. Ober, President, Massachusetts Medical Society, 7 Feb. 1942.

Corps of the Army of the United States if they met the following conditions: The applicant must, in addition to possessing the doctor of medicine degree, have had a 1 year's rotating internship, and have a license to practice medicine in one of the States or in the District of Columbia; he must also have been engaged in the ethical practice of medicine and must present five letters to this effect from doctors who knew him and who were graduates of recognized schools of medicine. The Surgeon General would determine whether the graduate was eligible. The final stipulation—that the applicant must be a member of his local county medical society and be indorsed by his State medical society—had to be changed later because some medical societies refused to admit graduates of unapproved schools until they had been practicing for 5 years. The Surgeon General agreed, therefore, that he would accept those who met the other conditions if they presented a statement from the secretary of the county or district medical society that they were engaged in the ethical practice of medicine and would be eligible for society membership except for the fact that they had been in practice less than 5 years.[88] Schools whose graduates the Medical Department agreed to accept on these terms were Middlesex University College of Medicine, the Chicago College of Medicine, and the Cincinnati College of Eclectic Medicine. The Surgeon General judged the graduates of two other schools more on their individual merits. Doctors graduated from any of these unapproved schools were commissioned only in the grade of first lieutenant.

When in the fall of 1943 the State authorities of Massachusetts declared that graduates of the Middlesex University College of Medicine would not be eligible for the licensing examinations held after June 1944, the Medical Department refused to recommend for appointment additional graduates of that school (not waiting until Massachusetts examined the last ones it had stipulated it would admit to examinations); in July 1944, the Medical Department announced, however, that it would accept recent graduates of that school under terms previously in effect. No figures are available on the total number of graduates of unapproved schools who joined the Army Medical Corps under the terms laid down by The Surgeon General, although in early 1944 it was stated that between 200 and 300 graduates of Middlesex University College of Medicine alone had been appointed.[89]

The problem of unapproved schools did not arise in the case of dentists, there being no such dental schools. As for veterinary schools, The Surgeon General refused to commission graduates of the sole unapproved institution of

[88] (1) Letter, The Adjutant General, to The Surgeon General, 28 Apr. 1942, subject: Admission of Graduates of Certain Nonrecognized Schools of Medicine to the Army of the United States. (2) Letter, The Surgeon General, to Dr. Frank H. Lahey, Boston, Mass., 15 July 1942.

[89] (1) Letter, The Surgeon General, to Dr. Frank H. Lahey, War Manpower Commission, 24 Aug. 1942. (2) Memorandum, The Surgeon General, for Officer Procurement Service, Army Service Forces, Attn: Col. E. G. Welsh, Acting Director, 3 Dec. 1943, subject: Discontinuance of Appointments * * * of Graduates of Middlesex University College of Medicine. (3) Memorandum, The Surgeon General, for Director, Officer Procurement Service, Army Service Forces, 20 July 1944, subject: Middlesex University School of Medicine. (4) Letter, The Surgeon General, to The Adjutant General (for forwarding to the Hon. David I. Walsh, U.S. Senator (Mass.)), 7 Jan. 1944.

that kind, the veterinary school of Middlesex University.[90] Graduates of that school who were drafted served in enlisted status—unless they received commissions in an officer component, such as the Medical Administrative Corps, which required completion of the regular course at an officer candidate school.

Alien and Naturalized Physicians

Alien and naturalized physicians in the Army in an enlisted status could be commissioned in the Army of the United States provided they met the following requirements: (1) Citizens of cobelligerent Allied countries had to meet requirements for professional training and the necessary War Department investigations, such as those of the Military Intelligence Service and the Provost Marshal. Such applicants had to have a release from the military attaché of their country's legation in the United States, and as The Surgeon General pointed out, that process involved many difficulties. Since the applicant's government had to be acceptable to the U.S. Department of State, it was often necessary for The Adjutant General to determine from day to day that Department's evalution of the foreign government concerned. (2) Enemy aliens had to meet the investigation of all agencies, including that of the Assistant Chief of Staff, G–2 (intelligence), and in addition had to be naturalized. (Naturalization had been rendered easier in March 1942 by an enactment of Congress that persons who had served 3 months in enlisted status could obtain citizenship immediately.)[91] They must, moreover, have arrived in this country before 1 January 1938, and also "as a general, but less rigid rule," they had to prove that they did not have relatives remaining in enemy countries. (This meant that, even though naturalized, they had some of the legal disabilities of aliens.) As a further barrier, most foreign physicians applying for commissions had been educated in foreign schools and hence had to meet the special requirements The Surgeon General had laid down for such graduates.[92]

The question of what to do about alien physicians not serving in the Army was a matter of concern to the Procurement and Assignment Service. Since many States required applicants to establish American citizenship as one prerequisite to admission to State licensing examinations, and other States issued temporary licenses which were subject to cancellation unless the holder obtained American citizenship within a specified time, the Department of Justice took steps in January 1943 to have the Immigration and Naturalization Service assist in relieving the shortage of civilian physicians by expediting the legal process of naturalizing alien physicians.

---

[90] Letter, Office of The Surgeon General (Col. J. F. Crosby, VC), to Dr. Louis Karasoff, Middletown, N.Y., 17 Apr. 1942, with 2d wrapper endorsement thereto, 10 Jan. 1945.

[91] 56 Stat. 182.

[92] Memorandum, The Surgeon General (Chief, Personnel Service), to Col. Richard H. Eanes, Medical Division, National Headquarters, Selective Service, 8 Feb. 1943.

Japanese-American Medical Personnel

Physicians and dentists

Japanese-American citizens were treated differently from other groups. The Surgeon General recommended in May 1942 against commissioning them, whether they were serving in enlisted status or were civilians. He stated that although they might meet all the requirements for commissions "they would be placed at a personal disadvantage and in many embarrassing positions. They would inspire a lack of confidence and distrust throughout the Army * * * rendering no military value and being under suspicion at all times." [93]

Regulations prohibited the assignment of Japanese-American officers to units made up of others than their own group. At Camp Shelby, Miss., however, when the 442d Regimental Combat Team (a Japanese-American unit) had an oversupply of doctors and dentists, the commander loaned one of the doctors to another unit and the excess dentists to the camp dental clinic, where their services proved very satisfactory. They could not, however, be permanently assigned to these organizations for the reason stated above. On a visit to Camp Shelby in October 1943, the Assistant Secretary of War learned of this incident and called it to the attention of The Surgeon General as an indication of what might be done if War Department policy were changed, remarking that Japanese-American medical talent was "not being usefully employed." The Surgeon General followed this suggestion by attempting to detach some of the Japanese-American doctors from the Army Ground Forces, but without success.[94]

Nurses

The question of whether to commission nurses who were Nisei (that is, American citizens of Japanese ancestry) caused considerable discussion, particularly after it had been announced (January 1945) that a draft of nurses was necessary to meet the Army's needs. The Surgeon General had previously stated that there were no position vacancies for Nisei nurses. This assumed that because of their racial background they could be placed only in special jobs. Possibly the belief existed in some quarters that use of such nurses would antagonize soldier patients. In August 1944, however, the Secretary of War ruled out the factor of race by announcing that qualified Nisei nurses could be appointed in the Army if their loyalty was vouched for by the

[93] Letter, Office of The Surgeon General (Col. J. A. Rogers, Executive Officer), to The Adjutant General, 11 May 1942, subject: Physicians, Dentists, and Veterinarians of Japanese Ancestry.

[94] (1) Letter, Assistant Secretary of War, to The Surgeon General, 23 Oct. 1943. (2) Letter, Surgeon General Kirk, to Assistant Secretary of War (McCloy), 10 Nov. 1943.

Provost Marshal General's Department, and that The Surgeon General would direct their assignment to duty.[95]

Early in 1945, the Surgeon General's Office estimated that about 300 of the 800 Nisei nurses in the United States would be available for military duty. Under pressure from the New York newspaper, *PM*, which had also previously criticised him for rejecting these nurses because there were no vacancies for them, The Surgeon General announced that he would take them on the terms laid down by the Secretary of War. This meant that while they were subject to the same conditions of availability, professional training, and physical condition as other nurses they would not be rejected because of ancestry alone. They would, however, be used only in the United States. These transactions did not lead to the admission of any large number of Nisei nurses into the Army. By February 1945, only four had been appointed, all that were accepted during the war.[96]

Female Doctors and Dentists

With a few possible exceptions, before World War II, the Army had not accepted women of any group in full commissioned status,[97] although nurses had held relative rank. In late 1942, dietitians and physical therapists received the same status. During World War I, 55 female doctors had served on a contract basis.[98] Even before World War II, certain civilian groups had agitated to have women commissioned in the Medical Corps in the event of war. In England, after war broke out, female doctors were commissioned in the "women's forces," but not in the Royal Army Medical Corps.[99]

In June 1942, the Services of Supply took steps to procure female doctors, not for service with the Medical Corps, but with the Women's Auxiliary Army Corps. They served as contract surgeons when first placed on duty and if found acceptable were made members of the corps, in the status of "second officer," which was not a commissioned status. In January 1943, 25 female doctors were assigned to the Women's Auxiliary Army Corps or were being considered for assignment.[100]

In 1942, The Surgeon General testified before the Committee to Study the Medical Department that he had requested that a few women doctors be com-

[95] Letter, G–1, to The Adjutant General, 11 Aug. 1944, subject: Enlistment of Japanese-American Nurses.

[96] (1) Memorandum, Acting Chief, Personnel Service, Office of The Surgeon General, for The Surgeon General (and others), 17 Mar. 1945. (2) Weekly Diary, Acting Chief, Personnel Service, Office of The Surgeon General, week ending 17 Mar. 1945. (3) Manuscript, Col. [Florence A.] Blanchfield, and Mary [W.] Standlee, The Appointment of Racial Minorities in the Army Nurse Corps, p. 32.

[97] During the Civil War, at least one woman, a Dr. Mary Walker, was commissioned as an Assistant Surgeon. (Letter, Office of The Surgeon General (Col. Albert G. Love), to Dr. Morris Fishbein, American Medical Association, 5 Apr. 1943.)

[98] Letter, Office of The Surgeon General (Lt. Col. Francis M. Fitts), to Unit Director, 2d General Hospital, Presbyterian Hospital, N.Y., 16 Aug. 1941.

[99] Crew, F. A. E.: Army Medical Services, Administration. London: Her Majesty's Stationery Office, 1953, vol. 1, p. 206.

[100] Memorandum, Office of The Surgeon General (Brig. Gen. Larry B. McAfee, Acting Surgeon General), for Commanding General, Services of Supply, 4 Jan., 1943, subject: Utilization of Women Doctors, with 1st endorsement thereto, 19 Jan. 1943.

missioned to serve the Women's Auxiliary Army Corps, but the Comptroller of the United States had informed him that women could not hold commissioned rank in the Army of the United States. A few months later, he reiterated the Comptroller General's ruling to General Somervell and added that if enabling legislation were introduced, women belonging to other professional and technical groups might feel that they had been discriminated against. He stated that there was no other objection to commissioning qualified female doctors in the Army of the United States, but suggested that their use be limited to service with the Women's Auxiliary Army Corps either in the United States or abroad. The Secretary of War, undeterred by the thought that introduction of a bill to grant commissions to female doctors might antagonize women of other professional and technical groups, pressed for such legislation; he suggested that, once commissioned, female doctors should be confined for the time being to duties with the Women's Auxiliary Army Corps and to hospitals where there was a large number of women patients.

The necessary legislation was passed in April 1943. Applying to both Army and Navy, it provided that licensed female physicians could be granted commissions in the Army of the United States or the Naval Reserve, "during the present war and six months thereafter." Such officers were to enjoy the same rights, privileges, and benefits as other members of those organizations having the same grade and length of service.[101] This law did not limit their service to the United States, and a number served abroad. It made female doctors the first women to hold full commissioned rank in the Army of the United States, antedating not only the nurses,[102] dietitians, and physical therapists (by more than a year), but the officers in the Women's Army Corps, who attained that status a few months later (1 July 1943).

Desirable though it was in itself, the new law did little to meet the Medical Department's demand for personnel. Although the Army placed no limit on the number of professionally and physically qualified female doctors it would accept, only 76, or 1 percent of the approximately 7,600 women doctors in the United States, were ultimately commissioned.[103] On 28 February 1945, when 74 women were serving in the Army Medical Corps, 4 were majors, 36 captains, and 34 first lieutenants; on the same date, 17 were overseas. At least one received a promotion to the grade of lieutenant colonel upon being separated from the Army.[104]

Between June 1943 and March 1945, several attempts were made in Congress to authorize the commissioning of women dentists, but all attempts failed,

---

[101] 57 Stat. 65.

[102] Two exceptions were the Army Nurse Corps Superintendent, and her Assistant Superintendent, promoted to the grade of colonel and lieutenant colonel, respectively, in March 1942. (Letter, Col. Florence A. Blanchfield, USA (Ret.), to Col. J. B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 21 Feb. 1956.)

[103] (1) Memorandum, Lt. Col. D. G. Hall, Office of The Surgeon General, for Brig. Gen. G. F. Lull and Col. J. R. Hudnall, Office of The Surgeon General, 21 Apr. 1943. (2) Sixteenth Census of the United States: 1940, Population: The Labor Force, vol. III, p. 75 (table 58).

[104] Army Medical Bulletin No. 88, 1945, p. 50.

probably because the War Department felt that there was no shortage of dentists in the Army.[105]

Other Minority Groups

Efforts to secure commissioned status for certain other groups serving in the enlisted ranks occurred spasmodically throughout the emergency and war periods. Groups who sought such status included chiropractors, optometrists, osteopaths, and podiatrists. Of these groups, the optometrists alone were commissioned and these only after the cessation of hostilities.

CONTRIBUTIONS OF ORGANIZED MEDICINE AND NURSING

Before the end of 1940, civilian professional organizations in the medical field were becoming involved in the process of recruiting medical officers and nurses for the Army. The most influential of these organizations was the American Medical Association, whose interest in procurement extended beyond the Reserves—at first the main source of officers—and included the entire civilian profession. It was for this reason that The Surgeon General requested the cooperation of the association. To obtain much larger numbers of officers than it already had, the Medical Department would have to go outside the ranks of those previously enrolled in the Reserves and recruit officers directly from civilian life. Moreover, if a major war occurred, even though the United States had more physicians per capita of population than any other country,[106] the supply would have to be rationed between the military and civilian medical services. The civilian professional organizations would be vitally interested in both processes and might render valuable aid in solving the problems they involved. A precedent for collaboration had been set during World War I, when the American Medical Association and its constituent groups, the State medical societies, had participated in the recruitment of medical officers.

Committee on Medical Preparedness

The American Medical Association, having offered its services to the Federal Government in May 1940, responded to The Surgeon General's request at its annual session in June 1940 by creating a Committee on Medical Preparedness. This committee, consisting of 10 members, was to establish and maintain contact with appropriate governmental agencies "so as to make available at the earliest possible moment every facility that the American Medical Association can

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

[106] According to figures compiled probably in 1942, by the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, the United States had 1 physician for each 750 people. The latest figures available for other countries, published in 1932, showed that England and Wales, on the other hand, had only 1 for each 1,490; Germany, 1 for each 1,560; France, 1 for each 1,690; and Sweden, 1 for each 2,890. "Final Report of the Commission on Medical Education" (New York, 1932), p. 99.

offer for the health and safety of the American people and the maintenance of American democracy." [107] The committee was to cooperate with the Advisory Commission to the Council of National Defense, the U.S. Public Health Service, and other Federal agencies, as well as with the Medical Department of the Army and the Bureau of Medicine and Surgery of the Navy. The committee was also to consider problems in other fields besides those concerned with providing medical personnel for military needs.

At the same session, the American Medical Association considered a plan presented by The Surgeon General of the Army; at his request, it agreed to conduct a survey of the medical profession, and accepted in principle his suggested procedure for designating physicians who could be spared from civilian practice and brought into the Army. The plan had to receive the sanction of the General Staff before it could become in all respects operative, and was evidently intended to take full effect only "in the event of a national emergency of great magnitude" [108]—or, more specifically, a war.

The survey of the medical profession, however, was undertaken immediately by the Committee on Medical Preparedness. To get information for the preparation of a roster, the committee sent questionnaires to all physicians in the United States. The committee realized that the returns would be based on the individual doctor's own estimate of his availability and utility as a medical officer, but it planned to control this by using data from the various specialty boards and other information in the possession of the American Medical Association. The questionnaire was a single-sheet schedule, coded for transfer to machine record cards. In addition to the usual personal data, the committee asked for information concerning details of medical education, licensure, membership in medical societies, full-time appointments, type of practice, certification of examining boards, details of specialty practice, previous military experience, present commission, willingness to volunteer in the event of war, "service you consider yourself best qualified to perform," and physical disabilities.[109]

The questionnaires were mailed in July 1940. Eventually, more than 185,000 physicians received them, and by 2 January 1942, 85.8 percent had been returned. About 26,000 had to be completed for those who failed to do so for themselves. These were prepared from available information on file in the offices of the State and county medical societies. Eventually, 96 percent of the questionnaires were completed.[110] Meanwhile, the process of transferring the information on the returned questionnaires to punchcards began, and the cards were sorted into specialist groups and others. Various directories and lists were constantly used in editing the returns.

The object of the survey was to determine (1) the number of physicians licensed to practice medicine, (2) the number suitable for active service and the

[107] Medical Preparedness. J.A.M.A. 114 : 2466, 22 June 1940.
[108] Memorandum, Colonel Dunham, for The Surgeon General, 14 June 1940.
[109] Medical Preparedness. J.A.M.A. 115 : 137, 13 July 1940.
[110] Information from Lt. Col. Harold C. Lueth, MC, former liaison officer, Office of The Surgeon General, with Chicago office of the American Medical Association, 26 May 1945.



FIGURE 29.—Lt. Col. Harold C. Lueth, MC, liaison officer from the Office of The Surgeon General, to American Medical Association, 1942–45.

number incapacitated, (3) the number and location of physicians who were qualified and available for the Armed Forces and for other essential services in case of national emergency, (4) the number available for service to the civilian population under emergency conditions, (5) the availability and qualifications of those who could serve in special fields of medicine, (6) the number and identity of physicians qualified for teaching and research who were essential to the maintenance of educational institutions, and (7) the number, age, qualification, availability, and other characteristics of all members of the medical profession.

In planning and carrying out this project, there was close liaison between the Committee on Medical Preparedness and the Office of The Surgeon General. The latter assigned a representative, Lt. Col. (later Col.) Charles G. Hutter, MC, to the headquarters of the American Medical Association in Chicago; he reported for duty in October 1940. His successor, from 15 March 1942 to 26 March 1945, was Lt. Col. Harold C. Lueth, MC (fig. 29). An important part of the liaison work consisted of an exchange of information. From data supplied by corps area commanders, the *Journal of the American Medical Associa-*

tion published weekly lists of Medical Corps Reserve officers ordered to active duty, and the same information was recorded in the files of the committee. In turn, the corps area surgeons were assisted in the classification and procurement of Reserve officers by members of the committee.[111]

When the federalization of the National Guard and the inauguration of selective service created a heavy demand for more medical officers in the fall of 1940, the Committee on Medical Preparedness offered to aid in procuring and classifying physicians qualified to act as chiefs of services, if a sufficient number could not be obtained from the Reserve. The Surgeon General accepted this offer.

Acceptance of The Surgeon General's Plan

Meanwhile, in August 1940, The Surgeon General presented to the General Staff for approval a revised version of the plan placed before the American Medical Association in June. The original plan had involved a rather elaborate system of cooperation between Army authorities and the national, State, and county organizations of the American Medical Association for the purpose of designating physicians available for the Army. This one developed the first more fully in some respects and curtailed it in others. The General Staff criticized two points of the proposal—the decentralization of responsibility for the Army's part in the program to the corps area commanders and the commissioning of newly appointed civilians in a rank appropriate to the position they were to fill. Nonmedical officers of the War Department had difficulty in appreciating the fact that the average Medical Department Reserve officer who held advanced rank by virtue of length of service and the fulfillment of certain nonprofessional training requirements was not necessarily qualified to act as chief of the medical or the surgical service in a large hospital. To bring in qualified civilians for such positions and commission them in grades appropriate to their responsibilities meant changing the rules pertaining to rank and promotion in the Reserves, which the General Staff wished to uphold. After some discussion, however, G–1 was inclined to go part of the way, conceding that the grade should "in all cases be appropriate to the age of the applicant." [112]

The approved version of the plan appeared on 3 February 1941.[113] It made no mention of advanced rank (although this was already being granted in some cases) and allowed for only a small part of the decentralization which

---

[111] (1) Letter, Office of The Surgeon General, to each Corps Area Surgeon, 30 Oct. 1940, subject: Weekly Report for Liaison Officer, U.S. Army, in Care of the American Medical Association. (2) Letter, Office of The Surgeon General, to Corps Area Surgeons, 27 Nov. 1940, subject: Assistance of the American Medical Association in Classification and Procurement of Physicians.

[112] Memorandum, Office of The Surgeon General (Col. L. B. McAfee), for Assistant Chief of Staff, G–1, for Chief of Staff, 7 Oct. 1940, subject: Assistance of American Medical Association in Classification and Procurement of Physicians.

[113] Letter, The Adjutant General, to The Surgeon General and Corps Area and Department Commanders, 3 Feb. 1941, subject: Assistance of American Medical Association in the Classification and Procurement of Physicians.

The Surgeon General had recommended as a means of speeding the appointment of new medical officers. The plan stated that the American Medical Association would prepare and maintain a roster of civilian physicians, with their specialties and qualifications, who had agreed to accept commissions in the Army of the United States when needed for active duty in a "national emergency." The Surgeon General was to designate one or more officers to represent him at the headquarters of the American Medical Association in Chicago for all matters concerning the association and the Medical Corps Reserve. Vacancies existing in any corps area were to be reported to the War Department, which would attempt to fill them by transfers of Reserve officers from the Arm and Service Assignment Group or from the surplus of other corps areas before the services of the American Medical Association were called upon. If no qualified Reserve officers could be found, The Surgeon General was to notify the American Medical Association concerning the professional vacancies required to be filled and their respective locations. His representative would then forward the recommendations of the association to the corps area commander who would have the designated person or persons examined physically and send their applications for commissions to The Adjutant General for final action. The corps area commander could not grant waivers for physical defects, but could reject an applicant on these grounds. Applicants appointed in this way must not be more than 55 years of age and their appearance before the examining board would be dispensed with.

The War Department General Staff announced that the plan would be put in operation "at such time as the War Department may direct." It took no further action before Pearl Harbor. Nevertheless, The Surgeon General, the American Medical Association, and the corps areas had already carried out some features of the plan before it was approved. The American Medical Association had compiled its roster (which was intended to include all physicians in the country, not merely those willing to accept commissions), The Surgeon General had appointed his liaison officer with the association in Chicago, and information had been exchanged concerning the availability of civilian physicians for certain appointments in the Army.

The plan, while it might have met the requirements of a war situation from a military standpoint, would not have insured adequate civilian medical service under war conditions. In his original proposal to the American Medical Association, The Surgeon General had made the point that in time of war such a plan would "distribute the professional load, and if properly administered, should prevent the stripping of rural and isolated communities of their necessary medical personnel."[114] This was a point that greatly concerned the profession before and during the war. But, in the first place, neither The Surgeon General's original plan nor the one finally approved by the War Department specifically exempted members of the Reserves from a call to active duty even if their departure should "strip" the local com-

[114] See footnote 108, p. 157.

munities. As early as November 1940, the secretary of the American Medical Association warned the Surgeon General's Office that certain localities in Kentucky and Tennessee were being deprived of doctors by that means.[115] Moreover, nothing prevented a civilian doctor from volunteering his services to the Army, and only the self-restraints of the latter and the limits of the procurement objectives would keep it from accepting him. There were few volunteers, however, in relation to the total need.

The plan had certain advantages in that it initiated joint action between various agencies of the Federal Government and the American Medical Association, and after it was approved by the association, several conferences took place between representatives of the Army, Navy, and Public Health Service. It failed, however, to provide for the creation of an "independent" government agency to control the apportionment of doctors between the civilian community on the one hand and Federal agencies on the other.

Origin of the Procurement and Assignment Service

While The Surgeon General was seeking the approval of the War Department for his procurement plan, the American Medical Association was projecting a broader plan of collaboration which led ultimately to the establishment of the Procurement and Assignment Service in October 1941. The association's Committee on Medical Preparedness, seeing "evidence of duplication of effort and of much confusion," felt that "the early appointment of a coordinator for medical and health services is greatly desired to speed mobilization of medical resources for any emergency." It voted that a message to that effect be sent to President Roosevelt and the Advisory Commission to the Council of National Defense. Whether or not as a result of this action, the Council of National Defense established a Health and Medical Committee in September 1940 to coordinate these aspects of defense and to advise the Council concerning them.[116] Its membership consisted of the chairman of the American Medical Association's Committee on Medical Preparedness, who served as chairman, the Surgeons General of the Army, Navy, and Public Health Service, and the chairman of the National Research Council's Division of Medical Sciences. Six months later (31 March 1941), its Subcommittee on Medical Education[117] recommended the establishment of an official procurement and assignment agency. The Health and Medical Committee transmitted this proposal to the American Medical Association, which resolved on 3 June 1941 that the Government be urged "to plan * * * immediately for the establishment of a central authority with representatives of the medical profession to be known as the Procurement and Assignment

[115] Letter, O. G. West, American Medical Association, to Gen. A. G. Love, 18 Nov. 1940.

[116] (1) Medical Preparedness. J.A.M.A. 115: 465, 10 Aug. 1940. (2) Minutes of the Advisory Commission to the Council of National Defense, pp. 90, 92.

[117] Membership: The Chairman of the Health and Medical Committee (chairman), the Commissioner of Hospitals of New York City, and members of the Harvard, Minnesota, and Tulane Medical Schools and the Stanford University Hospital.

agency for physicians for the Army, Navy, and Public Health Service and for the Civilian and Industrial needs of the nation." The Surgeon General's Office expressed its full support of this resolution.[118]

The Health and Medical Committee in turn voted to adopt the association's resolution in principle and held a meeting on 22 October 1941 to "initiate the development of a Procurement and Assignment Service." At this meeting, which included the Surgeons General of the Army, Navy, and Public Health Service, a number of consultants from the American Medical and Dental Associations and one from the Veterans' Administration, a committee was appointed to draft a program for the proposed agency.

The committee submitted a detailed report analyzing the medical and allied personnel needs of the various public and private agencies and outlining the organization and duties of the proposed Procurement and Assignment Agency. Two days later (30 October 1941), Paul V. McNutt, the Director of Defense Health and Welfare Services (under whom the Health and Medical Committee now functioned), sent a letter containing the substance of these proposals to President Roosevelt for his approval which was given the same day. After outlining the purpose and organization of the new agency, Mr. McNutt stated:

> The functions of the Agency would be: (1) to receive from various Governmental and other agencies requests for medical, dental and veterinary personnel; (2) to secure and maintain lists of professional personnel available, showing detailed qualifications of such personnel; and (3) to utilize all suitable means to stimulate voluntary enrollment, having due regard for the overall public needs of the Nation, including those of governmental agencies and civilian institutions.

The letter concluded with a statement proposing to instruct the Agency to draft legislation providing for the "involuntary recruitment" of medical, dental, and veterinary personnel if the national emergency appeared to require it.[119]

On 17 November 1941, The Surgeon General appointed Capt. (later Lt. Col.) Paul A. Paden, MC, as his liaison officer with the Procurement and Assignment Agency.[120] (The "Agency" had been designated a "Service" shortly after its creation.) Another medical officer of the Army, Maj. (later Col.) Sam F. Seeley, MC (fig. 30), became Executive Officer of the Service's Directing Board.[121]

War came a few weeks after the new Service was established and before it had begun to function. It should be emphasized here, however, that the Procurement and Assignment Service neither procured nor assigned personnel. Its purpose was simply to assist in these operations. In that respect, it differed

---

[118] (1) Proceedings of the Cleveland Session [American Medical Association], 2–6 June 1941. J.A.M.A. 116: 2783, 21 June 1941. (2) Letter, American Medical Association, to Henry L. Stimson, Secretary of War, 12 June 1941, with 2d endorsement thereto, 23 July 1941.

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

[120] (1) Letter, Paul V. McNutt, Administrator, Federal Security Agency, to The Surgeon General, 14 Nov. 1941. (2) Letter, The Surgeon General, to Paul V. McNutt, 17 Nov. 1941.

[121] For composition of the directing board, *see* Mordecai, Alfred: A History of the Procurement and Assignment Service for Physicians, Dentists, Veterinarians, Sanitary Engineers, and Nurses—War Manpower Commission.

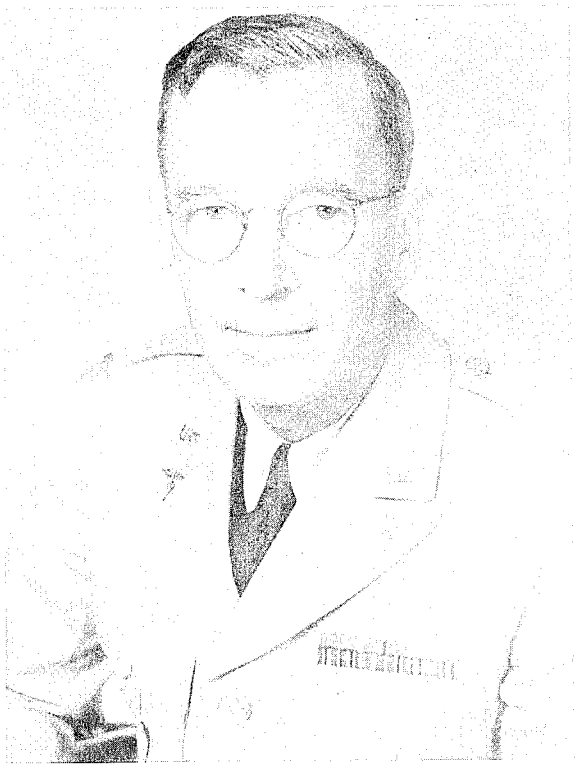


FIGURE 30.—Col. Sam F. Seeley, MC, Executive Officer, Directing Board, Procurement and Assignment Service.

little from the machinery contemplated in The Surgeon General's plan approved by the War Department 9 months before—which, in fact, it superseded. The Procurement and Assignment Service had no powers of compulsion—other than moral force—over the men it declared available for Federal service; and if they entered the service, it could only exhibit their qualifications, not insure their assignment to jobs for which they were specially equipped; in fact, "assignment" in the title of the new agency referred to the declaration of availability for one or other of the services rather than for a particular job. Some of the objections that might have been made to the earlier War Department plan therefore applied to the new agency. It met the request of the American Medical Association, however, in being a coordinating body for all Federal services; it also had the prestige of a Federal agency.

Subcommittee on Nursing

Meanwhile, the nursing profession was being organized for defense purposes not only by the Red Cross but by other organizations as well, both governmental and private. A Federal agency, the Subcommittee on Nursing,

established late in 1940 under the Medical and Health Committee of the Office of Defense Health and Welfare Services, had the following broad functions: [122]

To coordinate on a national level all nursing for defense in the Government agencies and the American Red Cross.

To act as a two-way channel between the Government agencies and the Nursing Council on National Defense.

To assist the Health and Medical Committee and its various subcommittees in all questions dealing with nursing.

To act as the Nursing Advisory Committee to the Office of Civilian Defense.

To suggest Federal legislation regarding nursing and to assist in the development of policy under which nursing programs are carried out.

The National Nursing Council

Private nursing groups had also created organizations designed to assist in supplying the Armed Forces and to distribute nurses equitably in civilian life. The National Nursing Council for War Service, originally formed on 29 July 1940 as the Nursing Council for National Defense, represented five national nursing organizations—the American Nurses Association, the National League of Nursing Education, the National Organization for Public Health Nursing, the Association of Collegiate Schools of Nursing, and the National Association of Colored Graduate Nurses—together with the Red Cross. The National Council encouraged the creation of State councils. In 1940, it had also initiated a National Survey of Registered Nurses, "to determine the number of professional nurses, their availability for military and particularly, for civil duty, and their special attainments." Lacking the money to complete such an ambitious project, however, it turned it over to the Subcommittee on Nursing, where it was placed under the guidance of a Special Inventory Committee, which completed it in 1941.[123] The Public Health Service assisted in coding and compiling the information gathered. This survey was comparable in purpose to the survey of doctors conducted by the American Medical Association.

PROCUREMENT OF ENLISTED MEN

The enlisted strength of the Medical Department on 30 June 1939 was 9,359 and by 30 November 1941 had risen to 108,674, representing 8 percent of that of the Army as a whole (table 1). Most of the increment came by way of voluntary enlistment, or after November 1940 by selective service, although the induction of the National Guard into Federal service also added sizable

---

[122] Haupt, Alma C., Executive Secretary of Subcommittee: Report of the Subcommittee on Nursing, Health and Medical Committee, Office of Defense Health and Welfare Services. Read before Joint Boards of the National Nursing Associations, New York City, N.Y., 24 Jan. 1942.

[123] (1) See footnote 49 (3), p. 135. (2) "News About Nursing." Am. J. Nursing 41: 223, 1941. (3) Speech presented by Pearl McIver, 12 July 1941, to joint meeting of the Subcommittee on Nursing, Nursing Council on National Defense, and the American Red Cross Advisory Committee.

numbers. The Medical Department Enlisted Reserve was only a negligible source of personnel; in contrast with the Medical Corps Reserve, which had many times the strength of the Regular Army Medical Corps, the medical sections of the Enlisted Reserve Corps and the Regular Army Reserve in June 1940 together numbered 1,524, only a little over one-tenth of the Regular Army enlisted strength of the Medical Department. None of its members was on active duty.[124]

The supply of enlisted personnel could be increased—in effect and over short periods—by speeding the production of trained men, for the Medical Department could not make full use of a man's services until he had received a modicum of instruction in medical techniques. The establishment of training centers was one means of attaining this goal. In the prewar period, medical replacement training centers were established at Camp Lee, Va., and Camp Grant, Ill., in January 1941, and at Camp Barkeley, Tex., in November 1941. In the latter month, The Surgeon General asked for additional training-center facilities and requested that those in being should be kept at full capacity by the prompt shipment of selectees to them. Reduction of the training period from 13 to 11 weeks at those centers and elsewhere, which The Surgeon General recommended at the same time, would also increase the rapidity of supply. It was the maximum reduction he then considered possible.[125]

It was important that after enlistment or induction enlisted men with medical skills should find their way into the Medical Department and remain there; it was also important that if possible they should be put in jobs where their civilian experience or natural intelligence could best be utilized. One interesting experiment to this end was undertaken by the Medical Department in collaboration with the Red Cross. Under an agreement signed in January 1940, the Red Cross established a Registry of Medical Technologists, listing individuals who met age and technical qualifications set by the Medical Department. Male registrants who qualified physically were to serve as either staff or technical sergeants in the Medical Department when called to duty in case of mobilization. Female registrants and men who did not qualify physically would be employed as civilian workers by the Medical Department in case of war, and civil service grades were established for them. The Army set age limits of 21 to 45 years. Members of the Regular Army, National Guard, or Reserve were not eligible for enrollment. Types of technologists enrolled included the following: Dietitians; physiotherapy and occupational therapy aides; dental hygienists; dental and orthopedic mechanics; laboratory, chemical laboratory, pharmacy, and X-ray technicians; meat and dairy hygiene inspectors; and statistical clerks. By September 1940, after almost 80,000 announcements had been mailed to these groups, 639 men and 403 women technologists were enrolled.

---

[124] Annual Report of the Secretary of War. Washington: U.S. Government Printing Office, 1940, pp. 45, 61.

[125] Letter, The Surgeon General, to Assistant Chief of Staff, G–1, 3 Nov. 1941, subject: Replacements From Medical Replacement Training Centers.

Vastly more important than any other means of channeling newly inducted men with appropriate backgrounds into the Medical Department was the system of classification used from September 1940 onward at the Army's reception centers, a system which performed a similar service for all branches of the Army. The classification at reception centers, although it did not, or could not, always produce the desired results, was not only extremely useful in channeling new recruits into the proper branch of the Army but aided in directing them to the proper type of job within that branch.

The Medical Department experienced difficulty in the emergency and war periods in retaining trained noncommissioned officers. During the emergency, many Regular Army enlisted men and some National Guardsmen in the first three grades (master or first sergeants, technical sergeants, and staff sergeants) quickly became commissioned officers. Some were commissioned directly, others after a course in officer candidate school; still others accepted active duty under commissions which they already held in the Officers' Reserve Corps. Most of these were only "paper" losses, for the great majority of the men concerned accepted commissions within the Medical Department as Sanitary and Medical Administrative Corps officers; thus, a loss in the enlisted group became a gain in officer personnel.

CHAPTER VI

Procurement, 1941–45: Medical, Dental, and Veterinary Corps

LEGISLATION

Immediately following Pearl Harbor, two important measures were passed regarding manpower in the Army. An act, approved on 13 December 1941,[1] extended the tour of active duty of all officers and enlisted men, including retired officers in service, to a date 6 months after the end of the war. Under it, reservists no longer served a stipulated period of time on active duty and then reverted to inactive status. Reserve officers who had been relieved from active duty following a period of satisfactory service were recalled. Restrictions on age-in-grade for service other than with troop units were removed as were geographic restrictions on the use of reservists and guardsmen.

A week later, 20 December 1941, an amendment to the Selective Service Act provided for registration of all men between the ages of 18 and 65, and sanctioned military service for those between 20 and 45. The same law permitted the President to defer the military service of draftees by age groups if this seemed in the national interest. The subsequent lowering of the maximum induction age from 45 to 37 years, which had certain adverse effects on the procurement of Medical Department officers, did not, however, take place until a year later.

Believing that it was unnecessary for officers to meet the rigid physical requirements then in force in order to perform many types of duty, the War Department about the same time took steps to relax the physical requirements for Reserve officers not yet called to active duty and for civilians who might be commissioned as officers. For minor deficiencies such as slight overweight or defective vision, the prospective officers were permitted to sign waivers, subject to final acceptance or rejection by The Surgeon General in accordance with the recommendations of his Division of Physical Standards.[2] The "limited service" category was later used as a means of designating and classifying such officers.

---

[1] 55 Stat. 799.

[2] (1) Memorandum, Under Secretary of War, for The Surgeon General, 12 Dec. 1941. (2) Statement of Dr. Durward G. Hall, to the editor, 27 May 1961.

MEDICAL CORPS

Lag in Procurement During the First Months of War

There were three means of getting physicians into the Army: By calling up those who belonged to the Reserve or the National Guard; by organizing affiliated units to be called into service when needed; and by direct commissions from civilian life. The hard core of the wartime Medical Department was the Reserve, made up for the most part of men who believed in their obligation to perform military service. The ranks these men held in the Reserve were often lower than those given to men of no greater competence who volunteered at later dates.

In the first months after Pearl Harbor, the number of doctors that came into the Army was relatively quite small. It is true that the Army in general was growing rather slowly. Nevertheless, the Medical Department wished to have more than enough doctors for immediate needs so as to be well prepared for the vast increases in the size of the Army that were bound to come. Physicians entering the Army directly from civilian practice needed some training in military methods before they could work with full effectiveness; moreover, it was better to have an adequate system of medical care ready beforehand than to build one in the midst of pressing need.

Five months after the declaration of World War II, approximately 3,000 fewer physicians were on active duty with the Army than at the end of the same length of time after the declaration of World War I.[3] In the first place, the Army depended on the doctors to volunteer. In the second place, many doctors misunderstood the functions of the Procurement and Assignment Service and, believing that that agency actually did procure, waited for some notification from the agency. And, finally, the prevalent rumors about the idleness and misassignment of Reserve doctors after they had gone into service undoubtedly discouraged some from accepting active duty in an Army which, they believed, either did not need them or could not or would not use them properly. As time went on, the knowledge of affiliated units which had been called early in the war and had remained in this country without useful work confirmed many doctors in their belief that the Army did not—at least not yet—need additional doctors.

Role of the Procurement and Assignment Service

Organization

Although the Procurement and Assignment Service was established in November 1941, it became an active factor in procurement only after the United States entered the war. For several months, it was engaged in setting up its organization, and functions changed somewhat during the course of the war.

[3] Memorandum, Procurement Branch, Military Personnel Division, Office of The Surgeon General, for Director, Historical Division, Office of The Surgeon General, 20 Apr. 1944.

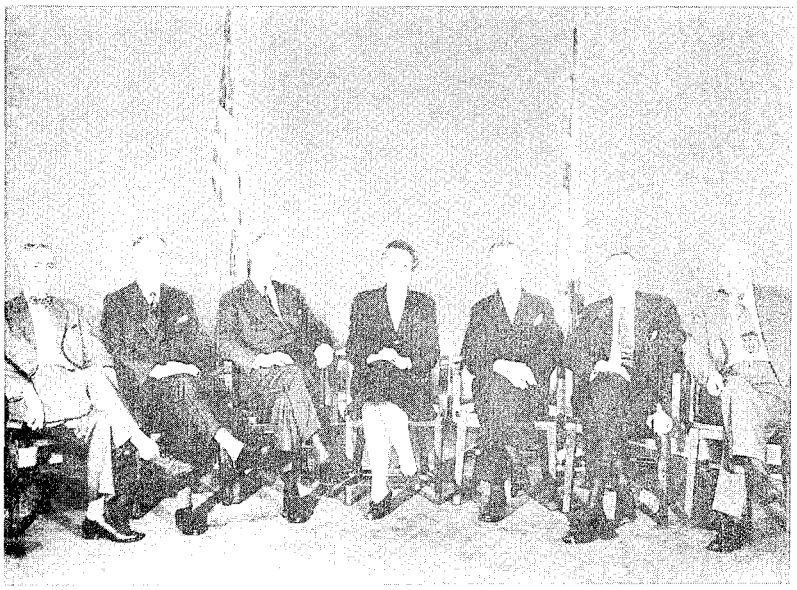


FIGURE 31.—Directing Board, Procurement and Assignment Service. Left to right: Abel Wolman, Dr. J. E. Paullin, Dr. H. S. Diehl, Miss Mary Switzer, Dr. F. H. Lahey, Dr. H. B. Stone, and Dr. C. W. Camalier.

From the standpoint of governmental organization in general, the Procurement and Assignment Service was one of the agencies in the Executive Office of the President. There, it occupied a subordinate position, being at first directly responsible to the Office of Defense Health and Welfare Services, a branch of the Office for Emergency Management, which in turn was a main division of the President's Executive Office. Later, in April 1942, it was shifted to the Bureau of Placement of the War Manpower Commission, another main division of the Office for Emergency Management. In both positions, the Procurement and Assignment Service was under the jurisdiction of Paul V. McNutt, at first directly when he was Director of the Office of Defense Health and Welfare Services, and then indirectly when he became Chairman of the War Manpower Commission. Its head throughout the war continued to be Dr. Frank H. Lahey, Chairman of the Volunteer Directing Board. Whatever its position on an organization chart happened to be, the Procurement and Assignment Service in practice seems to have worked somewhat independently of control from above other than from Mr. McNutt.[4]

The Procurement and Assignment Service at first concerned itself only with doctors, dentists, and veterinarians. Eventually, nurses and sanitary engineers also came within its scope. The Directing Board (fig. 31) was the policymaking body of the Service and was instrumental in establishing the

[4] Letter, Mary E. Switzer (Administrative Assistant to Mr. Paul V. McNutt, during World War II), to Col. C. H. Goddard, Office of The Surgeon General, 19 Aug. 1952.

central and field organizations. It also created a number of advisory committees. Their names indicate the aspects of the Board's work with which it believed it would need special assistance; there was a committee on each of the following: Allocation of Medical Personnel, Dentistry, Hospitals, Industrial Health and Medicine, Information, Medical Education, Negro Health, Public Health, Sanitary Engineering, Veterinary Medicine, and Women Physicians. In 1943, two members of the nursing profession were appointed to the Directing Board, and a Nursing Advisory Committee and a Nursing Division were created.

To carry out its functions locally, the Procurement and Assignment Service early established a system of committees for the corps areas, States, and districts or counties. The committees were composed of members of the medical professions—physicians, dentists, veterinarians, medical and dental educators, hospital administrators, and public health representatives. Later, in 1943, a system of State and local committees on nursing was also organized. Most of this apparatus was modeled on or taken over from agencies set up by the national nursing organizations.

Since it was agreed that representatives of the Procurement and Assignment Service should act in an advisory capacity to the Selective Service System, the relationship between these two agencies was close. In fact for a time (5 December 1942 to 23 December 1943), both were part of the War Manpower Commission. Other agencies with which the Procurement and Assignment Service worked closely were the National Roster of Scientific and Specialized Personnel, the National Research Council, and the national medical, dental, and veterinary associations.

Functions

The unique function of the Procurement and Assignment Service was to assure the continuance of adequate medical care for the civilian population by determining minimum local needs and calling a halt to recruitment when the supply of physicians and dentists dropped to the indicated level. For a short time, the Procurement and Assignment Service also assisted in ascertaining the professional eligibility of applicants for the Army and Navy, but for the greater part of the war, this function was carried out in the Chicago offices of the American Medical Association by personnel of the Office of The Surgeon General.

On 21 January 1942, the War Department issued a directive to corps area and department commanders stating that applications received by the Army were to be sent to the Procurement and Assignment Service, who would then determine the eligibility of the applicant according to the requirements of Army regulations on the basis of information from the authorities of the National Roster of Scientific and Specialized Personnel and send eligible applicants forms for appointment. When returned, the completed forms were forwarded to The Surgeon General together with a statement of the applicant's

eligibility and a description of his classification and evaluation as determined by the recent nationwide survey made by the Medical Preparedness Committee of the American Medical Association.[5]

In May 1942, however, The Surgeon General requested the Service to send all applications to him after retaining them only long enough to obtain a statement of the applicant's availability from the Service's State chairman. Three months later, he recommended revocation of the directive of 21 January, stating that the Procurement and Assignment Service no longer took any part in processing applications.[6] The reason for The Surgeon General's action undoubtedly included the need to speed commissioning as the flow of applications increased, but it also reflected some dissatisfaction with the existing state of things. The Procurement and Assignment Service, with its nonmilitary orientation, protected the civilian community better than The Surgeon General could have done, but it was only as effective as its local administration. At this time and throughout the war, the actual recruitment of medical and paramedical personnel for the Army was the primary business of the Personnel Service in the Office of The Surgeon General.

While the Procurement and Assignment Service ceased to have much to do with determining the eligibility of professional men applying for appointment in the Army, it continued to need information concerning the qualifications of civilian professional personnel. A number of agencies had been collecting information of this nature since before the war, information which in many instances proved useful to the Medical Department as well as to the Procurement and Assignment Service. One of these agencies was the National Roster of Scientific and Specialized Personnel. The National Roster had as its function the registration of all persons trained in the sciences and in other specialized fields, the coding of their registrations, the machine processing of data, and the machine selection of papers of qualified registrants. As the American Medical Association was engaged in a similar task for physicians, the National Roster at first registered only a small specialized group of the medical profession. However, the American Medical Association, the American Dental Association, and the American Veterinary Medical Association made available to the National Roster all punchcard files they had collected. Later on, the Roster, cooperating with the Procurement and Assignment Service, developed questionnaires and enrollment forms which were sent to all physicians, dentists, and veterinarians. The National Survey of Registered Nurses, initiated in 1941 by the Nursing Council for National Defense, was also carried on and completed in 1941.

---

[5] (1) Letter, Office of The Surgeon General, to War Department General Staff, subject: Appointment of Physicians, Dentists, and Veterinarians in Army of the United States. (2) Letter, Office of The Adjutant General, to all Corps Area and Department Commanders, 21 Jan. 1942, subject: Procurement of Officers for Medical Department, Army of the United States.

[6] (1) Memorandum, Office of The Surgeon General, for Procurement and Assignment Service, 12 May 1942. (2) Letter, Office of The Surgeon General (Maj. D. G. Hall), to The Adjutant General, 31 Aug. 1942, subject: Procurement of Officers for Medical Department, Army of the United States.

In determining minimum local civilian needs and deciding which and how many professional men could be spared for the Armed Forces, the Procurement and Assignment Service began with an individual approach. If the doctor was so necessary to his community that he could not be permitted to volunteer for military service, he was classified as essential and prohibited from accepting a commission. If not, the Service classified him as available and encouraged him to enter the Army or the Navy. This procedure was soon partially superseded, in the case of doctors, by what amounted to classifying them as essential en masse; that is, the Procurement and Assignment Service prohibited recruitment in any State which had less than the ratio of doctors to population it considered a necessary minimum. In States having a higher ratio, recruitment was permitted on the former basis. As the ratios were computed on the basis of each State as a whole, urban areas might conceivably have a much higher ratio than rural districts, but the Procurement and Assignment Service had no power to redistribute doctors.

The Procurement and Assignment Service attempted to classify as available or essential all doctors within the age group which was eligible for military service, but it did not do this fast enough to prevent some doctors from accepting commissions before being classified.[7] The difficulty would have been obviated if the Service had promptly classified all applications for commissions. In some cases, however, this was not done.

The task of classification was performed mainly by the State committees of the Service. If an individual objected to the way he was classified, or if his community or institution protested that he had been wrongly designated "available," an appeal could be carried to the corps area committee, which would reappraise the judgment. If the decision there went against the appellant, he could carry the matter to the Directing Board in Washington, D.C.

Probably the most important of the Directing Board's advisory committees, so far as the Medical Department was concerned, was the Committee on Allocation of Medical Personnel. This committee obtained information for the Directing Board and appraised the sources of medical manpower. The committee based its determination of civilian needs on studies carried on in cooperation not only with the official agencies concerned (the U.S. Public Health Service, the Children's Bureau of the Department of Labor, and the Department of Agriculture) but also with the American Medical Association, the American Dental Association, the American Public Health Association, and other similar groups.[8] It established criteria for determining the minimum personnel requirements of medical schools, hospitals, industry, and the civilian population. In this respect, it was, to some extent, a "rationing" board. The committee also determined and set up State quotas of physicians for military service, taking into consideration the overall needs of the civilian population.

---

[7] Committee to Study the Medical Department, 1942.

[8] See footnote 4, p. 169.

Since the Procurement and Assignment Service established the criteria which controlled the recruitment of professional personnel for the Medical Department of the Army and Navy, the Service could state rather definitely the maximum number of doctors, dentists, veterinarians, and other groups which the Armed Forces could contain. It thus restricted, and at the same time promoted, the procurement of medical personnel for the military forces. It forbade any procurement whatever in certain States; in others, it classified certain individuals as essential to their communities and so kept them from entering either the Army or the Navy. On the other hand, by classifying a person as available, it directed recruiting effort toward him and in effect told him that he should be in uniform. True, it had no legal power to compel him to join up—the legal power was all on the side of preventing essential practitioners from doing so—but the moral pressure which a committee of professional men could exert on their colleagues by labeling them "available" must in many cases have been decisive. Another effective influence was the pressure from local medical societies. And back of these intangibles stood the ever-present threat that local draft boards could if they chose call up any able-bodied man within the prescribed age group, regardless of his professional training.

Medical Officer Recruiting Boards

The Procurement and Assignment Service came too late, and had too little actual authority, to effect Medical Department procurement in the early months of the war. In March 1942, the Surgeon General's Office had no alternative but to inform Headquarters, Services of Supply, that there was a serious shortage of physicians for the Army. The 1940–41 procurement program had fallen 1,500 short at the end of that fiscal year, and was still falling behind. There were in fact only 12,465 medical officers then on active duty, with orders for another 500 requested, compared with an objective of 28,656 by the end of 1942. Although the Procurement and Assignment Service was sending applications and related papers to the Office of The Surgeon General at a rate of about 75 a day, an average of only 50 a day could be completed and sent to The Adjutant General, owing to inadequate data. These figures, if projected through the remainder of 1942, forecast a shortage of some 4,000 medical officers by 1 January 1943.[9] The analysis impressed both the Services of Supply and the Assistant Chief of Staff, G–1, resulting in the establishment of the Medical Officer Recruiting Board.

Procedures

On 12 April 1942, the Director of Military Personnel, Services of Supply, instructed The Surgeon General to prepare a plan embodying the following points: (1) The authority to accept, examine, and commission applicants

[9] Memorandum, Office of The Surgeon General (Col. G. F. Lull), for Gen. J. E. Wharton, Military Personnel Division, Services of Supply, 20 Mar. 1942, subject: Shortage of Medical Corps Officers.

was to be decentralized to 48 State representatives; (2) commissions in sufficient numbers were to be tendered in grades above the lowest to attract qualified applicants, and upper age limits were to be relaxed to provide experienced Medical Corps officers in appropriate grades; (3) corps area and station surgeons were to be charged with active participation in the campaign to recruit Medical Corps officers; and (4) an intensive publicity campaign would be launched to call the attention of physicians and the public to the Army's need for doctors.[10]

These provisions were carried out, and as his contribution to the plan, The Surgeon General issued instructions to the new recruiting boards, each board consisting of one Medical Corps officer and one officer whose branch was not specified (branch immaterial). They were authorized to secure applications for commissions in the Army of the United States (Reserve officers were to apply to The Surgeon General himself for active duty) of qualified physicians under the age of 55 and of dentists under 37. The boards were to function in cooperation with the Procurement and Assignment Service and where possible would obtain office space at or near the headquarters of the State chairman of the Service. Medical societies also cooperated with the board, rendering them considerable assistance. The boards were to obtain applications, authorize physical examinations at the most convenient Army medical installation empowered to perform such examination, and evaluate the professional qualifications and physical findings. They could appoint, without further delay, applicants under the age of 45 years to the grade of first lieutenant or captain, the grade to depend upon experience and professional qualifications. The boards were to administer the oath and forward the completed papers to The Surgeon General. Regulations which determined rank on the basis of age and professional qualifications were to remain unchanged—applicants under the age of 37 years were appointed in the grade of first lieutenant, except that those who had passed the age of 30 were appointed as captains when they had been certified by an American specialty board or had completed 3 years' residency in a specialty in addition to the required 1 year's internship; or, if they were older than 36 years and 10 months and would reach 37 years about the time active duty began, they could be appointed in the grade of captain. The boards were not empowered to appoint certain types of applicants, but were to complete the applications and send them to The Surgeon General. Such were applicants in the age group from 45 to 54, those applying for a grade higher than that of captain, Negro physicians, graduates of American substandard or foreign schools, Federal employees, or persons drawing Federal pensions, and others whose qualifications the board questioned.[11]

---

[10] Memorandum, Director, Military Personnel Division, Services of Supply (Brig. Gen. James E. Wharton), for The Surgeon General, 12 Apr. 1942.

[11] Instructions to Medical Officer Recruiting Boards, by Col. John A. Rogers, Executive Officer, Office of The Surgeon General, May 1942.

The Surgeon General's control

Until 1 September 1942, The Surgeon General controlled the boards on behalf of the War Department, and he issued instructions to them either directly or through The Adjutant General. His authority included the power not only to establish but to close a board. He might also be directed by higher authority to open additional boards.[12]

Accomplishment of the boards

The boards had remarkable success in recruiting doctors. Bringing to doctors, individually or in groups, for the first time during the war the story of the Army's urgent need for their services, clearing up misunderstandings, and having the power to examine and commission directly, they swore in very large numbers in their few months of operation. One board reported in June that its record for minimum time elapsed between receipt of an application and the commissioning of the applicant was 5 days and that it was prepared to maintain an average of 7 days.[13] For the most part, the board cooperated closely with the State representatives of the Procurement and Assignment Service, requesting availability clearance for doctors who expressed willingness for Army service. In some instances, however, the boards, in their enthusiasm, did not await these availability rulings.[14] The Surgeon General informed the Procurement and Assignment Service that the need for medical officers was so pressing that it would not be possible to delay appointment of qualified applicants to ascertain their availability "as determined by anyone other than the applicant himself." But Mr. McNutt complained to the Secretary of War, and The Surgeon General was directed to agree not to commission any more medical officers unless they had been cleared by the Procurement and Assignment Service.[15] Thus, however great his need, The Surgeon General's attempt to shake off the reins of a civilian agency was unsuccessful.

Air Forces activities

The Army Air Forces, meanwhile, had sought authority as early as March 1942 to procure its own medical officers, on the ground that The Surgeon General was not able to allot enough physicians to meet Air Forces needs, nor proc-

---

[12] (1) Instructions to Medical Officer Recruiting Boards, by Order of The Surgeon General, 23 May 1942. (2) Memorandum, The Surgeon General, for The Adjutant General, 28 Apr. 1942. (3) Letter, The Surgeon General, to Hon. E. D. Smith, Senator from South Carolina, 20 June 1942. (This refers to a request to The Adjutant General for removal of a board from South Carolina to another State.) (4) Letter, Director, Military Personnel Division, Services of Supply (Brig. Gen. James E. Wharton), to The Surgeon General, 23 June 1942, subject: Officer Procurement Program Medical Department.

[13] Letter, Lt. Col. R. F. Olmsted, to Col. J. R. Hudnall, Office of The Surgeon General, 22 June 1942.

[14] Memorandum, Lt. Col. Durward G. Hall, Office of The Surgeon General, for Director, Historical Division, Office of The Surgeon General, 20 Apr. 1944, subject: History of Procurement Branch, Military Personnel Division, Personnel Service, Office of The Surgeon General.

[15] (1) Memorandum, Office of The Surgeon General (Col. F. M. Fitts, MC), for Executive Officer, Procurement and Assignment Service, 15 May 1942. (2) See footnote 7, p. 172.

ess them fast enough. The Surgeon General agreed to place Air Forces medical officers on duty with the recruiting boards to handle the applications of those interested in serving with the Air Forces, although each applicant's preference as to branch of service already appeared on the papers sent to The Surgeon General.[16]

Simultaneously, the General Staff granted the Air Surgeon the right to determine the grade of appointment for doctors in company grade and to send the papers directly to The Adjutant General; papers recommending appointment in grade of major or above he still had to send to The Surgeon General.[17] The following tabulation shows the results of the Air Surgeon's procurement efforts from 21 March 1942 to 1 July 1942:

Applicants physically disqualified	280
Applicants rejected by the Air Surgeon	486
Applicants not desiring Air Forces service (presumably persons who had changed their minds)	155
Orders requested for duty with Air Forces	2,053

The figure of 2,053 approximated the objective of 2,200 which the Air Surgeon had set for this period.[18]

Officers in the Surgeon General's Office were forced to admit that the Air Surgeon's efforts had relieved them of the responsibility of recruiting for him. Probably the "glamor" which many people attached to service in the Air Forces, in addition to the aggressiveness with which the recruiting campaign was waged, accounted in a considerable degree for its success. It accounted also for much of the dissatisfaction that later developed, especially among qualified specialists who had come on active duty from the Medical Corps Reserve, often at some personal sacrifice. As the Chief Surgeon of the European theater recalled it: "These specially trained men understandably expected that their special skills would be used; but the Air Forces did not have sufficient beds under their control to utilize all of this talent * * *. In the E.T.O., from 1944 on, we traded * * * with the Air Forces, giving it good young medical officers without special training for qualified specialists." [19]

Procurement and Assignment Service reaction

In June 1942, Dr. Frank H. Lahey, Chairman of the Directing Board of the Procurement and Assignment Service and President of the American Medi-

---

[16] (1) Letter, Air Surgeon (Col. David N. W. Grant, MC), to The Surgeon General, 22 June 1942, subject: Medical Corps Officers for Duty. (2) See footnote 12 (1), p. 175.

[17] Letter, The Adjutant General, to Commanding General, Army Air Forces, 6 July 1942, subject: Coordination, The Surgeon General and The Air Surgeon. (The Army Air Forces Medical Service historian states, however, that it appears that the Air Surgeon never used the authority to "sign and issue letters of appointment" of Medical Corps officers in company grades. *See* Link, Mae Mills, and Coleman, Hubert A.: Medical Support of the Army Air Force in World War II. Washington: U.S. Government Printing Office, 1955.)

[18] (1) Memorandum, Chief Clerk, Personnel Division, Air Surgeon's Office, for Chief, Personnel Division, Air Surgeon's Office (undated). (2) See publication cited in footnote 17.

[19] Letter, Maj. Gen. Paul R. Hawley, USA (Ret.), to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 12 Mar. 1956.

cal Association, and Mr. Paul V. McNutt, Chairman of the War Manpower Commission, took occasion in addressing the House of Delegates of the American Medical Association in Atlantic City, N.J., to inform doctors of the Army's great need for them. Dr. Lahey stated that he believed that the medical profession was still not facing the facts as frankly as it should and that the country was still not convinced that its situation was one of urgent necessity. Mr. McNutt spoke much more bluntly, saying: "We are not getting enough [doctor] volunteers." Then, reviewing the armed services' need for doctors, and pointing out the different fields of civilian medicine where needs were large, he told the delegates that the careful safeguards that the Procurement and Assignment Service had set up had apparently slowed down the rate of recruitment. "The voluntary plan must work and work promptly—or some other more vigorous plan will have to be produced." After stating that the medical profession was the first to require rationing, he concluded: "The issue is who shall do the rationing, for America must have the doctors it needs." [20] Although he did not explain what the "more vigorous plan" would be, many believed Mr. NcNutt was referring to the possibility of a draft of doctors.

Dental officers assigned to boards

Since the boards had been commissioning dentists as well as doctors and since there were few vacancies in the Dental Corps during the first 2 months of their existence, the efforts of the two original officers on each board filled the needs. In July 1942, however, when The Surgeon General received authority to procure 4,000 more dentists, a Dental Corps officer was added to each of the 30 boards then operating in 25 States. (In June 1942, the Services of Supply had ordered additional recruiting boards created in seven of the more populous States—New York, Pennsylvania, Illinois, Ohio, Massachusetts, California, and Texas.) [21] The objective was soon reached; the Dental Corps officers were removed from the boards on 1 September 1942, and the boards were instructed at that time to process no more dental applications except for men classified as I–A by selective service—those who might be drafted.[22] The boards did not procure veterinarians or any other Medical Department personnel. In September 1942, the boards were limited to appointing first lieutenants only, forwarding the papers of applicants for all other grades to The Surgeon General, who decided whether to commission the applicant.[23]

---

[20] (1) Medicine and the War. J.A.M.A. 119: 647–648, 20 June 1942. (2) McNutt, P. V.: The Urgent Need for Doctors. J.A.M.A. 119: 605–607, 20 June 1942.

[21] See footnote 12 (4), p. 175.

[22] (1) Medical Department, United States Army. Dental Service in World War II. Washington: U.S. Government Printing Office, 1955. (2) Letter, The Adjutant General, to Commanding Generals, all Service Commands, 9 July 1942, subject: Dental Corps Member for Certain Medical Department Recruiting Boards.

[23] (1) War Department Memorandum No. S605–5–42, 1 Sept. 1942. (2) Radio, Commanding General, Services of Supply, to Commanding General, each Service Command, 10 Sept. 1942.

Civilian reaction

Although the total number enrolled by these boards was gratifying to The Surgeon General, physicians' responses to the boards' appeals varied in different sections of the country. Some States went far beyond the 1942 quota set by the Procurement and Assignment Service; others lagged. In some areas, critical shortages of doctors for civilian care were developing, due in part to voluntary enrollment and in part to the shifting of population to industrial areas. On the other hand, several populous States, where the number of doctors was relatively large, fell far behind their quotas.

The boards drew criticisms of various kinds, the most frequent being that they antagonized doctors and threatened them with being drafted if they did not volunteer.[24] Learning of such conduct by the boards, the Director of the Selective Service System issued a strong statement declaring that the System had not delegated the power to induct and could not if it wished but that, despite this, some boards had told doctors they must accept a commission or they would be drafted. "This is a half truth and a misrepresentation of the worst possible kind," he asserted.[25]

On 20 June 1942, the Surgeon General's Office, possibly forewarned of the Director's concern in this matter, had informed the boards that they were not in a position to threaten induction; they might, however, tell physicians that need for them was so great that Selective Service might consider inducting them.[26]

The Chairman of the War Manpower Commission, although he had talked sternly to doctors in June about the Army's great need for them, testified in the fall of 1942 before the Committee to study the Medical Department that in many States the boards "use entirely unwarranted methods to scare doctors into volunteering * * *. Every possible means was used, short of shanghaiing, to force the doctors to join up." He complained to the committee that these boards had paid little attention to essential work a doctor might be doing and that before State Chairmen of the Procurement and Assignment Service could complete their lists of essential doctors in communities, health departments, the staffs of universities and hospitals, and industry, the boards had taken many essential men. "We have had," he said, "occasional instances where they have taken every single person [physician] in the community * * *. They have gone in and high-pressured these men."

In a move to regain the control he had lost when others were empowered to issue commissions, The Surgeon General stated in the fall of 1942 that as his Office possessed the machinery to handle applications and recommend commissions, the few boards still functioning were to do no more actual commis-

---

[24] Letter, Chamber of Commerce, Kalamazoo, Mich., to Senator Prentiss W. Brown, 23 Nov. 1942.

[25] Letter, Director, Selective Service System, to Brig. Gen. James E. Wharton, Director, Personnel Division, Services of Supply, 22 June 1942.

[26] Information Letter, Office of The Surgeon General, to Medical Officer Recruiting Boards, 20 June 1942, subject: Instructions.

sioning. With all applications for commissions in the Medical Corps passing through his Office, he could exercise tighter control on the initial rank granted an officer and on the classification of each man according to his training and experience. The Officer Procurement Service, established in November 1942 under the Commanding General, Services of Supply, to procure officers for the entire Army, was willing, however, to have the Medical Officer Recruiting Boards complete and send applications to The Surgeon General or the Air Surgeon; those officers then transmitted them to the Officer Procurement Service for consideration and for forwarding to the Secretary of War's Personnel Board.[27]

Closing of the boards

The recruiting boards were closed at different times, beginning with the board in South Carolina in June 1942; the last ones were closed in February or March 1943. As States approached the Procurement and Assignment Service's quotas of physicians that could be withdrawn from civilian practice, that Service became concerned that civilian medical care might suffer unduly and brought pressure on the War Department to close the boards in those States. Furthermore, in States which had reached their 1942 quota, the Service refused to declare any more doctors available for military duty. As a result of pressure from this Service, The Surgeon General in July 1942 ordered the boards in 16 States to be closed at the earliest practicable date.[28]

Control shifted to service commanders

At the end of the same month, General Somervell, on being reminded at a meeting of his service command commanders that the medical officer recruiting boards were under the orders of The Surgeon General, declared that they were to be "under the Service Commander, and I don't want any direct staff control any more." On 1 September 1942, an order was issued to that effect.[29] Accordingly, when a week later the Procurement and Assignment Service asked The Surgeon General to close the recruiting boards in additional States which had reached or nearly reached their quotas, the Surgeon General's Office suggested other channels.[30] On 21 October 1942, a War Department directive terminated the activities of the boards in all remaining States except California, Illinois, Pennsylvania, New York, and Massachusetts.[31] Early in 1943,

---

[27] Memorandum, Chief, Procurement Division, Officer Procurement Service, for Chief, Field Operations Branch, Officer Procurement Service, 1 Dec. 1942, subject: Appointment of Doctors of Dentistry, Veterinary Medicine, and Medicine.

[28] (1) General Report, Second Service Command, 1943, p. 26. (2) Proceedings, Directing Board, Procurement and Assignment Service, 24 July 1942. (This order closed boards in the following States: Delaware, West Virginia, Virginia, North Carolina, Georgia, Mississippi, Alabama, Oklahoma, Indiana, North Dakota, South Dakota, Idaho, Montana, Wyoming, Nevada, and New Mexico.)

[29] (1) Conference of Commanding Generals, Services of Supply, Fourth Session, 30 July–1 August 1942, 31 July 1942. (2) See footnote 23 (1), p. 177.

[30] Proceedings of the Directing Board, Procurement and Assignment Service, 19–20 Sept. 1942.

[31] War Department Memorandum No. S605–14–42, 21 Oct. 1942.

the Officer Procurement Service was authorized to recruit doctors and dentists, but responsibility for processing applications and recommending their approval still rested with The Surgeon General.

Direct commissions

During the life of the recruiting boards, doctors and dentists were permitted to apply for commissions directly to The Surgeon General or to the Procurement and Assignment Service, which would send the papers to The Surgeon General. In these cases, The Surgeon General did the work of getting all necessary information from the applicant and evaluating it; if acceptable, The Surgeon General recommended a grade and assignment and, if physically qualified, requested The Adjutant General to commission the applicant in that grade and to issue orders placing him on duty at the station specified. In all instances, whether the applications were received directly or from the boards, The Surgeon General classified the applicants as to specialty, made an assignment, and requested The Adjutant General to issue orders placing them on duty.[32]

Indeed, The Surgeon General often went further than merely processing papers of those who applied for commissions, actively seeking out and persuading candidates. Among those brought into the Medical Department in this way were a number of returned medical missionaries, whose intimate knowledge of climate, sanitary conditions, and endemic diseases in strategic areas, such as Okinawa, later proved of inestimable value. Many of these men went into preventive medicine; others devoted themselves to medical intelligence work.[33]

In late 1942, the Secretary of War, concerned about the method of appointing noncombat officers in the Army, had had a study made of the subject and created the Secretary of War's Personnel Board. (This group succeeded one known as the War Department Personnel Board.) The new board reviewed all applications for appointment in the Army of the United States from civilian life (or from the Army Specialist Corps) before appointments could be made; it performed a final review before recommending a commission.[34]

Increase in procurement in 1942

The success of the Medical Officer Recruiting Boards and of the Surgeon General's Office in getting doctors on duty is indicated by the growth of the Medical and Dental Corps during the time that the boards were in operation (table 1). The increase during the first month or so of their operation, significant though it is, cannot be compared with the numbers the boards brought

[32] Report, Albert W. Gendebien, Military Personnel Division, Office of The Surgeon General, of Survey of Non-Technical Segments of the Surgeon General's Office, 24 Sept.–10 Oct. 1942. This survey was made for the benefit of the Committee to Study the Medical Department.

[33] Statements of Durward G. Hall, M.D., and Maj. Gen. George F. Lull, USA (Ret.), to the editor, 27 May 1961.

[34] Memorandum, Deputy Chief of Staff, for Commanding General, Services of Supply, 31 Oct. 1942, subject: Procurement of Officers for Army of the United States From Civilian Life.

on duty later, after they had become accustomed to their work and were bringing the Army's need for doctors forcibly to the attention of increasing numbers. So far as the Air Forces was concerned, its most fruitful period for the procurement of doctors was during the 5 months from 1 July to 1 December 1942, when 4,576 entered the service; in the following 13 months to January 1944, only 1,102 came in.[35]

During that portion of 1942 in which the Medical Officer Recruiting Boards functioned, the strength of the Medical Corps of the Army of the United States increased by 24,252; during 1943, after these boards had been abolished, the increase was only 4,734. This comparison illustrates, however, not only the success of the boards as compared with that of the Officer Procurement Service that followed them, but likewise the increasing scarcity of physicians whom the Procurement and Assignment Service was willing to declare available in 1943, and the fact that the proportion of doctors whom this Service declared available but who did not apply for military duty increased as the scarcity became greater in civilian life.

The Officer Procurement Service

Procedures

The Officer Procurement Service, established on 7 November 1942 under the Commanding General, Services of Supply, dealt directly with the Army Air Forces, Army Ground Forces, and the chiefs of supply and administrative services.[36] It undertook to obtain not only doctors and dentists, as the Medical Officer Recruiting Boards had done, but also members for other Medical Department officer components. The Service continued the practice, initiated shortly before the Medical Officer Recruiting Boards were closed, of sending each application to the Secretary of War's Personnel Board for approval before a commission was granted; it never had the power to tender commissions directly to applicants as had the boards.

The Officer Procurement Service began its work for the Medical Department on 15 January 1943. The program for the procurement of doctors, dentists, and veterinarians constituted one of its major activities in 1943 and 1944.[37] In early 1943, the Service had district offices in 38 large cities throughout the country. In practice, it was a country-wide recruiting office, with its activities at first limited to procuring officers, although later in the war it also lent its efforts to procuring certain types of enlisted personnel as well.

---

[35] See footnote 17, p. 176.

[36] War Department Circular No. 367, 1942. (The Officer Procurement Service did not handle the appointment of graduating aviation cadets, officer candidates, or members of the Reserve Officers' Training Corps.)

[37] Memorandum, Central Office, Procurement and Assignment Service, for Col. Robert Cutler, Officer Procurement Service, Services of Supply, through Lt. Col. D. G. Hall, Personnel Division, Office of The Surgeon General, 16 Jan. 1943, subject: Correction Paragraph 6 in Covering Letter From Officer Procurement Service to Officer Procurement District.

The method of procuring physicians under the Officer Procurement Service appears to have been cumbersome and time consuming. The Office of The Surgeon General pointed out somewhat later that, although the Officer Procurement Service had been very cooperative, its functioning had of necessity lengthened the time required to appoint physicians and dentists from civilian life. Only the Procurement Service could solicit a doctor, dentist, or veterinarian, but before doing so it had to receive an application from him by way of the Procurement and Assignment Service, which had previously notified him of his "availability," ascertained his preference for the Army or Navy, and checked his professional qualifications and ethics with the Surgeon General's Office. The Officer Procurement Service interviewed him to gain information as to his character, reputation, and other qualifications for commission as an officer. If these were found satisfactory, it helped him to fill out a proper application for a commission. Since the Surgeon General's Office had already cleared him as to professional standing and ethics, that Office did not believe the interview by the Procurement Service was necessary. It considered this step a burden on the individual in time and expense, especially in the Middle West, where the offices of the Procurement Service were too widely dispersed, and in the densely populated Eastern States, where they were too few in number.[38] The Surgeon General recommended to G–1 that if by the end of March 1943 procurement of doctors and dentists had not reached a satisfactory rate, the Officer Procurement Service be divested of that function and the Medical Officer Recruiting Boards be set up again in those States which had not furnished their quotas.[39] G–1 did not permit him to restore the boards. The Officer Procurement Service had two advantages over its predecessor—it saved the time of a small number of Medical Corps officers who had been in recruiting duties in the field; it also procured Medical Department officers other than doctors and dentists and recruited enlisted women as well. But it did not succeed in speeding the procurement of medical officers.

Procurement lag in 1943

Information from the Officer Procurement Service showed that in the period from 15 January to 11 February 1943, 24 of its district offices had received the names of 868 doctors cleared by the State Chairman of the Procurement and Assignment Service. Of these, the Officer Procurement Service had had to abandon action on 302 (34.6 percent) because of their refusal to complete the papers or for "other reasons." The names of 103 had been sent to The Surgeon General as ready for his approval. Almost 400 cases (45.6 percent) were

[38] (1) Memorandum, Office of The Surgeon General (Lt. Col. Durward G. Hall), for Officers on Duty in the Office of The Surgeon General, 27 Jan. 1943. (2) Letter, Office of The Surgeon General, to G–1, through Director, Military Personnel, Services of Supply, 16 Feb. 1943, subject: Procurement of Physicians and Dentists. (3) War Department Circular No. 367, 1942. (4) Field Transmittal–24, Officer Procurement Service, to Officer Procurement Districts, 27 Jan. 1943, subject: Revision of FT–15 (1–13–43) : Processing Doctors, Dentists, and Veterinarians.

[39] See footnote 38 (2).

in process, awaiting completion.[40] Meanwhile, figures issued by the Procurement and Assignment Service for 31 January 1943 indicated that already a few States had reached their second quota, but these were States whose quota was very small. The States with large quotas for 1943 were ranging between only 70 and 83 percent of them.[41]

During April, when the total Army strength increased by more than 200,000, the number of doctors on duty not only did not keep pace with this increase, but actually declined (table 1). Some doctors were procured during this month, but a larger number evidently left the service. During the month, The Surgeon General advised the Procurement and Assignment Service that the monthly allotment should be revised upward in order to take care of losses.[42]

In July, The Surgeon General reported that between 15 January and 2 July 1943 the Procurement and Assignment Service had declared 6,357 doctors available. Of that number, the cases of 2,632 (41.4 percent) had already been closed because physicians refused to be processed or because they had moved from a State, had already been appointed, were already in process of being appointed, or for like reason. Of the remaining 58.6 percent, experience showed that slightly over half would be tendered commissions, the others being found unsatisfactory for physical or other reasons. In other words, the yield would be about 30 percent of the 6,357, or about 1,900. According to The Surgeon General, the trend was for a lower yield from the doctors declared available.[43]

Meanwhile, The Surgeon General, employing other means to get more doctors on duty, had, at the suggestion of the Secretary of War, instituted a program of reexamining doctors and dentists previously rejected on physical grounds, using the lower standards that had been promulgated since their first examination. These standards included more waivers for physical defects. Under this "reconsideration program," he reexamined over 14,000 doctors and dentists rejected before April 1942 on physical grounds. The result was that under this program, extended into 1944, 700 doctors were found acceptable and were tendered commissions.[44] The program encountered complications. After failing their original physical examination, men had been declared essential to civilian care by the Procurement and Assignment Service; some had

---

[40] Memorandum, Field Operations Branch, Officer Procurement Service (Maj. Edward W. Gamble, Executive Officer), for The Surgeon General, 20 Feb. 1943, subject: Report of Referrals of Doctors, Dentists * * *.

[41] Memorandum, Procurement and Assignment Service (Maj. Harold C. Lueth, MC, Consultant), for State and Corps Area Chairmen for Physicians, 1 Mar. 1943, subject: Percentage of Second Quota for Physicians Attained.

[42] Memorandum, The Surgeon General's Office, for Procurement and Assignment Service, 17 Apr. 1943.

[43] Memorandum, Office of The Surgeon General (Lt. Col. D. G. Hall), for Special Assistant to Secretary of War, 8 July 1943.

[44] (1) Annual Report, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1943–44. (2) Letter, Surgeon General Kirk, to Dr. Guy Caldwell, Secretary-Treasurer, American Board of Orthopedic Surgery, 3 Feb. 1944.

made arrangements in civilian practice that rendered it difficult for them to accept military duty; and others simply refused to apply for a commission.[45]

Early in 1943, several individuals, including the Chairman of the Directing Board of the Procurement and Assignment Service, and the Chairman of the War Manpower Commission, expressed the belief to The Surgeon General and the Secretary of War that granting doctors an initial rank higher than that of first lieutenant would speed procurement. The two latter officials demurred against holding out such an enticement, on the ground that records indicated that physicians who refused an appointment as first lieutenant in the Medical Corps because of the grade alone constituted a small proportion of the total number declared available by the Procurement and Assignment Service. Neither would such action be fair to others who, with no less civilian experience, had entered the Army at lower rank. Further, it would stagnate advancement for doctors already in the Army. The proposal was renewed at the end of 1943, but was again rejected for much the same reasons.[46]

The Reynolds Plan

As the Procurement and Assignment Service could not induce a high percentage of available physicians to accept commissions, in May 1943 General Magee recommended a special draft of doctors under the Selective Service Act.[47] However, The Surgeon General and the Procurement and Assignment Service soon afterward made an agreement which was designed to accelerate the procurement of doctors and which continued voluntary recruiting.[48] Since G–1 preferred this plan, the idea of a draft was not followed up for the time being. The agreement, later known as the Reynolds Plan, after the Director of the Military Personnel Division, Army Service Forces, who proposed it, was concluded on 22 May 1943.

Under this agreement, the Procurement and Assignment Service promised to take the following action: (1) Declare available at once the entire list of doctors already placed in that category; (2) permit representatives of the Officer Procurement Service to try to "persuade" the persons so designated to volunteer in the 20 States and the District of Columbia whose quotas had not been filled; (3) report all eligible doctors refusing commissions to their draft boards for reclassification (thus presumably placing them in the group under selective service which was available for immediate induction into the Armed Forces as enlisted men); (4) establish at once quotas

---

[45] Letter, New York State Procurement and Assignment Service, to Comdr. M. E. Laphman, Procurement and Assignment Service, 29 Mar. 1943.

[46] (1) Letter, Secretary of War, to Paul V. McNutt, Chairman, War Manpower Commission, 8 May 1943. (2) Proceedings, Joint Session With Representatives of the Several Federal Services and Directing Board, Procurement and Assignment Service, 20 Mar. 1943. (3) Letter, Dr. Frank Lahey, War Manpower Commission, to Commanding General, Army Service Forces, 23 Dec. 1943. (4) Transmittal Sheet, Brig. Gen. R. B. Reynolds, Director, Military Personnel Division, Army Service Forces, to The Surgeon General, 28 Dec. 1943, with endorsement thereto, 5 Jan. 1944.

[47] Letter, Surgeon General Magee, to G–1, through Director, Military Personnel Division, Army Service Forces, 13 May 1943, subject: Procurement of Physicians and Dentists.

[48] Disposition Form, G–1, to Military Personnel Division, Army Service Forces, 24 May 1943.

by States or "other areas" to be furnished the Army during 1943; the quota being arrived at as follows: subtract the total number on duty on 31 May 1943 from 48,000 (the current ceiling strength for doctors in the Army) and consider the remainder as the total number of doctors to be procured, which would be divided into "area quotas." The Army, for its part, agreed (1) to clear each doctor with the Procurement and Assignment Service before commissioning him, and not even to approach any doctor, such as a senior professor in a medical school or certain types of specialists in civilian hospitals, whom the Procurement and Assignment Service had declared irreplaceable; and, further, (2) to reconsider the physical qualifications for appointment as officers. The parties also approved of publicity to stress the medical needs of the American soldier and sailor.[49]

A month after this agreement was reached, it was abrogated by the Procurement and Assignment Service but subsequently (in July 1943) revived to permit the Army—and the Navy, if it so desired—to solicit physicians for appointment in Illinois and Massachusetts. The abandonment, or curtailment, of the plan helped to clear the way for the improvement in favor of a special draft of doctors.[50] However, one point about the plan is worth noting. The reference in the agreement to "State or other area" meant that instead of keeping the 1:1,500 physician-civilian ratio on a statewide basis, the Procurement and Assignment Service would have permitted the Army to procure doctors in certain well-stocked metropolitan areas, even though the statewide ratio might stand at no more than 1 physician per 1,500 civilians. It can be seen that by this concession the Procurement and Assignment Service recognized the irrationality of setting and attempting to maintain any statewide ratio when doctors were concentrated in the cities where the ratio would be much higher than 1 to every 1,500 of population. It also was a clear admission that the Procurement and Assignment Service lacked power to "relocate" doctors from areas of plenty to those of scarcity. The Service in fact frankly admitted that it had no such power of compulsion and, lacking that power, it must have seemed useless both to the Service and to the representatives of The Surgeon General to insist on statewide ratios of 1:1,500.

Procurement of doctors subsequent to the partially abortive plan of May 1943 showed no marked increase. During the following 7 months, June through December 1943, 3,801 doctors accepted commissions; and this figure must have included 1,000 or more interns and residents who came on active duty in July, after completing their training.

Thus, in 1943, procurement of doctors fell far short of the goal set by The Surgeon General. The Procurement and Assignment Service designation of "essential" placed on doctors narrowed the field of possible recruits,

---

[49] Proceedings, Directing Board, Procurement and Assignment Service, 8 June 1943.

[50] (1) Memorandum, Lt. Col. D. G. Hall, Office of The Surgeon General, for Chief, Personnel Service, Office of The Surgeon General, 24 June 1943. (2) Memorandum, Director, Military Personnel Division, Army Service Forces, for Deputy Director, Military Personnel Division, Army Service Forces, 13 July 1943.

and of those available, there were many who refused to accept a commission. It would appear that conscription of medical and allied personnel on a national basis would have obviated many of these problems.

A Special Draft of Doctors Proposed

The failure of doctors to volunteer for Army service in the numbers which The Surgeon General considered necessary led him to recommend stronger means of compulsion. Under the existing draft law, very few doctors were being brought into military service by that method—only 217 during the period from November 1940 to September 1942. Even these included a number of persons whom The Surgeon General would not have recommended for Medical Corps commissions—unethical practitioners, graduates of unapproved schools (drafted before The Surgeon General laid down the terms on which he would accept them as Medical Corps officers), doctors who had not been engaged in practice, and others. During the same period, more dentists (346) and almost as many veterinarians (211) were drafted, although both were much less numerous in civilian life than physicians.[51]

Probably the main reason why few doctors came into the Army by way of the ordinary draft was that local selective service boards were opposed to depriving their communities of the services of medical men. To induce the boards to act, the Procurement and Assignment Service in June 1943 agreed to report to their local draft boards all doctors whom the Service had declared "available" but who had refused to volunteer for the Army. This plan was soon very much curtailed, but in any event, it would have left the final decision in the hands of the local draft boards.

The Surgeon General proposed stronger methods—a "special call" on the draft boards requiring them to induct physicians. In order to gain his end, several authorities had to be persuaded of the necessity and legality of the step: The Chairman of the War Manpower Commission, who beginning in December 1942 controlled the Selective Service System, his adviser and subordinate in medical personnel matters, the Procurement and Assignment Service; and The Surgeon General's own superiors in the War Department. In the end, the decision was made at a White House conference.

A special draft of doctors had been proposed in the Surgeon General's Office as early as 5 November 1942. Nothing was done at that time, and on 16 February 1943, The Surgeon General recommended planning for it as an eventual step if the procurement of doctors did not move faster. Three months later (13 May), he counseled the draft of both doctors and dentists

[51] (1) For a period of 9 months beginning in September 1941 (the month in which the War Department ordered that appointments in the Officers' Reserve Corps cease to be made and that all future appointments must be made in the Army of the United States), there appears to have been no recognized way of commissioning drafted veterinarians. In July 1942, however, The Surgeon General succeeded in obtaining a quota of 250 from the General Staff for this purpose. *In* Medical Department, United States Army. Veterinary Service in World War II. Washington: U.S. Government Printing Office, 1961. (2) Selective Service in Wartime, Second Report of the Director of Selective Service, 1941–42. Washington, 1943.

under 45 years of age as an immediate necessity.[52] On 22 June, staff representatives agreed to the measure in principle and decided that the Secretary of War should be asked to present a proposal to the President. Later, G–1 suggested bringing the Navy into the negotiation, a step which was subsequently taken.[53]

In the following months, further discussion within the War Department took place, having to do with the number of doctors needed and the legality of the proposed draft. No occupational group had previously been singled out for induction in quite the way that was now suggested. However, War Department authorities decided that this could legally be done within the terms of the Selective Service Act, and on 18 October 1943, a letter signed by the Secretaries of War and the Navy was sent to the Chairman of the War Manpower Commission formally requesting a special call on Selective Service for doctors.

Meanwhile, the Procurement and Assignment Service and the War Manpower Commission had been informed that the Army intended to make such a request. There was some reason to believe that these agencies would support it. In October 1940, at the time that the Procurement and Assignment Service was being initiated, the future Chairman of its Directing Board, Dr. Frank H. Lahey, had stated, in effect, that a draft of doctors would be necessary if they failed to volunteer. Moreover, the future Director of the War Manpower Commission, Paul V. McNutt, in recommending the establishment of a Procurement and Assignment Agency, had proposed that it frame legislation to draft medical, dental, and veterinary personnel for submission to Congress if the emergency seemed to require it.

In July 1943, while the War Department had its own proposal under consideration, Dr. Lahey expressed the belief that the only way the Procurement and Assignment Service could obtain more doctors for the armed services was through some means of coercion.[54] On the same day, Mr. McNutt stated that stronger measures would be taken through Selective Service to bring doctors into the military forces. After October 1943, he said, every physican under 45 years of age who was reported to the Selective Service System as having refused to accept a commission after he had been declared available for military service by the Procurement and Assignment Service would be called for induction by his local board. At the same time, a system of appeals against the board's decision enabled the individual to carry his case as high as the National Headquarters of the Selective Service System, a procedure which might still have enabled a good many doctors to avoid military service.[55]

---

[52] (1) See footnote 47, p. 184. (2) Memorandum, Commanding General, Army Service Forces, for Chief of Staff, 11 Sept. 1943, subject: Special Call on Selective Service for Physicians.

[53] (1) See footnote 50 (1), p. 185. (2) Memorandum, G–1, for Director, Military Personnel Division, Army Service Forces, 11 July 1943.

[54] Proceedings, Directing Board, Procurement and Assignment Service, 31 July 1943.

[55] (1) Memorandum, Chief, Procurement Division, Officer Procurement Service, for Director, Officer Procurement Service, 2 Aug. 1943, subject: Procurement of Physicians. (2) Letter, Col. Richard H. Eanes, USA (Ret.), to Col. C. H. Goddard, Office of The Surgeon General, 5 Sept. 1952.

Two months later, 8 September 1943, The Surgeon General made an approach to the problem slightly different from the one he had previously advocated. After agreeing on the terms of this new proposal with officials of the Selective Service System, who considered a special draft of physicians "impracticable," he presented it in the form of a request to G–1 through Army Service Forces headquarters. Instead of a special call on Selective Service for doctors, he asked that:

> * * * in the next call placed by the War Department with the National Selective Service System for the delivery of registrants to the Army for purposes of induction, 7,000 such registrants between the ages of eighteen and forty-four years, inclusive, be included in said "regular call" who have the following qualifications: a. Are graduates of a school of medicine approved by The Surgeon General of the Army. b. Are physically qualified in accordance with [Mobilization Regulations]. c. Have completed one year of internship or its equivalent, as determined by The Surgeon General of the Army, after graduation from medical school.[56]

This move seems to have brought no results, and The Surgeon General returned to his original line of action. On 2 October, he and a representative of the Navy met with members of the Directing Board of the Procurement and Assignment Service, a spokesman for the Selective Service System, and others. The Procurement and Assignment Service felt that it should not initiate a special call for doctors, but it would be "glad to endorse and implement" one if the conditions of the call met with its approval. One indispensable condition, from the viewpoint of the Procurement and Assignment Service, was that only doctors declared available by it should be drafted. The Surgeon General was quite willing to accept this as a condition. Selective Service announced that physicians in the 18 to 45 age group could be drafted in given numbers with given qualifications if the War Department's request was approved by the Director of the War Manpower Commission.[57]

On 16 October 1943, 2 days before the Secretaries of War and the Navy made their formal request, at a meeting of the Directing Board of the Procurement and Assignment Service, an assistant to the War Manpower Commission's Director reported that both Mr. McNutt and the head of Selective Service thought that there was no present need for a special draft—that "the Army is not that short of doctors." The Acting Chairman of the Directing Board pointed out that he had given only a qualified support to the plan. "I also told General Kirk [The Surgeon General of the Army]," he added, "that it was the feeling of the Board, for all practical purposes, that the military services have obtained just about as many doctors as they are going to get under

---

[56] (1) Memorandum, Lt. Col. D. G. Hall, Office of The Surgeon General, for Director, Military Personnel Division, Army Service Forces, 8 Sept. 1943, subject: Inclusion of Physicians and Surgeons in Regular Selective Service Call for Inductees. (2) Memorandum, The Surgeon General, for Assistant Chief of Staff, G–1, through Director, Military Personnel Division, Army Service Forces, 8 Sept. 1943.

[57] (1) Minutes of Session, by Executive Officer, Directing Board, Procurement and Assignment Service, 2 Oct. 1943. (2) Memorandum, Lt. Col. D. G. Hall, Office of The Surgeon General, for G. H. Dorr, Special Assistant to the Secretary of War, 6 Oct. 1943. (3) Proceedings of Directing Board, Procurement and Assignment Service, 16 Oct. 1943. (4) Memorandum, The Surgeon General, for G. H. Dorr, Special Assistant to the Secretary of War, 30 Nov. 1943.

the present legal setup. There may be 2,000 or 3,000 more, plus the increment from [medical school] classes." [58]

The Secretaries' letter to Mr. McNutt stated that "despite the greatest effort" on the part of their departments "in cooperation with agencies under your leadership, including successive reductions in ratios of medical officers to personnel it has been found impossible to induce a sufficient number of qualified physicians to accept appointment as medical officers voluntarily." The shortage was "so critical as to endanger the health of our forces." The procurement measure remained "which the services feel must now be utilized in order to meet requirements. We are attaching hereto requests for a special call on the Selective Service System for 12,000 physicians (Army, 5,000 * * * Navy, 7,000)." [59]

The verbal reaction of Mr. McNutt was hardly propitious; he told G–1 that the Army and Navy "would get such a special call only over his dead body." [60] The Secretaries' letter, transmitted to the Procurement and Assignment Service, drew the charge from that agency that the terms of the proposed special call violated the understanding between the Armed Forces and itself in two ways: It was not limited to men marked available by the Service, and the total number of doctors asked for exceeded that "calculated in previous negotiations with the military forces to allow a safe reserve for the care of the civil population." Accordingly, the Procurement and Assignment Service authorized a letter to Mr. McNutt stating that it would approve a draft only if one could be legally formulated which would meet the original conditions; it believed that "at present not more than 7,000 additional withdrawals from the civilian medical profession would be wise." While the Procurement and Assignment Service thought that the draft "may prove to be the only method of securing any considerable number of additional medical officers," it should first "be determined that the actual need of the armed services, not merely an assumed or traditional need, is great enough to justify" such a "serious change of policy." [61]

On 23 November 1943, following a White House conference attended by the Surgeons General of the Army and Navy, Assistant Secretary of War John J. McCloy, and Mr. McNutt, Mr. McNutt formally replied to the Secretary of War.[62] In this reply, Mr. McNutt stated that a special draft of doctors would be approved if it was possible to formulate one with the restrictions that he and the Procurement and Assignment Service deemed essential. But they must first assure themselves by "a thorough study of the present needs of the military services and constant reevaluation of the manner in which physicians are employed" that such a call was necessary. He added that the Navy seemed

[58] See footnote 57(3), p. 188.

[59] Proceedings of Directing Board, Procurement and Assignment Service, 6 Nov. 1943.

[60] Memorandum Routing Slip, 26 Oct. 1943, attached to draft of proposed letter, The Surgeon General, to Chairman, Directing Board, Procurement and Assignment Service.

[61] Proceedings of Directing Board, Procurement and Assignment Service, 6 and 20 Nov. 1943.

[62] Letter, Paul V. McNutt, Federal Security Administrator, to Secretary of War, 23 Nov. 1943.

to be in more urgent need of doctors than the Army and should therefore have prior claim on the remaining doctors in civilian life "up to at least 3,000 or 3,500." This did not mean that "a number of physicians will not be added to the Army Medical Corps as a result of the recruiting campaign now under way and planned." While he would not object to a draft in the last resort,

> * * * a survey of the legal situation * * * appears to make it exceedingly doubtful whether the draft of doctors could be as selective as would be necessary to preserve the balance of distribution worked out by the Procurement and Assignment Service * * *. I believe you will agree that it is in the public interest to accomplish our objective or come close to it without resorting to a special call. It has been decided, therefore, that final action on the special call will be postponed until after the first of the year [1944] at which time the matter will be reviewed again by our respective staffs and appropriate recommendations made to the President.

In commenting on this letter, The Surgeon General felt that one reason for Mr. McNutt's rejection of the special call was that the Secretaries had failed to include in their request the proviso that only doctors declared available by the Procurement and Assignment Service should be drafted. He had advised including it, but it "was omitted * * * I understand, for the reason that, as Mr. McNutt controlled both Procurement and Assignment Service and Selective Service, he could take appropriate steps to see that the proper action was taken to make this plan effective." As to the magnitude of the numbers requested, he stated that although the Navy had asked for 7,000, when the White House conference was called the Surgeon General of the Navy had said that he could get along with half that number; he himself, on the other hand, having already cut down his estimate to 5,000, which he considered a minimum, felt and still felt that no further reduction should be made. He rejected Mr. McNutt's implication that the requirements of the Army were overstated and insisted that "the War Department and the War Department alone should * * * determine the need for Medical Corps officers * * * . This office has certain views relative to the needs of the civil population, but has accepted the arbitrary figure adopted by the Procurement and Assignment Service which is based on their opinion solely."[63]

Although there were further discussions of a draft of doctors during 1944, The Surgeon General's efforts in that direction during the remainder of the war came to nothing.

Procurement in 1944

Recruiting attempts

The number of doctors brought into active duty from civilian practice became very small during the 12 months preceding November 1944, when the War Department ordered procurement from that source stopped. Beginning in the fall of 1943, teams composed of representatives of the Surgeon General's Office, the Procurement and Assignment Service (national and State), the Navy, and the U.S. Public Health Service visited many large cities in an effort

[63] See footnote 57 (4), p. 188.

to procure additional civilian doctors. These visits were predicated on the belief that a personal appeal would get many who had been declared available to volunteer. A team first informed representatives of local and State medical associations and leaders in the medical profession of the need for doctors, then held a public meeting of doctors who had been certified as available. Interviews with these doctors followed the meeting. During the interviews, the members of the teams were able to clear up many of the problems that had been troubling these doctors, and according to The Surgeon General's representative, the conferences resulted in "a considerable number" of applications for active duty with the Army.

Probably, for several reasons, the success of these teams did not match that of the Medical Officer Recruiting Boards of 1942. They functioned only in large cities, where, to be sure, the proportion of doctors to civilian population was highest. But more important was the fact that by this time, and owing in no small part to the activities of the Boards in 1942, the surplus of doctors above civilian needs had been drained off. Probably, too, those left in civilian practice were more confident than ever that draft boards, feeling pressure from fellow citizens, would not induct them.

Supplementing and abetting the work of these traveling teams, other means, such as publicity by press and radio, were used to impress upon doctors the Army's need for their services. The Surgeon General complained in December 1943 that most of such publicity up to that time had stressed the need of retaining sufficient physicians in civilian and industrial practice. He suggested that an organized program pointed directly at doctors and involving the use of posters, pamphlets, radio announcements and programs, magazine articles, and other available means should be employed to stress military needs. Such a campaign was launched in early 1944, aimed at procuring nurses as well as doctors.[64]

Complaints of doctors' idleness in Army service continued to be made, and in February 1944, the Surgeon General's Office took cognizance of their bad effect on those still in civilian life whom it was endeavoring to persuade to accept commissions. An officer in The Surgeon General's Military Personnel Division admitted to a superior that "in many instances officers and Commanding Officers themselves, apparently, have too much free time, which is a fact that is generally known in the civilian profession." In these circumstances, The Surgeon General decided to draw to such an extent on service command installations for Medical Corps officers in order to fill table-of-organization units that those remaining in those installations would "be completely and economically utilized even though on an overtime basis * * * ."[65]

[64] (1) Letter, Deputy Surgeon General, to Appointment and Induction Branch, Office of The Adjutant General, 3 Dec. 1943, subject: Recruiting Publicity Program. (2) Memorandum, Lt. Col. D. G. Hall, Military Personnel Division, Office of The Surgeon General, for The Surgeon General, 2 Jan. 1944, subject: Procurement and Assignment Meeting With Surgeons General.

[65] (1) Memorandum, Lt. Col. D. G. Hall, Military Personnel Division, Office of The Surgeon General, for The Surgeon General, through Chief, Personnel Service, Office of The Surgeon General, and Director, Training Division, Office of The Surgeon General, 7 Feb. 1944. (2) Routing Slip, Lt. Col. Hall, to Col. J. R. Hudnall, Col. F. B. Wakeman, and others, 7 Feb. 1944.

The 9–9–9 plan

As already noted, service in the Army for students graduating from medical school had been deferred for at least the 1-year internship. At the end of that year, some received a further deferment of service for a junior residency and following that a senior residency. There was no assurance beforehand, however, that such deferments for residencies would be given, with the result that civilian hospitals, to fill their vacancies for residents, could depend definitely only on an inadequate number of women and of men who were physically disqualified for military service. A change in the system of internships and residencies, requested in the summer of 1943 by the civilian hospitals, concurred in by the medical schools and the Procurement and Assignment Service, and implemented by the Armed Forces, altered this situation to the advantage of the hospitals and at the same time speeded the production of interns and residents for the benefit of the Army. The new system provided that, beginning on 1 January 1944, internships and each class of residency should run for only 9 months apiece. This program applied to all personnel, both civilian and military. Furthermore, one-third of the interns holding military commissions were to be deferred for a junior residency and one-half of the latter number (one-sixth of the total) could be deferred for a senior residency. Thus, the Army got each intern who was not deferred for additional training 3 months earlier than previously; the greatest possible postgraduate deferment for military personnel became 27 months instead of the previous 36. It developed specialists not only for the armed services, but for the civilian population as well. Likewise, civilian hospitals received a guarantee of getting some number of both junior and senior residents. Those not under military control—physically disqualified male and all female doctors—although having a 9-month limitation for each of the three periods, might be continued on the staff of a civilian hospital as long as the hospital desired them.

When the Directing Board proposed this thing, which came to be known as the "9–9–9 plan," The Surgeon General stated that although he would accept it and take officers into the Medical Corps who had only a 9-month internship, he would not assume any responsibility for the plan or for persuading civilian hospitals to accept it. He made one proviso—that civilian hospitals should seek to fill the internships and residencies only with women and overage, or physically disqualified, men.[66]

A professional organization—the Association of American Medical Colleges—and individuals, too, criticized the plan, asserting that in shortening the internship it lowered the standards of medical education. The Council on Education and Hospitals of the American Medical Association, replying that while everyone interested in high standards of medical education and medical service shared the concern felt by critics of the plan, approved it as the best

[66] Annual Report, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1944.

one under conditions then existing.[67] The Surgeon General for his part directed (December 1943) that the 9-month interns who entered the Army be given not only 6 weeks of basic military training (either at the Medical Field Service School or a replacement training center), but an additional 6 weeks at a named general hospital. Nor were they to be sent overseas without having served a minimum of 60 days after completing their basic military training.[68]

After the 9–9–9 program had been underway for a year, the American Surgical Association in a long appeal to the President requested him to direct that the military service of resident surgeons in teaching hospitals throughout the United States be deferred. The Surgeon General stood out against this step, arguing that an exception could hardly be made in favor of one group when medical training generally was being curtailed. If the service of surgical residents was deferred, he foresaw "immediate requests for deferment of residents in all other specialties." [69] The matter was dropped without action.

Procurement of doctors from all sources during 1944 was only a little larger than it had been in 1943—6,897 as against 6,678. An additional 916 doctors came in from January to June 1945. Almost all of them were recent graduates; after November 1944, appointment of practicing physicians virtually ceased.

Training Medical Specialists

Throughout the war, the Army found it more difficult to procure qualified specialists than general practitioners. Therefore, in order to combat the procurement lag, the Army commissioned general practitioners and then trained them, either at military installations or in civilian schools, in the various specialties. While approximately 8,000 doctors completed some specialty training during the war, there is no record of how many of those 8,000 were actually classified as specialists at the end of the war or ever served in a specialist capacity.

Pressure From Civilian Sources

While military procurement was not entirely to blame for the decline of civilian medical service (other factors were the removal of doctors from rural to urban, and more lucrative areas and the rapid growth of war-boom towns), it was certainly an important cause and one of growing concern to the civilian population. The Surgeon General, therefore, encountered attempts to prevent or offset the effects of procurement of civilian physicians for the Army.

---

[67] (1) Letter, Chairman, Executive Council, Association of American Medical Colleges, to The Surgeon General, 29 Oct. 1943. (2) Letter to the Editor, the *Journal of American Medical Association*, 1 Jan. 1944, with reply of Council on Education and Hospitals.

[68] Report, The Surgeon General's Conference With Service Command Surgeons, 10 Dec. 1943.

[69] (1) Letter, W. M. Firor, Secretary, American Surgical Association, to President Roosevelt, 19 Feb. 1945. (2) Memorandum, Deputy Surgeon General, for William D. Hassett, Secretary to the President, 5 Mar. 1945.

As early as December 1942, a subcommittee of the Senate Committee on Education and Labor conducted hearings on the procurement objectives of the Army and the adequacy and distribution of doctors remaining in civilian life.[70] The subcommittee does not seem to have issued a final report. However, even before it had heard testimony from representatives of the Surgeon General's Office, the Procurement and Assignment Service, or any other members of the medical profession, it released (29 October 1942) a preliminary report on the recruitment of physicians for the armed services. That report shows clearly that the subcommittee, after almost a year of war, was alarmed at a maldistribution of doctors in civilian life—some communities having none at all or far too few—and was concerned by the heavy procurement of doctors for the armed services.

The report stated that it was submitted at that time "because of the need of speedy action to prevent an immediate peril to the health of the Nation." Conditions were so acute and dangerous, it continued, that this preliminary report was made public with the recommendation that at the earliest possible moment the following steps should be taken: (1) The President should order a survey of oversupply and undersupply of medical personnel for both the Armed Forces and civilian needs; (2) a reallocation should be made wherever it was determined an oversupply or undersupply existed; and (3) the War Manpower Commission should be ordered to cease its procurement drive for doctors in all States where quotas had already been attained. The report further suggested that "an overall civilian authority should be established at once to supervise and control the drafting and recruiting of doctors," and declared that "no recruiting of doctors for the armed forces should be permitted until this authority was actually functioning." There is no indication that any action was taken on this report.

In late 1943, a member of Congress proposed to the Secretary of War that Army doctors be furloughed to civilian life until "a more pressing need for their services arose [in the Army]." About the same time, the dean of a medical school requested the discharge of a doctor to replace a retiring professor. The Surgeon General turned down both requests on the ground of the Army's acute need for doctors.[71]

Eventually, however, the pressure of members of Congress on the War Department to do something to prevent further draining off of doctors from civilian practice became so intense that in October 1944 The Surgeon General asked that the General Staff stop procurement in all but cases involving individuals commissioned for specific vacancies. The request was complied with.[72]

[70] Hearings before a Subcommittee of the Committee on Education and Labor, U.S. Senate, 77th Cong., 2d sess., on S. Res. 291, Investigation of Manpower Resources (Washington, 1943), Part 2, 14, 15, and 16 Dec. 1942.

[71] (1) Letter, Representative A. Willis Robertson (Va.), to John J. McCloy, Assistant Secretary of War, 23 Nov. 1943. (2) Letter, Lt. Col. P. A. Paden, Military Personnel Division, Office of The Surgeon General, to A. Willis Robertson, 1 Dec. 1943. (3) Letter, Surgeon General Kirk, to Dr. William Pepper, Dean, University of Pennsylvania School of Medicine, 4 Dec. 1943.

[72] (1) Memorandum, Executive Officer, Office of The Surgeon General, for Commanding General, Army Service Forces, 14 Oct. 1944. (2) Memorandum, The Surgeon General, for General Somervell, 14 Nov. 1944.

The discontinuance was not to affect interns who completed the Army Specialized Training Program or residents. Since neither group had been engaged in civilian practice, they could be commissioned and placed on active duty without further adversely affecting the existing medical provision for civilians. Naturally, those male medical students who had accepted Medical Administrative Corps commissions pending completion of their medical training were not affected; they were considered military personnel, not civilians, and would be commissioned in the Medical Corps upon finishing their training. The Surgeon General also requested that he be permitted to continue to commission individuals for specific vacancies; what he had in mind was probably highly trained specialists for the most part.

In these ways, the Army was continuing to draw into its service many physicians who had just completed their education and who might otherwise have entered civilian practice. But it could no longer be charged with denuding the civilian community by taking large numbers of physicians who were already practicing civilian medicine.

DENTAL CORPS

The procurement of dentists did not become a serious problem until virtually the end of the war.[73] When, in July 1942, The Surgeon General received authorization for 4,000 more dentists, he anticipated some difficulty in procuring them and therefore obtained permission from The Adjutant General to make appointments from groups not previously considered eligible; that is, dentists who were between 37 and 45 years of age, or who were qualified only for limited service, or whose training and experience justified an appointment above the rank of lieutenant. Procurement under this quota was so successful, however, that between September and November 1942 applications were discouraged. In November, The Surgeon General obtained an additional quota of 7,500 to bring the total strength of the Dental Corps to 17,248. The Procurement and Assignment Service shortly afterward agreed to declare 400 civilian dentists a month available for military service; the remainder were expected to come from the output of the Army Specialized Training Program, from recent graduates holding interim Medical Administrative Corps commissions, and from dentists inducted into the service as enlisted men.

The procurement program lagged somewhat in early 1943, but the response improved by May of that year, and by September the Dental Corps was only 1,700 below the ceiling of 15,200 imposed upon it at that time. The procurement agencies were notified not to accept applications from dentists over 38 years of age or from those fit only for limited service. Early in 1944, the Dental Corps was within a few hundred of its ceiling strength, and a surplus appeared likely as a result of the coming influx of graduates from the Army Specialized Training Program.

---

[73] See footnote 22 (1), p. 177.

There were several possible methods of dealing with the anticipated surplus—the ceiling on the strength of the Dental Corps could be raised, some dentists already in the service could be discharged and replaced by others who were graduating under Army control, or the Army could give up its claim to some of the graduates. The last method would involve reducing the Army's commitments under the Army Specialized Training Program, since graduates of the Program constituted the principal source of supply. To all intents, the first of these alternatives was not resorted to; the peak strength of the Dental Corps, reached in November 1944, exceeded the ceiling by only about 100. Instead, the Army discharged some of its dentists to make way for new men; it also reduced its commitments under the Army Specialized Training Program. With regard to this latter action, the 900 members of the class of June 1944 were released from their obligations to the Army and—what was more important—the Program for dental students who would graduate after July 1945 was discontinued.

During 1944, out of about 1,400 dentists procured, some 70 percent came from the Army Specialized Training Program; 23 percent directly from the civilian profession; and the remainder—aside from a handful inducted under Selective Service—from graduates who had held temporary Medical Administrative Corps commissions.

Early in 1945, although the Dental Corps was near its maximum authorized strength (15,200), prospective replacements from the curtailed Army Specialized Training Program and from future graduates holding interim Medical Administrative Corps commissions numbered less than 300. Procurement during January–June was almost precisely the same. After V–E Day, The Surgeon General suggested certain measures to encourage procurement and advised that the Dental Corps be maintained at 15,000 until the end of 1945. The measures were not expected to produce any large increment of dentists and, even though adopted, the strength of the Corps declined rapidly to about 9,600 by the end of the year.

At least as late as October 1945, no serious difficulty in meeting the dental needs of the Army during demobilization seems to have been anticipated, although the possibility that demobilization might cause a temporary increase in the demand for dental treatment had been mentioned 4 months before. Full-scale demobilization brought the problem to a climax, however, and in 1946, a draft of dentists became a necessity.

VETERINARY CORPS

Up to the beginning of 1945, the Veterinary Corps was on the whole in a better position with regard to procurement than any other corps of the Medical Department, mainly because it entered the war with a Reserve unusually large in comparison to its needs. Until well into 1942, it drew almost exclusively on the Reserve for additional active-duty strength. In fact, at

one time, the Veterinary Corps had placed more of its Reserves on active duty than it actually needed.

The possible sources of procurement for the Veterinary Corps were veterinarians still in civilian practice, veterinarians who had been drafted as enlisted men, and graduates of veterinary schools who held student commissions in the Medical Administrative Corps or who had obtained their education under the Army Specialized Training Program.

In October 1943, G–1, War Department General Staff, restricted procurement of veterinary officers to the latter group, except in special cases which were to be referred to G–1 for decision. Later, however, permission was granted to commission veterinarians who had entered the Army by way of the draft.[74]

As late as March 1944, The Surgeon General's Chief of the Veterinary Service stated that the commissioning of graduates of the Army Specialized Training Program and those holding temporary Medical Administrative Corps commissions was more than sufficient to meet the needs of the Veterinary Corps, and that graduates in these categories for whom no vacancies existed were being discharged from the Army.[75] In May 1944, the veterinary phase of the Army Specialized Training Program was ordered discontinued after the graduation of the current senior class and the completion of current terms for other classes.[76]

In January 1945, the newly established ceiling strength of 2,150 was only 100 above existing strength, but very few additional officers could be obtained from the permitted sources.[77] Consequently, the strength of the corps never rose above 2,070 during the remainder of the war. The previous practice of discharging graduates of the Army Specialized Training Program and those holding temporary Medical Administrative Corps commissions when no vacancies existed for them at the time of graduation eventually made it difficult to find new officers. It also, in the opinion of Col. George L. Caldwell, VC, (fig. 32), assistant chief of The Surgeon General's Veterinary Division, caused much dissatisfaction among Reserve officers who had entered the service early in the war and were compelled to remain in it till the end of hostilities: "They felt, and quite properly, that these men who were partly educated at Army expense should repay their government with active duty service and by so doing permit the release of * * * officers with long service." [78]

---

[74] (1) Letter, The Adjutant General, to The Surgeon General, 26 Oct. 1943, subject: Requirements for Veterinarians. (2) Annual Report, Veterinary Division, Office of The Surgeon General, U.S. Army, 1944.

[75] Letter, Maj. Gen. G. F. Lull, to Hon. George H. Mahon, House of Representatives, 23 Mar. 1944.

[76] Army Service Forces Circular 164, 13 May 1944.

[77] Semiannual Report, Procurement Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1. Jan.–31 May 1945.

[78] History of Procurement of Veterinary Corps Officers. [Official record.] For further details concerning procurement for the Veterinary Corps, see publication cited in footnote 51 (1), p. 186.

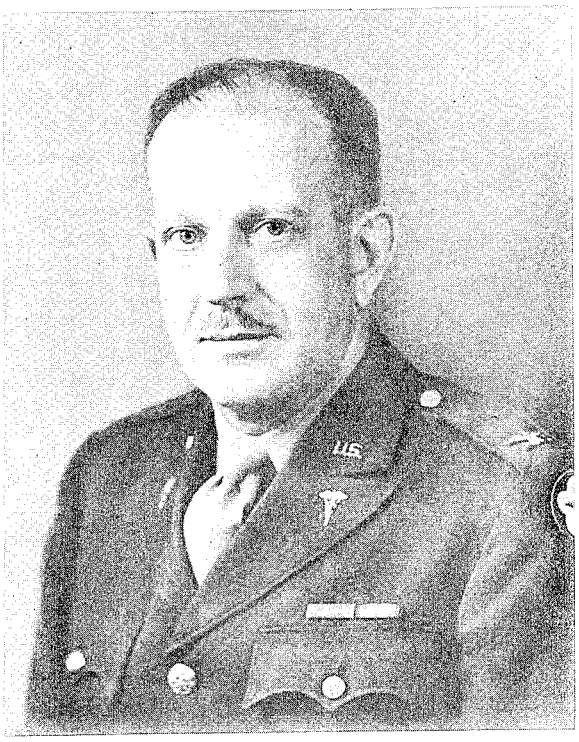


FIGURE 32.—Col. George L. Caldwell, VC, Assistant Chief, Veterinary Division, Office of The Surgeon General.

The following numbers of veterinarians accepted Army commissions during the later war years:

September–December 1943	87
January–June 1944	47
July–December 1944	26
January–June 1945	33

Of this total, 174 were described as coming from "enlisted" ranks and 14 from "civil life and other"; 3 were reported as flight officers, and 2 as members of the Officers Reserve Corps. Some few among the 174 were veterinarians who were commissioned after having been drafted; the rest were graduates of the Army Specialized Training Program.

DEFERMENT OF PROFESSIONAL STUDENTS

Early Methods

The outbreak of war, with the consequent acceleration of the draft, increased the pressure to grant students in all 4 years of dental and veterinary as well as medical schools some type of status that would not only permit them

to become practitioners in their chosen field but assure their service in that capacity in the Armed Forces. About a month after Pearl Harbor, the National Director of Selective Service, in an effort to protect the country's supply of doctors and dentists, advised his State directors of "the necessity of seriously considering for deferment" students in specialized professional fields, stating that the number of doctors and dentists needed by the Army and Navy would not be available "if those students who show reasonable promise * * * are inducted prior to becoming eligible for commissions." [79] This put a further damper on drafting students in the medical schools for service as enlisted men but left where it was the problem of eventually getting them into service as officers. For the time being, the only solution was to offer more categories of students a military status while permitting them to continue at school.

Medical Administrative Corps commissions

After some discussion, the Secretary of War approved the plan of The Surgeon General, and on 11 February 1942, corps area commanders received authority to commission as second lieutenants in the Medical Administrative Corps, Army of the United States, all physically qualified male citizens who had been accepted for matriculation at approved medical schools within the United States.[80] This was later changed to "within or without the United States," thus including American students in approved Canadian schools. Officers so appointed would not be ordered to active duty until eligible for appointment as first lieutenants in the Medical Corps, which meant after they had completed their internship. The authority also stated the circumstances under which an officer's commission would be terminated, which were essentially those already in operation for third- and fourth-year students.

There remained, however, the problem of protecting the future supply of dentists and veterinarians. On 17 April 1942, the War Department granted authority to corps area commanders to appoint as second lieutenants in the Medical Administrative Corps, Army of the United States, all physically qualified male citizens who were accepted matriculants in approved dental and veterinary schools in the United States. The terms were similar to those previously announced for commissioning medical students.[81]

As with individuals accepted for medical schools although not entered, those accepted as dental and veterinary students were likewise to be commissioned. Students in dentistry and veterinary medicine, however, received only 3 months' instead of a year's grace after graduation in which to apply for

[79] Memorandum I–347, National Headquarters, Selective Service System, for all State Directors, 12 Jan. 1942, subject: Supplement to Memorandum I–62: Occupational Deferment of Doctors, Internes, Medical Students, Dental Students, and Instructors (III).

[80] (1) Memorandum, The Surgeon General, for Special Assistant to the Secretary of War, 23 Jan. 1942. (2) Letter, The Adjutant General, to all Corps Area Commanders and The Surgeon General, 11 Feb. 1942, subject: Commissions for Medical Students.

[81] (1) Letter, Secretary of War, to Paul V. McNutt, Office of Defense Health and Welfare Service, 14 Apr. 1942. (2) Letter, The Adjutant General, to Corps Area Commanders, 17 Apr. 1942, subject: Commissions for Dental and Veterinary Students.

commissions in the professional corps. A month later, male citizens above the age of 18 years who were students at approved dental and veterinary schools outside the United States were included, and although the directive specified that all such students be physically qualified, it also stated that appointment would be made without physical examination.[82] It seems inconceivable that the Army would commission anyone clearly unfit; it must have planned, however, to accept the student's word that he had no hidden disabilities. The deans of the schools and the corps area commanders played important roles in the processes by which these commissions were issued.

The measures to protect medical, dental, and veterinary students raised certain problems. The provision that a student's commission in the Medical Administrative Corps would be terminated if he failed to secure an appointment in the Medical, Dental, or Veterinary Corps within a specified time after graduation made it possible for him to obtain his release from the Army simply by taking no action to convert his commission. The Surgeon General, in fact, recommended the discharge of certain dental students on these grounds. In 1943, however, the War Department prohibited such discharges and directed that students who failed to convert their commissions should be called to active duty in the Medical Administrative Corps.[83] Since professional men were not apt to prefer service in that corps, it is improbable that many delayed converting their commissions after the order was published.

Another problem, as the Chief of The Surgeon General's Veterinary Division saw it, was that the Veterinary Corps would not be able to absorb all veterinary students graduating with Medical Administrative Corps commissions, since he believed that the Veterinary Corps Reserve contained enough officers to meet war needs. If on the other hand it should absorb them, he feared that the civilian supply would be entirely cut off. Accordingly, The Surgeon General persuaded the War Department to direct that no more graduates be selected for veterinary and dental commissions than these corps actually required.[84] Why the Dental Corps was included is not apparent.

Not all newly eligible students accepted Medical Administrative Corps commissions, even though physically qualified, probably for much the same reasons that had deterred many third- and fourth-year medical students. Other arrangements were made for students then enrolled in Reserve Officers' Training Corps units in branches other than medical who intended to enter medical schools. No mention seems to have been made of dental or veterinary schools. If time permitted them to fulfill requirements for a commission, before they entered medical school, they were to be commissioned in the branch in which they had been trained. But even if commissioned in another branch, they were

[82] Letter, The Adjutant General, to all Corps Area and Department Commanders and The Surgeon General, 18 May 1942, subject: Commissions for Dental and Veterinary Students.

[83] (1) Memorandum, The Surgeon General, for The Adjutant General, 4 Aug. 1943, subject: Discharge of Medical Administrative Officers. (2) Letter, The Adjutant General, to all Services (and others), 15 Mar. 1943, subject: Authority to Order to Active Duty.

[84] (1) Memorandum, Brig. Gen. R. A. Kelser, Army Veterinary Service, for Chief, Personnel Division, Office of The Surgeon General, 3 Apr. 1942. (2) See footnote 82.

not be called to active duty until they had completed their medical education. If they could not complete the requirements for a commission before entering medical school, they were permitted to withdraw from their advanced Reserve Officers' Training Corps contracts with the Government. Medical units of the Reserve Officers' Training Corps were suspended in 1943 for the remainder of the war.[85]

Students who accepted interim commissions received no financial benefit from the Army. In July 1942, however, Congress appropriated $5 million to be loaned to students whose education in technical and professional fields, including medicine, dentistry, and veterinary medicine, could be completed within 2 years.[86]

Enlisted Reserve Corps

The Army and Selective Service insured the scholastic careers not only of full-fledged students and matriculants in medicine, dentistry, and veterinary medicine but of students who were in the preliminary stages of their training. Besides granting interim Medical Administrative Corps commissions, the Army permitted a number of premedical, predental, and preveterinary students to enter the Enlisted Reserve Corps and retain an inactive status in it while they continued their schooling. When, in September 1942, the Army announced that members of the Enlisted Reserve Corps would be called to active duty immediately upon reaching draft age (20 years, reduced 2 months later to 18), it exempted such of these students as had acceptances from professional schools for the 1943 and 1944 entering classes. Moreover, in March 1943, the Selective Service System granted deferment of service to premedical, predental, and preveterinary students who held acceptances from professional schools and who would finish their preprofessional training in 24 months.

The Army Specialized Training Program

The Army Specialized Training Program and the Navy College Training Program (V–12) were established in December 1942 under the auspices of the appropriate departments. The Army Specialized Training Program applied not only to students of medicine, dentistry, and veterinary medicine, but to all students of specialized or professional subjects who might constitute officer material for the Army at large. Enlisted men selected for the program were placed in training units at numerous colleges and universities throughout the country, where they began (or continued, if already students) the regular course of instruction.[87]

---

[85] (1) Letter, The Adjutant General, to all Corps Area and Department Commanders, 12 May 1942, subject: Commissions for Medical Students. (2) Information obtained from Albert McIntyre, Reserve Officers' Training Corps Unit, Officer Procurement Branch, Personnel Division, Office of The Adjutant General, October 1953.

[86] 56 Stat. 562.

[87] This section is based, almost in its entirety, *on* Final Report, Col. Francis M. Fitts, MC, Chief, Curricular Branch, Army Specialized Training Division, Army Service Forces, subject: Training in Medicine, Dentistry, and Veterinary Medicine, and in Preparation Therefor, Under the Army Specialized Training Program, 1 May 1943 to 31 December 1945.

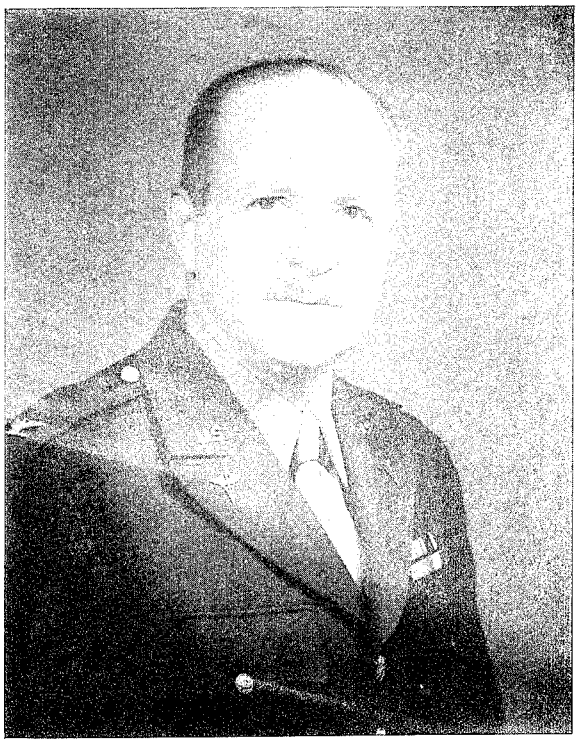


FIGURE 33.—Col. Francis M. Fitts, MC, Director of Military Training Army Service Forces.

To enter the Army Specialized Training Program, medical students who were members of the Medical Administrative Corps might resign their commissions and enlist in the Enlisted Reserve Corps, after which they, together with other medical students who were already members of the Enlisted Reserve Corps, were called to active duty with the program without interrupting their studies. The medical aspects of the program were handled in the Office of the Director of Military Training, Army Service Forces, by Col. Francis M. Fitts, MC (fig. 33).

Members of the program had the status and perquisites of privates, or privates first class, in the Army. The Army likewise defrayed all their expenses, including food, clothing, lodging, and the cost of schooling. For medical students, school costs, such as tuition, books, and laboratory fees, amounted to $62.47 per man per month; for dental students, $61.10; and for veterinary students, $45.50.

Upon graduation, students in these fields were to be commissioned in the Army of the United States. Graduation from other fields, such as sanitary engineering, gave students no similar assurance of a commission. It did not preclude them from receiving one, either directly (as may have happened in some cases) or after successfully completing a course at an officer candidate

school. But the mere fact of graduation did not necessarily enhance their opportunities in these respects, and the understanding was that unless such opportunities occurred they would continue to serve in an enlisted status.

Dental trainees were commissioned in the Dental Corps and called to active duty as soon as they graduated. Since the demand for Veterinary Corps officers was less acute, students newly commissioned in that corps were called up as the situation required. Medical trainees, commissioned upon graduation, were not called to active duty until they had completed a minimum of 9 months' civilian hospital intern training. In order to meet the needs of civilian hospitals, and so that the military service might profit by the additional postgraduate training, a small fraction was not called to duty until after 9 months' additional experience; an even smaller fraction until after total of 27 months' graduate training as residents.

At the time the program was set up, The Surgeon General estimated that the existing body of professional and preprofessional students as they were graduated would meet his needs until 1947; that is, 4 years longer. If the war lasted so long, new students brought in by the program would from then on furnish most if not all of the supply. To obtain the proper quota of graduates after 1947, a large number of new students would have to be placed in the pipeline of the program considerably before that date. The Surgeon General's Office decided that enough veterinary students had already been blanketed into the program so that no additional ones were needed. To meet the requirements for doctors and dentists after 1947, students were to be selected from among those who had successfully completed two or three terms of the "Basic Curricula" of the program—the introductory course which all new students had to enter.

By the end of 1943, the Army Specialized Training Program and its Navy counterpart had absorbed most of the male students of medicine, dentistry, and veterinary medicine who were in the professional and preprofessional stages of their training and who were physically qualified for military service. In addition, they were beginning to take in students of these subjects who were just entering upon their academic careers; like the others, they were committed to enter medical service of the Armed Forces upon completion of their studies.

Curtailment of the program

When the War and Navy Departments had first announced the program a much longer war had seemed inevitable. By late 1943, moreover, the men enrolled were urgently needed for combat duty. The Army Ground Forces had never expressed enthusiasm for the program, and by then, the Army Air Forces wanted to use those of their men who were assigned to the program. In March 1944, the War Department announced that the entire program would be cut back from 145,000 men to 35,000.

A month later, Army Service Forces headquarters announced that the Army's share of the classes entering medical schools during 1945 would be 28

percent instead of the previously planned 55 percent, and for dental schools 18 percent instead of 35 percent; no commitments would be made at that time to cover classes to start in 1946.[88]

Meanwhile, the question of reducing the dental Army Specialized Training Program was becoming involved with that of discharging dentists already in the service.[89] In March 1944, the Dental Corps reached its ceiling strength and had in immediate prospect more than enough graduates of the program to meet its needs in the way of replacements at the existing rate of attrition. On 18 July, the War Department announced the termination of the dental Army Specialized Training Program. Only those who were seniors in July continued under the program, and the dental Army Specialized Training Program came to an end with the classes graduating in April 1945.

In May 1944, the veterinary phase of the Army Specialized Training Program had been marked for closure with the approval of The Surgeon General. Apparently, his Veterinary Division considered this program no longer necessary since the Veterinary Corps was near its authorized strength and little difficulty was to be anticipated in inducing veterinarians in civil life to join the corps—a source of procurement which, in fact, the Director of the Division seems to have preferred.

The future of the medical phase of the Army Specialized Training Program was a matter of more concern to the Surgeon General's Office. The collapse of Japan brought discussion of whether the Army should continue to spend money to help meet civilian needs for doctors by maintaining the medical part of the program. Some War Department authorities feared the Army might be criticized for the lack of medical training during the war period if it did not continue such training, while others believed that the Army should limit its medical training to meet its own future needs.[90] General Somervell, believing that the Army could not justify large expenditures in continuing the Army Specialized Training Program as then contemplated, recommended, among other things, that medical courses be terminated during the school year 1945–46.[91] The Surgeon General for his part stated that his policy had been, and would be for the duration of the emergency, to order to active duty young medical officers who had received their education at Government expense. They were being used as replacements, he said, to accelerate the return of those older medical officers who had served for long periods of time.[92]

Two months after the defeat of Japan, the Deputy Surgeon General recommended to G–3 that the program be continued as a source of replacements. He

---

[88] Memorandum, Brig. Gen. W. L. Weible, G–3, for The Surgeon General, 18 Apr. 1944, subject: War Department Policy Governing Training in Medicine and Dentistry Under Army Specialized Training Program.

[89] A complete discussion of this phase of the Army Specialized Training Program is contained in the publication cited in footnote 22(1), p. 177.

[90] Letter, Maj. Gen. I. H. Edwards, G–3, to Prof. Philip Lawrence Harrison, Bucknell University, 23 Aug. 1945.

[91] Memorandum, Lt. Gen. Brehon Somervell, Commanding General, Army Service Forces, for Chief of Staff, 4 Sept. 1945, subject: Future of Army Specialized Training Program.

[92] Letter, Surgeon General Kirk, to Hon. Mendel Rivers, U.S. Congressman from North Carolina, 16 Oct. 1945.

said he could not view lightly the potential loss of 5,000 medical officers if the program terminated in June 1946, as had been suggested. He mentioned the difficulties experienced in the past in getting volunteers for the Regular Army Medical Corps.

The Chief of Staff, however, recommended that the medical program be terminated on 1 July 1946; men who had not graduated by that date should be dropped as soon as possible, but in accordance with a plan that would allow time for students and schools to make adjustments.[93] This policy was announced in November 1945. In the same month, the War Department ordered that Army Specialized Training Program students who were scheduled to graduate before 1 July 1946 should not be separated for either of two reasons applicable to other persons—their adjusted service rating score or the possession of three or more dependent children under 18 years of age. They might, however, be discharged for certain reasons that also applied to others—hardship (as in the case of enlisted personnel generally) or their importance to the national health, safety, or interest. Moreover, a claim based on the possession of dependents—though not the standard one just mentioned—might be considered sufficient to warrant their discharge.[94] The Army wanted all others of this group to graduate as doctors available for service in the Medical Corps, a desire expressed by the Secretary of War not long before. On the other hand, medical students who were scheduled to graduate after 1 July 1946 were directed to be separated from the program during March 1946. Enlisted men so separated who planned to continue their study of medicine and who were acceptable to an approved medical school were, upon their request, transferred to an inactive status in the Enlisted Reserve Corps. They were subject to recall to active duty if they quit school or made unsatisfactory progress in their studies. Those who did not plan to continue the study of medicine or who were unacceptable to an approved school were discharged if eligible or transferred to other duties upon separation from the program. The latter group of students could be discharged from the Army when they became eligible.[95]

Thus, the medical phase of the Army Specialized Training Program ended a year later than that of the veterinary or dental phases, enabling proportionately more medical graduates to become available for commissions and permitting the Medical Corps to solve its postwar personnel problem with less strain than the Dental Corps experienced. Assignment was not, however, automatic. Immediately after the war, the Navy Surgeon General, who was also the President's personal physician, persuaded the Commander in Chief to divert a thousand of these fledgling doctors, just through with their internships, to the Navy.

---

[93] Memorandum, Chief of Staff, for Secretary of War, 20 Nov. 1945, subject: Medical Training Under Army Specialized Training Program.

[94] Disposition Form, Maj. Gen. W. S. Paul, G–1, to Commanding General, Army Service Forces, through Deputy Chief of Staff, 29 Nov. 1945, subject: Policy Regarding Separation of Army Specialized Training Program Medical Students.

[95] (1) Army Service Forces Circular 7, 9 Jan. 1946. (2) Army Service Forces Circular 56, 6 Mar. 1946.

TABLE 17.—*The Army Specialized Training Program: Students of medicine, dentistry, and veterinary medicine assigned, separated, and discharged and transferred through curtailment of the program*

[Figures in parentheses are subtotals]

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

Source: (1) Final Report, Col. Francis M. Fitts, MC, Chief, Curricular Branch, Army Specialized Training Division, Army Service Forces, subject: Training in Medicine, Dentistry, and Veterinary Medicine, and in Preparation therefor, Under the Army Specialized Training Program, 1 May 1943 to 31 December 1945. (2) Letter, Col. Francis M. Fitts, MC, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 15 Nov. 1955.

One of those so transferred turned out to be the son of an Army dentist who promptly explained to The Surgeon General in two pages of well-chosen words that he had not raised his boy to be a sailor.[96] The total enrollment in and output of professional courses in medicine, dentistry, and veterinary medicine as a result of the Army Specialized Training Program are shown in table 17.

The maximum enrollment of members of the program in these courses was reached in March 1944, when 21,581 enlisted men were under instruction: 14,042 in medicine, 6,143 in dentistry, and 1,396 in veterinary medicine. The number of students receiving preprofessional training in the same fields under the program attained its peak in April 1944 with 4,093 enlisted men enrolled.[97] Satisfactory figures for the total number of Army Specialized Training Program students enrolled in preprofessional courses during the life of the program are not available, but approximately 3,500 were assigned to premedical, about 1,400 to predental, and an unknown number to preveterinary studies.[98]

THE AFFILIATED UNITS AFTER PEARL HARBOR

The affiliated units constituted one of the most important sources of officer personnel available to the Medical Department. Many of the physicians who entered the Army by this route were ones who would not have

[96] The incident is recalled in a letter, Maj. Gen. George F. Lull, USA (Ret.), to Col. John Boyd Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 31 May 1961.

[97] (1) See "Final Report" cited in footnote 87, p. 201. (2) Memorandum, G–1 (Brig. Gen. M. G. White), for Combined Chiefs of Staff, 30 June 1943, subject: Training of Female Students Under Government Program.

[98] (1) See "Final Report" cited in footnote 87, p. 201. (2) Letter, Col. Francis M. Fitts, MC, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 21 Nov. 1955.

volunteered as individuals, but were willing to accept military service as part of a familiar organization. The role was rendered more attractive by the deferment it carried until the unit was actually called up. Only the officers, however, were procured in peacetime. Nurses and other female elements, and enlisted men, all were added when the affiliated hospitals became eligible for activation with the actual advent of war.

The Surgeon General directed that nurses for the staff must be obtained exclusively from the Red Cross Reserve, though at least one hospital enrolled nurses first and then persuaded them to join the Reserve. Nurses and enlisted technicians could be recruited by these hospitals before activation. The Surgeon General urged nurses so recruited to volunteer for active duty immediately, thus making their services available anywhere in the Army. He assured them that they would be returned to their unit when it was activated. In the case of technicians recruited before activation, the General Staff permitted the units to place them in the Enlisted Reserve Corps, and in this way to protect them from the draft, pending activation of the unit. If, however, activation did not take place within 6 months, these men would be called to active duty elsewhere. With this exception, the corps area commander procured enlisted men for the affiliated units through the regular channels. Women could join these units as dietitians, physical therapists, or dental hygienists. Female dental hygienists could join them in civilian status, as could the dietitians and physical therapists before they attained military status.

Problems Connected With Keeping the Units Intact

Although The Surgeon General and other Army authorities did not commit themselves to a policy of untouchability where affiliated units were concerned, such a policy was nevertheless implied. In practice, the right of these units—or at least their commanding officers—to be consulted before removing any of the officers was recognized, and in general there were few changes in organization as long as the units remained in the United States. Keeping them intact had unduly divergent results. On the one hand, the members, particularly the officers, felt a certain esprit de corps, drawn as they were from a single institution. On the other hand, restriction of personnel to a single unit limited promotion and could have affected morale, for once the organization was completed there were no opportunities for advancement except when vacancies resulting from attrition within the unit occurred. One method of circumventing this problem was to initially give the officers a grade lower than the highest permitted by their tables of organization, thereby enabling promotions to be given later.

Restrictions on the transfer of personnel also had an adverse effect on medical service generally, if it prevented a man from being placed where he was most needed. Affiliated units were generally well staffed with specialists—sometimes with several of equal professional standing in the same specialty—

663076°—63——16

who were in greater demand than were any other category of personnel. If a specialist was kept from being transferred to a unit where his talents could be best utilized, it was a distinct loss to the medical service and a waste of personnel.

It is true that by no means all these units were kept intact, especially after their movement overseas. The Chief Surgeon of the European theater has stated that he was able to persuade the members of affiliated units within his jurisdiction to place regard for the needs of the Army above loyalty to their units and that this enabled him to use the affiliated units partly as specialist pools from which to staff or strengthen other units less fortunately provided.[99] In the South Pacific, affiliated units upon arrival were assured that they would remain intact, but that if they found themselves overstaffed they might apply to the surgical consultant or theater surgeon for transfer of the excess personnel to a unit where opportunities for promotion existed. This method proved very effective and was the only one used in that theater for removing a surplus of qualified personnel from the affiliated units.[100]

In several instances, The Surgeon General saw fit to cause changes in the category of certain affiliated general hospitals while they were still in this country. For example, shortly after Pearl Harbor, three medical schools responded to his request by forming a second unit to be affiliated with the school, at the same time reducing the bed capacity of the first from 1,000 to 500 beds. Moreover, in 1943, he recommended the disbandment of the 71st General Hospital, sponsored by the Mayo Clinic, while it was still in this country; the personnel that had been in that unit then formed two 500-bed station hospitals. In another case, the 30th General Hospital, activated in 1942 with only a 600-bed capacity, was increased to 1,000 after it reached the theater of operations.[101] Nevertheless, the understanding that affiliated units should usually be kept intact seems to have prevented the best possible use of all their members, at least so long as they remained in the United States. Early in 1942, when a number of institutions were applying for permission to organize new affiliated units, The Surgeon General refused many more of these requests than he approved on the ground that he needed doctors as individuals, available for assignment when and where they were required, and that he did not believe that still more doctors should be immobilized in groups.[102]

This is not to say that the drawbacks connected with the use of affiliated units outweighed the advantages; it is likely that if the Army had not virtually promised to keep these units intact many highly competent professional men

---

[99] Interview, Medical Department historians, with Maj. Gen. Paul R. Hawley, 18 Apr. 1950.

[100] Letter, Brig. Gen. Earl Maxwell, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 22 Nov. 1955.

[101] (1) Letter, Surgeon General Magee, to Dr. Elliott C. Cutler, Harvard University Medical School, 9 Mar. 1942. (2) Annual Reports, 42d and 105th General Hospitals, 1942. (3) Memorandum, Office of The Surgeon General (Lt. Col. D. G. Hall), for Officer Procurement Service, Army Service Forces, 4 Sept. 1943. (4) Letter, Headquarters, 233d Station Hospital, Charleston, S.C., to The Surgeon General, 24 June 1943, subject: Inactivation of 71st General Hospital. (5) Annual Report, 30th General Hospital, 1943.

[102] Letter, Lt. Col. Francis M. Fitts, MC, Office of The Surgeon General, to David P. Stearns, Boston, Mass., 22 Mar. 1942.

would have refused to join them, and that the Army would therefore have been deprived of their services, at least for the time being.

Other Problems

The slow rate at which the affiliated units were activated and sent overseas by the War Department was believed to have had adverse effects on the procurement of doctors and nurses generally.[103] Numerous units, organized either before or after hostilities began, continued for long periods on inactive status during the progress of the war. Even when activated, they frequently waited for many months before being sent overseas, while their personnel received necessary field training and supplemented the staffs of post, camp, and station hospital.[104]

Of some 70 affiliated hospital units activated during the war, only about 20 were sent overseas within 3 months. Of the remainder, about 20 stayed in this country for a year or more (2 for nearly 18 months), while the rest averaged about 8 months.[105] Meanwhile, the War Department was urging more doctors to join the Army or, if already in the affiliated Reserve, to accept active duty. Some doctors in the inactive affiliated units refused to heed the call until their own units were brought into service, probably on the theory that if they were really needed the units themselves would be called to duty,[106] and that units already activated would be put to full use. Other doctors were probably discouraged from entering the Army for much the same reasons; one of The Surgeon General's procurement officers stated that activation of the last affiliated units (in June 1943) would remove an obstacle to procurement.[107]

A problem of internal morale resulted from the length of time that elapsed between activation of some of the affiliated units and their departure for overseas. One of the original purposes of these units had been to provide the Army

---

[103] Major General Kirk, who became The Surgeon General when the last of these units were being activated, has stated his belief that the delay resulted from enemy submarine activity and from the fact that the troops whom these units were expected to serve did not expand in numbers or complete their training as rapidly as was anticipated. (Letter, Major General Kirk, to Col. J. B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 12 Dec. 1955.) Colonel Paden has interpreted the delay in a slightly different fashion which may supplement that of General Kirk. In his opinion, sections of the War Department General Staff responsible for furnishing hospitals to particular theaters competed with one another for units and often caused affiliated hospitals to be activated before they were actually needed. (Letter, Colonel Paden, to Col. J. H. McNinch, Office of The Surgeon General, 17 Jan. 1950.

[104] According to Lt. Col. Paul A. Paden, in his letter (17 Jan. 1950) to Colonel McNinch, "The Surgeon General's Office generally (as far as I know) and particularly the Personnel Service, did not know exactly when or where affiliated units were to be employed." He felt that The Surgeon General should have had this information. Troop movement bases "were available late in the war, but these were only very rough estimates, often reflecting the desires of General Staff Section, subject to frequent change, and late publication and distribution tended to nullify their value."

[105] 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, tables 6 and 7.

[106] Letter, Chairman, Ohio Procurement and Assignment Service Committee for Physicians, to Executive Officer, Procurement and Assignment Service, War Manpower Commission, 26 Mar. 1943, subject: Base Hospital Unit 25, Cincinnati, Ohio.

[107] Address by Chief, Procurement Branch, Military Personnel Division, Office of The Surgeon General, before District Officers, Officer Procurement Service, 17 June 1943.

with a group of medical units which would be ready to function in a theater of operations with a minimum of delay, and no doubt the members expected that their units would go into action promptly once they were activated. As might have been expected, idleness and delay in shipment caused dissatisfaction. One Medical Department authority reported that "we have had many letters about * * * people [in the affiliated units] twiddling their thumbs when we knew that they should have been under some kind of training program." [108]

Unaffiliated Units

During the emergency period and also after Pearl Harbor, individual physicians or groups of physicians offered to organize hospitals for service with the Army. In 1941, The Surgeon General declined these offers on the ground that he was authorized to accept only groups which were sponsored by and associated with a medical school or hospital capable of furnishing an adequate staff; in other words, only officially affiliated units were acceptable.[109] In 1942, however, the policy changed. The Surgeon General accepted a number of offers to form unaffiliated units and encouraged the sponsors to recruit staffs for them.[110] In one instance, he suggested that if the inquirer could recruit a balanced staff of about 16 medical officers for a 250-bed station hospital they could be commissioned and assigned as a group to such a hospital. However, he could not guarantee that officers so assigned would be kept together, since other hospitals might have greater need for them.[111]

It is unlikely that more than a very few hospitals were organized in this manner. One exception was the 61st Station Hospital, formed by a group of physicians and nurses from Camden, N.J. At the intercession of the executive assistant to the Medical Society of New Jersey, Dr. Norman M. Scott, the group was accepted and assigned to the 500-bed 61st Station Hospital, constituting its entire professional complement. All the members were drawn from the staff of the Cooper Hospital, a civilian institution, which approved their enterprise, but the military hospital was never considered a formally affiliated unit. The hospital arrived in North Africa in December 1942, and the group remained intact, except for two or three members who were evacuated because of illness, until September 1945, when it was relieved from duty with the 61st Station Hospital for return to the United States from the Mediterranean theater. At the request of Dr. Scott, The Surgeon General awarded the unit the certificate of appreciation customarily granted to affiliated hospitals.[112]

---

[108] Report, The Surgeon General's Conference with Chiefs, Medical Branches, Service Commands, 14–17 June 1943.

[109] Letters, The Surgeon General, to Dr. L. A. Andrew, Jr., Winston-Salem, N.C., 1 July 1941; Hon. Charles O. Andrews, Washington, D.C., 29 Dec. 1941; and Mr. C. V. Morris, Snyder, Tex., 30 Dec. 1941.

[110] Letters, The Surgeon General, to Dr. C. F. Fisher, Clarksburg, W. Va., 18 Aug. 1942; Dr. Addison G. Brenizer, Charlotte, N.C., 28 Nov. 1942; and Dr. A. K. Lewis, Homestead, Pa., 2 Jan. 1943.

[111] Letter, The Surgeon General, to Col. Charles P. Stahr, Lancaster General Hospital, Lancaster, Pa., 22 June 1942.

[112] (1) Letter, Dr. Norman M. Scott, to The Surgeon General, 8 Apr. 1946. (2) Letter, The Surgeon General, to Dr. Norman M. Scott, 24 Apr. 1946. (3) Letter, Mr. LeRoi N. Ayer, to The Surgeon General, 1 May 1946.

CHAPTER VII

Procurement, 1941–45: Other Military Components

SANITARY CORPS

Among the various specialties represented in the Sanitary Corps, the largest was the group of sanitary engineers. On 1 January 1943, the Procurement and Assignment Service, at the request of the National Research Council's Committee on Sanitary Engineering, extended its jurisdiction over this profession. The committee, in making its request, cited the Army's large need for these men and the depletion of State health department rolls through losses to the military forces and the U.S. Public Health Service. The committee suggested that a system of procurement and assignment should be instituted promptly, and that the Procurement and Assignment Service should, after study, recommend the proper allocation of the limited supply. Mr. Abel Wolman, Professor of Sanitary Engineering at The Johns Hopkins University and Chairman of the Committee on Sanitary Engineering of the National Research Council, was made a member of the Directing Board of the Procurement and Assignment Service. About 1 June 1943, an Adviser on Sanitary Engineers was appointed in each State, under the Procurement and Assignment Service; in most States, the Chief Sanitary Engineer of the State health department was designated the State adviser.

On 30 September 1943, the Sanitary Corps comprised 2,054 officers, having grown almost 80 percent since the preceding December.[1] Of this number, some 600 were sanitary engineers, the bulk of the members of the profession in the United States who were of military age and physically fit. As late as January 1945, of the more than 970 sanitary engineers then in the Sanitary Corps, approximately 75 percent had come from the civilian profession—largely from State and local boards of health. A "rough check" at that time revealed that about 22 percent had entered the corps from State health departments and 17 percent from city and county health departments. A further 20 percent had come from other governmental health agencies, while 20 percent more had been consulting engineers. In recognition of the limitations of procurement from these services, the experience requirement was reduced from 4 to 2 years.

[1] (1) Hardenbergh, W. A.: Organization and Administration of Sanitary Engineering Division, ch. 8. [Official record.] (2) Mordecai, Alfred: A History of the Procurement and Assignment Service for Physicians, Dentists, Veterinarians, Sanitary Engineers, and Nurses—War Manpower Commission. (For some time, Colonel Mordecai served as The Surgeon General's liaison officer with the Procurement and Assignment Service.) (3) See table 1, p. 10.

The Army had to draw upon other sources, however, not only to meet its need for sanitary engineers but for other types of specialists represented in the Sanitary Corps. In 1943, it was decided to make use of the Army Specialized Training Program to train enlisted personnel to serve as sanitary engineers. Of the men so trained, 153 became officers in the Medical Department. Upon completing their college course, they were sent to Medical Administrative Corps officer candidate schools to obtain commissions; after their appointment in that corps, they were detailed to the Sanitary Corps.

From the beginning of the war, it had been possible to commission men directly, not only from civil life but from the noncommissioned ranks of the Army, if they possessed special qualifications that would justify their appointment as officers.[2] As part of its effort to enlarge the Sanitary Corps in this manner, the War Department issued Circular No. 333 on 15 August 1944 to encourage enlisted men and warrant officers to apply for commissions in the corps, stating that a need existed for sanitary engineers, medical entomologists, serologists, biological chemists, parasitologists, and industrial hygiene engineers. A month later, the Medical Department succeeded in having a similar opportunity offered to enlisted members of the Women's Army Corps who could qualify as bacteriologists, biochemists, and serologists. In this case, however, the successful applicants were not to be commissioned in the Sanitary Corps but in the Women's Army Corps, being simply assigned to and immediately detailed to the Sanitary Corps.[3]

In addition, the Medical Department received permission to use Women's Army Corps officers who were trained in Sanitary Corps specialties. In December 1944, the War Department directed that every effort be made to utilize in medical installations such of these officers as were qualified in technical work appropriate to commissioned rank; the specialties mentioned as examples were those of laboratory officer, bacteriologist, biochemist, parasitologist, serologist, "and other positions established for Sanitary Corps officers."[4] No permission was granted, however, to commission women in the Sanitary Corps directly from civilian life. These moves followed a campaign begun in the spring of 1944 to recruit members for the Women's Army Corps to serve in medical installations.

On 7 December 1944, The Surgeon General stated that the reservoir of bacteriologists, biochemists, and parasitologists in civilian practice was almost exhausted and asked the Officer Procurement Service to stop procurement from this source.[5] Two months later, at his request, the War Department revoked the section of Circular No. 333 which encouraged applications for

---

[2] (1) Letter, The Adjutant General, to Commanding Generals, Services of Supply, Army Ground Forces, Army Air Forces (and others), 28 Apr. 1942, subject: Commissions in the Sanitary Corps for Enlisted Personnel, Army of the United States. (2) Army Regulations No. 605–10, 30 Dec. 1942.

[3] (1) Letter, The Adjutant General, to The Surgeon General, 9 Sept. 1944, subject: Procurement Objective in the Army of the United States of Sanitary Corps Officers. (2) War Department Circular No. 370, 12 Sept. 1944.

[4] War Department Circular No. 462, 5 Dec. 1944.

[5] Memorandum, Office of The Surgeon General, for Director, Officer Procurement Service, 7 Dec. 1944, subject: Procurement of Laboratory Sanitary Corps Officers.

appointment in the Sanitary Corps. Enough applications from the types of specialists referred to in the circular had been received to meet the existing needs of the Medical Department.[6]

During the period from 1 September 1943 through June 1945, 649 commissions were granted in the Sanitary Corps. Of these, 392 went to enlisted personnel, 239 to persons coming directly from civilian life, and the rest to various others.[7] The corps reached its peak strength of 2,560 in April–May 1945 (table 1). In May of that year, it contained 980 sanitary engineers, 521 bacteriologists, and 342 biochemists, each of the other specialities having smaller numbers.[8]

In the effort to build up the Sanitary Corps as rapidly as possible, men had been commissioned who did not have the scientific background to fit them for such work; they were, however, suitable for the Medical Administrative Corps. On the other hand, some who did have this background had been commissioned in the Medical Administrative Corps. In the fall of 1944, approximately 200 misassigned officers in each of the two corps were transferred to the corps for which their education and experience fitted them, and The Surgeon General took steps to prevent officers without an education in science from becoming members of the Sanitary Corps in the future.[9]

PHARMACY CORPS

When the Pharmacy Corps was created in July 1943, 58 members of the Regular Army Medical Administrative Corps were transferred to it. No new members were added to it, and the strength of the corps remained the same throughout that year. During 1944, The Surgeon General brought about the appointment of 14 officers to the Pharmacy Corps. The American Institute of Pharmacy, however, complained in 1945 that he was dilatory in building up the corps to full strength (72, exclusive of members taken over from the Regular Army Medical Administrative Corps), and that he had failed to make it a corps in function as well as in name by not naming a chief administrator. Further, he had not requested consultative service from a pharmaceutical association. In reply, The Surgeon General pointed out that the new officers for the corps were to be procured under such regulations and after such exami-

[6] (1) Memorandum, Office of The Surgeon General (Executive Officer), for the Office of The Adjutant General (Appointment and Induction Branch), 14 Feb. 1945, subject: Revocation of Section X, War Department Circular No. 333. (2) War Department Circular No. 61, 26 Feb. 1945.

[7] Monthly Progress Reports, Army Service Forces, War Department, 30 Sept. 1943–30 June 1945, Section 5: Personnel.

[8] The other specialties listed were entomologists, general laboratory workers, parasitologists, serologists, nutritionists, industrial hygienists, supply and other administrators. (Memorandum, Maj. H. M. Rexrode, Office of The Surgeon General, for Chief, Personnel Service, Office of The Surgeon General, 29 May 1945, subject: Semiannual History of the Medical Administrative and Sanitary Corps.)

[9] (1) Semiannual Report, Classification Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, June–December 1944. (2) Memorandum, Office of The Surgeon General (Executive Officer), for Publication Division, Office of The Adjutant General (through Military Personnel Division, Army Service Forces), 30 Nov. 1944. (3) See memorandum cited in footnote 8.

nations as the Secretary of War might prescribe; that officials had promulgated rules for the expansion of the corps similar to those that existed for the expansion of other corps and the Regular Army as a whole. Examinations had been given, but The Surgeon General held that "it was not contemplated that all seventy-two appointments * * * would be made at one time." He maintained that to form an integrated corps it was necessary to build it up over a period of years so that it would have new officers coming in year by year to provide continuity of changing personnel and distribution of ranks and seniority. He reminded critics that the law had not intended that every pharmacist inducted into the Army should be commissioned. Three thousand men were engaged in pharmacy work in the Army at that time (1945); approximately half were registered pharmacists, the remainder being men trained in Army schools in pharmacy duties directed particularly to Army needs. In addition, he pointed out that Army pharmacy service differed materially from that of civilian life. Many drugs and prescriptions customarily filled in civilian life by pharmacists were provided to the Army by the manufacturer ready for use. Thus, compounding of drugs and medicines by pharmacists was reduced to a minimum, and could be performed satisfactorily by specially selected and trained enlisted men. The character of this work was not such as to justify commissioned status.[10]

At the end of the war, the strength of the Pharmacy Corps was 68; the peak strength, 70, was reached in April 1945.

MEDICAL ADMINISTRATIVE CORPS

The Medical Department obtained Medical Administrative Corps officers from three sources, in addition to calling up those in the Reserve: (1) Civilians who by reason of their education and experience it believed qualified for commissions, including nonprofessional men who were hospital administrators and graduates of the American College of Hospital Administration; (2) enlisted men who, having had several years of Medical Department service, could also receive direct commissions in the corps; and (3) enlisted men who could be commissioned as second lieutenants upon completing a course in a Medical Administrative Corps officer candidate school.[11] Rank granted to individuals in the first two groups was not necessarily limited to that of second lieutenant, and many were given higher initial rank. In the Zone of Interior, the first two sources, although supplying several hundred officers, furnished a very much smaller group than those who were commissioned after completing a course at an officer candidate school.

---

[10] (1) Letter, American Institute of Pharmacy, to Surgeon General Kirk, 27 June 1945. (2) Letter, Surgeon General Kirk, to Hon. Andrew J. May, U.S. Senator, 6 July 1945.

[11] In addition to enrolling enlisted men who had had at least basic Army training, the officer candidate schools also for a short time, beginning early in the war, admitted Volunteer Officer Candidates. These were men who applied for induction in order to receive this training. They formed but a small percentage of Medical Administrative Corps officer candidates. (Army Regulations No. 625–5, 26 Nov. 1942.)

Direct Commissioning of Civilians

In the spring of 1942, The Surgeon General initiated a drive to recruit Medical Administrative Corps officers among civilian hospital administrators. A request for authority to appoint 100 in this category was approved, and The Surgeon General was directed to expand the field to include qualified hotel and restaurant managers. These men could be used as assistant executive officers, hospital inspectors, and medical supply officers in general hospitals and large station hospitals. By the end of September 1942, when The Surgeon General asked for an increase in the authorization to 200, 81 appointments had been recommended.[12]

On 13 October 1943, the commissioning of civilians in the corps was stopped. Some 8 months later, when The Surgeon General needed officers for his reconditioning program, he was again empowered to commission civilians in the Medical Administrative Corps, although Army Service Forces headquarters directed him to make his appointments from warrant officer and enlisted ranks as far as practicable.[13]

Direct Commissioning of Enlisted Men

Zone of Interior

With regard to the second source, enlisted men having had service in the Medical Department, the individual must have had a minimum of 8 years' service in the Department, 4 of them as warrant officer or first or master sergeant, technical sergeant, or staff sergeant. In the fiscal year 1943, The Surgeon General commissioned 222 of this group, 138 in the rank of captain or first lieutenant and 84 as second lieutenants. Finally in October 1943, deciding that practically all who would make acceptable officers had been commissioned, the Surgeon General's Office discontinued the program in the Zone of Interior.[14]

Oversea theaters

The Medical Administrative Corps in the theaters also was augmented by direct commissioning of certain warrant officers and enlisted men. Originally, this took place under special authorizations, granted to individual

---

[12] (1) Letter, The Surgeon General, to Personnel Section, Services of Supply, 26 May 1942, subject: Procurement Objective of Medical Administrative Corps. (2) Memorandum, Director, Military Personnel, Services of Supply, for Chief of Staff, Services of Supply, 1 July 1942, subject: Procurement of Doctors for the Military Establishment. (3) Letter, The Surgeon General, to The Adjutant General, 28 Sept. 1942, subject: Increase in Procurement Objective, Army of the United States, for duty with the Medical Administrative Corps.

[13] Diary, Procurement Branch, Military Personnel Division, Office of The Surgeon General, 1 July–18 Aug. 1944.

[14] (1) Annual Reports, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1942–44. (2) Memorandum, Capt. William Wesche, Military Personnel Division, Office of The Surgeon General, for Col. D. G. Hall, Military Personnel Division, Office of The Surgeon General, 24 Mar. 1944.

theater commanders early in the war, to commission individuals of warrant or enlisted status in the Army of the United States.[15] In July 1943, however, the authority of direct commissioning by theater commanders was restricted to the commissioning of flight officers, warrant officers, and enlisted men who had demonstrated their fitness for such advancement in actual combat. Furthermore, the appointments were limited to those needed to fill table-of-organization or table-of-allotment vacancies within the command.[16]

In the North African theater, at least, the restrictions did not prevent the direct commissioning in the Medical Administrative Corps of personnel from combat divisions, even if they themselves had not actually participated in combat. The Seventh U.S. Army while in that theater seems to have met most of its requirements for battalion surgeon's assistants in that manner. In the Fifth U.S. Army, over 85 enlisted men received direct combat appointments in the Medical Administrative Corps between June and December 1944.[17] To other Medical Department enlisted men, such as those with experience limited to general and station hospitals, this path to advancement was barred. Even when in December 1943 general prohibition of noncombat appointments was relaxed, they gained no relief. At that time, the War Department adopted a policy of permitting a limited number of second lieutenant vacancies in noncombat units to be filled by warrant officers and enlisted men who, though without combat experience, had demonstrated competence of an exceptionally high order in the performance of their duties. The authority to make such appointments was vested in commanding generals already possessing a similar power with regard to persons who had demonstrated their fitness for such appointments in combat. Vacancies in medical units, however, were specifically excluded from the operation of this provision.[18]

Nevertheless, the North African theater, probably because of its lack of an officer candidate school, was authorized early in August 1944 to make 30 direct noncombat appointments to the Medical Administrative Corps.[19] Later in the year, with greatly increased need for Medical Administrative Corps officers and the inability of the Zone of Interior to meet this need, the War Department, at The Surgeon General's request, temporarily empowered the commanders of various combat theaters to appoint second lieutenants to that corps from

---

[15] (1) Radio, The Adjutant General, to Commanding General, U.S. Army Forces, Iraq, 27 Nov. 1942. (2) Memorandum, Headquarters, European Theater of Operations, to The Adjutant General, Washingtin, D.C., 24 Dec. 1942, subject: Appointments. (3) Memorandum, Col. W. P. Ennis, Jr., for Chief of Staff, North African Theater of Operations, U.S. Army, 3 Apr. 1944.

[16] Memorandum, Maj. Gen. M. G. White, Assistant Chief of Staff, G–1, for The Adjutant General, 17 July 1943, subject: Policy Governing Appointment of Officers.

[17] (1) Report, Lt. Col. Stewart F. Alexander, Personnel Officer, Surgeon's Office, Seventh U.S. Army, of Medical Department Activities in Mediterranean Theater of Operations, 14 July 1945. (2) Annual Report, Surgeon, Fifth U.S. Army, 1944.

[18] Memorandum, Deputy Chief of Staff, for Assistant Chief of Staff, G–1, 24 Dec. 1943, subject: Extension of Authority Granted Theater Commanders to Appoint Officers.

[19] (1) Radio, War Department, to Commanding General, U.S. Army Forces, North African Theater of Operations, 22 Apr. 1944. (2) Radio, The Adjutant General, to Commanding General, U.S. Army Forces, North African Theater of Operations, 29 Apr. 1944. (3) Radio, Commanding General, Allied Force Headquarters, Caserta, Italy, to War Department, 25 July 1944. (4) Radio, The Adjutant General, to Commanding General, Allied Force Headquarters, Caserta, Italy, 3 Aug. 1944.

among Medical Department warrant officers and enlisted men without combat experience. Other personnel, including enlisted members of the Women's Army Corps, were also eligible for direct appointment, but decisive action on applications from them was left to the War Department.[20]

It was under this active encouragement on the part of the War Department that the great bulk of the direct commissioning of oversea personnel in the Medical Administrative Corps took place. On 15 January 1945, for example, 85 noncommissioned officers and warrant officers in the Pacific were given commissions in the corps, albeit after a brief "refresher" course.[21] Probably about 1,300 or 1,400 warrant officers and Medical Corps enlisted men in oversea areas became Medical Administrative Corps officers by direct appointment. The number so commissioned in the European theater, it has been estimated, was as large as 500.

War Department policy opposed the return of enlisted men directly commissioned to their old units, and in the European theater, this policy was observed at least in the communications zone.[22] A different procedure prevailed in the Seventh U.S. Army prior to coming under the command of the European Theater of Operations. The medical personnel officer of that command stated:

> The War Department offered to send us a number of MAC's as trained assistant battalion surgeons and we did take a certain number from the War Department, but most of our requirements were filled by direct commissions, battlefield commissions, as a rule, in the tactical units. The technical sergeant in the Infantry regiment had been there for a long time and he was qualified for the job. The man who had done "on the job" work was commissioned and kept in the same position, and this worked out very satisfactorily. I am not saying that those that came over from the United States were not satisfactory, because they were, but the units liked the men that were commissioned from within their own unit. The personnel that were commissioned in this manner had the confidence of the troops.[23]

Officer Candidate Schools

Zone of Interior

At the beginning of the war, the only Medical Department officer candidate school was located at the Medical Field Service School, Carlisle Barracks, Pa. In April 1942, The Surgeon General pointed out that units not included in the planning for 1942 were being activated and declared that the activation of these units required the Medical Department to take personnel from other units that were already operating short of authorized strength. He suggested,

---

[20] (1) Letter, Assistant Adjutant General, U.S. Army Services of Supply, to Commanding General, Base Section, U.S. Army Services of Supply, and Commanding General, Intermediate Section, U.S. Army Services of Supply, 6 Nov. 1944, subject: Noncombat Appointments of Qualified Warrant Officers and Enlisted Men as Second Lieutenants in Army of United States for Duty as Medical Administrative Corps Officers. (2) Letter, Adjutant General, European Theater of Operations, U.S. Army, to Commanding Generals, U.S. Strategic Air Forces in Europe, each Army Group (and others), 9 Nov. 1944, subject: Appointment of Second Lieutenants, Medical Administrative Corps.

[21] Whitehill, Buell: Administrative History of Medical Activities in the Middle Pacific. [Official record.]

[22] Memorandum for Record, Col. A. B. Welsh, 7 Mar. 1945, subject: Report of Visit to Pacific Theaters, with enclosure 6 thereto.

[23] See footnote 17 (1), p. 216.

and the Assistant Chief of Staff, G–3, and the Services of Supply authorized, a second officer candidate school to produce Medical Administrative Corps second lieutenants. G–3 originally established the school's capacity at 750; it opened in May 1942 at Camp Barkeley, Tex., where a Medical Department replacement training center was located,[24] and graduated its first class in July of that year. The number of second lieutenants commissioned thereupon stepped up sharply, although not enough to meet all needs.

Eighty-five percent of the peak strength of the Medical Administrative Corps on duty during World War II were former enlisted men or warrant officers who had been graduated from officer candidate schools. The great majority of these graduates (74.0 percent of the first 31 of a total of 40 classes turned out by the Camp Barkeley school) were men inducted by selective service. Many had civilian backgrounds in fields that were of direct use to the Medical Department; for example, there were laboratory, medical, and surgical technicians, male nurses, teachers, and men from supply and wholesale firms, whose understanding of warehousing and shipping proved useful in medical depots. Furthermore, great numbers of them were acquainted at least in an elementary way with the work of the Medical Department, having been assigned to it before attending these schools.

The Officer Candidate School located at Carlisle Barracks turned out an average of 177 per month in 1942. Unfortunately, it became necessary to close this school on 27 February 1943 to make room for other officer training, and even an increased output at the Camp Barkeley school failed to attain what the two schools could have produced.

From July through December 1942, the officers produced by these schools averaged 670 per month, or a total of 4,024. Output, however, did not meet demand until the fall of 1943 when large numbers of Medical Administrative Corps officers were in replacement pools in this country. On 31 October 1943, the total strength of the corps was 13,867, enough to justify a sharp curtailment at the Camp Barkeley school.

In March 1944, the decision to substitute a Medical Administrative Corps officer for one of the two Medical Corps officers serving as battalion surgeons, and to make similar replacements in other positions,[25] caused a heavy drain on the numbers in replacement pools. The officers chosen to become battalion surgeons' assistants were sent to Camp Barkeley for special training. As class after class was sent to this school, it became evident that the entire corps would have to be enlarged, and in May and June 1944 both officer candidate schools were reopened. By this time, not only had the facilities been

---

[24] (1) Memorandum, Office of The Surgeon General (Col. John A. Rogers, Executive Officer), for Commanding General, Services of Supply, 11 Apr. 1942, subject: Officer Candidate School. (2) Memorandum for Record, G–3, for Services of Supply, 11 Apr. 1943, subject: Additional Medical Corps Officer Candidate School.

[25] War Department Circular No. 99, March 1944. (In the early part of the war, the Surgeon General's Office had planned to substitute a dental officer as assistant battalion surgeon, but the scarcity of dentists in the Army caused their removal before the table of organization was published. Letter, Maj. Gen. Alvin L. Gorby, MC, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 3 Apr. 1956.)

scattered, but Medical Administrative Corps officers wanted for instructors were scarce in the United States. Hence, there was some difficulty in recruiting staffs for the reopened schools.[26] In any event, these schools produced no new graduates until September 1944.

The necessity and difficulty of accelerating the production of Medical Administrative Corps officers in 1944 and 1945 might have been at least partially avoided if the real situation had been appreciated and the demand foreseen and if, therefore, production had been maintained at a constant rate. The presence, in the United States, of large numbers of Medical Administrative Corps officers in pools during 1943 was deceptive, for although these officers were presumably free for assignment elsewhere, the service commands had actually been using them and when they were withdrawn for training as battalion surgeons' assistants and for other assignments the service commands were left inadequately manned.[27] The Surgeon General's Office may have hoped in 1943 that enough additional appointees for the Medical Corps could be obtained without supplementing them to a much greater extent by Medical Administrative Corps officers; the Surgeon General's Office was always conservative in its estimates of how many of them could be used to replace doctors in administrative work. It is true also that one officer candidate school had to be closed in 1943 for reasons unconnected with any supposed surplus of Medical Administrative Corps officers—the facilities of the Medical Field Service School were converted to training doctors in military subjects when a large number of newly commissioned officers entered the Army as the result of the procurement efforts during the summer of 1942.

In the period from 1 September 1943 through June 1945, the Medical Administrative Corps had 6,346 accessions:[28]

September-December 1943	1,713
January-June 1944	590
July-December 1944	1,038
January-June 1945	3,005

Of these, 5,328 were graduates of the officer candidate schools, while the next largest number, 877, were from the ranks of enlisted personnel; other sources —civilian life, warrant officers, and members of the Officers' Reserve Corps— furnished smaller numbers.

Oversea theaters

The administrative measures which led to the provision of replacements for Medical Administrative Corps officers included the grant of commissions to medical enlisted personnel who attended officer candidate schools in the

[26] Letter, Office of The Surgeon General (Director, Military Personnel Division), to Lt. Col. A. H. Groeschel, Army Service Forces Training Center, Camp Barkeley, Tex., 1 July 1944.

[27] Report, Military Personnel Division, Office of The Surgeon General, to Historical Division, Office of The Surgeon General, summer 1945, subject: Medical Department Personnel.

[28] See footnote 7, p. 213.

European theater and in the Pacific.[29] A special branch of the Officer Candidate School in the Southwest Pacific was devoted to the preparation of Medical Administrative Corps officers. It began to function in March 1943. By the end of August 1945, the branch school had graduated 153 men, some of whom may originally have been warrant officers.[30] Eighteen men were trained as Medical Administrative Corps officers at the Officer Candidate School in New Caledonia prior to 31 August 1945. In the European theater, there was no special course for Medical Administrative Corps personnel, but perhaps as many as 50 men were commissioned in that corps after having taken the general course for officers.



FIGURE 34.—Nurses' duty uniform, 1943.

[29] (1) Annual Report, Operations and Training Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1942. (2) Memorandum for Record, signed "E.G.," 5 July 1945. (3) TWX, CM–IN–2974, New Caledonia, to War Department, 6 Dec. 1942.

[30] (1) Essential Technical Medical Data, U.S. Army Forces, Far East, August 1943. (2) Memorandum, F. H. P[etters], to Commanding General, Headquarters, U.S. Army Forces, Far East, subject: Medical Administrative Corps, Officer Candidate School. (3) Memorandum, Col. G. D. France, for Chief Surgeon, U.S. Army Services of Supply, Southwest Pacific Area, 23 Nov. 1943, subject: Report. (4) Letter, Lt. Col. A. E. Miller, to Capt. John W. Haverty, Office of Chief Surgeon, U.S. Army Services of Supply, 20 Mar. 1945.

ARMY NURSE CORPS

During the first 2 years of war, the number of nurses in the Army rose steadily, but never to a point where the Army decided it had enough for all present and future needs. The Personnel Service of the Surgeon General's Office supplemented the familiar appeals to the humanity and patriotism of civilian nurses by active steps that resulted in improvements in the pay and status of Army nurses and ultimately benefited the whole nursing profession. The provision of more attractive uniforms (figs. 34 and 35) was another recruiting device. Failure to fill the gap completely by these methods resulted in several expedients: The reduction of authorized nurses in the tables of organization, the use of enlisted women without professional training who could perform some of the minor nursing functions, and improved classification of Army nurses to make better use of those already in service. It is safe to say, however, that much of this ancillary personnel would have been brought in even if the nurse quota had been filled, for it came to be recognized that such assistants could perform certain duties quite as well as nurses.

Procurement, 1942–43

In the months following Pearl Harbor, the number of nurses placed on active duty increased sharply, probably as a consequence of a keener desire of many to serve their country now that it was at war. An immediate lag in



FIGURE 35.—Nurses' dress uniforms, 1943.

processing applicants was overcome by February 1942 when procurement of 1,219 nurses tripled the figure for December. Over 18,000 nurses were brought on active duty in 1943, the peak year for procurement during the war.[31] One factor that contributed to this was the news that more Americans were fighting on more fronts and that casualties were beginning to reach the United States in sizable number. The procurement effort itself, however, together with the removal of certain obstacles to recruitment, must also have been largely responsible.

Early procurement agencies, 1942

During the war, the Nursing Division of the Surgeon General's Office, headed by the Superintendent of the Army Nurse Corps, continued to have as one of its functions a share in the procurement of nurses.[32] In late 1942, it was estimated that approximately two-thirds of the nurses who entered the Army came in by way of the Red Cross after enrollment in its First Reserve (renamed the War Reserve in December 1942). Membership in this Reserve, however, made a nurse eligible not only for active duty in the Army but for the Red Cross "disaster service," and some nurses were unwilling to commit themselves to the latter. Some also feared that even if brought into Army service they would be placed in a Red Cross unit and thereby lack the protection which military status gave them.[33] This fear proved groundless; Red Cross hospitals were used in the First but not in the Second World War. For these and other reasons, the effectiveness of the Red Cross as a procurement agency was somewhat reduced.

Although some members of the Medical Department complained that the necessity of working through the Red Cross slowed procurement unnecessarily, the arrangement continued until after the close of hostilities. In fact, when testifying before the Committee to Study the Medical Department of the Army (in the fall of 1942), both The Surgeon General and the Superintendent of the Army Nurse Corps spoke approvingly of the help received from the Red Cross. Asked if he would favor setting up his own organization for the procurement of nurses, The Surgeon General said: "I would hate to see anything arise to disrupt that fine recruiting scheme that the Red Cross has established."

The function of the Red Cross in nurse procurement was not limited to obtaining members for its Reserve. One of the most valuable services it rendered the Army was the examination of nurses' credentials for professional qualifications. Beginning in 1942, the Red Cross performed that service on the papers of nurses who entered the Army directly, as it had done previously in the case of nurses joining the First Reserve.

---

[31] Strength of the Army, 1 Oct. 1946. Prepared for War Department General Staff by Machine Records Branch, Office of The Adjutant General, under direction of Statistical Branch.

[32] Unless otherwise noted, much of the account of nurse procurement is drawn from Blanchfield, Florence A., and Standlee, Mary W.: Army Nurse Corps in World War II. [Official record.]

[33] (1) Committee to Study the Medical Department, 1942. (2) Kernodle, Portia B.: The Red Cross Nurse in Action, 1882–1948. New York: Harper & Brothers, 1949, p. 163, footnote 10.

Other organizations continued to take part in the drive for nurses. Early in 1942, the Subcommittee on Nursing of the Medical and Health Committee, Office of Defense Health and Welfare Services, the Federal agency engaged in such matters, voted to "transfer the further development of a plan for initiating the procurement and assignment of nurses through local nursing councils to the Nursing Council on National Defense," the association of nursing organizations.[34]

In April, the Council (renamed at this time the National Nursing Council for War Service) established a Supply and Distribution Committee. This committee laid down a program which included among other tasks that of helping through its State nursing councils (1) to recruit nurses into the Red Cross First Reserve and (2) to distribute nurses for civilian needs. The committee also decided to set State recruiting quotas, thereby giving the States something definite to aim at; State nursing councils would be responsible for breaking these quotas down to local ones. The State quotas were "determined on 75 percent of the number of nurses eligible"; that is, the unmarried nurses under 40 years of age, as shown in the National Inventory. Presumably, the figure of 75 percent was chosen to allow for the physically unfit, those with heavy obligations, or those who could not accept military duty for other reasons.[35] It was to be understood that these quotas were temporary and would be raised as needs increased.

Measures to speed procurement

Various steps were taken during the early war period, some along well-tried lines, to bring more nurses into the Army. The Army Nurse Corps and the American Red Cross carried on a publicity campaign, using radio and magazine announcements and nurses' conventions to broadcast the need for more Army nurses. Nurses served, too, in various cities with the Army War Shows, Inc., with a view to interesting civilian nurses in Army service. No figures are available on the numbers of nurses persuaded by these means to accept Army duty, but the Nurse Corps stated that reports on the Army War Shows indicated "that interest is being shown in each city visited"; apparently, too, more nurses applied for assignment to affiliated units as a consequence of these meetings.[36]

As another means of filling the gap, the Army Air Forces in September 1942 took steps toward procuring its own nurses. Because of shortages, assignment of the required number of nurses to Air Forces installations was often delayed. It was usual for new hospitals to be established without an adequate number of nurses, and at times, there were none for a matter of months; it was necessary to use enlisted men in nursing duties until adequate numbers of

[34] Minutes, Meeting, Supply and Distribution Committee, National Nursing Council for War Service, 16 Apr. 1942.

[35] See footnote 34.

[36] Special Report, Army Nurse Corps, to Army Service Forces, 5 Aug. 1942.

nurses could be assigned.[37] In February 1943, the Air Surgeon's Personnel Division began the processing of applications received from nurses. From that date until March 1944, when recruiting by the Air Surgeon's Office came to an end, 4,152 applications were completed and sent to the Nursing Section for appointment and assignment.[38]

About the time that the Air Surgeon was moving to procure his own nurses, the Secretary of War's Committee to Study the Medical Department was somewhat critical of the procurement activities of The Surgeon General's Nursing Division. The committee stated that while there was conflicting testimony on the relative merits of procurement through the Red Cross or by the Army directly, it felt that "with more aggressive leadership and stronger administration in the Army Nurse Corps the present system of recruitment would in all probability be satisfactory." Finding that the number of nurses, although adequate at the time, might become critical in the coming year, the committee believed that the Director of the Nursing Division (the Superintendent of the corps) was too complacent about the future and had apparently given insufficient thought to the methods by which the number of nurses available for Army duty could be materially increased.

The Surgeon General's Nursing Division showed somewhat less confidence than the committee in the ability of the Red Cross to produce the number of nurses required and late in 1942 favored employing another agency to conduct a recruiting campaign.[39] The Secretary of War disapproved the proposal.

At this time, also, the Director of the Military Personnel Division, Services of Supply, instructed the Army Nurse Corps to formulate a plan which would use not more than 50 Army nurses in recruiting activities, this plan to utilize the services of the Officer Procurement Service and the Red Cross. The Officer Procurement Service had offices in many cities of the country, which provided space and facilities, but the Red Cross, still responsible for all publicity and paper work in connection with the nurse procurement program, furnished clerical assistance. The Officer Procurement Service acted in an advisory capacity to the Army nurses, arranging administrative details for conferences and physical examinations at dispensaries, but it was forbidden to engage in procuring, processing or presenting for appointment candidates for the Army Nurse Corps. The Red Cross not only retained these prerogatives, but complained when it believed the Officer Procurement Service was encroaching on Red Cross functions by using the recruiting nurses for direct recruiting work rather than as liaison to the Red Cross.[40]

---

[37] Coleman, Hubert A.: Organization and Administration of the Army Air Forces Medical Service, Zone of Interior. [Official record.]

[38] Annual Report, Personnel Division, Office of the Air Surgeon, 1943–44.

[39] Memorandum, Col. Florence A. Blanchfield, USA (Ret.), for Col. C. H. Goddard, Office of The Surgeon General, 14 July 1952, subject: Medical Department History in World War II.

[40] Letter, Gertrude S. Banfield, Assistant in Charge of Enrollment and Procurement, American Red Cross, to Lt. Col. Florence A. Blanchfield, Superintendent, Army Nurse Corps, 23 Mar. 1943.

Various measures were introduced during 1942–43 relaxing nurses' qualifications and improving their conditions of service, most of which may have had, or were intended to have, a favorable effect on recruitment. Two early restrictions were age and marital status. When the United States entered the war, the Army Nurse Corps would accept neither married women nor women over 30 years of age. In the spring of 1942, the Army raised the age limit from 30 to 45 years for Reserve nurses joining the Army to serve in affiliated units or in a special assignment, such as anesthetist, operating-room supervisor, chief nurse, and instructor; [41] and the following year, it accepted nurses up to 45 years of age for general assignment.[42] The age for entering the Regular Army Nurse Corps was not raised above 30 years, but this limitation ceased to have meaning in January 1943 when procurement of Regular Army nurses was stopped.

Beginning on 1 October 1942, The Surgeon General at his discretion could retain in service for the duration of the emergency and 6 months thereafter any Army nurse who married. The number of discharges from the Army Nurse Corps declined from the total of 821 in the 4 months prior to October 1942 to only 265 in the first 4 months of 1943.[43]

In November 1942, the Army announced that it would accept married nurses for the duration of the war and 6 months afterward, but stipulated that they would not be stationed at the same installation as their husbands and that nurses with minor children would be accepted only after providing for their care outside military reservations. Later, no married nurses with children under 14 years of age were accepted.[44]

The Procurement and Assignment Service

As shortages of nurses increased in certain areas in civilian life, a country-wide control which would effect more equitable distribution both between the Armed Forces and the civilian community itself came to seem necessary to more people. Army and Navy representatives stood against such control, believing it would limit their ability to obtain the numbers needed. The question of how to guarantee nursing service to civilian communities arose during hearings of the Committee to Study the Medical Department of the Army. One committee member even insisted that the procurement activities of the Army Nurse Corps gave no consideration to the protection of community needs. The charge was not sustained by the record, which was good enough, on the whole, to make understandable the reluctance of the Corps Superintendent to accept the intervention of the Procurement and Assignment Service.[45]

---

[41] Letter, Superintendent, Army Nurse Corps (Maj. Julia O. Flikke), to Miss Alma C. Haupt, Nursing Consultant, Health and Medical Committee, Federal Security Agency, 7 Mar. 1942.

[42] Annual Report, Nursing Division, Office of The Surgeon General, U.S. Army, 1943.

[43] (1) War Department Circular No. 317, 1942. (2) See footnote 31, p. 222.

[44] (1) War Department Circular No. 365, 1942. (2) See footnote 42.

[45] Letter, Col. Florence A. Blanchfield, USA (Ret.), to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 21 Feb. 1956.

In September 1942, believing that Government assistance was needed, the National Nursing Council for War Service referred to the Subcommittee on Nursing of the Health and Medical Committee the question of the supply and distribution of nurses. In October, the Health and Medical Committee responded with a resolution urging that a Nurse Supply Board be established in the War Manpower Commission. After the War Manpower Commission had suggested a review of the proposal, the Subcommittee on Nursing and the National Nursing Council for War Service voted on 19 December 1942 to make no change in the original recommendation, which presented a fairly cogent argument as follows:

1. The problem of supply and distribution of nurses was essentially the same as that of other types of personnel and should be handled by the same overall agency.

2. Nurses, being women, fell altogether outside the jurisdiction of the Selective Service System—unlike male professional groups—and therefore needed even more than the latter the consideration of the War Manpower Commission.

3. If a supply and distribution system was to function on local, State, and national levels, the prestige, authority, and money of the War Manpower Commission were needed.

4. The U.S. Public Health Service was administering a $3,500,000 appropriation for nursing education and was using the Subcommittee on Nursing of the Health and Medical Committee as its advisory group. Needed expansions in this program could be maintained under the Public Health Service with close liaison with the proposed Nurses Supply Board.[46]

In January 1943, the Subcommittee on Nursing voted to approve the idea of the establishment of an advisory committee in lieu of a Nurses Supply Board on the ground that such a board would not have fitted in with the War Manpower Commission's organizational policy. In February 1943, the War Manpower Commission approved a Nursing Supply and Distribution Service, and in May, the Chairman of the Commission announced officially that this unit was established under the direction of the War Manpower Commission's Bureau of Placement at the request of the nurses represented by the National Nursing Council for War Service. Meanwhile, he had appointed an Advisory Committee to the new Service, choosing members from a list of names submitted by the Subcommittee on Nursing.

The Nursing Supply and Distribution Service was originally planned as an independent unit in the War Manpower Commission, but in June 1943, it was transferred to the Procurement and Assignment Service, its name changed to Nursing Division, and the Advisory Committee attached to it. The functions of the newly formed Nursing Division were (1) to consider the nursing needs of the Armed Forces and establish a quota for each State to meet these needs; (2) to determine the availability for military service or essentiality for civilian services of all nurses eligible for military service and submit these findings to

[46] Proposals for Administration and Operating Organization of the Nursing Supply and Distribution Service, Bureau of Placement, War Manpower Commission, 10 June 1943.

the American Red Cross for use in procuring nurses for the Armed Forces; (3) to insure maximum utilization of all members of the profession; (4) to maintain a complete roster of the nursing profession; and (5) to carry out these functions through State and local committees in accordance with policies and recommendations made by the Directing Board of the Procurement and Assignment Service.[47]

The organization of the Nursing Division followed in general the pattern of that for physicians, dentists, and veterinarians, with State and county chairmen and committees. In general, the State Supply and Distribution Committees of the National Nursing Council for War Service were redesignated State Committees of the Procurement and Assignment Service. Two outstanding members of the nursing profession were appointed as members of the Directing Board of the Procurement and Assignment Service. They were Miss Katherine Tucker of the University of Pennsylvania, and Miss Laura Grant of the Yale-New Haven Hospital.

Local boards classified nurses either as available for military duty or as essential to civilian nursing care. After the State committees had reviewed these classifications, they sent the names of those considered available for military service to the Red Cross recruiting committees in the areas where the nurses resided, and invited the nurses to apply to the Red Cross for military duty.

The Procurement and Assignment Service encountered difficulties in the first months of its jurisdiction over nurses. A questionnaire sent to State committee chairmen and designed to show how many local Nursing Councils for War Service already existed, how many were to be organized, where the State's copy of the National Inventory of Nurses was kept, and whether the committee considered the Inventory up to date, brought forth a picture of lack of uniformity in organization and uncertainty of knowledge. The National Nursing Council for War Service found that efforts to notify nurses of their classification presented difficulties. In an effort to relieve State and local committees at a time when the urgency to fill military quotas was increasing, the Council in September 1943 agreed to inform nurses of their classification only if they were declared eligible for military service, leaving all other nurses to be notified later.[48]

Procurement, 1944–45

The procurement of Army nurses, which had proceeded at a fairly rapid rate during the last 3 months of 1943, fell by somewhat more than half in the 3 months following, after which it dropped even more sharply. The net increase in the strength of the Nurse Corps from 31 December 1943 to 31 March 1944 was 1,931; in the succeeding 9 months, the increase was only 3,710 leaving

[47] See footnote 1(2), p. 211.

[48] (1) News About Nursing: Procurement and Assignment. Am. J. Nursing 43: 948–949, October 1943. (2) Letter, L. Louise Baker, to Miss Katherine E. Pierce, Chairman, State Committee for Nurses, Procurement and Assignment Service, Boston, Mass., 19 Oct. 1943.

the corps with a strength of 42,248 at the end of the year. The slowup probably resulted in part from doubt occasioned by certain transactions in late 1943 and early 1944. The supposed cut in the Nurse Corps ceiling, from over 50,000 to 40,000, became widely known in December 1943.

On 21 April 1944, the service commands were notified to cease making appointments to the Nurse Corps. The fact that a week later the War Department raised the authorized strength of the corps from 40,000 to 50,000 and that The Surgeon General took immediate steps to have the service commands resume recruiting does not seem to have dispelled a doubt on the part of civilian nurses and their organizations that the Army really needed many additional nurses; at any rate, procurement continued to lag. This feeling of hesitation was reinforced by a belief that, following the rapid progress of the Allies through Europe in the summer of 1944, the war would end in the fall. Therefore, although casualties mounted, applications for appointments to the Nurse Corps decreased. A recruiting campaign conducted in September failed almost completely; 27,000 letters sent to nurses whom the Procurement and Assignment Service had classified as available for military service brought the Superintendent of the Nurse Corps, Colonel Blanchfield, but 700-odd replies, of which only approximately 200 were from correspondents later found suitable for Army commissions.

The Surgeon General's Personnel Service and the Army Nurse Corps Technical Information Branch were thoroughly alarmed over the failure of nurses to volunteer. In September, when The Surgeon General was arranging to evacuate a large number of patients from Europe, Colonel Blanchfield warned the National Nursing Council for War Service that recruitment activities must be stepped up.

The Surgeon General became increasingly vocal over the nurse shortage and was concerned about restrictions laid down by the Procurement and Assignment Service. In October, he informed the various procurement groups that it was time they all pulled together without regard to credit for their accomplishments.

The Surgeon General's Military Personnel Division (Personnel Service) recommended procedures designed to bring more nurses onto active duty. The division urged, too, that civilian institutions should be restrained from proselytizing cadet nurses and that the Army should exert itself to persuade senior cadets serving in Army hospitals, of which there were only 486 at that time, to enter the Army Nurse Corps.

There was little agreement on why nurses were not volunteering in the numbers desired and on what remedial measures should be taken. The Red Cross admitted that its own procedures and those of the Army in handling nurses' applications took time but did not see how the process could be shortened in the face of the classification requirements imposed by the Procurement and Assignment Service. The Procurement and Assignment Service, on the other hand, believed some recruiting and assignment difficulties arose from lack of uniform appointment procedures. Certainly, the Army was not blameless, for

the service commands were not accepting nurses as soon as they applied. Rather, each service command waited until its own basic training course was beginning. Although the longest wait thus involved was only a month, the delay permitted people to conclude that the Army still did not urgently need nurses. It is possible that if at this time The Surgeon General's Military Personnel Division had been given a free hand it might have simplified appointive procedures and reduced the delays.

H.R. 2277: the nurse draft

Fanned by public relations releases, the nation's press was at this time adopting the nurse shortage as headline material. Beginning in November 1944, increasingly critical articles were appearing, some of them denouncing what they termed "bureaucratic delays." On the other hand, rumors of a nurse draft persisted, some coming from members of the Procurement and Assignment Service and the National Nursing Council for War Service, groups which had discussed such a possibility much earlier. Despite the diverse ideas on why nurses were not volunteering in the desired numbers, the two segments of the Surgeon General's Office that were most closely concerned with the problem—the Nursing Division and the Military Personnel Division—agreed on one thing—nurses should not be drafted.

On 19 December 1944, however, Walter Lippmann, a nationally syndicated columnist, after conferring with The Surgeon General wrote a column entitled "American Women and Our Wounded Men," which focused the attention of the American people on the Army's nurse shortage. In the article which appeared in the 19 December 1944 issue of the *Washington Post*, Mr. Lippmann asserted that he was reporting only the stark truth, which was well known to the Army and to the leaders of the medical professional, that American soldiers were not receiving the nursing care they must have. It was Lippmann's article that precipitated the draft issue. Later the same day, the Secretary of War, having read the article, asked The Surgeon General informally to clarify the nursing situation. The Surgeon General assured him that Mr. Lippmann actually portrayed a nearly hopeless situation. The Secretary of War then decided in favor of a draft of nurses. The necessary legislation was prepared on Christmas Eve by Col. Durward G. Hall, MC, and Mr. Goldthwaite Dorr, Special Assistant to the Secretary of War, who worked through the night.[49] The proposal to draft nurses was incorporated into the President's State of the Union message delivered to Congress on 6 January 1945. The President told Congress that recent estimates had increased the total number of Army nurses needed to 60,000.

Bills were introduced and hearings held in both Houses of Congress. The ceiling on the corps, raised from 50,000 to 55,000 about 30 January 1945, was further boosted a week later to 60,000, the figure the President had mentioned

[49] (1) Memorandum, Henry L. Stimson, for the President, 30 Dec. 1944. (2) Statement of Durward G. Hall, M.D., to the editor, 27 May 1961.

in his message to Congress. A member of the Army Nurse Corps from the Personnel Division of the Surgeon General's Office, testifying before the House Military Affairs Committee, estimated that before 1 June 1945 the Army would need 60,000 nurses to assure sick and wounded soldiers adequate nursing care,[50] an estimate that the Superintendent of the Army Nurse Corps felt was too high.[51]

Late in February 1945, the House Military Affairs Committee approved the draft bill; as thus approved, the bill left the maximum age at 44 years, but raised the minimum age to 20 years (instead of 18, as suggested by the President); it provided that all nurses, married and single, were to register, although married ones would not be drafted; the Procurement and Assignment Service was designated as the authority to declare which nurses would be available for military service; and cadet nurses were to be inducted first.[52] The House passed the bill on 7 March.

Three weeks later (28 March), the Senate Military Affairs Committee approved a draft of nurses, but while a bill to that effect awaited further Senate action, events occurred which indicated that it might not be needed after all. The response to the President's message had been immediate. In February, the monthly increase, which recently had been measured in hundreds and sometimes fewer, reached nearly 1,900; in March, it was over 4,100. Beginning in April, the rate of increase fell off although the total strength of the corps continued to increase to the end of August, when it amounted to 55,950, or 13,702 more than the strength at the end of December 1944.

In April while the European theater reported a shortage of 2,000 nurses, it stated that the problem was only potential: There were always enough nurses in staging areas who could be transferred to units needing temporary assistance.[53] At the same time, the chief nurse of the theater, Lt. Col. Ida W. Danielson, ANC, requested an officer from The Surgeon General's Military Personnel Division to report, upon his return to the United States, to the Superintendent of the Army Nurse Corps that the theater required no additional nurses; so many were there already that there was no housing at the hospitals for them.[54] The Superintendent of the Nurse Corps questioned whether there was any real shortage of nurses either in the European or the Mediterranean theater at this

---

[50] Am. J. Nursing 45: 175, March 1945.

[51] The fact that during the hearings the figure was raised by 10,000 so impressed the Directing Board of the Procurement and Assignment Service that after the war, in commenting on weaknesses in the Army's program for procuring nurses and others, it pointed this out as an example of rapidly changing statements of needs. The Directing Board expressed the opinion that "this [Army] uncertainty made it extremely difficult to undertake a sustained, consistent recruitment campaign." (Memorandum, Frank H. Lahey, M.D., Chairman, Directing Board, Procurement and Assignment Service, for Watson B. Miller, Administrator, Federal Security Agency, 26 June 1946. Mr. Miller sent a copy to the Secretary of War on 5 Sept. 1946.)

[52] Senate Committee on Military Affairs, 79th Cong., 1st sess., Hearings, on H.R. 227, "Nurses for the Armed Forces."

[53] Semiannual Report, Nursing Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, January–June 1945.

[54] Information from Colonel Danielson, 4 Nov. 1959.

time. Early in April 1945, she returned from a tour of inspection of these theaters with assurances from the respective chief surgeons that their requirements for nurses would be limited to prompt replacements. She concluded that even though "there may be a shortage of nurses based on T/O allotments in Medical Department units, there was no shortage based on need at the time of [her] visit." [55]

Meanwhile, procurement had been so good that on 4 May 1945 the Surgeon General's Office advised Army Service Forces headquarters that current assignments then amounted to 52,000 and it was estimated that 1,000 more would join in the next 2 months. As requirements after the defeat of Germany would amount only to 52,800, the Surgeon General's Office recommended to Army Service Forces headquarters that the War Department cease to press for legislation to draft nurses.[56] As a consequence, a letter was addressed on 24 May to the appropriate member of the Senate stating that the War Department believed there was no longer a need for special draft legislation. Some time earlier, action in the Senate had already been stalled by a decision on the part of the acting majority leader not to call up the draft bill when Senators Edwin C. Johnson and Robert A. Taft signified their intention of opposing it. Shortly after these events, recruiting for the Army Nurse Corps came to an end.

DIETITIANS AND PHYSICAL THERAPISTS

As the expansion of medical facilities continued and the need for dietitians and physical therapists grew more acute, it became apparent that The Surgeon General needed assistance in recruiting them. Although his Office was informed as to the availabilities of these personnel, it was unable to exploit them because it lacked the means of publicizing the Army's needs.[57] Needing a salesman, he turned to the Officer Procurement Service of the Army Service Forces, which performed the task very satisfactorily. By bringing information to the public about work in dietetics and physical therapy, that agency assisted the Medical Department immeasurably not only in immediate but in long-range procurement.[58] The Officer Procurement Serv-

[55] See footnote 45, p. 225.

[56] Memorandum, The Surgeon General, to Commanding General, Army Service Forces, 4 May 1945, subject: Nurse Requirements After V–E Day.

[57] Unless otherwise noted, this account is based on: (1) Manuscript histories of the dietitians and physical therapists prepared by the Directors of the respective components. (2) Letter, Col. E. E. Vogel, USA (Ret.), to Director, Historical Unit, U.S. Army Medical Service, 28 Mar. 1956.

[58] (1) Account of interview with Dr. John D. Currence, Director of Physiotherapy, Post-Graduate Hospital, Columbia University, *in* Memorandum, Maj. Edwin E. Nash, Officer Procurement Service, N.Y.C., for Lt. Col. John B. Marsh, 1 July 1943, subject: Physical Therapy Aides Available. (2) Account of interview with Dr. Don W. Gudakunst, Medical Director, National Foundation of Infantile Paralysis, N.Y.C., *in* Letter, 1st Lt. Willard F. Ande, MC, Officer Procurement Service, N.Y.C., to Major Nash, 12 July 1943. (3) Field Transmittal 88, Officer Procurement Service, to Officer Procurement Districts, 7 July 1943, subject: Procedure for Procurement and Processing of Physical Therapy Aides and Dietitians.

ice succeeded in recruiting about 250 physical therapists for the Medical Department.

A nationwide survey in 1942 demonstrated that the number of dietitians and physical therapists available was inadequate to meet both civilian and military needs. On the recommendation of the Directors of the two groups, therefore, The Surgeon General undertook the most extensive program of training in dietetics and physical therapy ever conducted by a civilian or military organization in the United States. Without such action, the Army's needs could not have been met. In the course of the war, the Medical Department conducted 10 programs for physical therapists in selected Army general hospitals, and 3 on a contract basis in civilian institutions. It also established a student-apprentice program for dietitians, the students being trained at four Army general and several civilian hospitals, and the apprentices at other selected Army hospitals. In addition, the Medical Department provided short physical therapy technician courses for enlisted members of the Women's Army Corps. Graduates were qualified to relieve the physical therapist of many nonprofessional duties, thus enabling her to devote most of her time to the actual care of patients. This program was undertaken in 1945 when it appeared that the number of fully qualified physical therapists was too small to care for the large number of patients then arriving from overseas. The program produced 413 trained technicians.[59]

Earlier, in 1944, believing that a certain number of women, though properly qualified to be commissioned as dietitians and physical therapists, had entered the Women's Army Corps, The Surgeon General made arrangements permitting such women, whether officers or enlisted personnel, to be discharged from the corps and commissioned as dietitians or physical therapists.[60] In 1945, an opportunity was offered to properly qualified enlisted women to become second lieutenants in the dietitians group upon completion of a 6 months' course given by the Medical Department.[61]

Despite all the measures taken, the numbers on duty never reached the largest objective set for them (in May 1945)—2,150 in the case of the dietitians, 1,700 in that of the physical therapists.[62] The peak active-duty strength of the former was 1,580; of the latter, 1,300 (table 1). Procurement figures for dietitians and physical therapists, which began only in December 1944, show the following acquisitions for the 7-month period ending on 30 June 1945: Dietitians, 205; and physical therapists, 293.

---

[59] Memorandum, Director, Physical Therapists, for Lt. Col. Fred J. Field, Office of The Surgeon General, 17 Sept. 1945.

[60] War Department Circular No. 90, 1944. (Under the provisions of this circular, nurses who were enrolled in the Women's Army Corps could also be released and appointed in the Army Nurse Corps, where they could practice nursing. See also War Department Circular No. 208, 1944.)

[61] War Department Circular No. 71, 1945.

[62] Letter, The Adjutant General, to Commanding General, Army Service Forces, 30 May 1945, subject: Requirements for Dietitians and Physical Therapists.

ENLISTED PERSONNEL

Enlisted Men, Zone of Interior

The number of enlisted men in the Medical Department increased from 108,674 in November 1941 to a peak of 567,268 in August 1944, whence it declined to 454,989 in September 1945 at the conclusion of the war (table 1). These figures represent men on duty, not authorized strength; in the middle of 1942, for example, The Surgeon General presented figures to show that the Medical Department had 35 to 45 percent less than its authorized enlisted complement.[63]

The method of procuring enlisted men for the Medical Department did not differ greatly during the war years from what it had been previously. Only a comparatively small number of enlisted men were earmarked for the Medical Department before or at the time they were inducted. Affiliated units were permitted to enroll technicians in the Enlisted Reserve Corps for future duty with those units. For a short time, persons enlisted voluntarily could choose the branch of service (medical or other) they preferred, but volunteers were not accepted after December 1942.

The plan devised before war broke out whereby technicians of value to the Medical Department registered with the Red Cross with a view to being assigned to medical organizations upon entering the Army probably served to produce but few trained men for the Medical Department. Early in 1943, the Acting Surgeon General stated that the "normal" functioning of selective service did not permit calling civilians into the Army to fill a particular need, although at the same time he expressed confidence that the Army classification system was funneling the great majority of drafted medical technologists into the Medical Department.[64] With few exceptions, therefore, enlisted men found their way into medical units and installations after being drafted and with no previous claim on them by the Department.

Problem of illiterates

Dependence on the draft was in one way more satisfactory than having to rely upon volunteers, the system by which the Medical Department had to fill its officer corps; instead of conducting recruiting campaigns it could bank with reasonable certainty on receiving each month a stipulated number of enlisted men from reception centers. On the other hand, in recruiting officers, the Department could establish minimum educational and professional qualifications; in accepting enlisted men from The Adjutant General, it had no direct control over the amount or type of training and experience of those it

[63] Report, Albert W. Gendebien, Military Personnel Division, Office of The Surgeon General, of Survey of Non-Technical Segments of the Surgeon General's Office, 24 Sept.–10 Oct. 1942.

[64] Letter, Acting Surgeon General, to Dr. Albert McCown, Medical Director, American Red Cross, 18 Feb. 1943.

received. In fact, the Department's most serious problem seems to have been not a failure to obtain enough enlisted personnel but the difficulty of obtaining the right kind and of keeping them after they had been obtained. The low quality, both physical and mental, of many men assigned to the Medical Department posed a continuous problem.

The mental aptitude for Army service of enlisted men caused some concern. Medical cadres shipped to the Air Forces early in the war were filled largely with men whose scores in the Army General Classification Test—the device for measuring this aptitude—fell in groups IV and V (the lowest categories). At Coffeyville, Kans., for example, of 97 medical recruits who joined an initial cadre of less than 30 men, all had scores in groups IV, V, or were illiterate. At Hondo, Tex., 75 percent of almost 250 medical recruits added to an initial cadre of 34 "were in group V or below." [65] The War Department took notice of the problem in August 1942 when it limited the percentage of illiterates (defined as those unable to read and write English of 4th grade level) to be included in each shipment of men from reception centers to Services of Supply replacement training centers. By this order, enlisted men assigned to the Medical Department were to include 2½ percent illiterates. In comparison, the Chemical Warfare Service, Engineer Corps, Ordnance Department, Quartermaster Corps, and Signal Corps were each to receive 3⅓ percent of their enlisted manpower in illiterates. Only the Finance Department and the Military Police were required to take none at all.[66]

Limited-service personnel

Complaints about the equality of enlisted men seem to have centered chiefly, however, on those who were designated as "limited-service"; that is, incapable of bearing the full rigors of military duty, especially in oversea areas.[67] Hospitals frequently charged that this type of personnel was physically unable to do the heavy and long-sustained work required in such institutions or were without previous medical instruction and had to be trained on their jobs. Some had too low mentality and too little education to absorb technical training. At first, the Army did not make a practice of accepting limited-service men. Nevertheless, some were inducted, and in December 1941, the authorities ordered Field Forces units to transfer all their men of that type to Services of Supply installations, including hospitals and other Medical Department facilities in the Zone of Interior. Unfortunately, in some instances, the Field Forces seized this opportunity to get rid of their "problem" men and promoted others before transferring them, thereby creating a morale problem in the installations to which they were sent.

---

[65] See footnote 37, p. 224.

[66] War Department Memorandum S 615–2–42, 24 Aug. 1942, subject: Limitations on Trainee Capacity for Illiterates at Services of Supply Replacement Training Centers.

[67] In July 1943, the War Department announced that the term "limited service" would not be applied to enlisted men. (War Department Circular No. 161.) Army authorities, however, including those of the Medical Department, continued to apply it informally to them.

Some months later (July 1942), the Army adopted the policy of inducting limited-service men and sending them exclusively to these Army Service Forces installations, at the same time requiring the latter to requisition such men in numbers equal to 60 percent of the assigned strength. This was raised to 80 percent in April 1943. This in effect required Zone of Interior installations to replace most of their personnel with limited-service men whereas, formerly the hospitals had absorbed their share of these men by simply adding them to their existing force.[68]

The policy appears to have had an indirect effect on the staffing of oversea units. In October 1942, The Surgeon General stated that the Medical Department was receiving too many limited-service men in service command installations to permit it to continue to man units destined for overseas with the type of personnel they required. According to a report from The Adjutant General, he stated, medical units intended for theaters of operations were receiving from 50 to 95 percent limited-service personnel. Moreover, in one such unit, whose complement was 500 enlisted men, information showed that of 436 men sent to it, 16 were illiterate and 131 had an Army General Classification Test score below 70; the average test grade for the 436 was 82. A score of 100 was considered normal. In addition, many of the men lacked teeth or had arthritic joints. General Magee felt that excessive numbers of limited-service men were being assigned to medical units, and he recommended that action be taken to correct the situation. Headquarters, Services of Supply, responded that medical battalions were there receiving their full strength of general-service men and that evacuation hospitals and hospitals designed for a communications zone were being given varying percentages of limited-service personnel. Services of Supply reminded The Surgeon General that "the key to the efficient utilization of limited-service personnel is careful assignment on the part of the Unit commander." [69]

In December 1942, The Surgeon General tried to obtain a commitment from Services of Supply headquarters that at least 10 percent of the limited-service men assigned to the Medical Department should have high mental and educational attainments. The attempt was unsuccessful.

In the following April, The Surgeon General established a training regiment for 2,400 limited-service men to relieve the hospitals of some of their problems in using them. The regiment was located at the Medical Replacement Training Center, Camp Barkeley. It was planned, after men in it had completed basic training, to send about 20 percent of them to enlisted technicians' schools for training in the technical specialties peculiar to the Medical Department. The regiment was not at first, however, built up to full strength as planned. During the first 12-week period after it was established, in which

[68] 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.

[69] Memorandum, The Surgeon General, for Commanding General, Services of Supply, through Military Personnel Division, Services of Supply, 16 Oct. 1942, subject: Limited Service Personnel With Medical Department, with 1st endorsement thereto, 28 Oct. 1942.

it had been planned to send 2,400 men to it, only about 850 were dispatched. The remainder of the 2,400 who arrived in that period were classified as general service.[70]

Key technicians

The problem of keeping as many able-bodied men as possible in the Medical Department became perhaps most troublesome when highly trained technicians were involved. A War Department directive of November 1943 requiring that the use of enlisted men should be based on their physical capacity was followed 2 months later by an order of Army Service Forces headquarters dealing with the same subject. The latter directive specified that Army Service Forces enlisted men up to the age of 35 who had been in the Army for a year or longer, who had not served overseas although qualified for duty there, and who were serving in "operating" positions [71] in the United States were to be reassigned to units or installations destined for overseas. The order excepted a few types of Medical Department enlisted men, such as "those few rare technical specialists developed through long periods of individual technical training whose special skills cannot be fully utilized in any unit destined for overseas;" this exception, it was stated, coverd certain key surgical, dental, and laboratory technicians.[72]

About the time this directive appeared, The Surgeon General, commenting on the original War Department order, expressed to the Commanding General, Army Service Forces, the fear that the document might be interpreted so as to deprive the Medical Department of key technicians capable of oversea service and replace them by men of limited physical capacity and inadequate technical experience. He suggested that no medical technician should be removed until a fully qualified replacement was available and that replaced technicians should be assigned to medical installations which could properly utilize them.[73] Perhaps in response to this suggestion, the Commanding General, Army Service Forces, some weeks later (16 February 1944) "reminded" commanders under his jurisdiction that trained Medical Department enlisted men would be required in large numbers for assignment to units destined for oversea service and pointed out that many of these men were scarce in civil life as well as in the Army. He directed that when a physically qualified enlisted technician was judged available for oversea service he be reported to the commanding general of the service command for assignment to a medical unit. If there was no appropriate vacancy in a unit under the jurisdiction of the com-

---

[70] (1) Letter, The Surgeon General, to Commanding Generals, Medical Replacement Training Centers, named general hospitals, and others, 16 Apr. 1943, subject: Utilization of Limited-Service Personnel. (2) Annual Report, Medical Replacement Center, Camp Barkeley, Tex., 1942–43, pt. 1.

[71] The Glossary, Army Service Forces Manual M807, June 1945, defined operating personnel as: "The workers, both military and civilian, who aid the Commanding General, ASF, in the performance of his assigned mission; includes T/O units assigned for functional duty."

[72] (1) War Department Circular No. 293, 11 Nov. 1943. (2) Army Service Forces Circular No. 26, 24 Jan. 1944.

[73] Memorandum, Surgeon General Kirk, for Commanding General, Army Service Forces, 22 Jan. 1944.

mander of the service command, that officer must report the man to The Adjutant General for reassignment.[74]

A few months later, Army Service Forces headquarters issued another order directing the removal of enlisted men qualified for oversea service from its installations and units. On this occasion, however, the Medical Department succeeded in having most of its key technicians exempted from the order.[75]

In April 1944, the General Staff stipulated that certain qualified enlisted men who were in the United States might volunteer for duty in the infantry; scarce category specialists of all branches were excepted, however; hence, although some Medical Department soldiers undoubtedly transferred to the infantry under this authorization, highly trained technicians were kept in the Medical Department.[76]

The foregoing orders, although they exempted from their operation most highly qualified Medical Department technicians, resulted in the transfer from the Department of numerous men who, though less skilled, were nevertheless trained in medical work. This imposed a serious burden on the Medical Department, in view of the increased flow of oversea casualties to the United States. In January 1945, therefore, The Surgeon General urged the Secretary of War to reconsider "the recent action diverting to the infantry medically trained personnel in the Zone of Interior, until all current personnel replacements for medical service have been adequately met." [77] Whether or not this plea had any effect, it did not alter the fact that many valuable men had already been lost. The results were less severe than they might have been, but only because, as an Air Forces historian put it, there were "no severe, widespread epidemics during January and February of 1945, when hospital staffs were in their leanest period." [78]

The steps taken to insure the Medical Department, and other technical services, against the loss of their highly trained technicians through transfer to assignments overseas in which their capabilities could not be fully used were accompanied by the introduction of a new procedure for channeling men of this caliber who were just entering the Army into the proper branch of the service, medical and other. Along with this procedure, there also developed a new method by which certain enlisted technicians already at work in the Army but assigned to jobs outside their specialties could be transferred to tasks suitable to their training. The procedure was outlined in War Department Memorandum W615–44 entitled "List of Critically Needed Specialists," published on 29 February 1944, the first of a series. It directed that men well qualified in the occupations listed should be assigned by reception centers to the

---

[74] Army Service Forces Circular No. 50, 16 Feb. 1944.

[75] (1) Army Service Forces Circular No. 193, 26 June 1944. (2) Annual Report, Enlisted Personnel Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1 July–30 Sept. 1944, fiscal year 1945.

[76] (1) War Department Circular No. 132, 6 Apr. 1944. (2) War Department Circular No. 262, 26 June 1944.

[77] Memorandum, Surgeon General Kirk, to Secretary of War, 10 Jan. 1945, subject: Medical Mission Reappraised.

[78] See footnote 37, p. 224.

replacement training centers of the arm or service that had a critical need for them. The list included some 90 specialties, several of them representing requirements of the Medical Department. Somewhat later, the General Staff directed that reception centers assign men in the listed specialties directly to units as well as to replacement training centers; certain priorities were to be followed in sending them.

The second list of "Critically Needed Specialists," dated 29 May 1944, divided the various types of specialists into two categories, those for which the need was continuous and those for which it was temporary. Reception centers were to assign those in the first category to specified training centers; members of this category who were already in jobs other than their specialty were to be reported to The Adjutant General for reassignment. None of these persons were to be placed in the infantry simply because they volunteered for it. Personnel in the category of temporarily needed specialists were to be assigned to other units in accordance with their specialty only if they were in reception or reassignment centers.

This list reappeared at frequent intervals and proved extremely valuable in the proper assignment of Medical Department specialists. The staff officer in the Surgeon General's Office in charge of enlisted personnel wrote that the monthly report be submitted requesting that certain types of Medical Department technicians be included in the next issue of the list, was perhaps the most important one compiled on enlisted personnel. Through the aid of this list, he asserted, the Army Service Forces was receiving scarce category personnel from the Army Air Forces and Army Ground Forces; previously, this had been impossible.[79]

Army Service Forces maintained an independent list of key military specialists which was of primary concern to its own technical services and staff divisions.[80] The list was designed to assure the proper utilization of certain skills that were scarce in the Army Service Forces, but did not meet the definition of a critically needed skill within the meaning of the War Department memorandum; this also helped the Medical Department to obtain the trained technicians it needed. Moreover, in January 1945, 2 months before Army Service Forces promulgated its own list of specialists, that headquarters "in view of the increasing need for both officer and enlisted personnel of the Medical Department" ordered all its commands to reassign medical personnel to appropriate medical duties if they were not already so assigned. For that purpose, Army Service Forces directed its redistribution stations (where soldiers reported upon returning from overseas) to make a "continuing search" for "trained and experienced Medical Department personnel." It also ordered all other Army Service Forces commands not to transfer such personnel to other arms or services or to use them in any position that individuals outside the

[79] Weekly Diary, Enlisted Personnel Branch, Military Personnel Division, Office of The Surgeon General, 12–16 Aug. 1944.

[80] Army Service Forces Circular No. 100, 21 Mar. 1945.

Medical Department could fill. These instructions appear to have covered not merely highly skilled technicians but all members of the Medical Department.[81]

After the end of hostilities in Europe, the War Department modified its list of critically needed specialists to include individuals who had skills that were particularly necessary during redeployment. Such persons were to be retained in the Army even though normally eligible for separation.[82]

Enlisted Men, Oversea Theaters

Convalescent patients

In meeting the need for personnel above their assigned strength, hospitals in oversea areas were able to make some use of convalescent patients. This practice also was in accordance with traditional Army procedures and was reinforced by the principles of the reconditioning program which aimed to restore patients to full duty in the shortest possible time.[83] At the 42d General Hospital, located in the Southwest Pacific, patients were used from the time this installation began to operate in September 1943. They helped in the care of grounds, maintenance of neatness in and around the establishment, food preparation, and dispensing food in dining rooms. Occasionally, they were used for ward duties, provided that they displayed particular aptitude for such work.[84] At the 96th General Hospital in the European theater, similar use was made of patients, who were also employed in clerical tasks.[85]

Limited-service personnel

The European and Mediterranean theaters were distinguished by intensive attempts to obtain from the Medical Department enlisted personnel suitable for combat duty and to replace them through the reinforcement system by men, regardless of the branch or service to which they originally had been assigned, who had become incapacitated for such duty. In accordance with War Department policies already mentioned, the theaters began to plan for this interchange early in 1944.[86] By July 1944, certain hospitals were replacing general-

---

[81] Army Service Forces Circular No. 10, 9 Jan. 1945.

[82] Davenport, Roy K., and Kampshroer, Felix: Personnel Utilization: Selection, Classification, and Assignment of Military Personnel in the Army of the United States During World War II. [Manuscript.]

[83] On the reconditioning program, see "Developments in Military Medicine During the Administration of Surgeon General Norman T. Kirk," *in* Bull. U.S. Army M. Dept. (No. 7) 7: 628–631, July 1947.

[84] Letter, George H. Yeager, to Col. C. H. Goddard, Office of The Surgeon General, 29 Sept. 1952.

[85] Annual Report, 96th General Hospital, 1944.

[86] (1) Circular No. 50, Headquarters, European Theater of Operations, U.S. Army, 11 May 1944, subject: Conservation of Manpower. (2) Circular No. 68, Headquarters, European Theater of Operations, U.S. Army, 12 June 1944, subject: Theater Manpower Board. (3) Annual Report, 6th General Hospital, 1944.

663076°—63——18

assignment troops with limited-assignment personnel, but the substitutions at that time were only small proportions of the hospitals' enlisted complements.[87]

In the European theater, a directive of 7 August 1944 stated that in military installations of the communications zone it would be "suitable" to have 50 percent of the basic labor strength and 50 percent of certain specified specialist positions filled by limited-assignment personnel, and each communications zone unit was required to submit periodic reports to the Commander, Ground Force Replacement System, detailing the number of limited-assignment personnel assigned and the number of additional positions to which more could be assigned.[88]

As the drain on general-assignment personnel in the medical installations of the communications zone continued, they were often replaced by former soldiers of the combat arms released from the theater's hospitals. Replacements of this kind were not satisfactory for several reasons. Few of them had any Medical Department training or experience prior to their new assignment; hence, they had to receive on-the-job instruction after they had been assigned to the hard-pressed communications zone units.[89] Many of them were not physically capable of doing the manual labor, such as moving supplies and patients, which the men they replaced had performed.[90] Furthermore, they could not perform duties for the Medical Department commensurate with the rank they had earned in a combat arm, and a great deal of reshuffling and individual reassignment was made necessary on that account.[91] Finally, a high percentage of these replacements did not want to be "pill-rollers," objected to their noncombatant status and the loss of combat pay, and, in general, presented serious problems of cooperation and discipline.[92]

Victims of combat exhaustion were especially difficult to retrain and assimilate, and after unsuccessful attempts to use them in the hospitals of the Advance Section, Communications Zone, of the European theater, it became necessary to establish the policy that replacements of this type would not be sent to medical units located in areas subject to aerial attack, V-bombs, and artillery fire.[93] Indeed, as early as 1943, it was noted in the Mediterranean theater that "Class B" (limited assignment) enlisted men were not satisfactory replacements for

---

[87] (1) Annual Report, 64th General Hospital, 1944. (2) Annual Report, 15th Hospital Center, 1944.

[88] (1) Circular No. 86, Headquarters, European Theater of Operations, U.S. Army, 7 Aug. 1944, subject: Limited Assignment Personnel. (2) See footnote 86 (1), p. 239. (3) Circular No. 109, Headquarters, European Theater of Operations, U.S. Army, 1 Nov. 1944, subject: Limited Assignment Personnel.

[89] (1) Administrative and Logistical History of the Medical Service, Communications Zone—European Theater of Operations, ch. XV. [Official record.] (2) Semiannual Report, Training Branch, Operations Division, Office of the Chief Surgeon, Headquarters, European Theater of Operations, U.S. Army, 1 Jan.–30 June 1945.

[90] (1) History, 724th Medical Sanitary Company, 1 Jan.–31 Mar. 1945. (2) Annual Report, 37th General Hospital, 1944. (3) Report, General Board, U.S. Forces, European Theater, Study No. 88.

[91] (1) Annual Report, 300th General Hospital, 1944. (2) See footnote 89 (2).

[92] (1) See footnote 89 (1). (2) See footnote 90 (2). (3) Annual Report, 70th General Hospital, 1944. (4) See footnote 87 (1). (5) Report, Col. Richard T. Arnest, of Medical Department Activities in Mediterranean Theater of Operations, 12 Feb. 1945.

[93] (1) Annual Report, Advance Section, Communications Zone, European Theater of Operations, U.S. Army, 1944. (2) Semiannual Report, 30th General Hospital, 1 Jan.–30 June 1945.

an evacuation hospital, and normally, large numbers of this type of personnel were not assigned forward of the communications zone.[94]

How extensive was the replacement of general-assignment enlisted men by men who had become disabled for full duty cannot be stated with much precision. There is reason to believe that resistance to the practice was more extensive and more successful in the European theater than in the Mediterranean. It is certain that, during the period of land combat in the European theater, not more than one-fifth of the enlisted replacements obtained by the Medical Department were in the limited-assignment category, that some of these came from the Zone of Interior, that others came from the Medical Department itself, and that this maximum proportion would not constitute more than 6 or 7 percent even of the communications zone medical enlisted strength (100,680—15 March 1945) in the period approaching V–E Day. It also appears that the Medical Department was not required to accept a significantly larger proportion of replacements unable to perform general duty than was the Army as a whole. Since it may be assumed that the combat arms received few replacements in this category, the Medical Department apparently was compelled to take a smaller proportion of these than were other services. That only a minority of the enlisted replacements supplied to the Medical Department were in the limited-assignment category does not mean that all vacancies created in the Department above the number filled by limited-assignment men were filled by general-assignment personnel, for many vacancies remained unfilled.[95]

The resistance of the European theater to the use of limited-assignment enlisted replacements also did not prevent the development of a large body of personnel in the communications zone medical installations that was incapable of general duty. As already noted, men in this category comprised nearly 38 percent of the strength of such installations in mid-March 1945. Since the great majority of these did not reach the units through the theater replacement system, the logical inference is that they came with them from the Zone of Interior.

This state of affairs contrasted with the situation in the Mediterranean theater, where, in spite of the probability that the proportion of limited-assignment enlisted men in the medical installations of the communications zone was even greater, that is, about 50 percent, than it was in the European theater, the great majority of the men so classified were excombat men provided locally. Units reaching the Mediterranean theater came almost entirely before the end of 1943, when the manpower situation permitted organiza-

[94] (1) Annual Report, 9th Evacuation Hospital, 1943. (2) Essential Technical Medical Data, Mediterranean Theater of Operations, U.S. Army, for November 1944, dated 1 Dec. 1944. (3) Annual Report, Headquarters, 3d Infantry Division, 1944.

[95] (1) Semiannual Report, 25th General Hospital, 1 Jan.–30 June 1945. (2) Annual Report, Surgeon, Headquarters, United Kingdom Base, March 1945. (3) Semiannual Report, 803d Hospital Center, 1 Jan.–30 June 1945. (4) Semiannual Report, 814th Hospital Center, January–June 1945. (5) Semiannual Report, Advanced Section, Communications Zone, European Theater of Operations, January–June 1945. (6) Annual Report, 1st General Hospital, Seine Section, Communications Zone, European Theater of Operations, 1944.

tions in the Zone of Interior destined for overseas to be filled very largely with personnel capable of full duty. On the other hand, many units sent to the European theater received their personnel when it no longer was possible to be so selective. A survey of February 1945 revealed, however, that the substitution of the less competent limited-service men had occurred at a time when hospitals were not overburdened and that they had been successfully absorbed. Nevertheless, some of the units were not satisfied with the situation.[96]

In order to increase the availability of their personnel for replacement uses, Medical Department units were directed to provide special training for their members. For example, in April 1943, the Surgeon, U.S. Army Services of Supply (Southwest Pacific Area), issued instructions requiring all enlisted personnel to act as "medical and surgical nursing assistants, for possible future assignment in hospitals of the mobile types to replace female nurses when necessary because of the tactical situation." [97] Some months later, in November 1943, he issued the following statement:

> It is the duty of the Commanding Officer of all hospital units in this theater to conduct courses of instruction for the training of their enlisted personnel in technical duties. There are no experienced personnel available in the United States, and hospital units, especially those on the mainland of Australia, must serve as pools from which efficient, well-trained personnel may be obtained for units incurring casualties.[98]

Enlisted Women, Zone of Interior

Procurement of technicians

In the early part of 1944, The Surgeon General, having many unfilled requisitions for members of the Women's Army Corps, recommended that Army Service Forces headquarters initiate a program to recruit them directly for the Medical Department.[99] The transfer of numerous trained Medical Department enlisted men to other branches of the Army at that time made the need for these women more urgent. Hence, in the spring of 1944, the Women's Army Corps began a program called Procurement of Female Technicians for Medical Installations.[100]

Recruitment under this procurement program was designed to be selective, bringing in only women qualified as bacteriologists, pharmacists, optometrists, psychiatric social workers, orthopedic mechanics, and numerous other

---

[96] (1) Munden, **Kenneth W.: Administration of the Medical Department in the Mediterranean Theater of Operations, U.S. Army. Vol. I. [Official record.]** (2) Annual Report, 45th General Hospital, 1944. (3) See footnote 92 (3), p. 240.

[97] Letter, Surgeon, U.S. Army Services of Supply, to Surgeons, Base Sections 2, 3, 4, and 7, 29 Apr. 1943, subject: Training of Medical Department Enlisted Men in Nursing.

[98] Technical Manual No. 22, U.S. Army Services of Supply, Southwest Pacific Area, 9 Nov. 1943.

[99] Memorandum, Brig. Gen. R. W. Bliss, Chief, Operations Service, Office of The Surgeon General, to Director, Personnel Division, Army Services Forces, 11 Feb. 1944, subject: Recruiting Program for WAC's for Medical Department.

[100] See footnote 75(2), p. 237.

types of technologists. Specifications were set for education, training, and experience. As women were exempt from the draft, recruiting campaigns using various publicity mediums were necessary; to get these technologists, The Surgeon General turned to the Officer Procurement Service. Women joining any branch of the Army under this program were beneficiaries of the Station and Job Assignment Recruiting Plan, which enabled them to choose not only their station but also their job in the Army. The Army, of course, determined, on the basis of aptitude and training, whether they were fit for the job.

Procurement of these women specialists progressed reasonably well considering the relatively high qualifications which the Medical Department had stipulated. By September 1944, about 1,800 women had joined the Women's Army Corps for jobs in the Medical Department, and at that time, about 200 were entering basic training each week. A special school to train members of the Women's Army Corps for Medical Department work was established at Fort McPherson, Ga.

Another campaign for enlisted women to be trained as medical and surgical technicians was conducted simultaneously, but by the regular recruiting stations, not by the Officer Procurement Service. This campaign aimed at recruiting women for 3 months' training as technicians. Prerequisites for dental, laboratory, and X-ray technicians included graduation from high school, while others needed only 2 years of high school credit; certain minimum scores also had to be attained in Army tests.[101] The women recruited ordinarily had had little or no experience in matters relating to medicine. The campaign had progressed well enough by the fall of 1944 that the Surgeon General's Office recommended it be stopped.[102]

Beginning in September 1944, however, a heavy flow of casualties to the United States and the winter fighting in Europe, which added to the prospective patient load in the United States, made the situation tighter. The position of the Medical Department planners was not made easier by the knowledge that they were short of nurses, that the Army had failed to obtain more than a few hundred cadet nurses, and that the Medical Department was being forced to release enlisted men for training as combat soldiers. The Surgeon General's Office accordingly asked for 8,500 enlisted personnel—men or women—to be trained as technicians to replace men who had been transferred to the Army Ground Forces.[103] The Surgeon General later recommended that all the technicians be women.

---

[101] Letter, Headquarters, Army Service Forces, to Commanding Generals of Service Commands and Military District of Washington, 13 June 1944, subject: Procurement of Female Technicians for Medical Installations, with enclosure thereto.

[102] Except where otherwise noted, the account which follows is largely taken from Treadwell, Mattie E.: The Women's Army Corps. United States Army in World War II. Special Studies. Washington: U.S. Government Printing Office, 1954.

[103] Letter, Maj. Gen. Norman T. Kirk, USA (Ret.), to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 12 Dec. 1955.

Organization of Women's Army Corps companies

Complaints that women were being used in minor jobs, after joining the Army with the understanding that they would be medical and surgical technicians, induced Col. Oveta Culp Hobby, Director of the Women's Army Corps, to oppose assigning more women to hospitals unless assurance was given that recruiting promises could be fulfilled. General Marshall, for his part, expressed the opinion that sufficient women of the high caliber desired could not be recruited unless they were guaranteed a technical job and rating. If this guarantee were not given, he refused to sanction any further procurement of enlisted women for Army hospitals. Since such assurance could not be made under the current system, he proposed that the new members of the Women's Army Corps be assigned to hospitals in table-of-organization companies. Such a unit carried its own allotment of grades and also specified the exact job of each member. Hospital commanders could change neither the job nor the grade. Such identical, inflexible units might be expected to work satisfactorily in general hospitals, since all had similar functions and organizations and all used technicians.

The tables of organization, as drafted in a meeting between representatives of The Surgeon General and the Women's Army Corps, called for 100 enlisted women per hospital company. Since all were to be skilled technicians or clerks, the lowest rating was technician, fifth grade. Companies were allotted to named general hospitals in proportion to the number of beds.[104] Each hospital desiring such a company could requisition it and women would be recruited with assurance of assignment to that hospital and of at least a fifth grade technician's rating if they performed satisfactorily.

With intensive publicity to promote it, the general hospital campaign was a success. General Marshall solicited the assistance of State Governors: "The care of the increasing number of casualties arriving in the United States, together with an acute shortage of nurses and hospital personnel generally, necessitates urgent measures being taken to recruit and rapidly train women for service in Army hospitals." [105] A quota of about 6,000 by 1 May 1945 was established; about halfway through the campaign, it was raised to 7,000. Nevertheless, recruiters passed that number a month ahead of schedule. In fact, recruiting was so successful that in 1945 the Surgeon General's Office was embarrassed by a surplus of enlisted women.

A total of 120 Women's Army Corps hospital companies served in this country, each with a table of organization calling for 101 members. So far as possible, the enlisted women working in hospitals before the companies were created in early 1945 were absorbed by the new units. Those left out were generally in assignments not included in the tables of organization of the hos-

---

[104] Memorandum, Lt. Col. E. R. Whitehurst, Military Personnel Division, Office of The Surgeon General, for Director, Training Division, Office of The Surgeon General, 18 July 1945.

[105] Letters, Chief of Staff, to all State Governors, 7 Jan. 1945.

pital companies. A serious drawback to the use of Women's Army Corps companies in Zone of Interior hospitals was that they were too large and too inflexible to meet the requirements of the smaller hospitals.

Enlisted Women, Oversea Theaters

It is doubtful whether the total number of Women's Army Corps personnel used by the Medical Department overseas prior to V–J Day numbered much more than 400. No Women's Army Corps hospital companies went overseas, and it is unlikely that any member of the corps arrived there as part of a Medical Department unit. A few may have arrived as members of a Women's Army Corps headquarters company; in that case, they were assigned to the company and merely allotted to the medical section of the headquarters.

The limited use of Wacs overseas is explained by the small numbers available for such service and the fact that their utilization was being questioned until the very close of hostilities, with the result that certain of the oversea authorities, medical and other, were reluctant to use them.[106]

The majority of the Wacs who served the Medical Department overseas were employed in nonprofessional types of jobs, such as clerks, typists, and chauffeurs, located mainly in theater and base headquarters. In the Office of the Chief Surgeon, European theater, most of the Wacs were concentrated in the Medical Records Section of the Administrative Division. About the middle of 1944, virtually all enlisted male personnel in the Chief Surgeon's Office, U.S. Army Forces in the Middle East, were replaced by enlisted members of the Women's Army Corps, who provided very satisfactory service and remained in their jobs until the theater was inactivated. At the end of 1944, a total of 12 enlisted women were used in the Office.[107]

Although most of the Wacs possessing medical skills were needed in the Zone of Interior, a few were used in at least three theaters. In the Southwest Pacific, during the latter part of 1944, nurses who were needed in hospitals as a result of increased admissions occasioned by the campaign in the Philippines were relieved from duty in dispensaries caring for Wacs and replaced by Women's Army Corps medical technicians.[108] At the 133d General Hospital in the same theater during the first part of 1945, on a trial basis, Wacs were used as technicians in dental and medical laboratories, but the trial was not successful.[109] During the second half of 1944, the Hastings Air Base Medical Unit, located in the India-Burma theater, used one WAC dental technician and two WAC medical technicians.[110]

---

[106] Letter, Eli Ginzberg, to Col. C. H. Goddard, Office of The Surgeon General, 16 Sept. 1952.

[107] (1) Annual Report, Surgeon, U.S. Army Forces, Western Pacific, 1945. (2) History of the Medical Section, Africa-Middle East Theater, September 1941–September 1945. [Official Record.] (3) Annual Report, Administrative Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1944.

[108] Annual Report, Surgeon, U.S. Army Services of Supply, Southwest Pacific Area, 1944.

[109] Letters, Col. I. A. Wiles, to Col. C. H. Goddard, Office of The Surgeon General, 14 Aug. 1952, and 17 Sept. 1952.

[110] Semiannual Report, Hastings Air Base Medical Unit, June–December 1944.

On 1 August 1945, 1.7 percent of the Women's Army Corps enlisted personnel in the European theater were serving as medical or dental laboratory technicians.[111] Since the number of Women's Army Corps enlisted personnel in the theater on that date was 7,007, the number of these technicians must have been about 130. On 1 July 1945, a Women's Army Corps detachment was activated at the 116th General Hospital, Nuremberg, Germany, in the same theater. Wacs were ordinarily assigned to the units in which they worked, but were attached to units of their own (called detachments) for housekeeping and similar purposes. Not long afterward, this detachment was transferred to the 98th General Hospital in Munich, Germany. It is not certain, however, that even a majority of the members of the detachment functioned as Medical Department technicians.[112]

---

[111] Percentage by Military Occupational Specialties of WAC Personnel in European Theater of Operations, 1 Aug. 1945. (Report, General Board, U.S. Forces, European Theater, Study No. 11.)

[112] (1) Report, WAC Staff Director, Headquarters, U.S. Forces, European Theater, 1 Jan. 1945–1 Aug. 1945, subject: Women's Army Corps Personnel, European Theater, 15 Nov. 1945. (2) Annual Report, 98th General Hospital, 1945. Upon the transfer, this unit consisted of 4 officers and 66 enlisted women.

CHAPTER VIII

Procurement of Civilian Personnel

ZONE OF INTERIOR

Overall Employment

A considerable number of civilians worked in headquarters offices, most of them in the Surgeon General's Office where their numbers in the early stages of mobilization grew slowly enough to permit an effective classification of skills. Many who entered the Office at this time developed their own potentials to a point where, before the war was over, they were performing a large portion of the duties normally assigned to officer personnel. It was thus possible to keep down the requirements for officers, and even to release some officers for oversea service. It was these civilian employees who furnished the continuity so necessary to the smooth running of an office, at a time when both law and War Department policy put severe limitations upon the length of time Regular Army officers might remain in nontroop duty assignments. The tabulation which follows shows both the rise in the number of civilians employed in the Surgeon General's Office, especially during the year ending on 30 June 1941, and the growing proportion they bore to the officer and nurse personnel assigned to the Office.[1]

	Number
30 June 1939:	
Officers	31
Civilians	161
Nurses	3
Total	195
30 June 1940:	
Officers	40
Civilians	201
Nurses	3
Total	244
30 June 1941:	
Officers	98
Civilians	717
Nurses	4
Total	819

[1] Annual Reports of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1939 to 1941, inclusive.

The great expansion of the hospital system after the calling up of the National Guard and the introduction of selective service in 1940 was largely responsible for an increase in civilian employment to supplement the supply of enlisted men assigned to hospitals—an increase bringing the proportion of civilians on hospital staffs considerably above the 20 percent which The Surgeon General had considered the maximum desirable.

More than 3,000 civilian employees of the Medical Department at large were paid from various special funds during the fiscal year 1939. Of these, 595 were paid from the Medical and Hospital Department, Army, appropriation; 600 from Veterans' Administration funds; and 1,985 were paid by the Civilian Conservation Corps. These numbers grew rapidly during 1940 and 1941 (table 18).

As the figures demonstrate, the most important of these funds as a source of civilian employment during 1939–41 came to be the Medical and Hospital Department Fund, which was appropriated by Congress to finance strictly Medical Department activities, exclusive of the pay of military personnel. In addition, the Veterans' Administration, lacking adequate hospital beds of its own, and the Civilian Conservation Corps, wholly dependent for long-term hospitalization on the Medical Department, each year paid the latter to care for certain of their patients in the Department's hospitals; the money could be used for all expenses incident to patient care, including the pay of civilians.

In addition to the above, a number of civilians in hospitals were employed under the Construction and Repair of Hospitals Fund, another separate appropriation of Congress. Exact figures on civilians paid from this fund are lacking. Appropriations for the year ending on 30 June 1940, however, were sufficient to cover 52 "positions." Budget estimates for the following year covered 724 positions, but as further appropriations raised the total amount of the fund from $2,892,886 to $4,489,886, the number of civilians employed may have been considerably higher.[2] The fund was used particularly for hospital maintenance and was disbursed by the Medical Department. During this period, however, it was legally a Quartermaster fund.[3]

Until 1940, the Office of The Surgeon General acted as the employing agent for civilians in all installations of the Medical Department and kept records on them. In September 1940, however, when it became evident that the numbers employed would increase greatly, the authority to employ civilians in station hospitals was delegated to the corps area surgeons, The Surgeon Gen-

[2] The Budget of the United State Government. Washington: U.S. Government Printing Office, Fiscal Years Ending 1942 and 1943.

[3] The U.S. Office of Education also appropriated money to be used by State authorities in conducting vocational courses for servicemen on or off military posts. Some civilian instructors were employed at the medical replacement training centers; information is lacking, however, as to whether any or all of them were paid from this fund. (Letter, The Adjutant General, to Chief of Staff, General Headquarters, and Commanders of Arms and Services, February 1941, subject: Assistance From Civilian Educational Institutions.)

TABLE 18.—*Civilians employed by the Medical Department from various funds, March 1940–December 1941*

Fund	1940				1941			
	March	June	September	December	March	June	September	December
Medical and Hospital Department:								
District of Columbia	150	146	157	239	534	813	954	925
Elsewhere	724	913	1, 143	3, 572	8, 730	18, 396	22, 297	26, 425
Total	874	1, 059	1, 300	3, 811	9, 264	19, 209	23, 251	27, 350
Civilian Conservation Corps:								
District of Columbia	138	148	138	122	34	41	17	14
Elsewhere	1, 628	1, 587	1, 376	989	774	751	565	486
Total	1, 766	1, 735	1, 514	1, 111	808	792	582	500
Veterans' Administration:								
District of Columbia	84	85	98	102	106	116	6	6
Elsewhere	495	544	488	409	495	491	513	359
Total	579	629	586	511	601	607	519	365
Total Medical Department:								
District of Columbia	372	379	393	463	674	970	977	945
Elsewhere	2, 847	3, 044	3, 007	4, 970	9, 999	19, 638	23, 375	27, 270
Grand total	3, 219	3, 423	3, 400	5, 433	10, 673	20, 608	24, 352	28, 215

Source: Civilian Personnel Division, Office of The Surgeon General, U.S. Army.

eral retaining the right in connection with general hospitals.[4] Under this arrangement, The Surgeon General continued to control all the funds but allotted certain amounts to the corps area surgeons; whereas, previously, he had allotted funds to the individual stations. The Surgeon General's Office constructed tables showing job titles, numbers, and grades to guide those actually engaged in staffing installations.

At the end of July 1945, the Department had in its employ more than 70,000 civilians in the United States, most of whom were under the jurisdiction of the service commands.[5] On 30 June 1945, about 8,100 civilians were employed in activities under the direct command of The Surgeon General. The majority of these worked in medical depots; others were assigned to the Army Medical Center, the Army Medical Library, and the Army Medical Museum, all located in Washington, D.C. The Surgeon General's Office itself employed 1,402, about 200 of this number being in his Personnel Service, which at that time included both the Military and Civilian Personnel Divisions.[6]

Contract Surgeons

Among civilian employees were a few contract surgeons[7] and specialists, the latter engaged temporarily for particular cases. Early in 1941, civilian physicians began to be used for other purposes when the Secretary of War, acting on the recommendation of The Surgeon General, created the Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army. The board was composed of outstanding civilian doctors and Medical Corps officers, the former acting as consultants to the Secretary of War to advise The Surgeon General on problems of infectious diseases in the Army.[8] Civilian members were to be paid a per diem of $20 plus transportation expenses. Eventually, this board comprised about 200 members, divided into various commissions. Civilian consultants had been used during the First World War; the creation of the new board meant the revival of an important practice which continued throughout World War II.

Nursing Personnel

To help perform nursing duties for the Army in the United States, sizable numbers of civilians were obtained. The number of civilian graduate nurses so

---

[4] (1) Letter, Office of The Surgeon General (Lt. Col. F. C. Tyng), to Surgeons, Corps Areas and Departments, 12 Sept. 1940, subject: Use of Civilian Personnel in Army Hospitals. (2) Letter, The Adjutant General, to Commanders of Arms and Services, Commanding Generals, all Corps Areas, and Commanding Officers of Exempted Stations, 21 Oct. 1940, subject: Provision for Civilian Employees in Hospitals of Exempted Stations.

[5] Monthly Progress Report, Army Service Forces, War Department, 31 Aug. 1945, Section 5: Personnel and Training.

[6] War Department Civilian Personnel Statistics Bulletin, vol. 3 (12), June 1945, p. 5.

[7] On 30 June 1939, 31; on 30 June 1940, 28; and on 30 June 1941, 36.

[8] Letter, The Surgeon General, to The Adjutant General, 27 Dec. 1940, subject: Establishment of Board for Investigation of Influenza and Other Epidemic Diseases in the Army, and 1st endorsement thereto, 11 Jan. 1941, reprinted *in* Bull. U.S. Army M. Dept. No. 64, 1942.

employed amounted to somewhat more than 1,000 in April 1945,[9] a figure that was probably close to the peak, since, with the return of nurses from overseas, civilian nurses were released from Army hospitals.

The influx of civilian nurses' aides into Army hospitals was considerably larger. The Office of Civilian Defense and the American Red Cross cooperated in training such personnel and, by March 1942, had some 12,000 to 15,000 in training. In January 1945, The Surgeon General informed the Red Cross that the quota for paid nurses' aides was set at an additional 5,000, and he requested the latter to train and recruit that number; later, however, on War Department orders, he withdrew the request. An agreement was thereupon made whereby further recruiting would cease and only those already in training would be hired.[10] The peak strength of nurses' aides—paid and unpaid—serving in Army hospitals reached about 2,000 (in June 1945); [11] it seems likely that more than half of that number were in the paid category.

The cadet nurse program also furnished a large quota. During the period from 15 June 1944, when the first cadet nurses were placed in Army hospitals, to 1 October 1945, The Surgeon General received from the Civil Service Commission a total of 9,891 cadet nurse applications for service in Army hospitals. Of this number, 5,688 cadets were accepted and assigned to hospitals; 3,953 of these completed the course, and 1,674 were on duty on 1 October 1945. A total of 61 were dismissed or resigned during the whole period. There is no record of the total number who accepted Army Nurse Corps commissions upon completing the course, although it is known that 93 who had had senior cadet nursing experience in Army hospitals had been commissioned up to 1 January 1945.[12] Some, either not physically qualified for or not desiring a commission, served in civilian status after graduation.

Occupational Therapists

At the time the United States entered the war, only 12 graduate occupational therapists were working in Army hospitals. Their numbers increased only slowly before late 1943. In August of that year, The Surgeon General, pointing out that their work was of professional character and formed an important part of the treatment given to patients especially in orthopedic and neuropsychiatric cases, stated that of the 71 then employed in Army hospitals in

---

[9] Civilian Nurses in Army Hospitals. Am. J. Nursing 45 : 263, April 1945.

[10] (1) Letter, Surgeon General Kirk, to Mrs. Walter Lippmann, National Director, Volunteer Nurses' Aid Corps, American Red Cross, 1 Jan. 1945. (2) Letter, Surgeon General Kirk, to Basil O'Connor, Chairman, American Red Cross, 6 Jan. 1945. (3) Memorandum, Deputy Assistant Chief of Staff, G–1, for Deputy Chief of Staff, 13 Jan. 1945, subject: The Surgeon General's Campaign for Red Cross Nurses' Aides.

[11] Information furnished by Resources Analysis Division, Office of The Surgeon General.

[12] (1) Memorandum for Record, Capt. J. D. Boole, MAC, 2 Oct. 1945. (2) Annual Report, Valley Forge General Hospital, 1945. (3) Memorandum, Brig. Gen. R. W. Bliss, Assistant Surgeon General, for Director, Bureau of Public Relations, War Department, 27 Jan. 1945, subject: WAC Technician Program.

the United States, about 25 were probably not qualified. He succeeded at that time in getting the authority to pass upon qualifications of therapists procured in the service commands by compiling lists of qualified individuals from which the appointments were to be made. He also obtained the right to pass on the professional qualifications of those whose names the service commands submitted to him. However, responsibility and authority for the employment of occupational therapists remained with the service commanders. Procurement increased rapidly after this date, and in August 1945, the Army was employing a peak strength of 447 graduate occupational therapists and 452 apprentices in more than 70 of its hospitals.[13] None served overseas during the war.

Dietitians and Physiotherapy Aides

Women dietitians and physiotherapy aides served in civilian status until 1942. Their number increased during the emergency until, by May 1941, dietitians on duty in Army hospitals numbered 103, and physiotherapy aides, 47. At that time, there were 350 vacancies for dietitians and 125 for physiotherapy aides.

Nonprofessional Personnel

In addition to the professional and trained personnel, the Medical Department employed large numbers of civilians in clinical and administrative positions and as laborers and skilled workmen. The turnover in these jobs was more rapid than in the professional categories and also required on-the-job training for many of the people recruited.

Red Cross Workers

The number of Red Cross workers in Army hospitals in the United States likewise increased. Although statistics are not complete, the American National Red Cross reported that on 30 November 1942 a total of 244 paid staff workers were serving in 22 general hospitals and 787 in 122 station hospitals in the Zone of Interior. As regards the volunteer staff, the Red Cross reported that it would be "fairly accurate to say" that 1,300 were serving in Army hospitals in November 1942 and 7,500 in December 1944, the last month in the war period for which figures are available. Shortly after the war, there were 1,213 paid workers in 203 station hospitals. Numbers in general hospitals at that time are not available.

---

[13] (1) Letter, The Surgeon General, to Commanding General, Army Service Forces, 13 July 1943, subject: Occupational Therapy Personnel, with 2d endorsement thereto, 7 Aug. 1943. (2) Letter, The Adjutant General, to The Surgeon General and Service Commands, 12 Aug. 1943, subject: Occupational Therapy Personnel in Zone of Interior General Hospitals. (3) The Surgeon General's Letter No. 149, 12 Aug. 1943.

Red Cross workers assigned to hospitals overseas were of course not military personnel, but they occasionally performed work in the wards in addition to preparing patients for the operating room.[14]

OVERSEA THEATERS

Under regulations in existence even before the establishment of any theater of operations, theater commanders were authorized to facilitate the use of local civilians within their commands to the extent needed to prevent diminution of the efficiency of their troops.[15] However, while the Surgeon General's Office was aware that local labor would be used—as is shown by a reference to it in TOE 8–500, published on 23 April 1944 and revised on 18 January 1945—no general policies were established which specifically promoted the use of such manpower sources outside the continental United States.[16]

The Medical Department's use of civilian employees in oversea areas developed in accordance with policies and conditions in these areas. The theater commander established policies applicable to the entire theater and not solely for the benefit of the Medical Department. By virtue of their location, relative stability, and type of function, installations in the communications zone or base sections were able to utilize such personnel on a greater scale than those troops in combat areas.[17] The actual procurement, administration, and payment of extra-Army personnel usually was effected through nonmedical channels, such as base section headquarters.

Types of Personnel Utilized

Civilian labor used by the Medical Department overseas may be divided into four general classes: (1) Professional (including certain "subprofessional" personnel such as laboratory technicians and nurses' aides); (2) clerical (including messengers and interpreters); (3) skilled; and (4) unskilled.

The professional category of civilian employees was relatively unimportant, because highly trained civilians were rarely available overseas. However, in certain emergency situations, they were temporarily helpful.

[14] In field hospitals, Red Cross workers "assisted in removing bloody or torn clothing, removing excess blood from the patient, removing his shoes and washing his face and hands under the guidance of medical authorities." Occasionally, where there were not enough psychiatrists on the staff of a convalescent hospital, a Red Cross social worker was asked to conduct the interviews in which patients "ventilated" their personal anxieties. (Letter, C. H. Whelden, Jr., Chief Statistician, American National Red Cross, to Max Levin, Office of The Surgeon General, 6 June 1952, with enclosure thereto.)

[15] War Department Field Manual 100–10, Field Service Regulations, 9 Dec. 1940, p. 121; and 15 Nov. 1943, p. 151.

[16] The oversea portion of this chapter is very largely a condensation of a manuscript, "Medical Department Utilization of Civilian and POW Labor Overseas in World War II," prepared by Cpl. Alan M. White in the Historical Unit, U.S. Army Medical Service, under supervision of the authors of this volume. The major sources for Corporal White's work are the periodic reports of medical units and headquarters, too numerous to list here.

[17] (1) Letter, Lt. Col. Irvine H. Marshall, to Col. C. H. Goddard, Office of The Surgeon General, 1 Aug. 1952. (2) Letter, Col. I. A. Wiles, to Col. C. H. Goddard, Office of The Surgeon General, 14 Aug. 1952.

Civilian surgical teams contributed much to the care of casualties at the time of Pearl Harbor, and in the invasion of Luzon, volunteer Philippine doctors and nurses worked with Medical Department personnel in certain Army hospitals which were flooded with casualties. Immediately after the fall of Rome, 12 young Italian-American graduates of the University of Rome Medical School, who had been interned in Vatican City during the German occupation, together with Italian doctors and medical students recruited by them, served as prophylactic station attendants in the Italian capital.[18] In Australia, the services of a few physical therapy aides were obtained, and in various theaters, small numbers of Catholic nuns, missionary or native, were utilized as nurses. Civilian nurses' aides worked in some Army hospitals in France, the Philippines, and China, and sometimes there were as many as 50 in a single hospital. Laboratory assistants and other technically trained individuals were used when available.

Civilian clerical workers were used in various types of Medical Department units, but particularly in fixed installations. Typists, stenographers, and clerks were employed in all theaters, but, of course, in such areas as New Guinea, Burma, parts of Africa, and some of the Pacific islands, the educational level of the population was not high enough to make many available for service in hospitals.

The skilled workers probably were the most valuable of the Medical Department's civilian employees. Especially in the North African theater and Southwest Pacific Area, the Medical Department had to do a great deal of its own construction because of the shortage of Engineer personnel. Carpenters, plumbers, masons, electricians, and painters were hired in these areas and elsewhere to supplement the meager strength of the hospitals' utilities departments both in construction and in maintenance work.[19] The services of other skilled civilians, such as barbers, tailors, and cooks, were less essential but were often used by Medical Department units. Skilled workers were more plentiful in the North African-Mediterranean and European theaters than elsewhere and, hence, were used more extensively there, but the 95th Station Hospital at K'un-ming, China, reported having hired "carpenters, masons, plumbers, tinsmiths, etc." in 1944, and the 49th General Hospital in Leyte, the Philippines, in 1945, listed 49 skilled workers (including carpenters, plumbers, electricians, and mechanics) among its 353 civilian employees.

Unskilled workers were by far the most important category of civilian employees numerically, not only because the Medical Department needed a great deal of heavy labor but also because this was the category most available; indeed, in most areas, there was a very large supply of unskilled labor. Employees of this class performed such diverse duties as ditching, draining, spraying, and oiling required in malaria control projects; clearing undergrowth

[18] Annual Report, Surgeon, Mediterranean Theater of Operations, U.S. Army, 1944.

[19] Letter, Col. I. A. Wiles, to Col. C. H. Goddard, Office of The Surgeon General, 17 Sept. 1952. (Although the construction of hospitals in North Africa and Europe usually was accomplished by the Engineers, a great deal of minor construction was left for the unit personnel, and this was often more than the hospital utilities sections could handle.)

from hospital sites; aiding in construction work; cleaning dirt and rubble from buildings and grounds; landscaping and gardening; waste disposal and sanitation; "kitchen police" and mess help; cleaning of hospital wards; movement of supplies and equipment and litter bearing.

Resultant Savings of Military Personnel

The use of civilians, prisoners of war, and similar local labor made it possible to release Medical Department enlisted men for service as combat troops, to relieve such men from unskilled and routine work for more technical duties within the Medical Department itself, and in certain instances to effect considerable reductions in the table-of-organization strength of units. By this means, the 814th Hospital Center, in the European theater, in January 1945, was able to order its attached general hospitals to reduce their enlisted complements to 400, instead of the 450 allotted by the relevant tables of organization. It further directed its attached station hospitals and smaller units to reduce their enlisted strength 20 percent. This resulted in a total saving of nearly 800 Medical Department enlisted men. The 815th Hospital Center, located in the Seine Base Section (Paris), European theater, was able by the employment of local labor, in 1945, to reduce the aggregate military strength of its general hospitals by 557 men (table 19).

TABLE 19.—*Economies in enlisted personnel through utilization of local labor, 815th Hospital Center, European theater, 1945*

General hospital	T/O capacity (number of beds)	Authorized T/O enlisted strength	Reduced enlisted strength	Percent saving
1st	1, 500	562	450	19. 9
191st	1, 500	562	450	19. 9
194th	1, 000	450	375	16. 7
198th	1, 000	450	375	16. 7
203d	2, 000	641	550	14. 2
217th	1, 500	562	450	19. 9

Source: Annual Report, 815th Hospital Center, European Theater of Operations, U.S. Army, 1945.

The Situation in the Various Theaters

The number of civilians hired by a particular Medical Department unit depended not only on that unit's needs in a particular situation, but also on the availability of local labor. In the European theater, an attempt was made to develop a plan for civilian employment in Army hospitals based on the patient census, but this proved impossible because it was found that a unit's personnel needs were more dependent on the type of buildings in which it operated than on the number of patients in its care. The numbers of civilian employees in Army hospitals overseas thus varied widely from theater to theater

and, within a theater, from hospital to hospital. Even within a particular hospital, there were substantial fluctuations over relatively brief periods.[20]

Southwest Pacific theater

The variety of situations within a given major area is illustrated by the Southwest Pacific. Civilians were used in headquarters and in hospitals in Australia, but the manpower shortage there did not permit their employment in great quantity on that continent. In New Guinea, native litter bearers were used to carry casualties over the rugged Owen Stanley Mountains and to bring casualties to collecting points on the beaches during amphibious operations (fig. 36). Few natives, however, were employed by the hospitals, although in 1944 the 2d Station Hospital, west of Lae, had from 15 to 20 native workers who were used for common labor outside the hospital (fig. 37). At Milne Bay, approximately 100 natives per month were used by malaria control units in the summer of 1944.[21]



FIGURE 36.—Native litter bearers carrying a wounded American soldier from the frontlines, vicinity of Buna, New Guinea, November 1942.

[20] This is perhaps one reason for lack of comprehensive statistical information concerning employment by the Medical Department of civilians in oversea areas.

[21] See footnote 17(2), p. 253.



FIGURE 37.—Natives building a covered bomb shelter, under the direction of a medical technician, Southwest Pacific Area, January 1944.

In the islands north of Australia, the average number of natives employed per day in 1943 for purposes of malaria control exceeded 1,000 and reached 2,000 in 1944.[22] The picture in regard to hospital employment was very different in the Philippines. The 49th General Hospital had 60 workers on 1 January 1945, 353 on 31 March, 448 on 30 June, and a peak of 465 on 30 September 1945. The 125th Station Hospital averaged 180 Philippine employees daily in the first quarter of 1945, and 150 in the second.

A recent rough estimate based on recollection alone indicates that, at the peak of activity at Base K in Leyte (that is, about the end of 1944 and the early part of 1945), 2,500 civilians were employed by the Medical Department within the area covered by that command.[23] This was equal to about 4 percent of the military medical personnel of the entire theater.

South and Central Pacific theaters

In the South and Central Pacific Areas, there were relatively few civilian employees outside the Hawaiian Islands. This may have been because many of the natives in the Japanese mandated islands were hostile to the American forces, because shortages of military labor were infrequent, or because Navy

[22] Letter, G. L. Orth, to Col. C. H. Goddard, Office of The Surgeon General, 17 Sept. 1952.
[23] See footnote 17(2), p. 253.

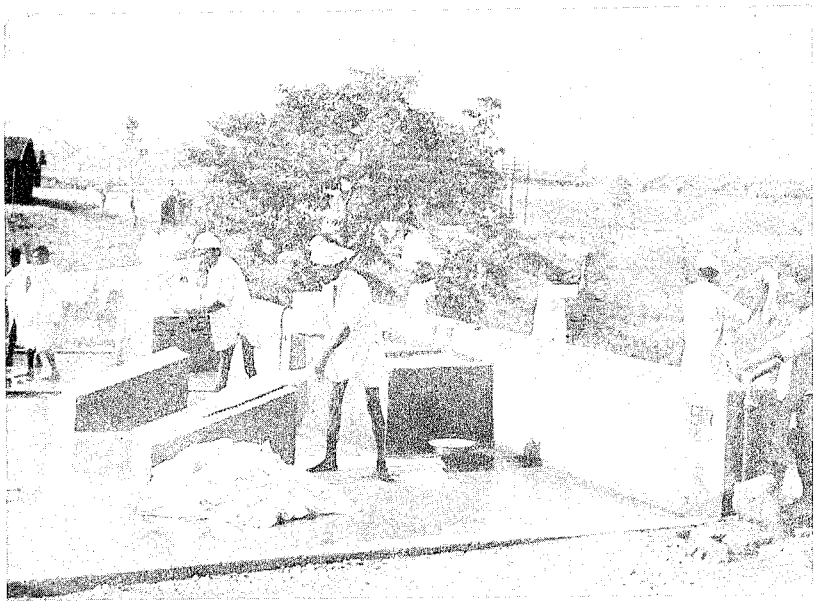


FIGURE 38.—Indian laundry workers, 371st Station Hospital, Rāmgarh, India, 28 February 1945.

construction personnel and corpsmen were sometimes used to build and work in Army hospitals.[24]

In the Central Pacific, the number of civilians employed by the Medical Department remained relatively constant throughout the war, totaling 526 in December 1941 and 464 in August 1945. The peak of employment was reached with 656 in June 1942. Apparently, a large proportion of civilian Medical Department personnel in this area was located at old Tripler General Hospital or the 218th General Hospital as it was later known. This, the largest hospital in the Hawaiian Islands, was authorized to employ as many as 168 civilian employees (including several with strictly medical duties) in 1942.

China-Burma-India theater

The China-Burma-India theater was probably the region with the most acute shortage of medical personnel, a shortage caused in part by its responsibility for the care of Chinese Army personnel, and it seems likely that most Medical Department units in that theater used natives for common labor (fig. 38).

The 20th General Hospital in 1944 (at Margherita, Assam, India) employed 120 natives in the mess department and 100 more for general mainte-

[24] Two exceptions may be noted: Some native labor was used in construction of the 222d Station Hospital on Banika Island in the Russells, and native labor was used to clear ground preparatory to the actual construction work on the 48th Station Hospital at Guadalcanal.

nance. When the 18th General Hospital shifted from Assam to Burma in 1945, it took 165 civilians with it. Only 125 of these were actually employed by the hospital, however, since 40 were used as "aiyahs" and "personal bearers." In 1943, the 95th Station Hospital at Ch'ung-ch'ing, China, employed 15 Chinese nurses in lieu of its American nurse contingent, Army nurses having been excluded from China on General Stilwell's orders. In its first year of operation (1942), the 159th Station Hospital at Karachi, India, hired 100 native laborers. From 100 to 500 laborers were engaged in various malaria control projects in the Calcutta area in early 1943. In Burma, native litter bearers were used. During 1944, the number of civilian personnel used by the Medical Department in the China-Burma-India area was, at the lowest, equal to 10 percent of the strength of the military elements of the Department in that area.

Africa-Middle East theater

In the Africa-Middle East theater, native employees, used primarily in malaria control and waste disposal and other sanitary activities, were hired in considerable numbers. In 1943, there were over 100 employed at the 67th Station Hospital in Accra, and at Roberts Field, Liberia, the employment of over 1,800 natives at all times during 1944—a number considerably greater than the entire Medical Department military personnel in the Africa-Middle East area—was estimated to have saved the labor of 800 to 1,000 troops. Natives were used in malaria control operations in the Persian Gulf Command. Civilians were also employed there in hospital work, and the number in relation to that of military medical personnel in the Command was considerable (table 20).

TABLE 20.—*Ratio of civilian hospital workers to military medical personnel, Persian Gulf Command, 30 April 1943–31 July 1945*

Date	Civilian hospital workers [1]	Military medical personnel [2]	Ratio of hospital workers to military medical personnel (percent)
1943			
30 April	197	1, 812	10. 9
31 December	419	3, 067	13. 7
1944			
31 August	703	2, 017	34. 9
31 December	421	1, 980	21. 3
1945			
31 July	64	496	12. 9

[1] From table 13, "Distribution of U.S. Army civilian employees in the Persian Corridor, 1943–45," *in* Motter, T. H. Vail: The Persian Corridor and Aid to Russia. United States Army in World War II. The Middle East Theater. Washington: U.S. Government Printing Office, 1952, p. 500.

[2] From unadjusted data in table 31 for dates shown therein and from pertinent issues of "Strength of the Army" for other dates.

North African-Mediterranean theater

In the North African-Mediterranean and the European theaters, possibly because operating conditions were more uniform than in other areas, various hospitals of like type tended to engage more equal numbers of civilian employees than did similar hospitals elswhere. Even so, variations in numbers of civilian personnel utilized by like medical units in both theaters existed. The number of French and Arab civilians utilized by Army hospitals in North Africa and the number of Italian civilians used by such hospitals in Italy depended very largely on the availability of Italian service troops, since the latter, after the organization of Italian service units in late 1943, were almost universally preferred to the civilians. For a general hospital not using Italian troops, the average number of civilians employed in the North African theater was probably from 150 to 200, although as many as 275 were used on occasion. The normal civilian complement for an evacuation hospital in similar circumstances was about 50, but at times well over 100 civilian workers were employed.

Available statistics do not justify generalizations about the number of civilians normally employed in station and convalescent hospitals and in malaria control and other Medical Department units.[25] However, if the average number of personnel, not including U.S. troops, that were used in Medical Department installations at the end of the war be taken as a criterion of the strength of civilian employment prior to the use of Italian service personnel, it is likely that as many as 4,000 civilians were employed in the Medical Department in the North African theater about the time of the invasion of Italy (table 21). This was equal to 7 percent of the strength of the Medical Department elements in the theater on 31 October 1943.

European theater

The high educational level of the civilian population in Europe, as compared with that of peoples in other parts of the world, meant that it was possible to utilize European indigenous labor in a wider variety of occupations than elsewhere and to place greater reliance upon their ability to perform relatively unskilled tasks. This partly explains why the number of civilians employed by the Medical Department was greater in the European theater than in any other oversea area. Shortly after V–E Day, the number of civilians so employed in medical installations of the communications zone alone exceeded 20,000 (table 22). However, the fact that the Army overseas had its greatest strength in that theater, helped to produce the same result. Indeed, the number of civilians employed in the communications zone Medical Depart-

[25] Station and convalescent hospitals and malaria control units in the North African theater employed civilians, but statistics of the number used are available only in isolated instances. The 7th Station Hospital at Oran at one time employed 80 French civilians, and an unspecified number of civilians were used in malaria control work.

TABLE 21.—*Utilization of civilian workers and Italian prisoners of war, by Medical Department service-type units, Mediterranean theater, 1 May 1945*

Type of unit [1]	Number in theater	Civilian workers		Italian prisoners of war	
		Number	Average per unit	Number	Average per unit
General hospital:					
2,000-bed	2	----	0	204	102
1,500-bed	9	119	13. 2	815	90. 5
Station hospital:					
750-bed	1	----	0	33	33
500-bed	17	219	12. 8	1, 423	83. 7
250-bed	2	----	0	223	111. 5
150-bed	1	----	0	35	35
Malaria survey detachment	1	----	0	170	170
Malaria control detachment	10	25	2. 5	1, 707	170. 7
Medical base depot company	4	20	5	224	56
Medical general dispensary	2	16	8	----	0
Medical general laboratory	1	----	0	65	65
Medical service battalion	1	10	10	112	112

[1] One medical laboratory, 6 prophylactic platoons, 13 veterinary food inspection detachments, 2 veterinary evacuation detachments, and 1 hospital train used no local labor.

Source: "Digest of Principal Type Service Units Utilized in MTO," compiled by G–4 Section, Mediterranean Theater of Operations, U.S. Army; revised November 1945, pp. 8–12.

ment activities around V–E Day was equivalent to about 5 percent of the number of troops utilized in the entire medical service of the theater, and while civilians also were used in the combat zone, they probably did not raise this percentage by a very great amount.[26] Thus, it appears that in relation to the military strength of the Medical Department in the European theater the number of civilians employed by that branch of the Army was less than it was in many other places.

Since labor was scarce in Great Britain and strictly rationed by the British authorities, an Army hospital there usually employed no more than from 20 to 30 civilians. On the Continent, an entirely different situation prevailed. General hospitals in France at times had from 600 to 700 civilians in their employ, although the average may have been somewhat lower. In April 1945, the 11 general and 3 station hospitals of the Seine Section had a total of 7,513 civilian employees, an average of 609.9 per general and 268.0 per station hospital; and in May 1945, the 203d General Hospital established what was probably an oversea record with 1,248 civilian employees. When they were not using German prisoners of war instead, most evacuation hospitals in the European theater employed from 60 to 80 civilians, although as many as 120

[26] Letter, Brig. Gen. Alvin L. Gorby, to Col. C. H. Goddard, Office of The Surgeon General, 30 July 1952.

TABLE 22.—*Medical Department civilian labor, Communications Zone, European theater (exclusive of headquarters), June-December 1945*

Type	15 June 1945	15 July 1945	15 August 1945	15 September 1945	15 October 1945	15 November 1945	15 December 1945
General (all branches of Army):							
Number	171, 477	156, 025	154, 787	131, 818	101, 452	89, 151	81, 729
Mobile: [1]							
Number	38, 908	31, 587	24, 281	21, 887	14, 677	11, 330	12, 212
Percentage of general	22. 7	20. 2	15. 7	16. 6	14. 5	12. 7	14. 9
Static: [2]							
Number	132, 569	124, 438	130, 506	109, 931	86, 775	77, 821	69, 517
Percentage of general	77. 3	79. 8	84. 3	83. 4	85. 5	87. 3	85. 1
Clerical: [3]							
Number	15, 009	15, 323	15. 882	15, 463	13, 545	13, 180	12, 750
Percentage of general	8. 8	9. 8	10. 3	11. 7	13. 4	14. 8	15. 6
Male:							
Number	6, 419	6, 816	7, 503	7, 581	6, 548	6, 379	6, 236
Percentage of clerical	42. 8	44. 5	47. 2	49. 0	48. 3	48. 4	48. 9
Female:							
Number	8, 592	8, 507	8, 379	7, 882	6, 997	6, 801	6, 514
Nonclerical:							
Number	117, 558	109, 115	114, 624	94, 468	73, 230	64, 641	56, 767
Percentage of general	68. 6	69. 9	74. 1	71. 7	72. 2	72. 5	69. 5
Medical Department:							
Number	20, 099	15, 418	12, 133	10, 220	7, 223	5, 083	3, 650
Percentage of general	11. 7	9. 9	7. 8	7. 8	7. 1	5. 7	4. 5
Mobile: [1]							
Number	3, 086	2, 170	2, 356	2, 947	1, 051	707	559
Percentage of Medical Department civilian labor	15. 4	14. 1	19. 4	28. 8	14. 6	13. 9	15. 3
Percentage of general mobile	7. 9	6. 9	9. 7	13. 5	7. 2	6. 2	4. 6

Static: [2]							
Number	17,013	13,248	9,777	7,273	6,172	4,376	3,091
Percentage of Medical Department civilian labor	84.6	85.9	80.6	71.2	85.4	86.1	84.7
Percentage of general static	12.8	10.6	7.5	6.6	7.1	5.6	4.4
Clerical: [3]							
Number	963	757	573	519	412	344	341
Percentage of Medical Department civilian static	4.8	4.9	4.7	5.1	5.7	6.8	9.3
Percentage of general static clerical	6.4	4.9	3.6	3.4	3.0	2.6	2.7
Male:							
Number	329	231	199	171	139	91	93
Percentage of Medical Department clerical	34.2	30.5	34.7	32.9	33.7	26.5	27.3
Percentage of general static male clerical	5.1	3.4	2.7	2.3	2.1	1.4	1.5
Female:							
Number	634	526	374	348	273	253	248
Percentage of general static female clerical	7.4	6.2	4.5	4.4	3.9	3.7	3.8
Nonclerical:							
Number	16,050	12,491	9,204	6,754	5,760	4,032	2,750
Percentage of Medical Department civilian labor	79.9	81.0	75.9	66.1	79.7	79.3	75.3
Percentage of general static nonclerical	13.7	11.4	8.0	7.1	7.9	6.2	4.8

[1] Employees working from day to day in whatever locality their services were required. Includes all civilians, other than German nationals, employed in Germany.

[2] Employees residing in the locality of their employment.

[3] Office workers, including clerical and administrative personnel such as clerks, typists, stenographers, and accountants. These are not necessarily the total of such workers since there also may have been office workers among the mobile employees.

Source: (1) Progress Report, Communications Zone, U.S. Army Forces, European Theater, for months shown. (2) Circular No. 72, Headquarters, Communications Zone, European Theater of Operations, U.S. Army, 22 May 1945.

69307°—53——19

were "profitably" employed in one instance. In the medical units of the Continental Advance Section, European theater, in February 1945, civilian labor reached a peak of 1,770 workers against an enlisted strength of 7,871, or 1 civilian for every 4.4 enlisted men.

As late as June 1945, the United Kingdom employed 8.9 percent of the total communications zone Medical Department civilian employees while it had only 5.3 percent of communications zone employees in general. Indeed, while the two ratios tended to approach each other, this situation was in existence even at the end of August 1945 (table 23).

TABLE 23.—*Geographic distribution of medical personnel, European Theater of Operations, Communications Zone,[1] April 1945 to October 1945, inclusive[2]*

Group	1945					
	April [3]	May [3]	June	July	August	October
Total manpower:						
General (all branches of the Army):						
Total	1,076,445	1,185,957	1,130,948	1,134,845	1,142,590	947,520
United Kingdom:						
Number	114,729	105,644	103,414	88,542	80,226	49,281
Percent of general manpower			9.1	7.8	7.0	5.2
Medical Department:						
Total	183,632	196,426	191,762	142,892	116,732	89,887
United Kingdom:						
Number	60,550	59,247	50,595	35,019	28,173	12,135
Percent of Medical Department manpower			26.4	24.5	24.1	13.5
Total troops:						
General (all branches of the Army):						
Total	569,635	571,284	522,211	497,162	491,437	458,581
Percent of total general manpower			46.1	43.8	43.0	48.3
United Kingdom:						
Number	93,479	80,989	70,657	57,925	51,349	30,778
Percent of total troops	16.4	14.2	13.5	11.7	10.4	6.7
Medical Department:						
Total	125,868	123,338	114,228	86,393	68,379	58,621
Percent of total Medical Department manpower			59.5	60.4	58.5	65.2
United Kingdom:						
Number	54,674	50,846	41,292	29,898	23,371	10,305
Percent of Medical Department troops	43.4	41.2	36.1	34.6	34.2	17.6

See footnotes at end of table.

TABLE 23.—*Geographic distribution of medical personnel, European Theater of Operations, Communications Zone,[1] April 1945 to October 1945, inclusive*[2]—Continued

Group	1945					
	April [3]	May [3]	June	July	August	October
Total prisoners of war working:						
General (all branches of the Army):						
Total	263, 318	351, 968	400, 518	454, 625	463, 577	387, 487
Percent of total general manpower			35. 4	40. 0	40. 5	40. 8
United Kingdom:						
Number	20, 755	24, 905	25, 222	23, 501	23, 390	15, 666
Percent of total prisoners of war working	7. 8	7. 1	6. 3	5. 2	5. 0	4. 0
Medical Department:						
Total	39, 064	54, 782	53, 882	39, 325	33, 966	24, 043
Percent of total Medical Department manpower			28. 0	27. 5	29. 0	26. 7
United Kingdom:						
Number	5, 876	8, 401	7, 518	3, 857	4, 140	1, 549
Percent of total Medical Department prisoners of war working	15. 0	15. 3	14. 0	9. 8	12. 2	6. 4
Total Italian service unit personnel:						
General (all branches of the Army):						
Total	37, 776	38, 712	39, 976	34, 291	32, 789	0
Percent of total general manpower			3. 5	3. 0	2. 8	0
United Kingdom:						
Number	0	0	0	0	0	0
Percent of total Italian service unit personnel	0	0	0	0	0	0
Medical Department:						
Total	3, 436	2, 919	3, 559	2, 095	2, 254	0
Percent of total Medical Department manpower			1. 8	1. 4	1. 9	0
United Kingdom:						
Number	0	0	0	0	0	0
Percent of total Medical Department Italian service unit personnel	0	0	0	0	0	0

See footnotes at end of table.

TABLE 23.—*Geographic distribution of medical personnel, European Theater of Operations, Communications Zone,[1] April 1945 to October 1945, inclusive*[2]—Continued

Group	1945					
	April [3]	May [3]	June	July	August	October
Total civilian workers: [4]						
General (all branches of the Army):						
Total	20, 516	223, 993	168, 243	148, 767	154, 787	101, 452
Percent of total general manpower			14. 8	13. 1	13. 5	10. 7
United Kingdom:						
Number			7, 535	7, 116	5, 487	2, 846
Percent of total civilian workers			4. 5	4. 8	3. 5	2. 8
Medical Department:						
Total	15, 264	15, 387	20, 093	15, 079	12, 133	7, 223
Percent of total Medical Department manpower			10. 4	10. 5	10. 3	8. 0
United Kingdom:						
Number			1, 785	1, 264	662	281
Percent of Medical Department civilian workers			8. 9	8. 4	5. 5	3. 9

[1] All strengths from Progress Report, Communications Zone, European Theater of Operations, U.S. Army, for corresponding months. General and Medical Department data exclude headquarters personnel.

[2] September has been omitted as a result of numerous errors in the corresponding issue of the Progress Report.

[3] All data exclusive of civilian workers in the United Kingdom.

[4] Does not include U.S. civilians or British civilians employed on the Continent.

In 1944 in the South Atlantic, the Medical Department had a daily average of 150 employees, used mostly in malaria control work, which was greater than one-fourth of the average military strength (534) of the Department in the theater for the year. In the Caribbean Defense Command, the peak civilian-employment totals in 1943 and 1944 included 10 civilians in the Office of the Surgeon, Antilles Department, and approximately 270 workers engaged in malaria control duties in the Panama Canal Department. These alone, without considering hospital workers and sanitation workers in areas outside the Panama Canal Department, were equal to about 6 percent of the mean Medical Department military strength in the Caribbean during 1944 (4,425).[27]

[27] Mean strengths are the average of the adjusted strength on 31 January, 30 April, 31 July, and 31 October 1944, and 31 January 1945 as shown in table 31.

CHAPTER IX

Classification

OFFICERS AND NURSES, 1939–41

Proper classification, in the Army as elsewhere, is a major factor in proper utilization of available resources. This is particularly true where the resources concerned are highly trained individuals whose total number is strictly limited. It was clearly recognized by The Surgeon General that, while the Medical Department must be prepared at all times to carry out its military mission, the members of the various corps must also keep abreast of civilian professional developments. The emphasis shifted between military preparedness and professional accomplishment in terms of the current mission of the Army as a whole.

Background of the Classification System

During World War I, while the Medical Department utilized professional consultants, little if any official classification of its officers took place. Between the two World Wars, specialization developed greatly in many civilian occupations and professions. The years in the 1930's were especially important to the medical profession in the various fields of specialization. In 1935, the first American specialty board, the American Board of Ophthalmology, was organized, followed by many others in the next few years. The Surgeon General kept in close contact with civilian medicine, and a count of Regular Army medical officers qualified as specialists shows that their number in 1938, on an overall percentage basis, was not seriously at variance with that of the civilian specialists. The distribution did, however, reflect the difference in needs in the various categories between civilian and military medical practice. Of all the members of the Medical Corps, 6.71 percent were diplomates of specialty boards, as against 8 percent of all physicians in the country.[1] Nevertheless, specialization in the peacetime Medical Department was restricted by the limited number of personnel available to perform all the necessary tasks, and by the constant awareness that in a national emergency involving a general mobilization the officers of the Regular Army would be the nucleus on which the enlarged forces would be built. The role of leadership that would under emergency or war conditions fall to the officers of the Regular Army Medical

[1] (1) Kubie, L. S.: The Role of the Specialist in Military Medicine. Surg. Gynec. & Obst. 80: 109–110, January 1945. (2) Kubie, L. S.: Problem of Specialization in Medical Services of Regular Army and Navy Prior to the Present Emergency. Bull. New York Acad. Med. 20: 495–511, September 1944. (3) Correspondence: Letter, Maj. Gen. George F. Lull, USA, Deputy Surgeon General, to Editor. Surg. Gynec. & Obst. 80: 448, April 1945.

Department also required that these officers be thoroughly versed in military subjects, such as command, tactics, logistics, and medical administration.

Although the pressure to do so was not great, the Medical Department between World War I and 1939 made constant but ineffective efforts to classify its Reserve officers professionally. On the Army-wide level, the Mobilization Regulations of September 1939 required that assignments which individuals would occupy during mobilization should be designated beforehand, and could be based not only on the qualifications of the individual but also on the requirements of the situation. By that date, neither the Medical Department nor the War Department General Staff had worked out a comprehensive and detailed system of classifying officers.

Classification of Reserve Officers, 1940

In 1940, however, the War Department ordered a classification of Reserve officers. Under this plan, all Reserve officers of the Army were required to fill out information forms (W.D., A.G.O. Form No. 178), supplementary information being required from Reserve officers of the Medical Department. These forms were reviewed in corps area headquarters and in the Office of The Surgeon General.[2]

Establishment of position categories

The Surgeon General established a set of position categories for Medical Corps officers, necessarily the first element in a system of classification for any group. It distinguished various types of positions and also four degrees of proficiency within each. A symbol was provided for each type of position and capacity, and the appropriate symbol could be entered in the individual's records as a guide to assigning him. Thus "S–3" stood for a general surgeon in the third degree of capacity, fourth being the lowest; "S (Ortho)–1" stood for an orthopedic surgeon in the highest grade, and so forth, the degree originally based on civilian credentials, education, and length of experience in his field. After he had been tested by performance in the Army, his classification could be changed, if necessary,[3] although this kind of change was made more commonly in the later war period than earlier.

Work of civilian agencies

Various agencies throughout the country assisted the Medical Department in classifying the Medical Reserve officers. Soon after this work was undertaken in 1940, the American Medical Association, through its Committee on Medical Preparedness, began its survey and classification of all physicians

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

[3] An officer's classification was different from his efficiency rating. The latter was a grade—"superior," "excellent," "satisfactory," "unsatisfactory"—assigned at intervals to an individual by his commanding officer and denoting his general value to the service.

throughout the United States. This project supplied much information on specialty training and type of practice to The Surgeon General.[4] But final classification could not be made from this information alone. Committees of the National Research Council began cooperating on this project with the American Medical Association as early as July 1940. The general plan was for these committees to send lists of specialists to the American Medical Association, where its committee would record additional information obtained from its survey or from other sources. Some of the lists submitted by the National Research Council were graded to show a man's proficiency within his specialty. The National Research Council sent duplicates of some lists to The Surgeon General, thus aiding him directly to evaluate members of the Reserve and National Guard, then coming on active duty.[5]

The system developed by committees of the National Research Council, for designating the proficiency of men in a specialty—assigning them a number from 1 to 4—was the first one adopted by the Medical Department.[6]

The National Roster of Scientific and Specialized Personnel, established in June 1940, also rendered assistance. The primary function of this agency was "to provide for the most effective utilization of * * * scientifically and professionally trained citizens * * * ."[7] Because the American Medical Association was developing its own lists of physicians, the National Roster during the early part of its existence undertook to list only the smaller groups of specialists, such as bacteriologists, immunologists, pathologists, anatomists, physiological chemists, psychologists, physiologists, zoologists, and entomologists.[8] Colleges of medicine and specialty boards also cooperated in this effort, contributing whatever information they possessed. Of course, those charged with classifying officers used, in addition to other information, directories of physicians, such as those of the American Medical Association, the American College of Physicians, the American College of Surgeons, and the directory of medical specialists certified by American specialty boards.[9] In the early phases of the work of classifying officers, The Adjutant General's Office gave little assistance, and the systems it devised seem to have been none too effective.[10]

---

[4] Letter, The Surgeon General, to Dr. R. G. Leland, Committee on Medical Preparedness, American Medical Association, Chicago, Ill., 22 Jan. 1941.

[5] (1) Minutes, Meeting of Subcommittee on Cardiovascular Diseases, 23 July 1940, Division of Medical Sciences, National Research Council. (2) Minutes, Eighth Meeting of Subcommittee on Venereal Diseases, 20 Sept. 1945, Division of Medical Sciences, National Research Council.

[6] (1) Farrell, Malcolm J., and Berlien, Ivan C.: Neuropsychiatry, Personnel. [Official record.] (2) Special Meeting of Personnel Group, 16 Dec. 1940, Division of Medical Sciences, National Research Council. (3) Minutes, Meeting of Subcommittee on Tuberculosis, 23 Dec. 1940, Division of Medical Sciences, National Research Council.

[7] Carmichael, L.: The National Roster of Scientific and Specialized Personnel. Scient. Month. 58: 141, February 1944.

[8] (1) Mordecai, Alfred: A History of the Procurement and Assignment Service for Physicians, Dentists, Veterinarians, Sanitary Engineers, and Nurses—War Manpower Commission. (2) See footnote 6(2).

[9] Letter, Office of The Surgeon General (Col. C. C. Hillman), to Surgeon, each Corps Area, 10 Apr. 1941.

[10] Davenport, Roy K., and Kampshroer, Felix: Personnel Utilization: Selection, Classification, and Assignment of Military Personnel in the Army of the United States During World War II. [Manuscript.]

The work of classifying Reserve Medical Corps officers had only been initiated when mobilization began, but was completed by Pearl Harbor. This classification constituted a long step forward in providing the Medical Department with knowledge of its qualitative resources in the Reserve sections.[11] Being the first real attempt to classify Medical Department officers, it served as the basis of the more intensive procedures developed during the war. Had this classification been completed before mobilization began, the Medical Department would have been in a much more advantageous position to make studies and satisfactory assignments. It is true that formal classification as a guide to filling jobs was less necessary when the number of persons and the number of places for them were small, as had been true before the great expansion of the Medical Department began. Officers responsible for making job assignments could be personally familiar with the attainments of each member of the group and assign him accordingly. Many assignments even in the early war years continued to be made on the basis of this kind of personal knowledge. Formal classification could not, of course, eliminate all or perhaps even most of the work in making assignments, for no system of classification—at least none that was devised—could take account of all variations in jobs (even of the same category) or in the personal qualifications of individuals. Nevertheless, formal classification became practically indispensable at least as a preliminary sifting when large numbers of personnel had to be dealt with.

OFFICERS AND NURSES, 1941–43

Although The Surgeon General had established a system of position categories for Medical Corps officers during the emergency period, no system of categories covering all types of positions to which officers of the Army at large were assigned appeared until 1943. In that year, The Adjutant General published such a comprehensive series, which included medical categories developed and tested by the Military Personnel Division of the Surgeon General's Office. Those mainly responsible for it were Lt. Col. Gerald H. Teasley, MC, and 1st Lt. (later Lt. Col.) Robert W. W. Evans, MC. This classification system, which served throughout the war, was first presented in January 1943 as Army Regulations No. 605–95 (Tentative). Volume I of the regulations was entitled "Officer Civilian Classification," and volume II, "Officer Military Classification and Job Specifications." Volume II is the more important to this discussion. Some months after its publication, the Surgeon General's Office was called upon to furnish additional information. This was incorporated in War Department Technical Manual 12–406, "Officer Classification, Commissioned and Warrant," which appeared in October 1943 and superseded the tentative regulation. The latter listed a code number, an MOS (military occupational specialty), and a job specification for nearly 700 Army

[11] Letter, Lt. Col. Francis M. Fitts, MC, Military Personnel Division, Office of The Surgeon General, to Maj. Gen. C. R. Reynolds, formerly The Surgeon General, 25 June 1941.

jobs. The job specifications consisted of a summary statement of duties, a list of typical tasks, special skill and knowledge requirements, military and civilian occupational experience prerequisites, educational prerequisites, and the civilian jobs whose occupants would be most likely to meet the requirements of the military.

Establishment of the Code Number System

The tentative regulations (and also its successor, the technical manual), in its listing of job categories for Medical Corps officers, followed that already in use in the Medical Department, except that it substituted numerical symbols for the symbols previously used and fitted them into a series of job categories for all officers of the Army. Each numerical symbol or code number consisted of four digits, the first digit (0 to 9), indicating a major grouping. The major grouping for most types of medical jobs was that relating to health, distinguished by the figure "3." The second digit represented a subgroup while the third and fourth digits stood for a specialty within that subgroup. Thus, an orthopedic surgeon, instead of having the symbol "S (Ortho)," now had the code number 3153. Moreover, in designating degrees of capacity or proficiency within each job category, the letter A, B, C, or D was used instead of 1, 2, 3, or 4, and "S (Ortho)–1" became A–3153. Dietitians and physical therapy aides were listed in the technical manual but not in the earlier regulations, which was issued only a month after they achieved military status.

In April 1943, it was proposed that after the following 5 May Army officers should be requested by code number, but as Medical Department personnel had not yet been coded, they were not included in the proposal.[12] Apparently, The Surgeon General found the changeover to the numbered coding system quite time consuming, for not until 1944 did that system supplant the lettered code.

Since the categories listed in the regulations and the technical manual did not include every type of position separately, the more difficult aspect in the whole process of classifying officers was choosing men for an unlisted category. The classifier would then have to consult the whole record of each of a number of officers and decide which of them fitted the need. There could be no automatic or pushbutton system of classifying officers; individual judgment played an indispensable part in the process.

Role of the Surgeon General's Office

In the Medical Department, the Surgeon General's Office continued to do much of the work of classification, and as early as March 1942, there was a Classification Branch in that office. For a time, however, it appears to have lost its identity and to have been reestablished under that name in

[12] Report of conference called by Military Personnel, Army Service Forces, signed by Lt. Col. Gerald H. Teasley, MC, Military Personnel Division, Office of The Surgeon General, 23 Apr. 1943.

March 1943. At the latter date, this branch not only classified officers of the Medical Corps but recommended their original assignments, searched for misassignments, and recommended changes. It kept a body of records containing an enormous amount of information on which to base its classifications and its recommendations for assignments—surveys of the ability and assignments as well as records of the special schools officers had attended and of their attainments in foreign languages.[13] Classification of officers other than members of the Medical Corps—and little of this took place during the early war years—was done not in the Classification Branch but in other segments of The Surgeon General's Military Personnel Division.

Role of the Field Commands

Classification was performed not only in the Surgeon General's Office but, at least during 1942, in corps area (service command) and Army headquarters as well. Since many Medical Department officers reported directly to these headquarters from civilian life, which meant that they had received no classification of any kind, it was necessary to classify them on the basis of data given on questionnaires and whatever additional information could be obtained about them.[14] Although such methods were necessary in order that the officers be given assignments, unfortunately they did not always tend to promote the kind of uniformity The Surgeon General desired.

After the consultant system was established in 1942, some of the tasks of these specialists concerned the proper classification and grading of personnel. As used by the Medical Department, the word "consultant" applied not merely to specialists who acted as advisers only, but to those who, as in this case, had administrative functions. In early 1942, The Surgeon General brought to his Office from civilian life a consultant in surgery and one in medicine and, later in that year, one in neuropsychiatry. As the Office organization grew in size and complexity, other specialists were assigned to handle subspecialties. In the summer of 1942, a beginning was made in supplying a consultant in each of the three aforementioned specialties to each service command. All these men assisted, through their knowledge of specialists in their fields and through their training and accomplishments, in the proper classification of medical specialists. Those in the Surgeon General's Office not only aided in initial grading but in reviewing and revising the classification of officers after they had had an opportunity to demonstrate proficiency in a specified field while on duty with the Army. Those in the service commands traveled to hospitals, induction stations, and other installations where, by interview and inspection of the specialist's work,

[13] Annual Report, Classification Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1944.

[14] (1) Annual Report, Surgeon, Third U.S. Army, 1942. (2) Committee to Study the Medical Department, 1942.

they were able to make more accurate judgments of ability than those who had only the records.

Classification Within the Air Forces

The Army Air Forces used similar measures to assure that a physician was properly classified according to his qualifications. The Chief of the Medical Branch and the Chief of the Section on Professional Care of Air Forces hospitals testified before the Committee to Study the Medical Department of the Army that they not only classified officers initially but also made investigations at Air Forces hospitals and in a man's civilian locality. The former stated that he had "somebody traveling all the time checking this thing."

The sources of information made use of by Medical Department classifiers at this period were much the same as those that had been available to them since 1940—the forms filled out by individual officers and data furnished by the American Medical Association, the Division of Medical Sciences of the National Research Council, the Procurement and Assignment Service, and the American specialty boards. The source that yielded more data than any other was W.D., A.G.O. Form No. 178–2, "Classification Questionnaire of Medical Department Officers," published on 1 August 1943. This was a revision of W.D., A.G.O. Form No. 178, published in 1940 when the War Department had begun to classify Reserve officers.

In helping the Medical Department to classify medical specialists, particularly as to the proper proficiency groups, the American specialty boards performed very useful work. They sent to The Surgeon General (or to his liaison officer, located at the headquarters of the American Medical Association) the names of men who had recently passed their examinations and had been certified by the boards as competent specialists. Sometimes, they indicated the proficiency grade they believed fitting for these men, together with information on whether they were in service, whether they were Reserve officers not yet called to active duty, or, if not committed to Army service, whether they were willing or unwilling to accept military duty.[15] Thus, they helped incidentally to procure officers as well as to classify them.

In early 1942, at the suggestion of The Surgeon General, the "Directory of Medical Specialists" established a "control file," which listed about 10,000 names of uncertified applicants to the American specialty boards, men who had done varying amounts of work toward board certification. (These names were in addition to the 18,000 physicians already certified by American specialty boards

[15] (1) Letter, Secretary-Treasurer, American Board of Otolaryngology, Omaha, Nebr., to The Surgeon General, 13 June 1942. (2) Letter, Secretary-Treasurer, American Board of Radiology, Rochester, Minn., to Col. G. F. Lull, MC, Office of The Surgeon General, 23 June 1942. (3) Memorandum, Surgeon General's Liaison Officer, American Medical Association, for The Surgeon General, 28 July 1942, subject: List of Recommendations of the American Gastro-Enterological Association. (4) Letter, American Proctologic Society, to The Surgeon General, 17 Dec. 1942.

who were listed in the "Directory of Medical Specialists.") The names in the central file were listed as "cleared" and "not cleared." The "cleared" group consisted of men whose training and other qualifications met board standards and requirements for admission to their examinations, but who had not yet gained certification. The "not cleared" group consisted of men who had done work in a specialty but who had not yet been accepted for examination, those who had had failures requiring complete reapplication for the examination, and those whose certification had been revoked. A set of name cards from this file was made available to The Surgeon General. He could also ask the appropriate specialty board for additional information on any man listed.[16] As changes were made in the list of those physicians "cleared" or "not cleared" the directing editor of the "Directory of Medical Specialists" made the changes known to The Surgeon General.

The cited sources of information for classifiers applied mostly to data on physicians. Apparently, during the early part of the war, the organizations of dentists and veterinarians furnished information as to specialists in these professions,[17] but methodical and painstaking efforts by the Medical Department to classify any officers other than members of the Medical Corps came only later in the war.

MALE AND FEMALE OFFICERS, 1943–45

Classification Measures

Throughout the war years, even though considerable emphasis had been placed by the Army Service Forces upon decentralization generally, an attempt was made to centralize more of the process of classification of medical officers in the Office of The Surgeon General. The effort to bring officer classifications up to date and, for that purpose, to assemble current information on their qualifications appeared in communications from the Surgeon General's Office and other agencies in the latter part of 1943 and afterward. A large part of this effort was directed toward revising the "proficiency" ratings of Medical Corps officers, which were more apt to be incorrect than placement of these officers in the larger categories of specialization. It was probably with the "proficiency" record in mind that The Surgeon General, in a letter to service command surgeons referring to changes in initial classification ratings of Medical Corps officers made by his office, advocated revising these ratings whenever competent professional observers found that the performance of officers, or their ability to perform, was not reflected in their ratings.[18]

---

[16] Letter, Directing Editor (Dr. Paul A. Titus), Board of Directory of Medical Specialists, 1942 issue, to Lt. Col. F. M. Fitts, MC, Office of The Surgeon General, 24 Apr. 1942, subject: Applicants for Certification by American Boards.

[17] Military Preparedness. J.A.M.A. 118: 634, 21 Feb. 1942.

[18] Letter, The Surgeon General, to Commanding General, First Service Command, attention Service Command Surgeon, 21 July 1944, subject: Classification of Medical Corps Officers.

At the end of 1944, The Surgeon General was able to induce higher War Department authority to order an annual review of all Medical Corps officer classifications.[19] Commanders overseas as well as in the Zone of Interior were directed to finish the first review by 31 March 1945 and forward the results to The Surgeon General. A fairly complete classification of all Medical Corps officers based on the latest available information was completed by the end of June 1945.[20] The war ended, however, before any more such reviews could fall due.

Questionnaires

Officers themselves furnished data for classifications in the form of answers to the classification questionnaire (W.D., A.G.O. Form No. 178–2), whose form was revised twice during the war—in August 1943 and January 1944. In November 1943, The Surgeon General advised the service command surgeons to have all medical, dental, and veterinary officers complete classification forms. The next month, a War Department circular required officers of these corps returning from duty overseas to do the same.[21] Some months later, Army Service Forces headquarters supplemented this directive by ordering all its officers who had not filled out questionnaires in the past to do so now; the order was intended to apply to officers returning from duty overseas, graduates of officer candidate schools, officers newly assigned to Army Service Forces from other commands, and officers newly commissioned from civilian life or from the enlisted ranks.[22]

Instructions of The Surgeon General

Aside from answers to questionnaires and reports from professional observers, there were other sources of information which The Surgeon General reminded the service commands to employ as a basis for classification. In his letter of 22 November 1943, he requested the service command surgeons to "establish a procedure by which information can be obtained from the professional consultants, the commanding officers of hospitals, and other available sources concerning the ability of Medical Department officers." This and "other pertinent information" should be "maintained on personnel records in the Office of the Service Command Surgeon." The medical officer responsible for classifying and assigning Medical Department personnel should be encouraged to obtain firsthand information by visiting the installations where such persons were assigned.

---

[19] War Department Circular No. 460, 5 Dec. 1944.

[20] Letter, Brig. Gen. Harold C. Lueth, USAR, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 10 Mar. 1956, with enclosure thereto.

[21] (1) Letter, Office of The Surgeon General (Maj. Gen. G. F. Lull, Deputy Surgeon General), to Commanding General, Second Service Command, attention: Service Command Surgeon, 22 Nov. 1943, subject: Classification and Assignment of Medical Corps Officers. (2) War Department Circular No. 33, 24 Dec. 1943.

[22] Army Service Forces Circular No. 212, 8 July 1944.

How information from these sources should be produced and evaluated so as to permit a reestimate of a Medical Corps officer's rating was described in a letter from The Surgeon General to service command surgeons on 21 July 1944. The original recommendations for changes in officers' ratings could come either from their commanders, who should be encouraged to submit such proposals, or from the appropriate professional consultants, who should be instructed to make recommendations in the course of their inspections. The consultants should screen and evaluate the recommendations made by officers' commanders. Their judgment should be based not only on the record of an officer's formal training and experience but on an appraisal of his capability. The Surgeon General's Office would furnish each service command a list of the Medical Corps officers assigned to it and their current ratings. The service command consultants were to return the list, marked with the changes in ratings they recommended. The Surgeon General would then take final action.[23]

Role of the Classification Branch

In November 1943, The Surgeon General informed the service commands that his Classification Branch would classify all the medical, dental, and veterinary officers who were ordered to fill out questionnaires at that time. The War Department circular of December 1943, which required answers to the classification questionnaire from all officers of these corps returning from overseas, directed that the classification forms be sent to The Surgeon General, who was to distribute them and issue instructions concerning their use. In August 1944, the War Department directed that each officer of the same three corps in the Army Air Forces should prepare answers to the classification questionnaire and send one copy to the Surgeon General's Office. Whether or not the latter was to use it in the exercise of any power of classification, however, the circular did not state.[24]

More effort to centralize the classification of officers was directed at members of the Medical Corps than at those of any other Medical Department officer group. A proposal of The Surgeon General that his Office make the initial classification of all Medical Corps officers was agreed to by the Army Ground Forces in April 1944. In December of the same year, the War Department granted him that authority with respect to any officer thereafter appointed to the Medical Corps.[25] As the War Department had stopped the procurement of doctors from civilian sources some months previously, this authorization applied mainly, if not exclusively, to future graduates in medicine who were enrolled in the Army Specialized Training Program or who held student commissions in the Medical Administrative Corps.

The classification of members of certain Medical Department officer components was not centralized in the Surgeon General's Office—at least not to the

[23] See footnote 18, p. 274.
[24] War Department Circular No. 349, 26 Aug. 1944.
[25] (1) Memorandum, Adjutant General, Army Ground Forces, for Chief of Staff, 26 Apr. 1944, subject: Assignment of Medical Corps Officers and Nurses. (2) See footnote 19, p. 275.

same extent as was that of Medical Corps officers. This was true of Dental Corps,[26] Medical Administrative Corps, and Army Nurse Corps officers. The Surgeon General carried on a classification of Medical Administrative Corps officers assigned to installations under his own jurisdiction; in the later war years, members of the corps graduating from officer candidate schools were classified at the schools where they received their commissions.

Efforts Toward Greater Uniformity in Classification

Manuals

The continuous efforts to promote uniformity in classification of officers for the whole Army came to fruition with the publication of War Department Technical Manual 12–406, on 30 October 1943. This manual was supplemented, so far as it related to the Medical Department, by special instructions embodied in War Department Circular No. 232, 10 June 1944. The groups of standard qualifications established by these instructions for each of the four degrees of proficiency within the Medical Corps specialties were stated in broad terms—so broad, in fact, that they could hardly, of themselves, produce a completely uniform classification of the officers to whom they applied. The four groups of proficiency qualifications were set forth as follows:

Group A (To be substituted for SGO Group 1). Officers with civilian or military background of recognized and outstanding ability in a specialty, for example, officers who were professors and/or heads of departments and associate professors in large teaching centers; officers who can function within their specialty without professional supervision.

Group B (To be substituted for SGO Group 2). Officers with superior training and demonstrated ability. Classification in this group indicates a probable training period of one year as an intern and a three year residency or fellowship devoted to the specialty in a recognized teaching center. Officers with mature experience and demonstrated ability may be classified in this group even though they have not had the formal training indicated above. Diplomates of American Specialty Boards are classified in this group or higher but absence of certification does not prohibit inclusion in this group. These officers can function within their specialty without professional supervision.

Group C (To be substituted for SGO Group 3). Officers who have recently completed periods of training including one year as an intern and one year of residency; officers who have demonstrated some ability in a specialty; officers with shorter periods of training but with minor proportion of practice devoted to a specialty such as general practitioners giving particular attention to the specialty for a period of at least three years.

The Air Forces issued its own classification manual in April 1944.[27] Every job category listed in the Air Forces manual for the Medical, Dental, Veterinary, and Army Nurse Corps and for the Hospital Dietitians and Physical Therapists had appeared in the War Department manual.[28] The only difference

---

[26] Report, Military Personnel Division, Office of The Surgeon General, to Historical Division, Office of The Surgeon General, summer 1945, subject: Medical Department Personnel.

[27] Army Air Forces Manual 35–1, 3 Apr. 1944, subject: Military Personnel Classification and Duty Assignment.

[28] No attempt has been made to compare the job listings in these manuals for members of the Medical Administrative, Sanitary, and Pharmacy Corps, since the job designations given do not always clearly indicate whether the post could be filled only by a member of one of these corps.

was that the Air Forces manual listed fewer job categories for some of the components than did the War Department manual, presumably because certain types of jobs would not be needed in the Air Forces. Both manuals also appear to have contained the same set of qualifications for each kind of job.

Role of consultants

The Surgeon General, in addition to making full use of the consultants in his Office, designated the service command consultant in each specialty as the final authority within the service command for recommending all changes in the rating of specialists in his field. If the consultant was consistent in maintaining his own standards, this would result in considerable uniformity of classification within the service command so far as the proficiency ratings were concerned. Uniformity throughout a broader area, however, was desirable; the task of classification, it was held, must be performed not from the point of view of a single service command,[29] but from that of the entire Army. No doubt, a certain uniformity of view among consultants in a given specialty resulted from their similar training and experience. Moreover, if The Surgeon General's scheme just mentioned was adhered to, their recommendations as to changes in ratings were passed upon finally in his own Office, where differences in standards could be reconciled.

Individual records

Uniformity of classification was also a matter of keeping the records up to date. If changes in men's capabilities were not promptly recorded, the effect was the same as if uniform standards were not being applied. It was necessary too that all records of a man's classification should agree with one another. The Surgeon General had urged uniformity in that sense when, in calling on the service commands for questionnaires from all medical, dental, and veterinary officers in November 1943, he had stated that the classification symbols given these officers by his Classification Branch should be entered on all their records in the service command surgeon's office. Almost a year later, he emphasized that revised questionnaires of all Medical Corps officers should be available in his Office and that copies of them should be filed in the service command headquarters. About the same time, a representative of The Surgeon General urged that the same classification should appear on all records used in the assignment and evaluation of an officer; when the rating was changed, it should be changed on all records simultaneously. It appears that in at least one service command, for a time at any rate, two groups of classification data were maintained—one determined by The Surgeon General, the other by the service command.[30]

---

[29] Speech, Maj. Robert W. W. Evans, MC, Office of The Surgeon General, "The Classification and Assignment of Personnel," 10 Oct. 1944. *In* Annual Report, Surgical Consultants Division, Office of The Surgeon General, U.S. Army, 1945.

[30] See footnote 29.

Evaluation of the Classification System

Doctors

The classification process for Medical Corps officers improved gradually, beginning possibly about the middle of 1943. This was at a time when the number of doctors accepting active duty had for several months been relatively quite small. Specialists who were diplomates of specialty boards probably fared better than others in their initial classification, simply because the evidence of their training was more readily ascertained and they could be easily placed in their specialty with a proficiency rating of at least B, as the classification manual prescribed. There were of course doctors well trained in some branch of medicine for which no specialty board yet existed, who therefore might be classified as nonspecialists. There was also the case of doctors who had simply not acquired membership in a specialty board, even though they were as competent in the specialty as those who had. On this point, The Surgeon General repeatedly declared that mere lack of board membership would not place a specialist in a lower proficiency bracket if he had demonstrated top professional capacity in his specialty.

Initial classification was not enough.[31] Reevaluations had to be made on the basis of actual performance. These were sometimes considerably delayed through lack of opportunity to make them. It was reported that even during 1943, units were arriving in the European theater in which the commanding officer and the chief of the medical service had had no opportunity to judge the capacity of officers in the field of internal medicine except by paper evaluation. Presumably, the same held true of officers in the surgical specialties. A period of confusion therefore ensued until a reevaluation, based on the officer's work, could be made.[32]

Knowledge of the workings of classification was not universal among Army doctors. In 1944, it was reported that few of them had any idea as to their own professional classification and that a considerable number, especially among those who had been overseas, were not even aware of the classification system itself. Their assignments, nevertheless, reflected their military occupational specialties as determined by the Personnel Service, Office of The Surgeon General, and a very high percentage of them were better than adequate.[33]

Dentists

While the major part of this classification discussion is given to the Medical Corps, it points up the problems and means of solving them as they relate to

[31] Initial classification in the sense of formally placing a man in one of the categories prescribed by the Army, so that this record would govern all future assignments, might be delayed until after his commander had examined his credentials and placed him in a job. The formal initial classification was therefore sometimes made on the basis of actual performance.

[32] Annual Report, Office of the Chief Surgeon, Headquarters, European Theater of Operations, U.S. Army, 1944, Exhibit A thereto.

[33] (1) Memorandum, Maj. Henry McC. Greenleaf, MC, for Colonel Schwichtenberg, MC, Office of The Surgeon General, 13 June 1944, subject: Informal Report of Trip to Several Zone of Interior Army Hospitals. (2) See also Chapter X, pp. 289–338, this volume.

the full officer strength of the Medical Department, even though considerably less control of classification for the other components was ever centralized in the Surgeon General's Office. The classification of Dental Corps officers seems to have been less satisfactory than that of doctors. The Military Personnel Division of the Surgeon General's Office stated in April 1945 that "incomplete, insufficient, and improper classification of Dental Corps officers was a major problem throughout the war." It gave three reasons for poor classification of these officers during the early part of the war: (1) Dental Corps officers originally did not have to fill out a classification questionnaire; (2) in spite of the fact that instructions to fill out the questionnaire were changed to cover all Medical Department officers, doubt whether this included Dental Corps officers was so persistent that as late as April 1945 the Surgeon General's Office considered it necessary to call the matter to the attention of those concerned; and (3) the early classification questionnaire did not call for sufficient information to make it a reliable basis for accurate classification. Even when complete information became available, accurate classification was hampered by several conditions. In the service commands and oversea theaters, there was considerable variation in the evaluation of dental skills. The early form of the classification questionnaire authorized the commanding officer of a unit to recommend the classification he considered appropriate for his subordinate officers. In the Army Ground Forces, this was usually a line officer who understood little or nothing of professional standards and qualifications. Later, the senior medical officer made recommendations, but this did not solve the problem of evaluating dental specialties in any installations other than the large ones in which the commanding officer, a Medical Corps officer, took the time to confer with the chief of the dental service.

Many Dental Corps classification records dated only from 1943, and classification records on 20 percent of the members of the corps were never received at all. Classification would certainly have been better for Dental Corps officers, if procedures had been centralized in the Surgeon General's Office, if classification questionnaires had been submitted annually so that records could be kept current, and if professional evaluations had been reviewed by qualified classification officers. Personal visits to dental installations for the evaluation of the utilization of Dental Corps officers would also have proved useful.[34] "Too much reliance had to be placed on the dentist's own estimate of his qualifications, so that men with little more than a desire to do a certain type of work were designated as specialists, while other trained officers were placed in routine jobs." [35]

Sanitary Corps officers

Some fault was also found with the classification of Sanitary Corps officers. In February 1945, The Surgeon General's Classification Branch heard

[34] See footnote 26, p. 277.

[35] Medical Department, United States Army. Dental Service in World War II. Washington: U.S. Government Printing Office, 1955, p. 107.

of "a pernicious method" of changing their classification—apparently one service command would sometimes alter an officer's classification simply to justify his promotion.[36] As regards sanitary engineers, in particular, who formed a substantial part of the corps, some acquired that classification who were unfitted for it, despite the efforts of The Surgeon General's Sanitary Engineering Division and the vigilance of the service commands. This was probably because part of the work of classifying was done by surgeons of posts and commands, who were ordinarily unqualified to judge whether a man had the proper training in sanitary engineering. Some officers were also improperly classified as entomologists, entomology being another specialty of the Sanitary Corps.[37]

Development of Local Classification Systems Overseas

As early as 1942, it became apparent to oversea commanders that the classification system as it applied to medical officers was not adequate. In the first place, many of these officers had never been classified prior to being shipped overseas while others who had been classified failed to bring their classification records with them.[38] Probably more inadequacies existed in the proficiency rating than elsewhere.[39] Proper classification overseas was no less necessary than it was at home, but the experience attained by officers abroad and the opportunity to observe them under field conditions would have called for reclassifications regardless of any classifying that might have been done in the Zone of Interior. The result was the development within the theaters of local systems of categorization which were independent of those in the continental United States.

The North African and European theaters

The North African and European theaters had similar systems based primarily on (1) questionnaires issued to each medical officer arriving in the theater (the North African theater went one step farther and distributed these questionnaires to all medical officers already in the theater); [40] and (2) evalua-

---

[36] Weekly Diary, Classification Branch, Military Personnel Division, Office of The Surgeon General, 24 Feb. 1945.

[37] Hardenbergh, W. A.: Organization and Administration of Sanitary Engineering Division. [Official record.]

[38] Letters, to Col. C. H. Goddard, MC, Office of The Surgeon General, from (1) Theodore L. Badger, M.D., 25 Sept. 1952; (2) Alan Chalman, M.D., 11 Sept. 1952; (3) John M. Flumerfelt, M.D., 8 Sept. 1952; (4) George P. Denny, M.D., 25 Sept. 1952; (5) Garfield G. Duncan, M.D., 8 Sept. 1952; (6) Robert Evans, M.D., 8 Dec. 1952; and (7) Joseph S. Skobba, M.D., 10 Oct. 1952.

[39] Letters, to Col. C. H. Goddard, MC, Office of The Surgeon General, from (1) Garfield G. Duncan, M.D., 19 Aug. 1952; and (2) Walter D. Wise, M.D., 23 Sept. 1952.

[40] (1) Annual Report, Personnel Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1942. (2) Munden, Kenneth W.: Administration of the Medical Department in the Mediterranean Theater of Operations, U.S. Army. Vol. I. [Official record.] (3) Annual Report, Surgeon, North African Theater of Operations, U.S. Army, 1943. (4) Annual Report, Surgeon, Mediterranean Theater of Operations, U.S. Army, 1944. (5) Report, Lt. Col. Stewart F. Alexander, MC, Personnel Officer, Surgeon's Office, Seventh U.S. Army, on Medical Department Activities in Mediterranean Theater of Operations, 14 July 1945.

tion by consultants. The latter method had already proved helpful in the Zone of Interior.

In the European theater, Col. William S. Middleton, MC, Chief Consultant in Medicine, personally interviewed all officers on the medical service in each hospital unit arriving in the theater, evaluated them, and reported on their qualifications to the Chief Surgeon.[41] Col. Elliott C. Cutler, MC, Chief Consultant in Surgery, requested the base section consultants to do virtually the same thing and send their reports to him.[42] In addition, as early as 1943, each officer entering the theater as a casual was evaluated, if he had a specialty, by a senior consultant from the Chief Surgeon's Office.[43] The consultants did not confine their attention to newcomers. As early as 1942, they assessed the quality of the personnel assigned to the medical and surgical specialties in hospitals.[44] The following year, all units within the theater were evaluated by the consultants from the Professional Services Division of the Chief Surgeon's Office as to the professional capacities of their medical officers. In 1944, Colonel Middleton visited and interviewed the medical officers of 112 general and 13 station hospitals.[45]

Col. Perrin H. Long, MC, medical consultant in the North African theater, also used this method, reviewing the qualifications of Medical Corps officers as soon as possible after the hospitals had reached the theater.[46] By the latter part of 1944, the consultants appear to have classified all of the medical officers in the theater.

Even in those theaters where classification activities were most advanced, however, they were marked by failure at least to use classification forms and job categories established by the Zone of Interior. Furthermore, in the case of individuals having more than one specialty, local conditions dictated which of these specialties was to be regarded as primary and which secondary. The Zone of Interior, for example, considered it important to classify a cardiologist primarily as such and secondarily as an internist whereas in the European theater the opposite was true. Similarly, an obstetrician and gynecologist was classified primarily as a general surgeon in the theater, but at home, his subspecialties were given first place. In each case, the practice was based on the principle of giving a man a classification in skills that the Army most needed. but the necessities of the Zone of Interior, with its comparatively large numbers of older troops, female personnel, and dependents entitled to Army medical

[41] Annual Report, Professional Services Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1943.

[42] Annual Report, Professional Services Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1944.

[43] Annual Report, Personnel Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1943.

[44] (1) Annual Report, Professional Services Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1942. (2) See footnote 43.

[45] Middleton, W. S.: Medicine in the European Theater of Operations. Ann. Int. Med. 26: 191–200. February 1947.

[46] Long, Perrin H.: History of the Medical Consultant in the North African and Mediterranean Theaters of Operation. [Official record.]

care, were different from those of the oversea theaters with their preponderance of young combat men.[47]

Efforts Toward Uniformity in Theaters of Operations

The European and Mediterranean theaters

On 13 May 1944, the final plans for demobilization and redeployment were approved by the Deputy Chief of Staff, based on the 1 October date for the defeat of Germany. While the plans for redeployment of Medical Department strength were being developed, the necessity for establishing uniformity among the classification systems of the Zone of Interior and theaters became apparent. To accomplish this Lt. Col. Gerald H. Teasley, MC, of the Personnel Service, Office of The Surgeon General, and others from the Surgeon General's Office were sent to the European and Mediterranean theaters to observe the systems in operation.

As a result of this visit, War Department Circular No. 460 was issued on 5 December 1944, requiring classification of Medical Corps officers in accordance with established procedures. This circular was designed primarily to promote uniformity in classification procedures for all Medical Department officers.

The circular further directed that the commanding generals of oversea theaters and oversea commands were to be given final responsibility for accurate up-to-date classification of all medical officers over whom they had assignment jurisdiction and were not to delegate this responsibility to field agencies or lower headquarters. In reviewing classifications, each commanding general, furthermore, was directed to utilize the advice of his surgeon and the professional consultants. Finally, by 31 March 1945, each pertinent headquarters was required to furnish each Medical Corps officer over whom it had assignment jurisdiction a copy of W.D., A.G.O. Form 178–2 with a publication date of 1 August 1943 or later. By this same date, the first annual review of the classification of each Medical Corps officer was scheduled for completion.

As a result of War Department Circular No. 460, many officers received for the first time a War Department, or standard classification, number as opposed to theater classification.[48] And for the first time in the European Theater of Operations, Medical Corps personnel came under the central classification activities of the theater.[49]

---

[47] (1) Memorandum, Lt. Col. J. C. Rucker, MC, for Lt. Col. G. H. Teasley, MC, 1 Nov. 1944, subject: Personnel Records in the European Theater of Operations. (2) Memorandum, Lt. Col. G. H. Teasley, MC, for The Surgeon General, 29 Nov. 1944, subject: Report of Trip to Mediterranean Theater of Operations. (3) Letters, Robert Evans, M.D., to Col. C. H. Goddard, MC, Office of The Surgeon General, 8 Dec. 1952 and 14 Apr. 1953.

[48] Letter, Col. Perrin H. Long, MC, to Col. C. H. Goddard, MC, Office of The Surgeon General, 29 July 1952.

[49] Annual Report, Personnel Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1944.

Difficulties were eventually encountered in carrying out the provisions of the circular. The supply of forms was short; in the spring of 1945, units were moving so rapidly and so freely from one command to another that it was difficult to ascertain which ones had reported; and finally, the "human factor" entered the picture—to many individuals and unit commanders, this was "just another form." As a result, a fairly complete classification was not accomplished until June 1945.[50]

The Pacific and China-India-Burma theaters

The Pacific theaters and the China-Burma-India theater do not appear to have placed any early emphasis on the classification problem. No individual systems were initiated, as in the European and North African-Mediterranean theaters. In 1944, in the Central and South Pacific, medical officers were classified in accordance with the system established by the Surgeon General's Office.[51]

In the Southwest Pacific Area, however, nothing was accomplished until Maj. Robert W. W. Evans, MC, Chief of the Classification Branch of the Military Personnel Division in the Surgeon General's Office was transferred to the Southwest Pacific at the request of Brig. Gen. Guy B. Denit, Chief Surgeon. Following the consolidation of commands in the Pacific, Major Evans became, in the latter part of July 1945, head of the Personnel Division of the Chief Surgeon's Office in the Pacific theater.[52]

The increased availability of consultants also facilitated the work of classification and reevaluation both in the Pacific and in India-Burma. In the latter theater, the source of classification data had been information obtained in the Zone of Interior in the early part of the war, and such classification as had been performed in the theater had been accomplished by a nonmedical officer.[53]

ENLISTED PERSONNEL, 1939–45

The same reservation must be made when discussing the placement of enlisted personnel as when discussing that of officers—a man assigned to a job that did not call for his best talents cannot be said to have been misassigned if the overriding needs of the Army required him to be used where he was. With that exception, proper placement will be considered here as one that fitted the job to the man.

---

[50] Administrative and Logistical History of the Medical Service, Communications Zone—European Theater of Operations, 1945. Ch. X. [Official record.]

[51] (1) Whitehill, Buell: Administrative History of Medical Activities in the Middle Pacific (1946). [Official record.] (2) Annual Report, Surgeon, Central Pacific Base Command, 1944. (3) Letter, Verne R. Mason, M.D., to Col. C. H. Goddard, MC, Office of The Surgeon General, 18 Dec. 1952.

[52] Annual Report, General Headquarters, U.S. Army Forces, Pacific, 1945.

[53] (1) Letter, Col. Herrman L. Blumgart, MC, to Col. C. H. Goddard, MC, Office of The Surgeon General, 7 Aug. 1952. (2) Letter, Hugh J. Morgan, M.D., to Col. C. H. Goddard, MC, Office of The Surgeon General, 7 Aug. 1952. (3) Graham, Stephens: History of Professional Surgical Experience in the India-Burma Theater in World War II (1945). [Official record.]

It was not nearly so important, for the most part, to fit the job to the man in the case of enlisted personnel as it was in the case of officers. With few exceptions, jobs for enlisted men in the Medical Department called for a much shorter period of technical training than did most jobs for officers. If necessary, therefore, the Medical Department could train its own enlisted technicians after they entered the service. A great deal of such training was done, although there were complaints that the quality of the material was not always adequate—that too many men of limited physical endurance or mental ability were assigned to the Medical Department. Nevertheless, in order to economize on the training effort, it was desirable to place men in jobs for which they were already qualified and to keep them there until they could be used more effectively elsewhere.

The first essential was to see that enlisted men who were qualified for distinctly medical work got into the Medical Department—and stayed there—instead of being placed in some other branch of the Army, but only a comparatively small number were earmarked for medical work upon induction into the Army. In the vast majority of cases, enlisted men went, after induction, to the reception centers of the Army as draftees without any previous arrangement as to where they would be used and were only then assigned to some particular branch of the service. The Medical Department received its enlisted personnel mainly in this fashion or by transfer from some other branch of the Army.

Classification Guides

As early as September 1940, the reception centers and other assigning authorities had a better guide for classifying and therefore assigning enlisted men than for officers. An Army regulation issued at that time contained a list of occupational specialties required in the Army and a list of the specifications for those occupations. This regulation included a serial number to identify each specialty. A three-digit number designated each job. Thus, for example, under the heading "medical technician" appeared the specification serial number "123" under which were listed duties in military service, qualifications, and civilian occupations in which medical technicians would be found. Male nurses and medical students were placed in the same category.[54] Later on, the job descriptions were refined, and some of the specification serial numbers were changed. In July 1944, the War Department replaced its existing guide with War Department Technical Manuals 12–426, "Civilian Occupational Classification of Enlisted Personnel," and 12–427, "Military Occupational Classification of Enlisted Personnel."

Such a guide, though useful, did not insure that all enlisted men would be either properly classified or assigned. In January 1942, The Adjutant General, after making a general statement on the need to utilize the abilities of

[54] Army Regulations No. 615–26, 3 Sept. 1940, subject: Enlisted Men: Index and Specifications for Occupational Specialists and Index to Military Occupational Specialists. (This list was superseded in December 1941, and still another appeared in September 1942.)

enlisted men to full capacity, listed several skills that must be carefully conserved. This list, antedating the list of scarce-category specialists published later in the war, included the following Medical Department enlisted specialties: Dental hygienist, dental laboratory technician, medical technician, surgical technician, optician, orthopedic mechanic, pharmacist, sanitary technician, veterinary surgical technician, and X-ray technician. The Adjutant General designated the specialties on this list in which the shortage could be overcome in part by Army training.[55]

Proper classification was necessary, as set forth in Army Regulations No. 615–25, 3 September 1940, in order that—

a. All units and installations obtain a proportionate share of the abilities possessed by personnel coming directly from civil life.

b. Combat units obtain priority in the assignment of personnel possessing military training and qualities of leadership.

c. Men with occupational skills are assigned to units or installations requiring those skills in the proportion and to the extent available, avoiding wastage.

The System in Operation

The system was designed to work as follows: Recruits were to be classified at the reception centers. Classification was always to be in terms of what the individual could do best for the Army. On the basis of his score on the Army General Classification Test and an interview with a classifier, each recruit was to be assigned to the training center of the arm or service which could best utilize his education and experience.

Difficulties encountered

The immediate needs of the Army took precedence, of course, over this planned method of classifying and assigning. Moreover, the system did not always operate according to plan. Improper classification and assignment often occurred in the emergency and early war periods, owing in part to a lack of trained classifiers and to the fact that numbers of individuals were assigned to branches merely so that quotas could be met.

Another difficulty was that recruits spent an average of only 72 hours at reception centers, a limit imposed by the lack of housing and the rapidity of mobilization. This was not always enough time to determine where a man could be most properly assigned. It also meant that centers could not retain a man until a requisition for his specialty arrived. Particular centers might not have requisitions for a given specialty for several weeks, although the centers were meanwhile receiving men with the required qualifications. As the war progressed, procedures were improved, more experienced classification personnel were available, and more efficient placement ensued.

---

[55] Letter, The Adjutant General, to Commanding General, each Army Corps; Chiefs of Arms and Services, 29 Jan. 1942, subject: Reclassification and Reassignment of Enlisted Personnel.

Continual reevaluations

Whether or not the reception centers did their work efficiently, men would in many cases have to be reclassified and in most cases reassigned after they left the centers. The reason, of course, was that some acquired specialized skills through Army training which entitled them to a new classification, and that most had to be moved about from post to post if not from job to job as the exigencies of the service demanded. In fact, The Adjutant General declared that classification procedure must be carried out during an enlisted man's entire Army career, and in January 1942, all commanders were directed to survey the classification cards of their enlisted men at least every 6 months for the purpose of improving their placement; commanders were to report any surplus of men whose skills they could not use "to the utmost." [56]

[56] See footnote 55, p. 286.

CHAPTER X

Utilization of Personnel

ASSIGNMENT OF MEDICAL DEPARTMENT PERSONNEL

The accuracy of classification in large measure determined the adequacy of assignment, which was in turn the key to maximum utilization of the tremendous reservoir of skills and experience that made up the Army Medical Department in wartime. Only because the classification of both officers and enlisted men—but particularly that of medical officers, including proficiency ratings—was by and large an outstanding accomplishment, was it possible to place a very high percentage where each individual's greatest potential could be realized.

The Surgeon General actually had assignment jurisdiction over only that small percentage of Reserve officers who belonged to the Army and Service Assignment Group. During the emergency period and until the creation of the Services of Supply in 1942, he assigned officers to all named general hospitals (of which there were 15 by the end of 1941, 10 of them having been established since the beginning of the emergency), medical supply depots, and the Medical Field Service School. Most Reserve officers, however, were in the Corps Area Assignment Group, under the assignment authority of the commanding generals of the corps area, who acted on the advice of their staff surgeons. This division of authority did not ordinarily prevent a proper distribution of assignments. The Surgeon General could communicate with the corps area surgeon through the latter's commander and tell him what types of personnel could be made available to him. If the corps area had vacancies for such personnel, the surgeon could then take steps to obtain them from outside the corps area.

The Problem of Proper Assignment, 1939–41

An officer's assignment was not always, or entirely, based on his classification, nor was he always kept fully occupied in the position for which he was best fitted. This gave rise to complaints of misassignment.

Letters from officers, and from civilians as well, told not only of the misuse of skills—they told, too, of the waste of physicians' time in idleness. Medical associations showed their concern by forwarding copies of these letters to the Surgeon General's Office.[1] That Office's reply to such criticisms was that there

[1] (1) Letter, Mrs. Margaret Black Warres, Harrington, Del., to Brig. Gen. Frederick Osborn, USA, Washington, D.C., 26 Nov. 1941. (2) Letter, Thomas A. Hendricks, Executive Secretary, Indiana State Medical Association, Indianapolis, Ind., to Olin West, M.D., Secretary, American Medical Association (and others), 12 Feb. 1941, with enclosure thereto.

would be small demand for some specialties during the training program; the soldiers were of an age at which very little surgery, for example, was necessary. The picture, however, would change entirely if we became engaged in war.[2]

There was little the Medical Department could do to keep many of these specialists constantly engaged in their own fields. A higher proportion of certain types of specialists existed in civilian life than the Army required (obstetricians, for example); consequently, some specialists had to perform duties outside their specialty. Attempts were made to assign them so that they could do some work in their special field, and they were assigned to hospitals whenever possible. For a time, the position of specialists within the National Guard was particularly hard. They were inducted with the regimental medical detachments of which they were members and restrictions on their reassignment prevented their transfer, even if outstanding specialists, from these units into hospitals giving the type of treatment where full use of their professional skill could be made. This restriction was not removed until September 1941.[3]

The problem of proper assignment was further complicated by the necessity of finding a place for certain officers of the Reserve and the National Guard who had been promoted to a rank higher than their professional capabilities. Finally, the shortage of medical administrative officers until well after Pearl Harbor compelled the employment of doctors, dentists, and veterinarians in administrative duties to a greater extent than was the case later on. However, the professional groups in the Army, as in civilian life, could at no time completely escape certain administrative functions.

Sometimes the cause of inappropriate utilization lay with the Medical Department, sometimes it was outside its control. Especially in the days of building camps, recruiting personnel, and obtaining equipment, the matching of need with supply was an intricate and at times impossible task. No doubt, the Medical Department sometimes erred on the side of safety. If, for example, medical officers arrived at a camp before other men and equipment, it was probably because the Department judged it better to have physicians present beforehand than to risk being without them when men needed treatment.

To prevent medical officers serving in field units from losing their skill, a plan of rotation was promulgated in February 1941; it provided that after an officer had spent 6 months in a fixed installation he could take a refresher course and be assigned to a tactical unit, or vice versa.[4] The plan affected few officers, however. It was voluntary, and although the Office of The Surgeon General was swamped with requests for transfers from field units to fixed installations, almost no one requested transfer in the opposite direction; hence, the system proved unworkable.

---

[2] Letter, Col. George F. Lull, Office of The Surgeon General, to Dr. Edwin F. Lehman, Department of Surgery, University of Virginia, Charlottesville, Va., 25 Nov. 1941.

[3] Letter, The Adjutant General, to Commanding Generals of all Armies, Army Corps, Divisions, (and others), 19 Sept. 1941, subject: Transfer and Reassignments—Officers of National Guard of United States.

[4] Letter, The Adjutant General, to Commanding Generals, all Armies and Corps Areas, 4 Feb. 1941, subject: Rotation of National Guard and Reserve Medical Department Officers.

Misassignment

Officers

Some of the same factors that hindered proper classification—rapid procurement during the summer of 1942, insufficient information concerning the professional qualifications of the doctors procured, and lack of experience with the established procedure—doubtless interfered with proper assignment; that is, the placement of officers in jobs that called for their best talents and that they were physically qualified to fill. In the fall of 1942, the Committee to Study the Medical Department as one of its "major findings" stated that it had heard numerous complaints of misassignment of professional personnel by the Medical Department, involving for one thing "the assignment of doctors, either part or full time, to clerical or other administrative duties." Under established practice, however, most of these duties were the direct responsibility of Army medical officers.

Although the committee heard complaints about "the assignment of specialists to the practice of general medicine or of other specialties not their own," the specialty boards themselves were on the whole well pleased and were of great assistance to the Personnel Service. The Chief of The Surgeon General's Personnel Service received conclusive evidence of this in replies to queries he had directed to them late in 1942—the great majority of officials replying for the boards expressed satisfaction with the classification and assignment performed by the Surgeon General's Office.[5] Spokesmen for the Army neuropsychiatrists asserted that, in spite of constant effort to keep neuropsychiatrists in jobs devoted to their specialty, the younger graduates were often assigned as general practitioners to ground force units or organizations alerted for oversea movement. The critics attributed this to The Surgeon General's lack of power to reassign medical personnel within certain commands, which made it impossible for him to compel proper use of these specialists. They compared the Surgeon General's Office to a fire department that procured and pumped water through a hose but was denied the right to direct the nozzle at the fire.[6]

It is true that The Surgeon General lacked authority for some time to order the reassignment of personnel within any service command, the Air Forces, the Ground Forces, or the oversea theaters. So far as reassignment within the service commands was concerned, however, the trouble was perhaps not entirely the want of authority on the part of the Surgeon General's Office but to some extent the situation within the service commands themselves, where the working of the assignment system seems to have been hampered by lack of personnel with training adequate to perform the task most efficiently.[7]

---

[5] Letters, American Specialty Boards, to Col. George F. Lull, Chief, Personnel Service, Office of The Surgeon General, September–October 1942.

[6] Farrell, Malcolm J., and Berlien, Ivan C.: Neuropsychiatry, Personnel. [Official record.]

[7] Letter, Robert W. W. Evans, M.D., to Col. C. H. Goddard, Office of The Surgeon General, 8 Dec. 1952, with enclosure thereto. (Dr. Evans was assigned to the Classification Branch, Military Personnel Division, Office of The Surgeon General, from 1942 to 1945, and served as its chief during the later war years.)

In spite of certain drawbacks, it is possible that the decentralization of the power to assign officers was the best system during the early war years. At that time, The Surgeon General was so largely occupied with adapting his Department to meet the demands of a two-front war and with procuring officers that he no doubt needed the assistance of others in making assignments. In the later war years, however, when he had improved classification procedures and acquired more thoroughgoing statistical information on the distribution of Medical Department officers, he certainly knew more about the relative needs for them, both as between the theaters of operations and the United States and within the United States itself. As this became increasingly apparent to War Department authorities in the higher echelons, he regained more control of the personnel of the Medical Department.

Some of the causes of misassignment that had raised difficulties during the period 1939–41 still operated during the war. Among those which became more obvious as time went on was one stemming from the Army's system of promotion. Men who had entered the service before or in the early part of the war had filled the higher ranking posts in many units and installations. Those who joined later were therefore sometimes placed in subordinate positions regardless of professional ability.

There were plenty of reasons why misassignments should occur, but some of the complaints on that score were unjustified. Apparently, some doctors not only believed they would practice medicine in the Army in much the same manner as they had in civilian life but understood little of the need for any time spent in training. When they were assigned first for training and later to a job that did not duplicate their civilian practice, many objected that the Army was wasting their professional skills. Others raised the same objection simply because they overrated their own capacity.

An assignment feature was the use of officer replacement pools, established by the Army just after the outbreak of war.[8] The existence of pools facilitated the task of meeting promptly the need for officers; they contained unassigned personnel who could be withdrawn for assignment to other units or installations as the occasion demanded. Many newly commissioned officers were sent to pools pending their initial assignments. As a matter of convenience, unassigned officers not available for jobs—for example, persons awaiting discharge or sick in hospital—might also be placed in the pools. Medical Department officer pools were located at replacement training centers, certain general hospitals, and—for the Veterinary Corps—at Quartermaster depots and ports of embarkation. When pools were first created, the Medical Department was allotted a maximum strength of 1,500 for them. This figure was changed from time to time as conditions required.

[8] Letter, The Adjutant General, to Chief of each Ground Arm and Service (and others), 19 Dec. 1941, subject: Officer Filler and Loss Replacements for Ground Arms and Services.

Enlisted men

Errors also occurred in the assignment of enlisted men. For example, men sent to technicians schools to receive specialized training sometimes received assignments on which such training was unnecessary. In August 1942, The Surgeon General asserted that this mistake was being made in numerous instances, due, he believed, partly to the errors of medical units in making requisitions on The Adjutant General and partly to the errors of The Adjutant General in filling them. Although he himself lacked personnel who understood the situation, The Adjutant General nevertheless failed to follow the recommendations of The Surgeon General, who had allocated certain numbers of technicians to these units. The Adjutant General had even assigned some graduates to Zone of Interior installations that possessed technicians schools as their own sources of supply. According to The Surgeon General, 56 percent of the technicians graduating in July 1942 had been assigned to units and installations other than those he recommended. He therefore proposed that Zone of Interior hospitals receive personnel direct from reception centers, that commanders of theater of operations units submit requisitions for Medical Department technicians in the numbers authorized by their tables of organization (that is, only for those shown as "rated" in the tables), that the Adjutant General's Office follow the recommendations of The Surgeon General in allotting technicians, and that a Medical Department officer be assigned to the Replacement Section of the Adjutant General's Office "who has a knowledge of permissible substitutions in technical specialties and who will maintain close liaison with the Office of The Surgeon General in the disposition of trained technicians." The response was generally favorable. Headquarters, Services of Supply, believed it unnecessary to assign a Medical Department officer to full-time duty with the Adjutant General's Office but suggested that a representative of The Surgeon General be designated to assist The Adjutant General "when occasion demands." That headquarters also instructed the Adjutant General's Office to follow The Surgeon General's recommendations as to the disposition of technically trained personnel "so far as possible subject to the priorities imposed by higher authority." It approved the remainder of The Surgeon General's recommendations and ordered directives to be issued putting them into effect.[9]

These measures did not settle the question of misassigned personnel, if only because they covered something less than the whole field. Various efforts were made to cope with the problem, including the occasional reclassification and reassignment of individual enlisted men.[10]

---

[9] (1) Memorandum, The Surgeon General, for Director of Training, Services of Supply, 28 Aug. 1942, subject: Dissipation of Trained Enlisted Personnel. (2) Memorandum, Director, Military Personnel, Services of Supply, for The Surgeon General, 14 Sept. 1942, subject: Request for Filler and Loss Replacements.

[10] Memorandum, The Surgeon General, for The Adjutant General, 14 Dec. 1942, subject: Reclassifications of Enlisted Men.

It would be difficult to estimate the precise extent of misassignment so far as Medical Department enlisted personnel were concerned, for one reason because proper assignment was a matter of degree and circumstances. An enlisted man was in a sense properly assigned to the Medical Department if his civilian experience or his training in the Army made him useful there, and his removal from the Department would constitute a misassignment. On the other hand, even if he remained in the Medical Department, he might be improperly assigned, either because he was actually needed more somewhere else or because the Department was not making the best possible use of his abilities.

The problem of transfers of qualified personnel was a serious one to the Medical Department. For example, in September 1943, The Surgeon General's Personnel Director cited the cases of 18 noncommissioned officers who had been transferred to other branches after 3 to 25 years of service with the Medical Department. The Surgeon General's Office, he said, heard of only a small percentage of such transfers. Taken together they meant that "a serious situation has arisen * * *. It seems uneconomical and foolish to train men for certain duties and then transfer them to other branches where they know nothing of the technical work and have to be retrained. To replace them, we have to train new men." [11] He pointed out that the transfers were made by the service commands, and it was their interposition which The Surgeon General's Personnel Office at the end of the war singled out as being responsible for transfers of this kind as well as for other personnel practices to which it objected. That office stated in September 1945:

> Distribution of enlisted personnel to installations was satisfactory until branch allotments [that is, bulk authorizations of certain numbers of enlisted men according to their branch of service] were discontinued during the summer of 1943, and authority was delegated to local commanders to make suballotments and assign personnel according to their own policies * * *. Operating policies were never uniform throughout the commands at such a low level, and the pride, loyalty, and efficiency of medical enlisted men serving under these conditions was greatly impaired. Perhaps the most demoralizing act was the transfer of many high ranking noncommissioned officers of long training to other branches and the transfer of noncommissioned officers of other branches into the Medical Department. Competent though these men undoubtedly were in their previous assignments, they were so inept, untrained and unskilled in the duties encountered in the Medical Department that some were reduced.[12]

In the middle of 1943, at any rate, the Director of Military Personnel, Army Service Forces, felt that the assignment of medical technicians was satisfactory. His office had investigated the "alleged misassignment" of technically trained personnel, particularly medical, and found itself in agreement with the Commanding General, Army Ground Forces, who had stated

---

[11] Letter, The Surgeon General, to Director, Military Personnel, Army Service Forces, 13 Sept. 1943, subject: Transfer of Medical Department Enlisted Men to Other Branches.

[12] Report, Military Personnel Division, Office of The Surgeon General, to Historical Division, summer 1945, subject: Medical Department Personnel. (The statement goes on to say that the Surgeon General's Office made a vigorous effort to recover the men so transferred and that the situation had improved "during the last eighteen weeks [that is, at the very end of the war] but only a return to the branch allotment system will fully correct the situation.")

that every effort was being made to prevent misassignments, and that when they did occur it was generally because of temporary surpluses of technicians, who were appropriately assigned later. This condition, the Director added, existed "in the Services as well as in the Ground Troops." [13]

The problem of proper assignment was involved with that of the procurement and retention of personnel. The number of men with medical backgrounds who were assigned by the reception centers to the Medical Department or who were reassigned to it by other branches of the service constituted an important part of the Department's procurement. Regulations against the reassignment of Medical Department personnel to other branches or to jobs outside the United States might have helped to reduce the amount of procurement that had to be done for the Department, at least in the Zone of Interior. From the early part of 1944 onward, the increased effort to channel critically needed medical technicians into the Medical Department both from the reception centers and from nonmedical branches of the Army probably helped to reduce misassignment not only in the Medical Department but elsewhere.

Assignment Problems in the War Years

Toward the end of 1943, Army Service Forces headquarters, prompted by a report submitted by The Inspector General "and other reports," ordered a survey of the classification and assignment of all military personnel in its command. Two examples of the findings with regard to Medical Department officers appear in the surveys conducted at the Army Medical Center, Washington, D.C., and in the Fourth Service Command. These surveys give some idea of how suitably officers were assigned and perhaps also how appropriately they were classified in the Medical Department as a whole up to this time. At the Army Medical Center, the survey of 427 officers showed that 366 (or 85.7 percent) had good assignments, 44 (10.3 percent) had fair assignments, and 17 (4 percent) had misassignments. The report on this installation pointed out that there were three kinds of misassignments: (1) An officer might have substantially more skill and experience or substantially more rank than was required for his assignment; (2) he might have substantially less skill and experience than were required for his assignment; or (3) he might he assigned to the wrong occupational field when his skill was needed elsewhere.[14] In the Fourth Service Command, a preliminary report covering somewhat more than half the Medical Department officers showed that about 86 percent had good assignments, over 13 percent fair assignments, and less than 1 percent misassignments. The surgeon of the command stated that it was difficult to transfer

[13] Memorandum, Director, Military Personnel Division, Army Service Forces, to Director of Military Training, Army Service Forces, 15 July 1943, subject: Transfer of Medical Department Enlisted Men.

[14] Letter, Maj. Fred J. Fielding, Office of The Surgeon General, to Army Medical Center, 13 Jan. 1944, subject: Officer Assignment Survey.

men discovered to have fair assignments or misassignments as no replacements were available.[15]

The Surgeon General's Office and the various service command headquarters of Army Service Forces placed considerable reliance on their professional consultants for assistance in assignment. Consultants in the Surgeon General's Office advised personnel officers there on the staffing of units, and in August 1944, this function became mandatory when The Surgeon General ordered that "assignments of key personnel will be made only with the concurrence of the appropriate service or division particularly concerned with, or possessing special knowledge as to the qualifications of the officers and the requirements of the specialty assignments." [16] While the order did not specifically mention consultants, the "appropriate service or division" would be, in many cases, one of the sections of the office headed by the consultant (or his equivalent) in a professional branch of medicine. At that time, those sections were the Medical Consultants Division, the Surgical Consultants Division, the Neuropsychiatry Consultants Division, the Reconditioning Consultants Division, the Preventive Medicine Service, the Dental Division, the Veterinary Division, and the Nursing Division.

In the later war years, it continued to be more difficult to assign than to classify doctors according to their capabilities, if only because the needs of the Army did not always match the material it had at its disposal. An example of doctors assigned outside their specialty for unavoidable reasons was the case of gynecologists and obstetricians. In November 1943, "considerably less than half" the 650 Army doctors so classified were engaged in that type of work. Those who were employed in their specialties attended female members of the Medical Department and the dependents of Army personnel. The use of a larger percentage in their specialty had to await the entrance of large numbers of Women's Army Corps members into the Army. Even in assignments requiring their professional skill, Army doctors were not able to devote all their time to their specialty. Administrative duties took a higher proportion of their time than it had done in civilian practice. In addition, some doctors found the Army system of evacuation unsatisfactory because it required passing many patients through a number of medical units before definitive treatment was given, and thus prevented the individual physician from following certain cases through to the end.

There were cases of assignment which not only did not take qualifications fully into account but which can hardly be excused on the score of Army necessity—as, for example, that of the war surgeon who was classified as a neurosurgeon although he had done nothing of the sort in his life.[17] Despite continuing vigilance on the part of The Surgeon General, there were instances of misassignment as long as the war lasted. These were sometimes brought

[15] Annual Report, Surgeon, Fourth Service Command, 1943.

[16] Office Order No. 175, Office of The Surgeon General, U.S. Army, 25 Aug. 1944.

[17] Memorandum, Director, Resources Analysis Division, Office of The Surgeon General, for Chief, Operations Service, Office of The Surgeon General, 10 June 1945, subject: Visit to England General Hospital.

to light through the complaints of doctors or members of their families addressed to the American Medical Association or to the White House. Whenever The Surgeon General learned of an actual case of misassignment he endeavored to rectify it.[18] This, of course, was more difficult during the early years of the war prior to establishment of firm classification criteria and when his authority in connection with assignment and reassignment of Medical Corps officers in the United States was considerably curtailed.

There is ample testimony that the assignment of doctors who were specialists was on the whole well done. In April 1945, the surgical consultant in the Surgeon General's Office reported that, of 922 surgical specialists certified by specialty boards or having equivalent qualifications who were serving in Army installations in this country, 96 percent (or 885) were doing surgery in their own specialty. The other 4 percent (or 37) who were not doing surgery, he reported, were serving as consultants either in the Surgeon General's Office or in the nine service commands.[19] Referring to surgical personnel, the Chief of the General Surgical Branch of the Surgical Consultant's Division, Office of The Surgeon General, wrote: "The competent performance of the surgical personnel who participated in World War II undoubtedly had more to do with the surgical results achieved than any other single factor. That performance was made possible, in turn, by the increased availability of such personnel, in comparison with World War I, and by proper assignment." [20] Likewise, the consultant in neuropsychiatry estimated that at the end of the war only 3 percent of the specialists in his field were misassigned.[21]

When in 1946 the Procurement and Assignment Service was summing up its wartime experience with the organization and administration of the medical branches of the Armed Forces, it wrote as follows:

> In spite of many difficulties the Office of The Surgeon General has accomplished a notable feat in the general assignment of medical personnel to work for which they have been especially trained. Much credit is deserved for overcoming an attitude formerly prevalent, "that any medical officer was a medical officer and could do anything equally well." The great improvement in results of medical care in this war is due more to the effective use of highly trained men than to any other single factor.[22]

THE REPLACEMENT SYSTEM

Vacancies overseas could be filled by direct transfer of personnel from other units, which in turn created vacancies in those units; from table-of-organization units having an overstrength; and from the Zone of Interior. The replacement system functioned with regard to enlisted men in the same man-

[18] Letter, Maj. Gen. George F. Lull, Deputy Surgeon General, to Dr. Morris Fishbein, Secretary, American Medical Association, 5 Nov. 1944.

[19] Rankin, F. W.: The Mission of Surgical Specialists in the U.S. Army. Surg. Gynec. & Obst. 80: 441–444, April 1945.

[20] DeBakey, M. E.: Military Surgery in World War II; Backward Glance and Forward Look. New England J. Med. 236: 341–350, 6 Mar. 1947.

[21] Information from Brig. Gen. William C. Menninger, Office of The Surgeon General, 11 June 1946.

[22] Memorandum, Dr. Frank H. Lahey, Chairman, Directing Board, Procurement and Assignment Service, for Watson B. Miller, Administrator, Federal Security Agency, 26 June 1946.

ner as it did for officer personnel—the theater commander was responsible for requisitioning the necessary replacements and the War Department for filling the requisitions as best it could. Medical Department authorities in the various theaters had the responsibility for finding suitable positions for such replacements or casuals as were allocated to them; for correcting any errors in assignment made initially by the responsible authorities in the Zone of Interior; and for transferring personnel, even when satisfactorily located, to assignments in which they could be of greatest service.[23]

Sources of Oversea Replacements

Replacement personnel for the Medical Department came from three main sources: (1) Personnel released from hospitals; (2) personnel made available by administrative actions; and (3) casuals from the Zone of Interior.

Personnel released from hospitals

Probably, the chief source of replacement personnel for the Medical Department consisted of individuals who had been hospitalized and dropped from assignment to their former units. In the European theater, 46 percent of the officers of the Medical Department entering the Ground Forces Reinforcement Command during the period of ground combat came from detachments of patients in hospitals. This was higher than the corresponding percentage of all officers, that is, 38. It was also higher than that of Medical Department enlisted men, that is, 44, which, in turn, exceeded the percentage of all enlisted personnel by three points (table 24).

In the case of both enlisted men and officers, the percentage of men from detachments of patients who returned to their old units was greater in the Army as a whole than it was in the Medical Department. For Medical Department enlisted men, the percentage was 53, while that of the Army in general was 60. Corresponding percentages for officers were, respectively, 51 and 63.

Among the replacements supplied to the Medical Department by the Ground Forces Reinforcement Command in the European theater, a smaller proportion of the officers than of the enlisted men appear to have been limited assignment personnel. The proportion of such officers seems to have been larger than that which the Command provided the Army as a whole.

Because of the lengthy professional education required for medical, dental, and veterinary officers, it is probable that very few officers, other than Medical Administrative Corps officers, whether suited for limited assignment or otherwise, were transferred to the Medical Department from any source outside itself.

---

[23] (1) War Department Field Manual, 100–10, Field Service Regulations, 9 Dec. 1940 and 15 Nov. 1943. (2) Annual Report, Surgeon, North African Theater of Operations, U.S. Army, 1943.

TABLE 24.—*Movement of Medical Department personnel in and out of Ground Forces Reinforcement Command, European Theater of Operations, D-day to V–E Day (6 June 1944–8 May 1945)*

Groups	Total officers	Medical Department officers	Total enlisted men	Medical Department enlisted men
Input				
Total	55, 966	2, 484	1, 259, 046	45, 002
On hand, 6 June 1944	4, 520	122	71, 506	2, 749
Arrivals:				
Total	51, 446	2, 362	1, 187, 540	42, 253
From ZI:				
Number	24, 428	801	511, 620	6, 318
Percent of total arrivals	47. 48	33. 91	43. 08	14. 95
From theater sources:				
Detachments of patients: [1]				
Number	19, 766	1, 079	484, 873	18, 547
Percent of total arrivals	38. 42	45. 68	40. 83	43. 90
OCS graduates: [2]				
Number	792	----------	----------	----------
Percent of total arrivals	1. 54	0	0	0
Other sources:				
Number	6, 460	482	191, 047	17, 388
Percent of total arrivals	12. 56	20. 41	16. 09	41. 15
Output				
Total	49, 633	3, 120	1, 073, 378	38, 331
Shrinkage: [3]				
Number	3, 686	404	48, 873	6, 238
Percent of total output	6. 59	16. 26	3. 88	13. 86
Shipped for service in theater:				
Total	45, 947	2, 716	1, 024, 505	32, 093
Percent of total output	92. 57	87. 05	95. 45	83. 73
Returnees to units: [4]				
Number	12, 495	550	291, 870	9, 839
Percent of total shipped	27. 19	20. 25	28. 49	30. 66
White:				
General assignment	11, 934	485	266, 647	8, 843
Limited assignment	248	24	11, 920	711
Negro:				
General assignment	39	1	9, 146	86
Limited assignment	--------	----------	519	9
Category unknown [5]	274	40	3, 638	190
Others: [6]				
Number	33, 452	2, 166	732, 635	22, 254
Percent of total shipped	72. 81	79. 75	71. 51	69. 34
White:				
General assignment	25, 465	1, 233	564, 002	16, 039
Limited assignment	2, 984	211	111, 491	3, 432

See footnotes at end of table.

TABLE 24.—*Movement of Medical Department personnel in and out of Ground Forces Reinforcement Command, European Theater of Operations, D-day to V–E Day (6 June 1944–8 May 1945)*—Continued

Groups	Total officers	Medical Department officers	Total enlisted men	Medical Department enlisted men
Output—Continued				
Total—Continued				
Others:[6]—Continued				
Negro:				
General assignment	165	11	13, 090	488
Limited assignment	6		1, 474	67
Category unknown[5]	4, 832	711	42, 578	2, 228
Percent of general assignment in number shipped	18. 84	63. 70	83. 25	79. 32
Percent of limited assignment in number shipped	7. 05	8. 65	12. 24	13. 15
On hand, 8 May 1945	6, 157	152	188, 669	8, 425
Excess of output and on hand (8 May 1945) over input[7]	—176	788	3, 001	1, 754

[1] Arrivals from the detachment of patients who are scheduled for return to units (but also includes those limited assignment men not eligible for return to combat units and who subsequently were assigned to other units).

[2] Enlisted men who became officers during the period of the report.

[3] Losses through absent without leave, transfer to detachment of patients, evacuation to Zone of Interior, and like reasons; also 4,056 Medical Department enlisted men retrained under infantry retraining program and 16 Medical Department enlisted men sent to officer candidate school.

[4] Individuals from detachments of patients who were returned to the units in which they served prior to hospitalization. They are designated as "casuals" in the source.

[5] Unreported as to race or ability to fill general or limited assignment. Represents shipments only from 10th Depot in United Kingdom for period from 6 June to 31 December 1944.

[6] Designated as "reinforcements" in the source.

[7] The following explanation of the discrepancies between output and input occurs in the source: "4. The violent flow of stockage through the Command precluded any attempt to account for all assignments outside of the originally reported branch to another branch * * *. A further factor * * * lies in the fact that the opening inventory (D-day) included approximately 35,600 men in packages prepared for Invasion Operations. Approximately 15,000 were returned to stockage after estimated requirements were found to be too high. A good portion of these men who were carried in packages as infantry, were members of branches other than infantry who subsequently shipped out in their original branches. Exact accounting of these transactions is not available. FA [Field Artillery] and TD [Tank Destroyer] were the branches principally affected * * *."

The above quotation probably helps to explain the discrepancy in the case of Medical Department enlisted men and, perhaps, officers. In the case of the Medical Department officers it is also possible that a certain number entered the replacement system as members of nonmedical services or arms and then were assigned to administrative duties with the Medical Department. It is doubtful, however, whether these would account for the entire discrepancy.

Source: Headquarters, Ground Forces Reinforcement Command, European Theater of Operations, "Flow of Enlisted and Officers Stockage for Period D-Day to V–E Day (6 June 1944 to 8 May 1945)," *in* History of the Ground Force Reinforcement Command, European Theater of Operations, U.S. Army, pt. II, ch. VI.

In the Southwest Pacific, theater headquarters in late 1944 and the early part of 1945 attempted to make arrangements under which limited service officers no longer fit for duty in their original branches would be made available for service in the Medical Administrative Corps. The scheme was carried into effect to some extent but it not only aroused opposition on the part of the services losing the officers but also failed, because of inexperience of the officers transferred in matters pertinent to the jobs to be filled, to arouse much enthusiasm in the Medical Department.[24]

Personnel made available by administrative actions

Units developed an overstrength in given types of personnel as a consequence of table-of-organization changes. This overstrength might be used by other units. In the European theater, for example, the reorganization of general hospitals under T/O 8–550, 3 July 1944, made available for other assignments particularly in units arriving from the Zone of Interior short of Medical Corps officers or specialist personnel, 450 Medical Corps officers. Indeed, it was with a view to meeting the needs of such units that the War Department directed this reorganization.[25]

By a directive of 30 November 1944, Headquarters, Communications Zone, European Theater of Operations, ordered 92 general hospitals in that theater to be reorganized with substantial decreases in the authorized nursing and enlisted personnel permitted for each and with minor reductions in male officer strength. The personnel thus made available was to be reported by the hospital commanders to the Commanding General, Ground Forces Replacement System, through base or section headquarters, for transfer to an appropriate replacement depot.[26] As of 30 November 1944, the reorganization of station hospitals under T/O 8–560, 28 October 1944, had made surplus, according to an estimate prepared in December of that year, a total of 477 medical officers in all theaters.[27]

In certain cases, units were abolished in order to supply personnel for others. Deactivation of six station hospitals in the North African theater made it possible to provide specialized personnel for the enlargement of general hospitals in that theater in 1944.[28]

In particularly pressing circumstances, certain medical units gave up personnel, without abolishing the pertinent positions, to units considered to be in greater need of the personnel than themselves. In 1942, units in the

---

[24] Memorandum, Deputy Chief Surgeon, U.S. Army Forces, Far East, to Chief Surgeon, 12 Apr. 1945.

[25] Administrative and Logistical History of the Medical Service, Communications Zone, European Theater of Operations. [Official record.]

[26] Organization Order 68, Headquarters, Communications Zone, European Theater of Operations, 30 Nov. 1944.

[27] Letter, Office of The Surgeon General (R. J. Carpenter, MC), to War Department, Assistant Chief of Staff, G–1, through Commanding General, Army Service Forces (attention: Director, Military Personnel Division), 8 Dec. 1944, subject: Memorandum of Transmittal.

[28] Logistical History of NATOUSA–MTOUSA, 11 August 1942–30 November 1945. [Printed in Naples, Italy, by G. Montanino, 1945.]

European theater designated to participate in the invasion of North Africa were brought up to strength by drawing upon other medical establishments which were to remain behind in the United Kingdom.[29] Subsequently, in 1944, when the cross-channel invasion of France was undertaken, personnel assigned to communications zone installations in the theater was sent forward into the combat zone in order to provide medical care in field units. When, on 22 June 1944, the First U.S. Army, spearheading the invasion of France, found it necessary to requisition 46 Medical Corps officer replacements, they were obtained not only from replacement depots located in the United Kingdom but also by transfer from general and station hospitals situated therein. Forty-eight hours after the requisition had been submitted, the replacements began to arrive and continued to do so until 30 June.[30]

At the time of the Battle of the Bulge in December 1944 and January 1945, there again was a heavy demand for both officer and enlisted replacements, and communications zone units were found to be virtually the only source of such personnel. Despite the fact that conditions at the front were doubling and tripling their patient loads, these installations were called upon for and did supply more than 300 medical officers for frontline units.[31]

Within a month and a half, more than 3,100 enlisted men also were sent forward to help provide the combat zone medical service. On several occasions, the Ground Forces Reinforcement Command, despite its responsibility to provide medical service to the personnel passing through the replacement system, supplied Medical Department officers to satisfy the more urgent needs of combat units.[32]

Some time in 1945, apparently, the Personnel Division of the Chief Surgeon's Office, European theater, stated that a base section might be rendered understrength by as much as 2 percent of its total medical strength in order to fill requisitions from an army.[33]

Shifts also took place within the combat zone. Not long after D-day, the First U.S. Army found that it had a shortage of 28 medical officers within its corps and divisions. Consequently, each 400-bed evacuation hospital in the army was asked to designate two medical officers and each 750-bed evacuation hospital was requested to designate four to aid in filling the vacancies. In this way, the needed replacements were obtained with great rapidity.[34]

Personnel obtained through transfers, overstrength, and deactivations of units constituted 20 percent of the whole number of Medical Department officers entering the European theater Ground Forces Reinforcement Command between D-day and V–E Day, but only 13 percent of the whole number

---

[29] Information from Col. James B. Mason, 1 Feb. 1952.

[30] First United States Army: Report of Operations, 20 October 1943–1 August 1944, Book VII, pp. 106–107.

[31] See footnote 25, p. 301.

[32] Annual Report, Surgeon, Ground Forces Reinforcement Command, European Theater of Operations, U.S. Army, 23 Oct. 1943–30 June 1945.

[33] Memorandum, Col. A. Vickoren, MC, for Colonel Liston, 2 Mar. 1945, subject: Reference Cable UK 27386.

[34] See footnote 30, p. 302.

of Army officers entering this command. The proportion of Medical Department enlisted men thus entering the Reinforcement Command was very much greater than that of Medical Department officers and vastly in excess of the corresponding proportion of enlisted men in general.

In the case of medical officers at least, the personnel made surplus by these procedures were not always satisfactory replacements. As a rule, the reorganizations which produced the surpluses were designated to relieve such officers of administrative duties which could be performed by members of the Medical Administrative Corps and thus permit the former to practice medicine. Yet, in many cases, the men thus relieved were precisely those least fitted to take up professional duties, for in the course of holding administrative posts, they had lost skills and acquired rank which greatly reduced their eligibility to fill vacancies for men of professional competence. The change in the table of organization of general hospitals by War Department Circular No. 99 of 1944 provided for the substitution of a lieutenant colonel of the Medical Corps by a lieutenant colonel of the Medical Administrative Corps in the position of executive officer. In the European theater, however, it was noted in June 1944 that, while this reorganization would render 79 medical officers surplus, only about 14 of these would be qualified to fill professional assignments suitable to their rank, since the great majority of them had been promoted strictly on the basis of their administrative ability.[35]

Even when officers made surplus through reorganization of hospitals were fully qualified to do professional work, there was difficulty in placing them where the need for them was greatest. In the European theater, for example, "the acute shortages that most needed to be filled and filled quickly," were positions of company grade in ground force combat units. The revision of the tables of organization, however, created overstrengths which consisted largely of field grade officers who had served in positions "totally foreign to combat medical assignments." The result was that the "needs were just as acute after reorganization of hospitals as they had been before."[36] Such difficulties account at least partly for the fact that some of the officers made surplus by table-of-organization changes were returned to the United States.

Casuals from the Zone of Interior

Comprehensive data on the number of Medical Department replacements that actually were provided by the Zone of Interior for oversea areas are lacking for most of the war period, completely so for the year 1942. We know, however, that because of the buildup of strength for the North African invasion, it was not until the end of that year that any significant number of nontable-of-organization personnel arrived in the European theater.[37] Statistics are available for the period March–November 1943 when a total of 2,737

[35] Memorandum, Col. C. D. Liston, for G–1, European Theater of Operations, 17 June 1944.

[36] Annual Report, Personnel Division, Officer of the Chief Surgeon, European Theater of Operations, U.S. Army, 1944.

[37] See footnote 25, p. 36.

Medical Department officers and 14,820 Medical Department enlisted men were dispatched overseas as replacements. During the year 1944, 2,906 male Medical Department officers were shipped overseas to all theaters, a decline from 1943.

In March to November of the latter year, the monthly shipments of such officers averaged 0.46 percent of the male Medical Department officer strength throughout the world and 1.89 percent of the same strength overseas. In the European theater, the monthly rate of shipments of Medical Department officer replacements in March–November 1943 was 1.26 percent of the mean strength of such officers in the theater. From the beginning of 1944 to the end of June 1945, a total of 1,096 officers arrived from the Zone of Interior as Medical Department replacements or casuals for use in other than units of the Army Air Forces.[38] This amounted, on a monthly basis, to 0.204 percent of the mean strength serving in Ground Forces and Services of Supply units in the theater within the dates mentioned. For the period from the beginning of the invasion of the Continent to V–E Day, the average monthly shipment was equal to 0.214 percent. Not only was the rate of shipment lower than it had been in 1943, but it was vastly lower than that of the service and ground forces as a whole; this, however, should occasion no surprise since these forces taken together had far greater combat losses, proportionally, than did the Medical Department.

Scattered information from other theaters also indicates the existence of meager replacement shipments in a stage of the war when they were needed most. Replacements for the Mediterranean Theater of Operations were scarce through nearly all of the campaign in Italy.[39]

The China-Burma-India theater in the summer of 1944 complained to the War Department of a shortage of 91 Medical Corps officers. Not only was that theater then told that under revised tables of organization this shortage amounted only to 12, but it also was informed that no more than 9 men would be shipped from the Zone of Interior to meet this shortage. The shipment was to take place during October; when the rest of the deficit would be wiped out was not stated. The theater was urged to report to the War Department shortages of other types of medical personnel although it was told that nurses, physical therapy aides, and dietitians might not be available until after January 1945.[40]

---

[38] (1) Memorandum, Army Service Forces, for Assistant Chief of Staff, G–3, War Department General Staff (attention: Colonel Stevenson), subject: Report of Overseas Replacements for the Period 16 September 1942 through 28 February 1944. (2) See footnote 32, p. 302.

[39] Statement of Maj. Gen. Joseph I. Martin to the author, 19 Feb. 1952.

[40] 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, vol. II, pp. 159–160. [Official record.] (The theater complaint was based on the fact that nearly all hospitals were operating far above rated capacities * * *. In the largest hospitals patients of the Chinese Army comprised from one-third to one-half of their totals. The shortage of medical officers (and units) at that time was so serious that the Theater Surgeon was sent by the Theater Commander to Washington for these conferences. Letter, Brig. Gen. Robert P. Williams, to Col. J. B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 22 Dec. 1955.)

Aside from the difficulties occasioned by lack of personnel, the provision of replacements by the Zone of Interior was complicated by delays in the requisitioning process. Requisitions went through channels to the theater G–1, or the replacement command, before being forwarded to the Zone of Interior.[41] Thus, although the surgeon of the Southwest Pacific theater submitted a requisition for 50 dental officers during December 1944, he was informed by a letter from the Office of The Surgeon General, dated 9 April 1945, that that Office had not yet received the requisition although it would be filled upon receipt.

The average waiting period for the arrival of a replacement in the Mediterranean theater was 3 months.[42] In that theater, at least, it was not possible to reduce the delay in filling requisitions by anticipating needs and calling for personnel from the Zone of Interior before vacancies actually existed for such personnel. A requisition for seven Dental Corps officers submitted in November 1944 by the Twelfth Air Force in anticipation of the establishment of new service groups and expectation of losses occasioned by hospitalization and other factors of attrition was disapproved on the ground that the theater would not requisition replacements unless a table-of-organization vacancy actually existed.[43]

Lack of replacements from the Zone of Interior and difficulties in obtaining such as were available forced the theaters increasingly to resort to local sources of supply to fill vacancies in units or to establish new organizations. Obviously, the closer the source of supply the less was the likelihood of delay in obtaining what was needed. Thus, in the course of the war, the importance of a careful check of personnel requisitions by representatives of the Medical Department on each level of an oversea command in order to make certain that all available personnel was utilized before resorting to a higher echelon or the Zone of Interior became manifest. It appears, however, that even in late stages of the war, this was not always done.[44]

Nevertheless, there is good reason to believe that a greater proportion of oversea replacements came from theater sources than from the Zone of Interior, and that the proportion was larger than in the case of Army replacements in general. There can be little question of this as regards the European theater, particularly during the period of ground combat.

---

[41] (1) Letter, Col. Homan E. Leech, to Department of Army General Staff, Personnel and Administrative Division, 23 Oct. 1947, subject: Replacement System Study. (2) Semiannual Report, Surgeon, Twelfth Air Force, June–December 1944. (3) Semiannual Report, Personnel Division, Office of The Chief Surgeon, European Theater of Operations, U.S. Army, January–June 1945, with enclosure 5 thereto.

[42] Munden, Kenneth W.: Administration of the Medical Department in the Mediterranean Theater of Operations, U.S. Army. [Official record.]

[43] See footnote 41(2), p. 305.

[44] (1) See footnote 25, p. 301. (2) Letter, Lieutenant General Devers to all concerned, 8 Aug. 1944, subject: Unit Personnel Requisitions for Medical Department Officers. (3) Pacific Conference, Panel III, Personnel, 31 July 1945.

Temporary Personnel

Personnel temporarily attached to a unit for training or in order to be provided with administrative services might be used as a source of manpower above the assigned strength. In May 1943, for example, the percentage of the total Services of Supply Medical Department strength in the European theater that was classified as "attached" exceeded 13 percent, dropping sharply as the time for the cross-channel invasion approached. The corresponding percentages for the Army as a whole were always higher than those of the Medical Department (table 25). A similar situation prevailed in the Southwest Pacific Area, where the 118th General Hospital, which complained of shortages of personnel in all categories, found, during the second quarter of 1943, that it was able to tide over several difficult periods as a result of temporary attachment of personnel of other organizations. The staff of the 9th Portable Surgical Hospital, consisting of 4 officers and 25 enlisted men, was attached to the general hospital for purposes of training for a period of about 1½ months. Both the officers and men were utilized in operating the general hospital.

Another method of obtaining additional personnel above assigned unit strength was to "borrow," on temporary duty from other organizations. This was particularly the case when it was desired to meet the requirements of frontline units. Thus, during periods of severe combat, personnel from corps and army medical units in the European theater were attached for temporary duty to divisional organizations. Litter bearers, company aidmen, and medical and surgical technicians were prominent among those attached.[45] On occasion, general or station hospitals in the Mediterranean theater were drawn upon for dental officers to serve temporarily in units lacking such personnel.[46] In general, it was the practice in that theater to fill vacancies temporarily with individuals from units that were not operating at full capacity.

ORGANIZATIONAL AND PROCEDURAL CHANGES

During the emergency and war periods, various methods were developed which led to a more efficient utilization of medical personnel. Primary among these were measures permitting freer use to be made of personnel, such as the extensive use of Medical Administrative Corps officers to relieve medical, dental, and other professional personnel of nontechnical duties; the use of trained medical technicians; and the shifting of minor nursing functions from Army nurses to nurses' aides and to some extent to members of the Women's Army Corps. The use of stenographers at certain hospitals to aid the doctors in preparing clinical records relieved the latter of much routine

[45] (1) Annual Report, Surgeon, Ninth U.S. Army, 1944. (2) Annual Report, Surgeon, Third U.S. Army, 1944.

[46] Report, Col. Lynn H. Tingay, of Dental Activities in North African Theater of Operations, 29 Dec. 1944.

clerical work, although such assistance was never widely furnished. Other expedients to meet the growing demands of the Army without lowering the standard of medical service or unduly increasing the number of medical personnel employed included undermanning of theater of operations units in training; changes in the Zone of Interior hospital system and its procedures; readjustment of personnel allowances to theater of operations units and Zone of Interior installations; redistribution of Medical Department officers among major commands in the Zone of Interior; and shipment of hospitals overseas with less than full complements.

Undermanning Theater of Operations Units in Training

A policy of deferring the assignment of part of the officer complement of newly activated theater of operations medical units and detachments which was gradually put into effect in 1942–43 doubtless resulted in some saving of personnel. Before this, it had been the practice to assign a full complement of officers to these units immediately upon activating them. This meant that while the unit or detachment was taking unit training and waiting to go into operation, the officers were not fully occupied, since there was little professional work for them to do unless they could be used to assist the station complement of the hospital at that post. This constitued a waste of professional personnel, and the complaints of officers so assigned was one reason for the change of policy.

The new policy was applied first to affiliated hospitals when in May 1942 The Adjutant General issued a directive providing for the assignment of only a small percentage of the authorized officer strength to these hospitals while in training.[47] Similar steps were taken to conserve the supply of medical officers in nonaffiliated hospitals—officers were to be assigned to these units only in the numbers needed and as they were needed.[48] The heavy demand for medical officers dictated the application of this policy to nonmedical units having assigned medical personnel.

In March 1943, a War Department directive announced that each table of organization calling for attached medical and dental officers would be revised to include a notation that this personnel was to be furnished only as required and available within the continental limits of the United States, but would be furnished in full prior to departure for oversea duty.[49]

---

[47] Letter, The Adjutant General, to Commanding Generals, Army Ground Forces, Army Air Forces, Services of Supply, and others, 29 May 1942, subject: Allotment of Officer Personnel to Medical Units of the Field Forces, Continental United States.

[48] (1) Memorandum, The Surgeon General, for Officers Branch, Office of The Adjutant General, 19 Dec. 1942. (2) Memorandum, Col. Francis M. Fitts, Office of The Surgeon General, 3 Jan. 1943, subject: Plans for Bringing Theater Hospital Units and Named General Hospitals to T/O or to Authorized Allotted Strengh.

[49] Memorandum, Deputy Chief of Staff, for Commanding General, Services of Supply, 10 Mar. 1943, subject: Availability of Physicians.

TABLE 25.—*Monthly Medical Department strength in Services of Supply or Communications Zone, European Theater of Operations (exclusive of Iceland), 30 September 1942–31 October 1944* [1]

Date and personnel	General strength								Medical Department strength				
	Theater	Services of Supply or Communications Zone [2]							Theater [5]	Services of Supply or Communications Zone [3]			
		Total		Net		Attached				Total		Attached	
		Number	Percent of theater strength	Total [4]	Percent of theater strength	Number	Percent of Services of Supply or Communications Zone strength	Percent of net		Number	Percent of theater Medical Department strength	Number	Percent of Services of Supply or Communications Zone Medical Department strength
30 September 1942	188, 497	49, 715	26. 37	49, 715	26. 37	10, 188	20. 49	20. 49	13, 031	3, 930	30. 16	102	2. 60
Officers	14, 513	4, 653	32. 06	4, 653	32. 06	880	18. 91	18. 91	2, 138	854	39. 94	4	. 47
Enlisted	173, 984	45, 062	25. 90	45, 062	25. 90	9, 308	20. 66	20. 66	10, 893	3, 076	28. 24	98	3. 19
31 October 1942	223, 794	52, 299	23. 37	52, 299	23. 37	11, 325	21. 65	21. 65	15, 792	4, 096	25. 94	515	12. 57
Officers	18, 142	4, 941	27. 23	4, 941	27. 23	1, 003	20. 30	20. 30	2, 586	863	33. 37	100	11. 59
Enlisted	205, 652	47, 358	23. 03	47, 358	23. 03	10, 322	21. 80	21. 80	13, 206	3, 233	24. 48	415	12. 84
30 November 1942	170, 227	43, 169	25. 36	43, 169	25. 36	11, 471	26. 57	26. 57	13, 257	6, 990	52. 73	830	11. 87
Officers	16, 374	4, 878	29. 79	4, 878	29. 79	962	19. 72	19. 72	2, 762	1, 393	50. 43	103	7. 39
Enlisted	153, 853	38, 291	24. 89	38, 291	24. 89	10, 509	27. 45	27. 45	10, 495	5, 597	53. 33	727	12. 99
31 December 1942	134, 808	44, 827	33. 25	44, 827	33. 25	12, 361	27. 57	27. 57	9, 988	6, 042	60. 49	519	8. 59
Officers	13, 877	4, 591	33. 08	4, 591	33. 08	980	21. 34	21. 34	2, 087	1, 296	62. 10	105	8. 10
Enlisted	120, 931	40, 236	33. 27	40, 236	33. 27	11, 381	28. 29	28. 29	7, 901	4, 746	60. 07	414	8. 72
31 January 1943	122, 097	49, 841	40. 82	49, 841	40. 82	13, 780	27. 65	27. 65	10, 738	6, 704	62. 43	413	6. 16
Officers	14, 564	5, 532	37. 98	5, 532	37. 98	1, 063	19. 22	19. 22	2, 465	1, 607	65. 19	101	6. 29
Enlisted	107, 533	44, 309	41. 21	44, 309	41. 21	12, 717	28. 70	28. 70	8, 273	5, 097	61. 61	312	6. 12

28 February 1943	104,510	46,352	44.35	46,352	44.35	14,016	30.24	30.24	10,333	7,610	73.65	815	10.71
Officers	11,086	5,303	47.84	5,303	47.84	1,081	20.38	20.38	2,298	1,786	77.72	193	10.81
Enlisted	93,424	41,049	43.94	41,049	43.94	12,935	31.51	31.51	8,035	5,824	72.48	622	10.68
31 March 1943	109,549	47,863	43.69	47,863	43.69	13,619	28.45	28.45	10,528	7,793	74.02	827	10.61
Officers	12,084	5,517	45.66	5,517	45.66	1,147	20.79	20.79	2,370	1,848	77.97	197	10.66
Enlisted	97,465	42,346	43.45	42,346	43.45	12,472	29.45	29.45	8,158	5,945	72.87	630	10.60
30 April 1943	110,818	47,204	42.60	47,204	42.60	13,318	28.21	28.21	10,855	6,593	60.74	816	12.38
Officers	12,709	5,643	44.40	5,643	44.40	1,044	18.50	18.50	2,464	1,803	73.17	197	10.93
Enlisted	98,109	41,561	42.36	41,561	42.36	12,274	29.53	29.53	8,391	4,790	57.08	619	12.92
31 May 1943	132,776	52,189	39.31	49,155	37.02	18,161	34.80	36.95	11,329	7,083	62.52	935	13.20
Officers	14,874	5,854	39.36	5,753	38.68	1,207	20.62	20.98	2,593	1,889	72.85	249	13.18
Enlisted	117,902	46,335	39.30	43,402	36.81	16,954	36.59	39.06	8,736	5,194	59.46	686	13.21
30 June 1943	184,015	69,743	37.90	65,570	35.63	20,299	29.11	30.96	15,899	9,833	61.85	1,017	10.34
Officers	19,347	7,379	38.14	7,239	37.42	1,250	16.94	17.27	3,406	2,592	76.10	265	10.22
Enlisted	164,668	62,364	37.87	58,331	35.42	19,049	30.54	32.66	12,493	7,241	57.96	752	10.39
31 July 1943	238,028	97,473	40.95	93,514	39.29	23,642	24.25	25.28	18,278	11,516	63.00	1,127	9.79
Officers	23,964	9,026	37.66	8,858	36.96	1,174	13.01	13.25	3,765	2,815	74.77	324	11.50
Enlisted	214,064	88,447	41.32	84,656	39.55	22,468	25.40	26.54	14,513	8,701	59.95	803	9.23
31 August 1943	278,742	102,210	36.67	97,589	35.01	22,312	21.83	22.86	21,043	12,919	61.39	881	6.82
Officers	27,758	9,663	34.81	9,474	34.13	1,059	10.96	11.18	4,188	3,091	73.81	220	7.12
Enlisted	250,984	92,547	36.87	88,115	35.11	21,253	22.96	24.12	16,855	9,828	58.31	661	6.73
30 September 1943	361,794	144,706	40.00	135,802	37.54	24,558	16.97	18.08	30,319	19,155	63.18	862	4.50
Officers	33,917	12,495	36.84	12,091	35.65	1,147	9.17	9.49	6,114	4,462	72.98	213	4.77
Enlisted	327,877	132,211	40.32	123,711	37.73	23,411	17.71	18.92	24,205	14,693	60.70	649	4.42
31 October 1943	466,562	175,858	37.69	168,065	36.02	27,412	15.59	16.31	38,084	24,431	64.15	434	1.78
Officers	43,295	15,058	34.78	14,560	33.63	1,215	8.09	8.34	7,586	5,579	73.54	110	1.97
Enlisted	423,267	160,800	38.00	153,505	36.27	26,197	16.29	17.07	30,498	18,852	61.81	324	1.72
30 November 1943	637,521	232,995	36.55	221,305	34.71	41,787	17.93	18.88	52,095	28,949	55.57	847	2.93
Officers	57,820	18,976	32.82	18,373	31.78	2,066	10.89	11.24	9,684	6,610	68.26	205	3.10
Enlisted	579,701	214,019	36.92	202,932	35.01	39,721	18.56	19.57	42,411	42,339	52.67	642	2.87

See footnotes at end of table.

TABLE 25.—*Monthly Medical Department strength in Services of Supply or Communications Zone, European Theater of Operations (exclusive of Iceland), 30 September 1942–31 October 1944* [1]—Continued

Date and personnel	General strength								Medical Department strength				
	Theater	Services of Supply or Communications Zone [2]							Theater [3]	Services of Supply or Communications Zone [3]			
		Total		Net		Attached				Total		Attached	
		Number	Percent of theater strength	Total [4]	Percent of theater strength	Number	Percent of Services of Supply or Communications Zone strength	Percent of net		Number	Percent of theater Medical Department strength	Number	Percent of Services of Supply or Communications Zone Medical Department strength
31 December 1943	773, 753	263, 915	34. 11	243, 221	31. 43	43, 723	16. 57	17. 98	65, 876	31, 238	47. 42	948	3. 03
Officers	68, 235	21, 623	31. 69	19, 682	28. 84	2, 133	9. 86	10. 84	11, 618	7, 094	61. 06	213	3. 00
Enlisted	705, 518	242, 292	34. 34	223, 539	31. 68	41, 590	17. 17	18. 61	54, 258	24, 144	44. 50	735	3. 04
31 January 1944	937, 308	319, 266	34. 06	289, 221	30. 86	45, 972	14. 40	15. 90	81, 616	40, 593	49. 74	416	1. 02
Officers	80, 197	26, 622	33. 20	24, 311	30. 31	2, 283	8. 58	9. 39	14, 359	9, 300	64. 77	99	1. 06
Enlisted	857, 111	292, 644	34. 14	264, 910	30. 91	43, 689	14. 93	16. 49	67, 257	31, 293	46. 53	317	1. 01
29 February 1944	1, 084, 057	339, 536	31. 32	304, 301	28. 07	39, 826	11. 73	13. 09	96, 320	42, 201	43. 81	422	1. 00
Officers	92, 702	29, 197	31. 50	26, 388	28. 47	2, 145	7. 35	8. 13	17, 089	9, 712	56. 83	98	1. 00
Enlisted	991, 355	310, 339	31. 30	277, 913	28. 03	37, 681	12. 14	13. 56	79, 231	32, 489	41. 01	324	1. 00
31 March 1944	1, 199, 077	372, 507	31. 07	333, 329	27. 80	46, 930	12. 60	14. 08	111, 024	51, 873	46. 72	518	1. 00
Officers	106, 334	30, 855	29. 02	28, 586	26. 88	2, 445	7. 92	8. 55	19, 819	11, 829	59. 69	98	. 83
Enlisted	1, 092, 743	341, 652	31. 27	304, 743	27. 89	44, 485	13. 02	14. 60	91, 205	40, 044	43. 91	420	1. 05
30 April 1944	1, 422, 276	448, 899	31. 56	389, 438	27. 38	56, 905	12. 68	14. 61	125, 729	61, 477	48. 90	521	. 88
Officers	125, 028	35, 720	28. 57	32, 146	25. 71	3, 042	8. 52	9. 46	22, 550	13, 643	60. 50	40	. 29
Enlisted	1, 297, 248	413, 179	31. 85	357, 292	27. 54	53, 863	13. 04	15. 08	103, 179	47, 834	46. 36	481	1. 00

31 May 1944	1, 526, 965	502, 443	32. 90	409, 242	26. 80	42, 932	8. 55	10. 49	133, 364	63, 820	47. 85	412	. 64
Officers	135, 453	39, 112	28. 87	33, 562	24. 78	2, 427	6. 21	7. 23	23, 839	14, 012	58. 78	35	. 25
Enlisted	1, 391, 512	463, 331	33. 30	375, 680	27. 00	40, 505	8. 74	10. 78	109, 525	49, 808	45. 48	377	. 76
30 June 1944	1, 635, 200	587, 664	35. 94	430, 636	26. 34	53, 833	9. 16	12. 50	146, 323	72, 198	49. 34	1, 419	1. 97
Officers	148, 531	47, 338	31. 87	35, 038	23. 59	2, 986	6. 31	8. 52	26, 132	15, 611	59. 74	110	. 70
Enlisted	1, 486, 669	540, 326	36. 34	395, 598	26. 61	50, 847	9. 41	12. 85	120, 191	56, 587	47. 08	1, 309	2. 31
31 July 1944	1, 770, 845	648, 570	36. 62	476, 953	26. 33	50, 802	7. 83	10. 65	159, 282	84, 550	53. 08	1, 099	1. 30
Officers	162, 286	52, 020	32. 05	40, 593	25. 01	2, 668	5. 13	6. 57	28, 425	17, 993	63. 30	98	. 54
Enlisted	1, 608, 559	596, 550	37. 09	436, 360	27. 13	48, 134	8. 07	11. 03	130, 857	66, 557	50. 86	1, 001	1. 50
31 August 1944	1, 905, 261	723, 550	37. 98						169, 672				
Officers	175, 070								29, 789				
Enlisted	1, 730, 191								139, 883				
30 September 1944	2, 041, 023	771, 632	37. 81	544, 839	26. 69	27, 468	3. 56	5. 04	183, 634	95, 466	51. 99	900	. 94
Officers	178, 782	60, 231	33. 69	46, 856	26. 21	1, 788	2. 97	3. 82	31, 657	20, 298	64. 12	246	1. 21
Enlisted	1, 862, 241	711, 401	38. 20	497, 983	26. 74	25, 680	3. 61	5. 16	151, 977	75, 168	49. 46	654	. 87
31 October 1944	2, 196, 785	823, 446	37. 48	606, 871	27. 63	68, 235	8. 29	11. 24	198, 410	101,496	51. 15	1, 160	1. 43
Officers	187, 837	62, 723	33. 39	49, 801	26. 51	3, 847	6. 13	7. 72	34, 183	21, 467	62. 80	107	. 50
Enlisted	2, 008, 948	760, 723	37. 87	557, 070	27. 73	64, 388	8. 46	11. 56	164, 227	80, 029	48. 73	1, 053	1. 32

[1] Basic data, unless otherwise specified, from successive issues of "Progress Report," Headquarters, European Theater of Operations, U.S. Army.

[2] Comprehends all persons assigned or attached to the command.

[3] Includes both assigned and attached personnel, but not personnel in headquarters installations, except prior to 30 April 1943, when personnel in base section headquarters may be included. Data, thus, are not strictly comparable to data pertaining to general Services of Supply or Communications Zone strength or net strength, since both of these include headquarters personnel.

[4] Includes all personnel assigned or attached to the command except nonoperating personnel for the period after 30 April 1943. The nonoperating personnel comprised replacements and members of detachments of patients and prisoners. An "in transit" group is included in the nonoperating category for the period beginning with 30 June 1944; this included patients en route to the United Kingdom from the European Continent and replacements en route to units. To what extent nonoperating personnel entered into the statistics prior to May 1943 is not known.

[5] From "Strength of the Army" for dates shown or approximations thereto with the following exceptions: 30 April 1944, from source shown in table 31, footnote 3; February–March 1944, obtained by prorating on the basis of data for January and April 1944; 30 June 1944 equals average of data for 31 May and 31 July 1944.

Changes in the Zone of Interior Hospital System

Use of specialty centers

As the Army and therefore the number of patients increased, a greater diversity of specialty centers in the general hospitals was established for the treatment of particular diseases, wounds, and injuries. In such a center, patients requiring a highly specialized type of care were concentrated in order to make the best use of the available specialists. Several centers of this sort had been in operation before the war; others were added in 1942, and the number was further increased in 1943, when the practice was announced as a settled policy. The system, which continued throughout the war, permitted the Army to place its limited number of specialists to the best advantage.[50]

Creation of convalescent hospitals

In April 1944, the War Department authorized convalescent hospitals, as distinct from convalescent centers, annexes, and facilities, which had been in operation since the preceding June. It was felt that the convalescent patient did not need the highly specialized care he was receiving in a general hospital and that the removal of patients from general to convalescent hospitals would permit fuller use of the former's highly specialized staff. A guide for the utilization of personnel in convalescent hospitals in the Zone of Interior was recommended by The Surgeon General and approved by the War Department (see table 7).[51] Comparison of this table with the guides for named general hospitals (table 6) will indicate the saving in Medical Corps officers that could be made by placing convalescents in the new type of hospital instead of keeping them in general hospitals.

Closure of station hospitals

Early in 1944, as the military population in the Zone of Interior was shrinking due to oversea movement of troops, The Surgeon General effected the closure or reduction in size of station hospitals. As this was done, doctors assigned to these hospitals could be reassigned either to hospitals scheduled for oversea service or to general hospitals in the Zone of Interior. Although in 1944, the General Staff sanctioned the establishment of so-called regional hospitals in the Zone of Interior by both the Army Air Forces and the Army Service Forces, general hospitals remained under the jurisdiction of the Army

---

[50] Memorandum, Director, Resources Analysis Division, Office of The Surgeon General, for Deputy Surgeon General, 19 Aug. 1945.

[51] (1) Memorandum, Brig. Gen. R. W. Bliss, Assistant Surgeon General, for Commanding General, Army Service Forces, attention: Director, Personnel Division, 18 Apr. 1945, subject: Personnel Guides for Convalescent Hospitals. (2) War Department Circular No. 170, 8 June 1945.

Service Forces, more exclusively for the care of highly specialized cases and of patients brought home from overseas.[52]

Reduction of time of hospitalization

During the war, the Medical Department initiated a number of measures designed to reduce the period of hospitalization to the absolute minimum. This released not only beds for incoming patients, but the personnel to care for them. In addition, The Surgeon General succeeded in having convalescent furloughs granted for periods not to exceed 90 days. On 1 June 1945, there were approximately 70,000 patients on furlough from the general and convalescent hospitals for whom otherwise beds would have had to be provided.[53]

Readjustment of Personnel Allowances

Oversea units

The overall personnel requirements of the Army are set forth in published tables of organization by type of unit. Revisions of the medical tables for oversea theaters during 1940–41 were made on the basis of World War I experience and partly as a means of adjusting medical units to the new triangular organization of the combat divisions.[54] The 1942–43 revisions reflected the difficulty in procuring Medical Corps officers and therefore authorized a smaller percentage of such personnel in proportion to the rapidly expanding Army as a whole (tables 9 and 10).

When the number of personnel available in certain categories proved insufficient to meet the requirements of all units that were being activated under these revised tables, further revisions were made during the later war years. For example, after it became permissible to substitute a Medical Administrative Corps officer for one of the two Medical Corps officers who served as surgeons in every infantry battalion, the tables of organization of the infantry regiment were revised to that effect (table 9).[55] Table 8 shows personnel changes in the tables of organization for selected hospitals. In all but two cases, the number of Medical Corps officers, nurses, and enlisted men was reduced while the number of Medical Administrative Corps officers was increased.

---

[52] 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.

[53] (1) War Department Circular No. 111, 7 Apr. 1945. (2) Memorandum, Director, Hospital Division, Office of The Surgeon General (Col. A. H. Schwichtenberg), for Director, Historical Division, Office of The Surgeon General, through Chief, Operations Service, Office of The Surgeon General, 18 June 1945, subject: Additional Material for Annual Report Fiscal Year 1945, with Tab A thereto.

[54] (1) Letter, Maj. Gen. Alvin L. Gorby, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 3 Apr. 1956. (2) See footnote 56, p. 314.

[55] (1) TOE 7–11, 1 June 1945, Infantry Regiment. (2) TOE 7–95, 12 July 1944, Infantry Battalion (Separate).

The tables issued in 1943 and 1944 also show for the first time small numbers of dietitians and physical therapists as military personnel.

Another device for making the most efficient use of the limited personnel available was the development of the "team" or "cellular" concept, which grew out of the auxiliary surgical groups and attained its most general usefulness in the 8–500 series of tables of organization. The basic principle was to so balance specialists and technicians in teams for specific purposes that each man's skills were extended by the complementary skills of those who worked with him. Such groups as malaria control units, dental operating detachments, and food inspection detachments were refined under the new concept of specialized group effort. Carried over into civilian medicine, the team concept has spread throughout the profession.[56]

Zone of Interior installations

In 1943, the War Department Manpower Board, in investigating all Army installations in the Zone of Interior to determine where savings in personnel could be made, developed "yardsticks" or criteria for manning various types of installations.

The General Staff used the yardsticks in making its bulk authorizations of personnel for the Army Service Forces and, to provide a guide for subordinate commanders, developed manning tables for hospitals of various sizes which were promulgated as War Department Circular No. 209, 26 May 1944. In general, these manning tables, or guides, agreed with the Manpower Board's yardsticks and the recommendations of the Inspector General's Office. They were not, however, meant to be followed as rigorously as tables of organization, and if in any particular case they failed to provide enough personnel for adequate medical care, a written request for increases could be submitted. The guides were announced as subject to correction by any future surveys made by the Manpower Board (tables 6 and 7). In general, these guides indicate that the greater the extent to which beds could be concentrated in large hospitals, the greater would be the saving in medical officers and in certain other categories of personnel.

The issuance of manning tables seems to have achieved considerable success in conserving medical personnel so far as general hospitals in the Zone of Interior were concerned. In July 1943, the number of personnel (military and civilian) assigned to these hospitals per 100 authorized beds was 94. By June 1944, the number had fallen to 68.6 and by July 1945, it had risen to 71.1; in the former month, however, less than half the beds were occupied, while in the latter month the general hospitals were operating at 122 percent of their rated capacity.[57]

[56] Statement of Durward G. Hall, M.D., to the editor, 27 May 1961.

[57] See footnote 52, p. 313.

Redistribution of Medical Department Officers

As has been noted, when in 1942 the Army Air Forces were authorized to procure their own doctors, their recruiting program was more successful than that of Army Service Forces. As a result, The Surgeon General felt that some of these medical officers should be transferred to understrength Army Service Forces installations in this country or to units scheduled for overseas.[58] However, there was no single authority to distribute doctors to the Army Service Forces, Army Ground Forces, and Army Air Forces according to need, and the Deputy Chief of Staff at first refused to take any action leading to the transfer of doctors from the Air to the Service Forces. He was said to believe that some general hospitals (all of which were under the jurisdiction of the Army Service Forces) were overstaffed and that the Service Forces should "make a thorough canvass of the situation" to utilize to the best advantage all its own doctors before calling on either the Ground or Air Forces for any of theirs. Army Service Forces headquarters thereupon urged The Surgeon General to continue his survey of medical personnel with a view to releasing the number necessary for oversea duty and at the same time retaining the minimum required to operate U.S. establishments.[59]

In the fall of 1943, when The Surgeon General declared that he did not have in Army Service Forces enough doctors to man all the hospital units scheduled for oversea movement the following January, he recommended that the Air Forces be directed to supply the doctors needed for nine such hospitals.[60] Approximately 10 days after these recommendations, the Air Forces having lost certain of their hospital functions, voluntarily transferred 200 Medical Corps officers to the Army Service Forces.[61]

Shortly after this the Personnel Planning and Placement Branch, Office of The Surgeon General, submitted a report on the numbers of medical specialists available and required in the Army Ground, Air, and Service Forces in this country; it showed that the Air Forces had 3,271 available against 1,271 required, whereas the Service Forces required 8,014 and had available only 6,571. The report showed no excess in Army Ground Forces. Based on this study, the General Staff ordered the Air Forces to transfer 500 Medical Corps officers to the Service Forces.[62] Of the 700 transferred altogether, a large

---

[58] Memorandum, Lt. Col. Francis M. Fitts, Office of The Surgeon General, for Colonel Lull, Office of The Surgeon General, 11 Jan. 1943, subject: Availability of Physicians.

[59] Memorandum, Maj. Gen. W. D. Styer, Services of Supply, for The Surgeon General, 3 Oct. 1943.

[60] Memorandum, Military Personnel Division, Army Service Forces, for The Surgeon General, 17 Nov. 1943, subject: Filling Officer Shortages in Medical Units Committed, with 1st endorsement thereto, 26 Nov. 1943.

[61] Memorandum, Headquarters, Army Service Forces, for Commanding General, Army Service Forces, attention: Military Personnel Division, 30 Nov. 1943.

[62] (1) Memorandum, Office of The Surgeon General (Maj. Fred M. Fielding), for G–1, 28 Dec. 1943. (2) Memorandum, G–1, for Chief of Staff, 4 Jan. 1944, subject: Requirements for Medical Corps Officers. (3) Letter, Brig. Gen. J. M. Bevans, Assistant Chief of Air Staff, to Commanding General, Army Service Forces, 26 Jan. 1944, subject: Reassignment of Medical Corps Officers to Army Service Forces, with endorsements thereto.

proportion were specialists, whom the Service Forces most needed to staff units destined for overseas. Other transfers of doctors occurred throughout the war period.[63] In addition to its relinquishment of doctors, the Air Forces during the year ending on 30 June 1945 transferred approximately 1,500 Army nurses, 72 Medical Administrative Corps officers, and 17 Medical Department dietitians to the Army Service Forces.[64]

Shipment of Hospitals With Less Than Full Complements

When, in 1944, The Surgeon General concluded that, despite all efforts to make the personnel supply meet the demand, the Army would not have enough medical specialists and nurses to staff both Army Service Forces hospitals in this country and units yet to be shipped abroad, he used the expedient of shipping some hospitals without their full table-of-organization complement of specialists and nurses. While no theater chief surgeon ever agreed that he possessed an excess of specialists, The Surgeon General considered this expedient feasible because the theaters in his judgment did possess a relative excess of specialists who could be used to balance the staffs of these hospitals. Accordingly, in early 1944, The Surgeon General received permission to ship general hospitals overseas with a full complement of doctors but with general practitioners in place of seven of the specialists authorized by the tables of organization: that is, the chiefs of medicine, surgery, orthopedic surgery, neurosurgery, psychiatry, radiology, and laboratory service. This policy was followed for several months; eventually, certain units were sent overseas with even fewer specialists.[65]

By July 1944, with an accelerated shipment of approximately 53 general hospitals requested by the European theater, it was considered impossible to staff all these units at full table-of-organization strength even by substituting nonspecialists. Consequently in that month, The Surgeon General recommended to the Commanding General, Army Service Forces, that general hospitals be shipped to the European theater with only 16 instead of the authorized 32 Medical Corps officers, until the excess of such personnel in the theater should be absorbed. This recommendation was returned informally without action. Later, however, units were shipped with only 16 doctors, but with attempts to balance the staffs. Proper classification and accurate accounting procedures enabled The Surgeon General to make such adjustments.

---

[63] Letter, The Adjutant General, to Commanding General, Army Air Forces, 23 Sept. 1944, subject: Medical Officer Requirements. (2) Weekly Diary, Operations Branch, Military Personnel Division, Office of The Surgeon General, for week ending 5 Mar. 1945. (3) Letter, Military Personnel Division, Army Air Forces, to Commanding General, Army Service Forces, 17 July 1944, subject: Transfer of Medical Corps Officers.

[64] (1) Letter, The Surgeon General, to The Adjutant General, 11 Feb. 1944, subject: Army Nurse Corps. (2) Letter, The Surgeon General, to The Adjutant General, 18 May 1944, subject: Designation of Medical Corps Personnel for 124th and 125th General Hospitals. (3) Annual Report, Personnel Division, Air Surgeon's Office, 1944–45.

[65] Memorandum, Military Personnel Division, Office of The Surgeon General, for Colonel Love, Historical Division, Office of The Surgeon General, 19 Oct. 1944.

The procedure of shipping hospitals without all of their Medical Corps officers was continued until practically the end of hostilities against Germany. In March 1945, The Surgeon General informed the Operations Division, General Staff, that orthopedic surgeons of grade C or better were not available to the European theater in April of that year and added that they would not be available for shipment from the United States at any future date.[66] The next month, April 1945, he recommended that 5 general hospitals, short 16 Medical Corps officers each, be shipped to the Pacific Ocean Areas. He based this recommendation on his knowledge that that theater had more doctors per 100 hospital beds occupied than either the Southwest Pacific Area or the Zone of Interior; and stated that in August or September he would ship sufficient Medical Corps officers to staff the hospitals fully.[67]

The Surgeon General also felt compelled to ship certain hospitals without nurses, thereby permitting the assignment of nurses to these hospitals from excess numbers resulting from cuts in tables of organization. In 1944, he received approval to ship several general hospitals without nurses to the European theater. (At that time, a 1,000-bed general hospital carried a complement of 83 nurses.) At least two general hospitals lacking nurses were shipped to the Southwest Pacific Area.[68]

UTILIZATION OF NEGRO PERSONNEL

In late 1940, when Selective Service was about to bring large numbers of Negroes into the Army, the Medical Department contained only a few Negro enlisted men and no Negro officers or nurses on active duty. Negro patients in Army hospitals were therefore attended by white doctors and nurses, and there was no segregation of Negro from white patients. In September 1940, the Medical Department Officers Reserve contained a small number of Negro officers eligible for service (that is, physically qualified and not overage): 60 Medical, 8 Dental, and 3 Veterinary Corps officers. About the same time, 40 nurses were in the Reserve maintained for the Army by the Red Cross.[69]

When, in 1940, it became likely that the Army would take in many more Negroes, the Surgeon General's Office made plans to place its share of the new personnel in the Medical Department. The Surgeon General recognized his responsibility in a memorandum to the General Staff in October 1940: "It ap-

---

[66] Memorandum, The Surgeon General, for Assistant Chief of Staff, Operations Division, through Commanding General, Army Service Forces, 9 Mar. 1945, subject: Inclusion of Orthopedic Surgeons for Staffs of General Hospitals.

[67] Memorandum, The Surgeon General, for Commanding General, Army Service Forces, attention: Director of Plans and Operations, 20 Apr. 1945, subject: Staffing of the 303d, 304th, 308th, 309th, and 310th General Hospitals.

[68] Letter, Office of The Surgeon General (Brig. Gen. Bliss, Chief, Operations Service), to Commanding General, Army Service Forces, 6 May 1944, subject: Staffing of Medical Units of July, with endorsement thereto, 31 May 1944.

[69] (1) Memorandum, Assistant Chief of Staff, G–1, for Chief of Staff, 28 Sept. 1940, subject: Use of Negro Reserve Officers Under 1940–41 Military Program, Tab C. (2) Blanchfield, Florence A. and Standlee, Mary W.: The Army Nurse Corps in World War II. [Official record.]

pears that * * * the Medical Department will have to utilize * * * around 4,000 Negro enlisted men and several hundred officers." [70] Six months later, The Surgeon General and his advisers had agreed among themselves that the Medical Department would be prepared to go as far in the use of Negro troops as any other service and could conform to any Army-wide policy of employing Negroes segregated from or in combination with whites. The Department, however, would "not willingly accord to a policy whereby any detachment will be part White and part Black unless this policy is adopted not only by the services but by the line." The Medical Department did, in fact, go further than any other service in the use of Negro officers.[71]

During the course of the war, the Medical Department used Negro enlisted men and male Negro officers in the medical detachments of all-Negro combat divisions, in a number of all-Negro theater of operations hospitals, in sanitary companies, in the Negro wards of certain Zone of Interior hospitals, and in at least two all-Negro hospitals in the United States. The Department used Negro members of the Nurse Corps in a number of hospitals at home and overseas and Negro members of the Women's Army Corps in some Zone of Interior hospitals. Negro Medical Department personnel constituted, at its wartime peak, about 4.2 percent of the Medical Department's overall strength. In the Medical Corps, the highest proportion was about 0.76 percent; in the Dental Corps, 0.78 percent; in the Veterinary Corps, 0.39 percent; in the Sanitary Corps, 0.34 percent; in the Medical Administrative Corps, 1.1 percent; in the Nurse Corps, 0.88 percent; and among enlisted men, 5 percent (tables 1 and 26). In the assignment of Negro medical personnel, Dean John W. Lawlah of the Howard University Medical School was of inestimable assistance to The Surgeon General.[72]

Hospital Personnel

As early as October 1940, the Surgeon General's Office proposed the establishment of Negro wards in certain hospitals in the United States.[73] When such wards were organized in the hospitals at Fort Bragg, N.C., and Camp Livingston, La., in May 1941, twice as many medical officers were at first allotted to them as were customarily assigned to ward duty. The commanders of both hospitals, however, later found that one Negro doctor instead of two per ward was sufficient, and the Surgeon General's Office revised its estimates accord-

---

[70] Memorandum, The Surgeon General, for The Adjutant General, 25 Oct. 1940, subject: Plan for Utilization of Negro Officers, Nurses, and Enlisted Men in the Medical Department, 1940–41 Military Program.

[71] (1) Memorandum, Lt. Col. C. B. Spruit, Office of The Surgeon General, for Colonel Love, Office of The Surgeon General, 10 Apr. 1940, subject: Use of Negroes in the Medical Department Under the PMP. (2) Letter, Maj. Ulysses G. Lee, Jr., Office of the Chief of Military History, to Col. C. H. Goddard, Office of The Surgeon General, 22 Aug. 1952.

[72] Statement of Durward G. Hall, M.D., to the editor, 27 May 1961.

[73] Memorandum, Office of The Surgeon General (General Love), for The Adjutant General, 22 Oct. 1940, subject: Assignment of Negro Medical Officers.

TABLE 26.—*Negroes in the Medical Department, 1943–45*

Date, end of month	Male officers							Female officers				Enlisted men
	Medical Corps	Dental Corps	Veterinary Corps	Medical Administrative Corps	Sanitary Corps	Pharmacy Corps	Total	Army Nurse Corps	Hospital Dietitian	Physical Therapist	Total	
1943												
October	276	73	4	115	4	-----	472	198	9	1	208	25, 296
December	284	76	2	126	6	-----	494	198	9	1	208	25, 431
1944												
March	297	70	2	117	5	-----	491	219	10	2	231	23, 720
June	340	102	6	146	6	-----	600	213	8	2	223	23, 347
September	327	101	2	118	5	-----	553	247	9	2	258	20, 544
December	342	104	8	178	5	-----	637	256	9	6	271	19, 587
1945												
March	326	95	2	189	6	-----	618	336	7	9	352	19, 352
June	325	114	1	210	6	-----	656	464	9	11	484	18, 534
September	307	101	2	213	8	-----	631	466	8	10	484	18, 213
December	208	79	6	116	1	-----	410	318	8	7	333	7, 440

Source: "Strength of the Army" for corresponding dates.

ingly.[74] This separation into white and Negro wards was abandoned before the end of the war.

At the same time, The Surgeon General recommended establishing all-Negro hospitals in the Zone of Interior and commissioning Negroes as Medical Administrative and Sanitary Corps officers. The General Staff informed him that no all-Negro hospital was planned and that commissioning Negroes in the two corps named was "not favorably considered."[75] Later on, however, Negroes were commissioned in the Medical Administrative Corps, and two all-Negro hospitals were eventually established.

The Air Forces Station Hospital at Tuskegee, Ala., activated in 1941, was the first of these two hospitals to receive its personnel, and played an important part in utilizing Negro doctors and nurses. It also supplied some of the first personnel to report to the Negro Station Hospital at Fort Huachuca, Ariz., which began operations in 1942.[76]

[74] Letter, Secretary, General Staff, to Judge William H. Hastie, Civilian Aide to Secretary of War, 1941, subject: Redistribution of Negro Medical Department Personnel.

[75] 3d endorsement, The Adjutant General, to The Surgeon General, 31 Jan. 1941, to memorandum cited in footnote 70, p. 318.

[76] (1) See footnote 52, p. 313. (2) See footnote 71 (2), p. 318.

Fort Huachuca was the training center for the 93d (Negro) Infantry Division. The National Medical Association (the Negro counterpart of the American Medical Association) was requested to assist in procuring medical officers for its hospital, which by the end of 1942 had 676 beds and a staff of 37 Medical Corps officers, 1 Sanitary Corps officer, 2 Medical Administrative Corps officers, 100 nurses, and 243 enlisted men. At that time, also four Negro Dental Corps officers had been assigned to the hospital dental clinic, which functioned under the post dental surgeon. Two Veterinary Corps officers were assigned to the post surgeon's office at that time. The commanding officer of this hospital from June 1942 until his return to civilian life in October 1945 was Lt. Col. Midian O. Bousfield. Chief of the medical service until March 1943 was Maj. Harold W. Thatcher. Both of these men, as well as many others on the Fort Huachuca hospital staff, made outstanding records under particularly difficult circumstances.

Sanitary Companies

In October 1940, also, The Surgeon General recommended a new type of unit which was to absorb most of the Negro enlisted increment and some Negro officers as well.[77] This was the "sanitary company" authorized in November 1940 for the purpose of performing "such general duties as the commanding officer [of the theater of operations general hospital to which a company was assigned] may prescribe."[78] The Surgeon General's Office insisted that activation of these companies should not reduce the medical department's overall requirements for enlisted men.[79]

The sanitary companies, established under T/O 8–117 (November 1940), found difficulty in obtaining useful work. In July 1942, after several had completed their training, The Surgeon General adopted the policy of assigning one to each named general hospital and Medical Department Replacement Training Center in this country. Large numbers of these companies remained unemployed, however, because the theaters and defense commands refused to requisition them when informed by The Surgeon General that they were ready for shipment.[80]

In January 1943, the Commanding General, Services of Supply, directed The Surgeon General to consider widening the scope of the work to be performed by the companies in order to obtain more useful employment for them. The Director of The Surgeon General's Sanitary Engineering Division voiced a belief that these companies could do valuable work in environmental sanitation at larger War Department installations, particularly in the South. He

---

[77] (1) Memorandum, Office of The Surgeon General (Col. A. G. Love), for Executive Officer, Office of The Surgeon General, 1 Oct. 1940, subject: Policy of The Surgeon General re Colored Troops (9/). (2) See footnote 75, p. 319.

[78] T/O 8–117, 1 Nov. 1940.

[79] Memorandum, The Surgeon General, for Assistant Chief of Staff, G–1, 5 May 1941, subject: Plan for the Use of Colored Personnel in the Medical Department.

[80] Letter, The Surgeon General, to all Surgeons, Defense Commands, and U.S. Army Forces in Oversea Bases, 18 Nov. 1942, subject: Sanitary Companies.

suggested that such work might consist, among other things, of mosquito and other insect control; constructing, maintaining, and operating the sanitary demonstration areas; and maintaining proper conditions at the incinerator, the dump, and the sewage disposal plant.[81] This recommendation led to a revision (June 1943) of the table of organization which would appear to have these companies used largely on mosquito control. In the new table, each of the two platoons now had two drainage, two oiling, and two spraying teams. None of the other suggested functions were ever incorporated in a table of organization.

Medical Administrative Corps Officers

In the Medical Administrative Corps, Negro officers almost without exception obtained their commissions on graduating from officer candidate school instead of by direct commissioning either from civil life or from the enlisted ranks of the Medical Department. By 1 April 1945, the school located at Camp Barkeley, had graduated 158 Negroes. At that time, a total of 189 had been admitted to the Medical Administrative Corps, some of whom had undoubtedly been commissioned by the school at Carlisle Barracks.[82]

The Surgeon General experienced difficulty in placing Negro members of the Medical Administrative Corps. In early 1943, the War Department, at his suggestion, established a pool of 100 Negro Medical Department officers at Fort Huachuca. The Surgeon General controlled the assignment, relief, and transfer of officers assigned to the pool. Those in it were used in the local station hospital, the 93d Infantry Division, and in other duties at that station while awaiting transfer to other posts.[83] But The Surgeon General had trouble in finding assignments elsewhere for many Medical Administrative Corps officers in the pool. His Office finally arranged with the Army Ground Forces to have certain numbers attend the special basic course for infantry officers. The understanding was that those who completed the course satisfactorily would be detailed to the infantry; at least 16 and possibly more were so detailed; the remainder were returned to the pool at Fort Huachuca.[84]

---

[81] (1) Memorandum, Services of Supply (Assistant Chief of Staff for Operations), for The Surgeon General, 16 Jan. 1943, subject: Sanitary Companies. (2) Memorandum, Col. W. A. Hardenbergh, Office of The Surgeon General, for Brig. Gen. L. B. McAfee, Office of The Surgeon General, 25 Jan. 1943, subject: Use of Medical Sanitary Companies.

[82] (1) Annual Reports, Army Service Forces Training Center, Camp Barkeley, Tex., 1944–45. (2) Strength of the Army, 1 Apr. 1945. Prepared for War Department General Staff by Machine Records Branch, Office of The Adjutant General, under direction of Statistical Branch.

[83] (1) Memorandum, Office of The Surgeon General (Col. F. B. Wakeman, Director of Training), for Director of Training, Services of Supply, 10 Mar. 1943, subject: Training Pool for Colored Medical and Dental Officer Personnel, with endorsement thereto, 8 June 1943. (2) Memorandum, Lt. Col. D. G. Hall, Office of The Surgeon General, for Colonel Wickert, Office of The Surgeon General, 20 Mar. 1943. (3) War Department Circular No. 132, 8 June 1943.

[84] (1) Weekly diary, Sanitary Corps and Medical Administrative Corps Section, Classification Branch, Military Personnel Division, Office of The Surgeon General, for weeks ending 3 Mar. and 11 May 1945. (2) Semiannual History of Medical Administrative Corps and Sanitary Corps, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1 Jan.–31 May 1945. (3) Semiannual Report, Records and Statistics Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1 July–31 Dec. 1944.

When hostilities came to an end in August 1945 and there appeared to be little likelihood of any demand for these Medical Administrative Corps officers, the Surgeon General's Office took steps to release them as being surplus to the needs of the Army.[85]

Army Nurse Corps

As to Negro members of the Army Nurse Corps, the Secretary of War in late 1943 committed himself to enlarging this group, which then consisted of about 200 individuals. The Surgeon General's Office, however, argued that there was no apparent demand for more on the part of commanders and suggested that, before additional Negro nurses were commissioned the service commands and oversea theaters should be asked how many more they could use.[86] Whether or not this suggestion was followed, more Negro nurses were actually brought in, especially during the recruiting drive at the beginning of 1945.

During the early years of the war, Negro nurses had been restricted to the care of Negro patients and had therefore served with white nurses only in the two hospitals that for a time possessed wards devoted exclusively to the care of Negroes. Later, however, Negro nurses were assigned to work alongside white nurses in at least 16 hospitals in the United States, where they attended not only Negro but white patients. According to the report of one of these hospitals, "no case was found where a white patient objected to a colored nurse taking care of him."[87]

Women's Army Corps

The early campaigns to recruit Women's Army Corps members for the Medical Department seem to have resulted in the acceptance of few Negro women but there was a Women's Army Corps detachment composed of Negroes stationed in at least one general hospital (Halloran) in 1943.[88] Six and possibly more Women's Army Corps hospital companies were formed of Negroes in 1945 after the War Department General Staff had authorized this type of unit. They functioned at the following general hospitals: Lovell, Fort Devens, Mass.; Tilton, Fort Dix, N.J.; Halloran, Staten Island, N.Y.; Wakeman, Camp Atterbury, Ind.; Thomas M. England, Atlantic City, N.J.; and Gardiner, Chicago, Ill.[89]

---

[85] Memorandum, Chief, Classification Branch, Military Personnel Division, Office of The Surgeon General, to Chief, Personnel Service, Office of The Surgeon General (attention: Procurement, Separation, and Reserve Branch, Office of The Surgeon General), 3 Sept. 1945, with endorsement thereto, 8 Oct. 1945. (2) War Department Circular No. 290, 22 Sept. 1945.

[86] (1) Memorandum, Maj. Gen. W. D. Styer, Army Service Forces, for The Surgeon General, 14 Dec. 1943, subject: Utilization of Negro Nurses. (2) Memorandum, Brig. Gen. R. W. Bliss, Chief, Operations Service, Office of The Surgeon General, for Commanding General, Army Service Forces (attention: Planning Division), 27 Dec. 1943, subject: Utilization of Negro Nurses.

[87] (1) See footnote 52, p. 313. (2) Annual Report, Station Hospital, Camp Livingston, La., 1944.

[88] Annual Report, Halloran General Hospital, N.Y., 1943.

[89] Directory of the Army of the United States (Exclusive of Army Air Forces and Attached Services), 1 Sept. 1945.

This did not represent any great demand for Negro enlisted women on the part of Medical Department commanders. The Enlisted Branch of the Surgeon General's Military Personnel Division reported in the fall of 1944 that with one exception there had been practically no demand for these women and "it has been found almost impossible to find suitable assignments for the few that had been enlisted. Many of the few installations that do have colored WAC's seem desirous of releasing them." [90] On the other hand, the surgeon of one service command reporting for 1943 declared: "Especial mention should be made of the success had in this service command with colored enlisted women." [91]

Demands for Use of More Negro Medical Officers

During the emergency period and the war, Negro leaders and others urged that more Negro members of the medical profession, especially doctors and nurses, should be brought into the Medical Department.[92] The Surgeon General's Office gave a number of reasons why the use of Negroes was limited as to numbers and range of jobs. One was the substandard ratings of the Negro professional schools.[93] Another was the results of the Army General Classification Tests, which were unfavorable to Negroes. These and the proposed demobilization of certain Negro combat units for lack of intelligence were cited as reasons for assigning most of the Medical Department's quota of enlisted Negroes to the sanitary companies.[94]

Moreover, with reference to Negro doctors, the Office of The Surgeon General had pointed out even earlier that the Army's requirements would have to be considered in relation to civilian needs and that the ratio of physicians to population was smaller in the case of Negroes than in that of whites.[95]

In the course of the war, it became plain that, despite the insistence by Negro doctors and their professional organization that the Army accept them, the country's total supply of Negro doctors was not great enough to spare many from civilian life. Estimates of the number of Negro physicians in the country ranged from about 3,300 to about 5,000. As late as October 1942, using a figure of 3,800, the Assistant Civilian Aide to the Secretary of War, Truman Gibson, stated that about 25 percent of the 1,900 who were practicing in the North "could be rather easily spared for Army service" and that about 5 percent of the 1,900 practicing in the South could be spared. This would give a total of 570, in addition to those already in service, although it is almost

---

[90] History, Enlisted Personnel, Military Personnel Division, Office of The Surgeon General, U.S. Army, July–September 1944.

[91] Annual Report, Surgeon, Fifth Service Command, 1943.

[92] Memorandum, Maj. Gen. James C. Magee, The Surgeon General, for Assistant Chief of Staff, G–1, 17 Mar. 1941, subject: Synopsis of Meeting Held Between The Surgeon General and Representatives of Negro Medical Association, 7 Mar. 1941.

[93] Letter, Brig. Gen. Albert G. Love, USA (Ret.), to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 29 Nov. 1955.

[94] See footnote 79, p. 320.

[95] Memorandum, The Surgeon General (Col. G. F. Lull), for Colonel Wharton, G–1, 28 Dec. 1940.

certain that not all of these could have qualified physically for Army service or would have volunteered for it, even though the Procurement and Assignment Service had classified them as available. The Chief of The Surgeon General's Personnel Service confirmed the 25-percent estimate of availables in June 1943 when he stated that 75 percent of the names of applicants which he submitted to a member of the Subcommittee on Negro Health of the Procurement and Assignment Service were turned down as being needed in their respective communities.[96]

UTILIZATION OF PRISONERS OF WAR AND NATIVE LABOR TROOPS

Zone of Interior

In accordance with the provisions of the Geneva Convention of 1929, the Medical Department as well as other branches of the Army used captured enemy personnel as they became available in this country. The two categories of such personnel assisted the Medical Department in different ways. "Protected" personnel, which included enemy nationals who had been employed in medical work, took over to an increasing extent the care of the sick and wounded of their own nationality, under the administration and supervision of members of the U.S. Army Medical Department. Except in cases of emergency, protected personnel were not to treat U.S. Army personnel who might be patients in the same hospital.[97] "Nonprotected" prisoners of war were used for other types of work according to their capabilities, the Medical Department's need, and the stipulations of the Geneva Convention as to the kind of duties they might perform.

In 1945, the War Department directed that protected personnel should be assigned to each service command in the ratio of 2 doctors, 2 dentists, and 6 enlisted men for each 1,000 prisoners. This quota did not include protected personnel in general hospitals that cared for sick and wounded prisoners of war.[98] As early as November 1943, the Secretary of War had directed that maximum use be made of enemy personnel in the care and treatment of prisoners of war of their own nationality and that so far as possible U.S. medical personnel should be relieved from duty in prisoner-of-war hospitals, wards and dispensaries.[99] In 1945, the question arose as to whether this injunction was being followed to the letter.

The two general hospitals devoted exclusively to the care of prisoners of war (Prisoner of War General Hospital No. 2 at Camp Forrest, Tenn., and

---

[96] Report of the Surgeon General's Conference With Chiefs, Medical Branch, Service Commands, 14–17 June 1943.

[97] War Department Technical Manual 19–500, "Enemy Prisoners of War," 5 Oct. 1944, with changes thereto.

[98] Annual Report, Prisoner-of-War Liaison Unit, Office of Provost Marshal General, 1945.

[99] War Department Prisoner-of-War Circular No. 6, 6 Nov. 1943.

Glennan General Hospital, Okmulgee, Okla.) for a time possessed duplicate staffs of American and German personnel.[100] Liberal use of American personnel along with protected personnel also seems to have characterized other hospitals receiving prisoner-of-war patients, for in February 1945 The Surgeon General sent a message on the subject to four service commands. Data in his Office, he stated, showed continued assignment of considerably more Americans to prisoner-of-war hospitals than appeared to be necessary if protected personnel were fully utilized; the needs of American patients made it essential that all American personnel at these hospitals beyond the minimum required for supervision be assigned elsewhere. The Surgeon General seems to have found it necessary to repeat this admonition five months later, in July 1945. At that time, a total of 345 officers and 3,300 enlisted men had been certified as protected personnel in the nine service commands.[101]

"Nonprotected" prisoners of war as distinct from protected personnel performed a variety of tasks in hospitals and other Medical Department installations. One service command reported that it was using them to the number of 191 officers and 2,875 enlisted men for cleanup work, care of grounds, landscaping, and mess duties. Hospital authorities seem to have found the work of prisoners of war generally satisfactory. The Director of Personnel at Valley Forge General Hospital, Pa., Capt. Francis E. Baker, MAC, went so far as to say: "As the prisoners of war learned their assigned jobs and became accustomed to the required standards, their services became invaluable and in almost every instance supervisors preferred them to any other type of personnel." [102]

Oversea Theaters

As in the Zone of Interior, the Medical Department overseas availed itself of the services of prisoners of war, using them in construction as well as in the operation and maintenance of medical installations. Prisoners of war used in these ways were in addition to those protected personnel who were generally assigned only to prisoner-of-war hospitals or to prisoner-of-war wards in Army hospitals. Prisoner-of-war labor, as long as hostilities endured, was important only in the European and North African theaters, since few or no Japanese captives were used by the Medical Department until after V–J Day, except to care for Japanese prisoner-of-war patients. [103]

---

[100] See footnote 52, p. 313.

[101] See footnote 98, p. 324.

[102] (1) Annual Report, Eighth Service Command, 1945. (2) Annual Report, Valley Forge General Hospital, Pa., 1945. (3) See footnote 52, p. 313.

[103] (1) Letter, Col. I. A. Wiles, to Col. C. H. Goddard, Office of The Surgeon General, 17 Sept. 1952, and letter, Col. Paul O. Wells, to Col. C. H. Goddard, 26 Sept. 1952. (2) The sections which follow, dealing with prisoners of war and native labor troops, are based largely on a manuscript account of "Medical Department Utilization of Civilian and POW Labor Overseas in World War II," prepared under the supervision of the authors of this volume by Cpl. Alan M. White.

Italian service troops

After the Italian armistice on 8 September 1943, Italian prisoners of war were organized into "Italian service units" under tables of organization and equipment established by the War Department. Some of these organizations, including "Italian sanitary companies" set up under TOE 8–117 (the only Medical Department table of organization utilized to establish Italian service units), were assigned to Army hospitals and other medical units throughout the communications zone, largely to supply common labor; although, occasionally, these units contained medical technicians or skilled artisans whose services were especially valuable.

Normally, at least one Italian sanitary company, consisting of approximately 3 officers and 115 enlisted men, would be assigned per general hospital, and frequently this company would be augmented by a platoon or more of a second. Such assignments usually meant the discharge of at least an equal number of Arab, French, or Italian civilians since it was more advantageous for the Medical Department to use personnel under military control who could be given longer and more thorough training in their duties. The fact that they could be required to work longer hours than civilian employees and could be moved with units to new locations probably reinforced their acceptability. Many commanders felt that Italian troops exhibited superior efficiency and a more cooperative attitude than civilians. Few, if any, disciplinary problems were encountered in the use of these troops, and they were described as "honest, industrious, and faithful," "willing and cooperative," and having "rendered inestimable service."

In addition to the Italian troops, Yugoslav service troops, who had been brought by the Germans to Sardinia as forced labor, "because," by all accounts, "the most effective and dependable source of labor available in the theater," when their "detested" Italian officers were replaced by Americans and they were given proper nourishment and medical care.

On 1 May 1945, medical service-type units in the Mediterranean theater employed more than 400 civilians and approximately 5,000 prisoners of war (table 21).

The invasion of southern France in August 1944, which was based on the North African theater, brought some Italian service troops into the European theater. However, they played a comparatively insignificant role in the latter area. In June 1945, they accounted for but 1.8 percent of the entire Medical Department communications zone personnel (exclusive of headquarters installations), the corresponding figure for the Army as a whole being 3.5 percent (table 23).

German prisoners of war

During the Normandy campaign (June and July 1944), German prisoners of war were used as litter bearers, sanitary details, and other "general work" at the evacuation hospitals of the First U.S. Army. Usually, 40 of these

men were assigned to each evacuation hospital. In August and September 1944, the Third U.S. Army used 40 prisoners of war per 400-bed evacuation hospital, 50 prisoners of war per 750-bed evacuation hospital, and about twice that number in each medical depot company. The general policy of the theater was that prisoners of war in the evacuation hospitals could be retained 7 days only, at the end of which period they had to be exchanged for a new group of prisoners. However, after October 1944, evacuation hospitals and medical depots in the Third U.S. Army were permitted to retain prisoners "after proper screening" for an indefinite length of time. The successful use of prisoners of war in the First U.S. Army evacuation hospitals during the early stage of continental operations suggested their further use in communications zone medical installations, and they were used extensively at general hospitals and depots on the Continent.

Probably, the average number of German prisoners used per general hospital was 250–300, although there are many instances where more were assigned. The 813th Hospital Center at Mourmelon, France, in 1945 had 7,321 German prisoners of war working in its 10 general hospitals. In April 1945, German prisoners of war working for the Medical Department in nonheadquarters installations of the communications zone of the European Theater totaled nearly 40,000. In May, this number increased considerably, perhaps because of redeployment of Medical Department troops. At the end of August, it amounted to 29 percent of the entire Medical Department personnel of the zone. Nevertheless, this proportion was smaller than the equivalent ratio for all branches of the Army, the same being true of all other months between June and October. The actual number used also began to decline after May, and whereas in the months April–June, inclusive, the Medical Department was utilizing in the vicinity of 13–15 percent of all nonheadquarters communications zone prisoner-of-war labor, this percentage fell well below 10 percent in subsequent months (table 23).

In the United Kingdom Base Section, the original plan was for 10 hospitals to use 250 German prisoners each and 30 hospitals to use 50 each; it was later decided that 100 was the minimum number that could be profitably utilized in a single hospital. In this base section, however, the Medical Department made little use of such labor until March 1945, but, thereafter, its importance increased greatly.[104] Even in May 1945, however, when more than 40 percent of nonheadquarters Medical Department communications zone troops were stationed in the United Kingdom, only slightly more than 15 percent of the German prisoners used in nonheadquarters communications zone medical installations were located there (table 23).

German prisoners of war performed the same general duties for the Medical Department as did civilian employees; that is, primarily manual labor (fig. 39). Sometimes this included ward duties although, generally, they were not employed in such duties. Enlisted prisoners with experience

[104] For the first half of 1945 the hospital employment figures were as follows: January, 317; February, 415; March, 2,525; April, 5,726; May, 8,228; and June, 7,236.

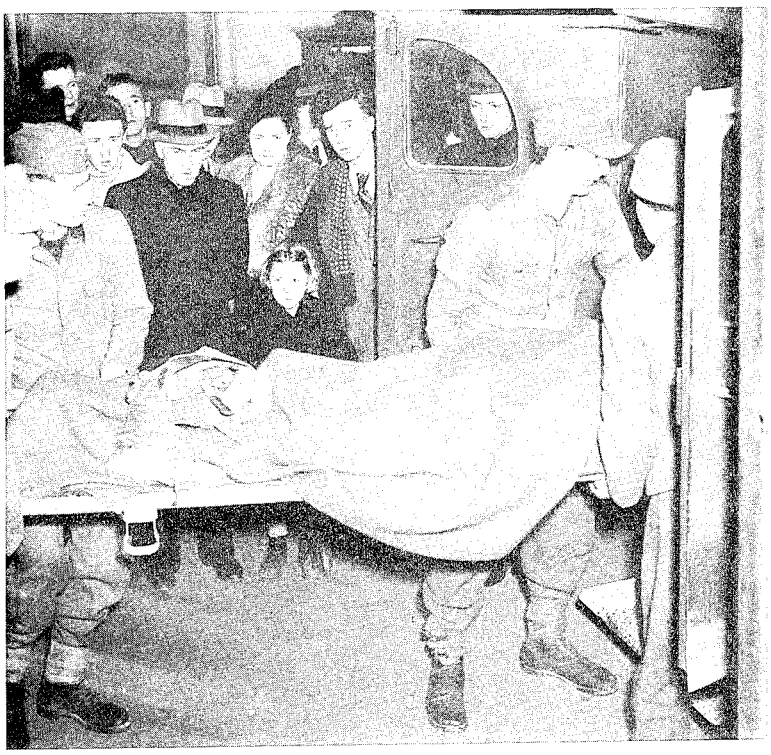


FIGURE 39.—German prisoners of war assist in unloading a hospital train. Liége, Belgium, 18 March 1945, Hospital Train No. 8.

in repair and maintenance of medical equipment were assigned to many of the medical depot companies in the theater.

In 1944 on the Continent, medical units drew their prisoner labor from the nearest prisoner-of-war stockade. In the communications zone, such enclosures were constructed at or near most general hospitals. As the need for prisoner labor increased, the European theater organized it in a more formal manner than previously. A directive of 2 October 1944 assigned to the base section commanders of the communications zone the responsibility for "formation of POW's into labor companies of approximately 250 each," and "military labor service companies" were organized accordingly. U.S. officer and enlisted personnel were attached to the prisoner-of-war labor companies for administration and supervision.[105] Displaced persons were recruited to replace American units on guard duty with the prisoners-of-war labor companies. In 1945, the 10 general hospitals of the 813th Hospital Center employed 935 Dutch guards and 788 Polish women.

[105] Lewis, George G., and Mewha, John: History of Prisoner of War Utilization by the U.S. Army, 1776–1945. Washington: U.S. Government Printing Office, 1955. [DA Pamphlet 20–213.]

In Italy, German prisoners of war were available only in isolated cases for Medical Department work before the end of the fighting in that country (2 May 1945) but many were used to replace civilians and Italian troops in Army hospitals in the summer of 1945. Indeed, German prisoners of war were regarded as the most skillful, efficient, and cooperative of all local labor groups at least in Europe.

Native labor troops

In addition to displaced persons and prisoners of war the Medical Department was able to obtain the services of native labor troops in certain areas. During the latter part of the war, such troops were sent into Assam from southern India and used by a medical supply depot.[106]

After the capitulation of Italy and the assumption by the Italian Government of a quasi-Allied status, that government supplied troops to the Medical Department who, unlike the Italian service unit personnel, were not technically prisoners of war. These were used in the combat zone of the Mediterranean theater; as has been stated, the service units were not expected to serve in that zone. Most evacuation hospitals in that theater had from 30 to 60 Italian soldiers working for them. Some Italian soldiers were reluctant to serve as litter bearers in forward areas but others performed this function with skill and courage. The attachment of the so-called military companies to Army malaria control detachments, where "they were organized as labor crews for ditching, larviciding and house spraying," was said to be "very satisfactory" and to have "enabled the control units to increase their work schedules many fold."

MORALE FACTORS IN EFFICIENT UTILIZATION OF PERSONNEL

Living and working conditions in the Army were sufficiently different from those in civilian life as to require considerable adjustment on the part of the new officer or soldier, whatever his branch of service. Conditions overseas might make the problem of adjustment a good deal more difficult. Very frequently prolonged service in unfamiliar surroundings was in itself a depressing factor. Even a year overseas was long enough for some Medical Department officers to reveal a distinctly "fed-up" attitude toward their environment, although the dissatisfaction appeared more often after a period of 18 months. The extent to which the condition manifested itself differed among individuals and probably many escaped it altogether. Others showed loss of interest in routine duties, irritability, and general inefficiency. Nurses found the first year of their service overseas both interesting and stimulating despite the attendant hardships and discomforts. At the end of 18 months of service,

[106] Letter, Lt. Col. Irvine H. Marshall, to Col. C. H. Goddard, Office of The Surgeon General, 1 Aug. 1952.

however, nurses serving in forward hospitals began to display signs of restlessness and homesickness. Enlisted men of the Medical Department displayed similar signs of discomfort, but when these most frequently appeared has not been ascertained.

Methods of Combating Morale Problems Overseas

Value of continued professional activity

Despite war weariness, the effect of long stays overseas was mitigated in the case of nurses if they had a sufficient amount of satisfactory work to keep them busy. Morale remained at a high level when the patient load and demands for the services of these women were heaviest. When there was little to do, it dropped drastically even after hostilities had ceased, as in the European theater in July 1945. Nurses were also anxious to care for battle casualties. Those who found themselves on protracted duty in Panama, for example, were unhappy because they had no opportunity to do so. Thus, although nurses could expect to withstand the conditions in rear areas for as long as 2 years without suffering harm, they were eager for forward duty, and their morale sagged when it was denied them. Many combat unit nurses were reluctant to move into rear areas, although they were unable to escape the wearing effects of the service they were performing.[107]

The value in terms of morale of keeping personnel busy in the professional tasks to which they were primarily suited was not confined to nurses. It was of demonstrated weight in the case of medical officers and others. When the immediate professional duties were not sufficient for the purpose, as well as at other times, library facilities, the circulation of professional journals, clubs for the discussion of such periodicals, and professional conferences and meetings all served to bolster morale. In the European theater, before D-day, a number of opportunities for professional refreshment were afforded: A theater medical society and several area medical societies meeting at short intervals; an Inter-Allied medical society which met in London every month and to which the Chief Surgeon could order 200 medical officers, thus affording them transportation; and weekly visits to the great teaching hospitals in London for 10 officers at a time. After V–E Day, groups from the European theater were sent to medical centers all over western Europe.[108]

In 1943, the Twelfth Air Force reported from the North African theater that among its medical personnel flight surgeons, being intensely interested in aviation medicine and flying, had shown the least staleness and loss of morale.

---

[107] (1) History of Medical Department Activities in the Caribbean Defense Command in World War II. [Official record.] (2) See footnote 45(2), p. 306. (3) Parsons, Anne F.: History of the Army Nurse Corps in the Mediterranean Theater of Operations, 1942–45. [Official record.] (4) Annual Report, 814th Hospital Center, European Theater of Operations, U.S. Army, 1945. (5) Report, Lt. Col. Alan P. Parker, MC, Executive Officer, 38th General Hospital, on Medical Department Activities in the Middle East, 23 Dec. 1943.

[108] Letter, Maj. Gen. Paul R. Hawley, USA (Ret.), to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 12 Mar. 1956.

On the other hand, dental officers in the Air Forces, although they were engaged in work quite similar to that which had occupied them in civilian life, still developed mental depressions of varying degree. Even the interest of flight surgeons in their work began to wane after they had been overseas in excess of 20 months.[109] It was in respect to nurses that the value of continued professional activities as a means of maintaining morale was considered greatest; nevertheless, even in their case, these activities served only to retard the cumulative effects of prolonged oversea service.[110]

Recreation

Personnel of the Medical Department, under other than combat conditions and just as in other branches of the Army, usually had access to various types of recreational facilities, including officers' and enlisted men's clubs, which were provided as a means of maintaining morale and alleviating the adverse conditions under which troops had to live in oversea theaters. Indeed, because of their proximity to the facilities provided for patients, Medical Department troops were perhaps better off in regard to spectator activities than those of most other arms and services. Recreational facilities of course were not always available. This was true particularly on some of the small islands in the Pacific. On Guam, for example, there were few recreational facilities and no club.[111]

Leaves, furloughs, and reassignments

Besides steady occupation and proper recreation, another means of restoring morale and efficiency was temporary or permanent relief from assigned duties. This could be accomplished without discharging a man from the service, by various administrative means which were used by the Medical Department as by other branches of the Army. Only scattered data are available as to the extent to which these devices were used overseas. Among them were leaves of absence for officers and their equivalent, furloughs, for enlisted men, both of which however were probably of much shorter duration, as a rule, than the standard 7 days in 4 months suggested by the field service regulations. Several medical officers who saw service in the Pacific and Mediterranean theaters believe that medical personnel in those areas fared about the same as others with respect to leaves and furloughs, although distances in the Pacific sometimes made return from leave areas unpredictable.[112]

---

[109] (1) Report, Col. Abram J. Abeloff, MC, on Medical Department Activities in the Persian Gulf Command, 29 May 1945. (2) Flick, John B.: Activities of Surgical Consultants, Pacific Theater, *In* History of Pacific Ocean Areas and Middle Pacific. [Official record.] (3) Annual Report, Surgeon, Twelfth Air Force, 1943. (4) Letter, Col. W. F. Cook, Surgeon, to Maj. Gen. D. N. W. Grant, Air Surgeon, Army Air Forces, 8 Aug. 1944.

[110] (1) Stone, James H.: History of the Army Nurses, Physical Therapists, and Hospital Dietitians in India and Burma. [Official record.] (2) Annual Report, 36th General Hospital, 1944.

[111] (1) See footnote 109. (2) The annual reports of hospitals during the war mentioned the sharing of facilities with patients.

[112] (1) Letter, L. K. Pohl, MC, USAF, to Col. C. H. Goddard, Office of The Surgeon General, 1 Aug. 1952. (2) Letter, G. H. Yeager, to C. H. Goddard, Office of The Surgeon General, 29 Sept. 1952. (3) Letter, T. C. Keramides, to Col. C. H. Goddard, Office of The Surgeon General, 12 Sept. 1952.

Reassignment in or outside an individual's organization and detached service or temporary duty away from it were other means of relief from assignments involving heavy strain, although, unlike leaves and furloughs, they served various additional purposes. Reassignment was practiced extensively within the Medical Department overseas as well as in the United States and between the United States and oversea areas.

Rotation

In popular parlance within the Army, some of the forms of transfer or reassignment—such as placing oversea personnel on temporary duty in the United States when that practice was instituted as a policy toward the end of the war—were loosely comprehended in the term "rotation." As defined by War Department Circular No. 58, 9 February 1944, rotation was "the exchange of personnel in theaters for replacements furnished from the United States as substitutes therefor in accordance with advance requisitions submitted periodically by theater commanders." Rotation within the theaters, to which the directive also referred, was presumably to be understood as also requiring the provision of substitutes for persons being sent elsewhere, in accordance with advance requisitions submitted by the units from which the transfers were to be made. An earlier directive (28 June 1943) was the beginning of an Army-wide rotation policy. Among the persons it specified as eligible for transfer to the United States were (1) those "whose morale or health has been adversely affected by prolonged periods of duty under unusually severe conditions, even though not requiring hospitalization," and (2) those whose experience and training would make them useful "in the training and formation of new units, or for other purposes." The directive of February 1944 added a third category—"personnel considered by the theater commander as deserving of such return." Both circulars provided that persons in the first category be returned to the United States only when their effectiveness could not be restored by rotation within the theater. In general, theater commanders were directed to rotate personnel within their jurisdiction in order to maintain the efficiency of their commands.

The Medical Department had practiced intratheater rotation to some extent even before the Army-wide policy was instituted. In the European theater, a program involving temporary exchanges of medical officers of company grade between the 5th General Hospital and tactical units training in Northern Ireland was carried on as early as 1942. Although the advantages of the scheme were generally acclaimed, a wider application of it did not follow for a long time.[113]

On 30 September 1943, 3 months after the first War Department directive favoring intratheater rotation appeared, instructions to apply it to medical

[113] Middleton, W. S.: Medicine in the European Theater of Operations. Ann. Int. Med. 26: 191–200, February 1947.

officers in the China-Burma-India theater were issued by the theater commander. Under these regulations, officers of the Medical Corps who had served with troops in the field for more than 12 months might apply for transfer to hospital duty, and officers with at least the same amount of service in hospitals might request transfer to a combat unit. In general, however, such rotation was not to be applied to specialists and flight surgeons, nor were applications for transfer to be approved if the transfer would lower the efficiency of a unit engaged in combat or one about to become so engaged. Each commander was directed to effect transfers within his own command if it was possible to do so, and if applications were not forthcoming, he was instructed to initiate such transfers as he believed good for the service.[114]

It was not until a year later that this policy was formally adopted by the Medical Department in the European theater. Two types of intratheater rotation were formulated by the theater surgeon. Permanent rotation from ground force units to communications zone installations was provided for officers and men who had served with line units for extended periods and whose value to the medical service in the opinion of the respective army surgeons would be enhanced by such reassignment. At the same time, rotation of specialists was introduced. Specialists were to be transferred for a 3 months' tour of duty from general and station hospitals to field and evacuation hospitals and auxiliary surgical groups operating in the army area, or vice versa. This program was adopted primarily for professional purposes, being designed to enable medical officers to follow the progress of their patients through various echelons of treatment.[115]

Precisely how much advantage was taken of these programs is not known, but it is certain that they were curtailed as a result of the German counteroffensive of December 1944. At that time, as has been stated the communications zone was called upon to supply large numbers of officers and men to army units without receiving replacements in return. The permanent type of rotation was especially affected by this development.[116] Nevertheless, on 5 January 1945, theater headquarters again authorized rotation of Medical Department officers and enlisted men between army area and communications zone units. The minimum period of service in a field army unit required to establish eligiblity for such rotation was 1 year, of which 3 months had to be subsequent to D-day. The age limit for men transferred to an army was fixed at 35, except in special cases, and they were to possess grades and professional or technical qualifications similar to those of the men they were replacing. Before a man could be transferred from an army to the communications zone, his replacement had to be immediately available. The monthly quota of trans-

[114] Circular No. 75, Headquarters, Rear Echelon, U.S. Army Forces, China-Burma-India, 30 Sept. 1943, subject: Rotation of Officers.

[115] (1) See footnote 36, p. 303. (2) Annual Report, Professional Service Division, Office of The Chief Surgeon, European Theater of Operations, U.S. Army, 1944.

[116] See footnote 36, p. 303.

fers for each army was fixed at 5 Medical Corps officers, 5 other Medical Department officers, and 25 enlisted men.[117]

Intratheater rotation of medical officers was practiced in the North African-Mediterranean theater as early as 1943. Company grade officers in combat units who were more than 35 years of age were moved to communications zone units and replaced, insofar as possible, by general service officers under 30. In most cases personnel wounded in combat or otherwise hospitalized also were reassigned to the communications zone if they so desired. Two or more years of constant field service, especially if a part of this was rendered in combat, gave an individual a strong claim to rotation from a field unit to a communications zone hospital.[118]

In the Mediterranean theater, it was reported that, up to 1 March 1945, 365 Medical Corps officers had been rotated between field units and communications zone hospitals. The impression of a former consultant in the theater was that more officers moved from field units to hospitals than in the opposite direction and that the losses of the former were made up by requisitioning replacements from the Zone of Interior.[119] In view of the charge that Zone of Interior replacements in the theater were scarce during the Italian campaign, there is some doubt as to how well the process of replacement was accomplished.

In the European theater, the exchange of personnel within the theater was not without its morale problems. Difficulties arose when men with relatively high rank who had served in forward units were rotated to establishments further in the rear where they outranked personnel with greater experience and talent in specialized work.[120] This situation has been attributed at least in part to the fact that interchangeability of personnel, as regards rank, was less possible in table-of-organization general hospitals than in evacuation hospitals.[121]

Not much information is available about the amount of rotation of Medical Department personnel between the theaters and the Zone of Interior. In early 1945, The Surgeon General asserted that the rate of rotation of medical officers from oversea theaters had been much higher than that of any other arm or service.[122] Yet there were complaints that the rotation of both medical officers

[117] Letter, Brig. Gen. R. B. Lovett, Adjutant General, European Theater of Operations, to Commanding General, each Army Group, and Commanding General, each Army, 4 Jan. 1945, subject: Rotation of Medical Personnel Between Communications Zone and Armies.

[118] Letter, Stewart F. Alexander, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 3 Dec. 1955.

[119] Letter, E. D. Churchill, to Col. C. H. Goddard, Office of The Surgeon General, 4 Sept. 1952, with extract from Lt. Col. M. E. DeBakey, for The Surgeon General, 5 Mar. 1945, subject: Report of Visit to the Mediterranean Theater of Operations.

[120] (1) Letters, to Col. C. H. Goddard, Office of The Surgeon General, from J. S. Skobba, M.D., 10 Oct. 1952; T. L. Badger, M.D., 3 Sept. 1952; M. E. DeBakey, M.D., 7 Aug. 1952; and C. S. Drayer, 3 Sept. 1952. (2) Annual Report, Professional Service Division, Office of The Chief Surgeon, European Theater of Operations, U.S. Army, 1945.

[121] Letters, to Col. C. H. Goddard, Office of The Surgeon General, from W. S. Middleton, M.D., 26 Aug. 1952; Alan Chaffman, M.D., 11 Sept. 1952; J. M. Flumerfelt, M.D., 8 Sept. 1952; and C. H. Bramlitt, M.D., 24 July 1952.

[122] Letter, The Surgeon General, to Dr. Olin West, Secretary and General Manager, American Medical Association, 31 Mar. 1945.

and other medical personnel was insufficient. About March 1944, the Surgeon of the Twelfth Air Force (Mediterranean theater), expressing his belief that "the rotation policy has not been adequate," called attention to the fact that since the inception of that Force only one dental officer in it had been returned to the United States for any reason except medical.[123]

In answer to criticism of the low rate of rotation of nurses, the Deputy Surgeon General pointed out that the rotation policy for these women was the same as that for other personnel.[124] He stated that although the Surgeon General's Office had concurred in a special policy proposed by the Mediterranean theater whereby 30 nurses would be returned to the United States each month, sufficient replacements for these women could not be supplied. As there were approximately 2,500 nurses in the Mediterranean theater in November 1944, it is readily seen that 30 rotations a month would have benefited only a small percentage of the nurses in the theater.

Despite widespread agreement on the physical and professional benefits of rotation, various medical commanders in the theaters saw drawbacks in the practice. They were disturbed by the prospect of losing an experienced member of a team and having to spend time training an inexperienced replacement. Such a task would, of course, be more difficult if the hospital or other type of unit was operating with a heavy patient load. The theaters, as already noted, had to wait until a replacement arrived before permitting a man to leave for the United States. Although authorities in the United States endeavored to send men with the same qualifications as those they were to replace, instances occurred in which the replacement lacked the attainments of the man being relieved.[125]

The North African theater refused to rotate within the theater a man of particular value in either a combat zone or communications zone assignment.[126] With reference to oversea rotation, the theater surgeon in a statement issued in early 1944, declared that "only under unusual circumstances should key professional personnel be recommended for rotation. Chiefs of professional services, psychiatrists, surgeons, medical or surgical specialists should be considered as key professional personnel." [127] There was a feeling in the theater that the policy of rotation had resulted in the loss during 1943 of many well-trained, experienced medical officers, and that replacements frequently had been relatively inexperienced men.[128] As a result of this feeling, and of the theater surgeon's directive, the more competent officers ceased to be nominated for rotation, which thus became a reward to the less deserving.[129] Indeed, in the European theater, the Chief Surgeon's Office, while not actively discouraging intratheater rotation, long looked upon it with suspicion because it might lend itself to efforts of

[123] See footnote 109 (3), p. 331.

[124] Letter, Maj. Gen. George F. Lull, Deputy Surgeon General, to Hon. Edith Nourse Rogers, 16 Feb. 1945.

[125] Annual Report, 15th Field Hospital, 1944.

[126] See footnote 118, p. 334.

[127] Annual Report, Surgeon, Mediterranean Theater of Operations, U.S. Army, 1944, vol. I.

[128] Annual Report, Surgeon, Mediterranean Theater of Operations, 1944, vol. II.

[129] Annual Report, 70th General Hospital, 1944.

commanders to rid themselves of undesirable officers or to create promotion opportunities for personnel within an establishment by requisitioning a replacement in a grade lower than that of the individual to be rotated out of the unit.[130]

Toward the end of the war, the War Department adopted an alternative to rotation in the form of temporary duty in the United States. This gave the persons so assigned a break in oversea service without ending it for them entirely. One method by which this was accomplished, particularly in the case of nurses, was to assign the officers as medical attendants of patients being evacuated to the Zone of Interior and upon their arrival in the United States to grant them emergency leave.[131]

Many officers in the Mediterranean theater preferred temporary duty in the United States to rotation, for they wished to continue as members of their units rather than be separated from them and risk being sent to another theater.[132] Commanding officers recognized certain advantages to this temporary-duty assignment, for it not only permitted them to give their subordinates a leave at home without the necessity of obtaining a replacement beforehand, but also assured them of the return of experienced personnel after a time.[133] In the very merits of the system, however, lay its disadvantages, for the same commander might be deprived of a valuable officer's service for a period of 60 to 90 days without any kind of substitute.[134]

Thus, in the Mediterranean theater at least, commanding officers became increasingly favorable to rotation as a method which was more likely than temporary duty to provide them with replacements.[135] Perhaps they also felt that it was better to have fresh personnel than war-weary veterans of oversea service, even after a period of leave at home, particularly since the approaching termination of the war made it less necessary than formerly to depend on experienced officers.

Although rotation was of limited scope, its influence, according to Col. Stewart F. Alexander, a former chief personnel officer in the medical service of the North African theater and the Seventh U.S. Army, "was a vital factor in maintenance of morale * * *. The benefits * * * extended far beyond the actual number of men rotated. The men in forward or unfavorable areas often were dominated by the thought that they were doomed in perpetuity to their assignments. Rotation was a very concrete expression that higher echelons were interested in their problems, and was a potent influence for good. This was particularly true in that rather small but very important groups were de-

---

[130] Memorandum, Col. D. E. Liston, Office of the Chief Surgeon, European Theater of Operations, for Adjutant General, Personnel, European Theater of Operations, 11 Mar. 1944.

[131] (1) Annual Report, Chief Surgeon, U.S. Army Services of Supply, Southwest Pacific Area, 1944. (2) Annual Report, Surgeon, United Kingdom Base, Communications Zone, European Theater of Operations, U.S. Army, 1944.

[132] (1) Annual Report, 43d General Hospital, 1944. (2) Annual Report, Surgeon, Fifth U.S. Army, 1944.

[133] See footnote 131 (2), above.

[134] (1) Annual Report, Surgeon, Mediterranean Theater of Operations, U.S. Army, 1944, vol. II. (2) See footnote 132 (2), above.

[135] (1) See footnote 132 (2). (2) Annual Report, Surgeon, Fifth U.S. Army, 1945.

tailed overseas early in the war, when neither the physical aids nor the incentives of imminent victory were present." [136]

Authorization of a medical badge

Promotion was not the only reward for exceptional service. In 1945, the Medical Department's enlisted men and lower ranking officers who were serving with troops in combat received something approaching the recognition that had already been accorded infantrymen. For the latter, the War Department in October 1943 had authorized an Expert Infantryman Badge and a Combat Infantryman Badge, and in June 1944, Congress had awarded $5 a month extra pay to holders of the first and $10 a month to holders of the second.[137] In late 1944, a Medical Department observer returning to the Surgeon General's Office after a visit to the European theater proposed serious consideration of increased pay for medical troops in the infantry. He added that many infantry companies made special arrangements by which medical aidmen were paid out of company funds, and said it was generally felt that such men did daily what, if the infantryman did it, would have brought him a Bronze Star award.

As it happened, a special badge had already been proposed for the medical aidmen. On 1 March 1945, the General Staff authorized a Medical Badge to be worn by Medical Department officers of company grade, warrant officers, and enlisted men who were "daily sharing with the infantry the hazards and hardships of combat." The badge could be temporarily withdrawn when the bearer was transferred or assigned outside the Medical Department to duties in which he might come into contact with the enemy. This, it was explained, was ordered so as not to impair the protected status of regularly assigned Medical Department personnel. In such cases, the right to wear the badge was restored on relief from combat duties or on reassignment to the Medical Department. The badge was of oxidized silver and showed a stretcher placed horizontally behind a caduceus with a cross of the Geneva Convention at the junction of the wings, the whole enclosed by an elliptical wreath 1 inch in height and 1½ inches in length. Like all ground badges, it was worn on the left breast of the service coat, jacket, or shirt.[138] At first, these badges were not awarded posthumously; later, the badge might be awarded to any individual eligible to receive it who had been killed in action or died as a result of wounds received in action on or after 7 December 1941. In 1945, Congress authorized pay of $10 per month to enlisted men (but not officers) entitled to wear the badge.[139]

For bravery in action, in World War II, as well as for meritorious service, many personnel of the Medical Department received citations ranging from the highest award conferred by the U.S. Government, the Congressional Medal of Honor, to the Bronze Star medal—as well as decorations from foreign governments. At least nine of these unarmed soldiers received the Congressional Medal of Honor (fig. 40).

---

[136] See footnote 118, p. 334.

[137] (1) War Department Circular No. 269, 27 Oct. 1943. (2) 58 Stat. 648.

[138] Army Regulations No. 600–70, 18 Apr. 1948.

[139] (1) War Department Circulars No. 66, 1 Mar. 1945, and 151, 23 May 1945. (2) 59 Stat. 462.

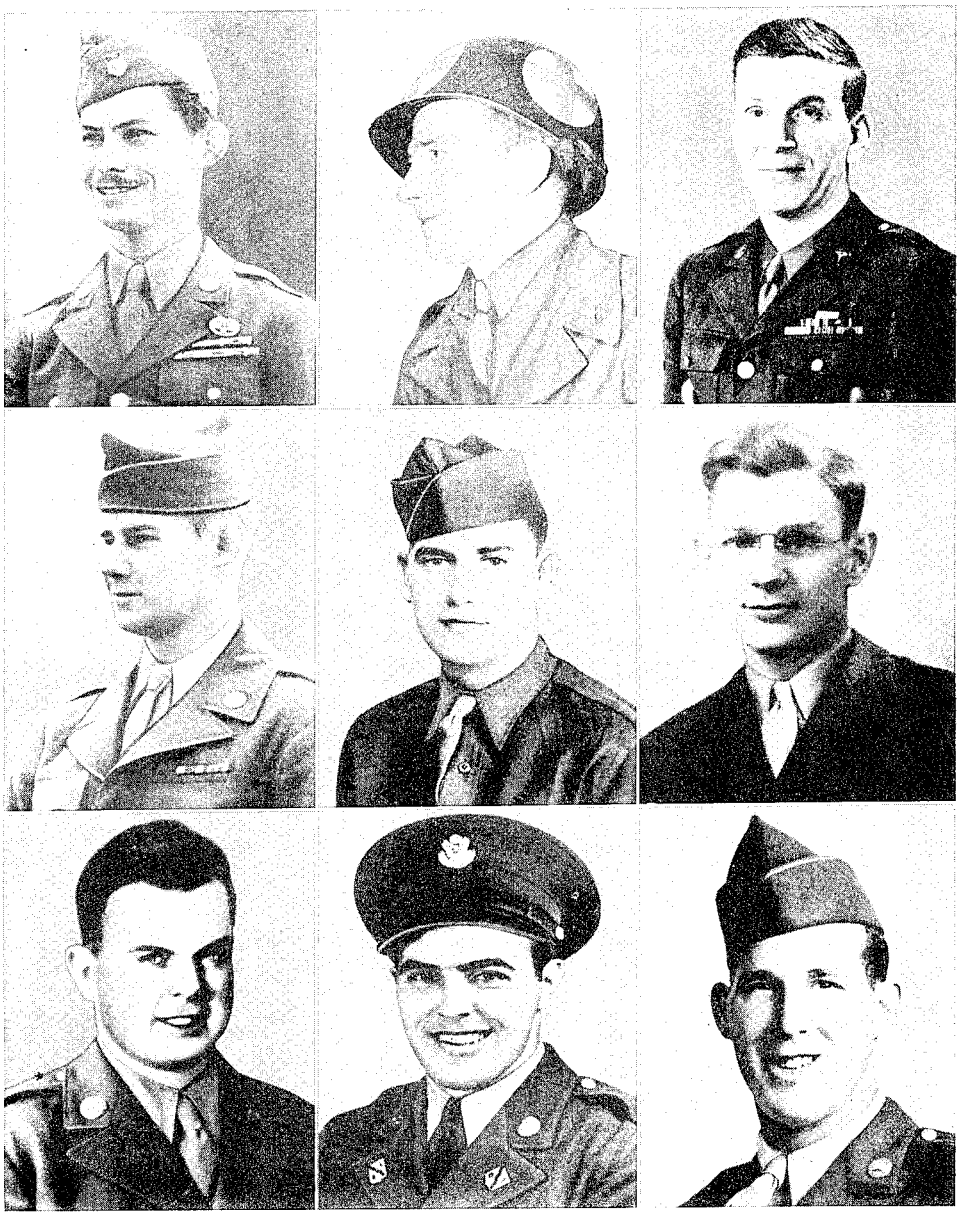


Figure 40.—Medical Department enlisted men awarded the Congressional Medal of Honor, in World War II. Upper row, left to right: Pfc. Desmond T. Doss, Okinawa; Pvt. Harold A. Garman, France; Pfc. Lloyd C. Hawks, Italy. Center row, left to right: Cpl. Thomas J. Kelly, Germany; Pvt. William B. McGee (died of wounds), Germany; Pfc. Frederick C. Murphy (killed in action), Germany. Lower row, from left to right: T4g. Laverne Parrish (died of wounds), Luzon, Philippine Islands; Pfc. Frank J. Petrarca (died of wounds), New Georgia, Solomon Islands; T5g. Alfred L. Wilson (died of wounds), France.

CHAPTER XI

Strength and Distribution of Military Personnel

OVERALL STRENGTH

Overall strength of the Medical Department and its military components during the emergency and war periods, in comparison with the strength of the Army as a whole, is shown in table 1. The figures include a sizable number of Medical and Dental Corps officers who, though placed on active duty in 1944, served in the Veterans' Administration and, therefore, were not available for Army duty (table 27).

DISTRIBUTION, OVERSEAS AND IN THE ZONE OF INTERIOR

Prior to the passage of the Selective Service Act in September 1940 and the Federalization of the National Guard, approximately 16 to 17 percent of the Medical Department's personnel were serving overseas (table 28). With the expansion of the Army, large numbers of men were assigned to the Medical Department, but since the vast majority of these remained in the Zone of Interior for training purposes, the proportion of the medical strength in

TABLE 27.—*Number of Medical Department officers assigned to the Veterans' Administration, January 1944–June 1946*

Month	1944		1945		1946	
	Medical Corps	Dental Corps	Medical Corps	Dental Corps	Medical Corps	Dental Corps
January	400		1,647	150	1,310	160
February	500		1,673	150	1,195	150
March	600		1,669	155	1,154	143
April	750		1,674	160	826	110
May	856	79	1,677	165	663	87
June	951	103	1,676	165	569	78
July	998	115	1,676	165		
August	1,124	122	1,671	165		
September	1,180	130	1,645	165		
October	1,237	141	1,565	165		
November	1,237	141	1,495	170		
December	1,622	149	1,356	160		

Source: "Time Series on Medical Department Personnel by Corps, 1942-46," furnished to Historical Division, Office of The Surgeon General, by Resources Analysis Division, Office of The Surgeon General, 24 January 1950.

oversea areas was considerably smaller in the months preceding Pearl Harbor than it had been a year earlier. The ratio of medical troops, and of service troops, in general, to total oversea strength also was low (table 29). After 7 December 1941, the shipment of service troops abroad was accelerated, and the proportion of medical personnel to total oversea strength likewise increased very considerably (tables 29 and 30). When, in January 1944, major emphasis again was placed on provision of combat troops, the rate of augmentation of medical personnel, in contrast to the earlier period, generally exceeded that of service troops as a whole (table 29). The ratio of medical to general Army strength overseas declined only slightly prior to V–E Day (table 31). Once the initial lag in shipment of medical troops was overcome, the percentage of total Army strength and the percentage of total Medical Department strength stationed in oversea areas were fairly equal (table 31).

TABLE 28.—*Oversea strength of the Medical Department, 30 June 1939 and 30 June 1940*

Group	Oversea strength [1]		Percent of worldwide strength [2]	
	30 June 1939	30 June 1940	30 June 1939	30 June 1940
Medical Corps	183	229	16. 7	14. 5
Dental Corps	42	57	19. 0	16. 1
Veterinary Corps	17	18	13. 5	10. 5
Army Nurse Corps	110	138	16. 4	14. 6
Enlisted personnel	----------	2, 556	----------	17. 1

[1] Annual Reports of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1939 and 1940.

[2] For worldwide strength, see table 1. To enlisted strength as shown there, 310 Philippine Scouts have been added.

TABLE 29.—*Development of Medical Department strength overseas, as compared with development of service strength, November 1941–September 1945* [1]

End of month	Total Army	Service strength			Medical Department [2]	
	Oversea strength [3] (percent increase)	Number [4]	Percent of total oversea Army	Percent increase	Percent of total oversea Army	Percent increase
1941						
November	----------	40, 234	24. 4	--------	4. 8	--------
1942						
March	98. 7	87, 178	26. 6	116. 7	5. 8	138. 9
June	83. 4	207, 266	34. 4	137. 7	7. 1	124. 0
September	36. 8	303, 808	36. 9	46. 6	7. 1	37. 5
1943						
January	36. 1	462, 049	41. 3	52. 1	7. 9	49. 7
April	25. 0	618, 398	44. 2	53. 8	8. 1	28. 6
July	27. 2	822, 167	46. 2	33. 0	7. 8	23. 3
October	20. 1	1, 059, 839	49. 6	28. 9	8. 4	28. 9
1944						
January	31. 6	1, 376, 992	48. 9	29. 9	8. 5	32. 8
April	26. 2	1, 695, 822	47. 7	23. 1	8. 5	25. 8
July	15. 3	1, 957, 559	47. 8	15. 4	8. 4	14. 5
October	13. 2	2, 148, 669	46. 3	9. 8	8. 4	13. 7
1945						
January	10. 5	2, 366, 840	46. 2	10. 2	8. 4	9. 9
April	5. 9	2, 463, 761	45. 4	4. 1	8. 3	4. 5
July	−9. 9	2, 389, 223	49. 1	−2. 7	8. 4	−8. 8
September	−15. 5	2, 044, 607	49. 5	−14. 7	7. 8	−21. 7

[1] For purposes of comparability, all data for April, July, and September 1945 exclude personnel under the command of the Commanding General, Army Air Forces.

[2] For basic data, see table 31.

[3] For basic data, see table 31.

[4] Basic data for 30 November 1941 provided by The Adjutant General's Strength and Accounting Branch, June 1958. All other basic data from "Strength of the Army" for dates corresponding to those shown; includes, in addition to the Medical Department, the following categories as shown in the sources: Chemical Warfare Service; Corps of Engineers; Signal Corps, Adjutant General's Department; Chaplains Corps; Finance Department; Judge Advocate General's Department; Ordnance Department; Quartermaster Corps; Inspector General's Department; Military Intelligence; General Staff Corps; Warrant Officers; Transportation Corps (September 1942–September 1945); Military Police Corps (March 1942–September 1945); Specialists Reserve (June 1942–April 1945); Army Specialist Corps (September 1942); WAAC or WAC (January 1943–September 1945); Detached List and/or Detached Enlisted Men's List (November 1941–October 1944); Not Member of a Branch/or Branch Immaterial (June 1942–September 1945); unassigned and miscellaneous detachments (November 1941–March 1942). Personnel shown under "service strength" minus those in the Corps of Engineers, Signal Corps, and Chemical Warfare Service. These originally were grouped with the combat arms.

TABLE 30.—*Movement of Medical Department troops overseas, compared with movement of all Army, all combat, and all service troops, July 1942–August 1945* [1]

Month and year	Army		Combat troops [2]			Service troops [3]										
	Total Army shipments					Total including miscellaneous			Total excluding miscellaneous			Medical Department				
												Total			Nurses	
	Number	Percent increase [4]	Total	Percent of total Army shipments	Percent increase [4]	Number	Percent of total Army shipments	Percent increase [4]	Number [5]	Percent of total Army shipments	Percent increase [4]	Number	Percent of total Army shipments	Percent increase [4]	Number	Percent increase [4]
Total, July 1942–August 1945	6, 490, 176		3, 683, 149	56. 7		2, 807, 027	43. 3		2, 244, 182	34. 6		421, 237	6. 5		31, 973	
1942																
Total, July–December	528, 029		244, 044	46. 2		283, 985	53. 8		190, 841	36. 1		30, 689	5. 8		1, 190	
July	66, 879		23, 759	35. 5		43, 120	64. 5		32, 661	48. 8		3, 608	5. 4		44	
August	116, 088		54, 511	47. 0		61, 577	53. 0		46, 015	39. 6		5, 094	4. 4		62	
September	84, 727		45, 579	53. 8		39, 168	46. 2		22, 458	26. 5		4, 646	5. 5		2	
October	95, 929		56, 547	58. 9		39, 382	41. 1		27, 702	28. 9		6, 899	7. 2		173	
November	76, 219		26, 359	34. 6		49, 860	65. 4		30, 760	40. 4		3, 936	5. 2		371	
December	88, 167		37, 289	42. 3		50, 878	57. 7		31, 245	35. 4		6, 506	7. 4		538	

1943															
Total, January–June	660, 802	25. 1	298, 794	45. 2	22. 4	362, 008	54. 7	27. 5	285, 026	43. 1	43. 1	44, 627	6. 7	45. 4	2, 814	136. 5
January	80, 526		26, 726	33. 2		53, 800	66. 8		40, 213	49. 9		7, 006	8. 7		478	
February	84, 412		36, 256	43. 0		48, 156	57. 0		40, 903	48. 5		5, 079	6. 0		258	
March	70, 399		28, 875	41. 0		41, 524	59. 0		35, 445	50. 3		5, 081	7. 2		152	
April	150, 038		78, 036	52. 0		72, 002	48. 0		61, 181	40. 7		11, 857	7. 9		803	
May	142, 787		65, 417	45. 8		77, 370	53. 9		59, 235	41. 5		8, 788	6. 2		588	
June	132, 640		63, 484	47. 9		69, 156	52. 1		48, 149	36. 3		6, 816	5. 1		535	
Total, July–December	1, 120, 376	69. 5	550, 364	49. 1	84. 2	570, 012	50. 9	57. 5	464, 549	41. 5	63. 0	86, 562	7. 7	94. 0	7, 297	159. 3
July	159, 904		72, 126	45. 5		87, 178	54. 5		59, 243	37. 0		10, 111	6. 3		701	
August	154, 489		66, 021	42. 7		88, 468	57. 3		70, 556	45. 7		15, 070	9. 8		1, 699	
September	159, 755		87, 215	54. 6		72, 540	47. 0		61, 914	38. 6		14, 574	9. 1		1, 409	
October	229, 787		129, 546	56. 4		100, 241	43. 6		84, 807	36. 9		13, 578	5. 9		962	
November	152, 483		63, 700	41. 8		88, 783	58. 2		79, 327	52. 0		11, 082	7. 3		1, 162	
December	263, 958		131, 156	49. 7		132, 802	50. 3		108, 702	41. 2		22, 147	8. 4		1, 364	
1944																
Total, January–June	1, 428, 115	27. 5	787, 239	55. 1	43. 0	640, 876	44. 9	12. 4	533, 440	37. 4	14. 8	108, 537	7. 6	25. 4	7, 163	−1. 8
January	248, 245		125, 633	50. 6		122, 612	49. 4		106, 953	43. 1		17, 670	7. 1		1, 412	
February	273, 858		159, 072	58. 1		114, 786	63. 8		95, 669	50. 6		21, 075	7. 7		1, 484	
March	278, 631		148, 789	53. 4		129, 842	46. 6		101, 434	53. 4		23, 771	8. 5		2, 166	
April	241, 571		142, 518	59. 0		99, 053	41. 0		84, 904	35. 1		15, 995	6. 6		965	
May	211, 715		112, 138	53. 0		99, 577	47. 0		86, 821	41. 0		13, 310	6. 3		519	
June	174, 095		99, 089	56. 9		75, 006	43. 1		57, 659	33. 1		16, 716	9. 6		617	
Total, July–December	1, 471, 015	3. 0	941, 826	64. 0	19. 6	529, 189	36. 0	−17. 4	455, 121	30. 9	−14. 7	91, 210	6. 2	−16. 0	7, 171	. 1
July	269, 384		181, 303	67. 3		88, 081	32. 7		75, 342	28. 0		18, 509	6. 9		1, 582	
August	238, 160		158, 745	66. 7		79, 415	33. 3		67, 336	28. 3		11, 081	4. 7		682	
September	235, 025		153, 955	65. 5		81, 070	34. 5		64, 516	27. 5		13, 068	5. 6		649	
October	268, 858		152, 338	64. 8		116, 520	43. 3		106, 532	39. 6		20, 876	7. 8		2, 059	
November	234, 568		168, 821	70. 3		69, 747	29. 7		57, 577	24. 5		10, 257	4. 4		507	
December	225, 020		130, 664	58. 1		94, 356	41. 9		83, 818	37. 2		17, 419	7. 7		1, 692	

See footnotes at end of table.

TABLE 30.—*Movement of Medical Department troops overseas, compared with movement of all Army, all combat, and all service troops, July 1942–August 1945* [1]—Continued

Month and year	Army		Combat troops [2]			Service troops [3]										
	Total Army shipments					Total including miscellaneous			Total excluding miscellaneous			Medical Department				
												Total			Nurses	
	Number	Percent increase [4]	Total	Percent of total Army shipments	Percent increase [4]	Number	Percent of total Army shipments	Percent increase [4]	Number [5]	Percent of total Army shipments	Percent increase [4]	Number	Percent of total Army shipments	Percent increase [4]	Number	Percent increase [4]
1945																
Total, January–June	1,043,377	−29.1	691,060	66.2	−26.6	352,317	33.8	−33.4	262,439	25.2	−42.3	49,671	4.8	−45.5	3,658	−49.0
January	278,852		202,727	72.7		76,125	27.3		60,769	21.8		12,381	4.4		285	
February	225,562		133,204	59.1		92,358	40.9		69,189	30.7		12,145	5.4		404	
March	199,660		136,159	68.2		63,501	31.8		39,471	19.8		8,313	4.2		836	
April	134,803		89,601	66.5		45,202	33.5		31,442	23.3		5,691	4.2		418	
May	88,519		60,260	68.1		28,259	31.9		21,150	23.9		4,464	5.0		959	
June	115,981		69,109	59.6		46,872	40.4		40,417	34.8		6,677	5.8		756	
Total, July–August	238,462	−77.1	169,822	71.2	−75.4	68,640	28.8	−80.1	52,766	22.1	−79.9	9,941	4.2	−80.0	2,680	−26.7
July	79,619		47,927	60.2		31,692	39.8		23,804	29.9		4,556	5.7		1,047	
August	158,843		121,895	76.7		36,948	23.3		28,962	18.2		5,385	3.4		1,633	

[1] Basic data from "Troops Embarked by Arms and Services," in Army Service Forces, Statistical Review, World War II, pp. 123–124. Includes troops embarked by the Transportation Corps only. Personnel shown for each arm or service is primarily the strength of the units belonging to these arms and services and therefore includes troops not assigned to the branch. In the case of the Medical Department, for example, the numbers shown do not include attached medical personnel in infantry and similar units; on the other hand, chaplains are included in the strength of the medical personnel. It is not known whether casuals are included.

[2] Air Corps, Coast Artillery, Armored Force, Field Artillery, and Infantry.

[3] Includes Chemical Warfare, Engineers, "Medical Corps" (that is, Medical Department other than nurses), Army Nurse Corps, Ordnance, Quartermaster Corps, Signal Corps, and Transportation Corps. A "miscellaneous" category also is included in the source, but its content is not known. If it includes all branches other than those specifically mentioned, it should be added to the service category since all the combat arms have been shown. On the other hand, if it also includes casuals, it may include combat troops. For this reason, the service troops are shown both with the miscellaneous category and without it.

[4] Percentage of increase over previous summary period shown.

[5] Includes Army Nurse as shown in column of this table so headed.

TABLE 31.—*Oversea strength of the Medical Department and oversea Negro medical strength, by area,*[1] *31 July 1941–30 September 1945*

Area	Army		Medical Department			Negroes—Army		Negroes—Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	31 July 1941									
Worldwide	1,531,012	100.00	127,221	100.00	83	82,037	100.00	0	0	0
Overseas	135,722	8.86	5,276	4.15	39	0	0	0	0	0
En route	190	.01	0	0	0	259	.32	0	0	0
Foreign	135,532	8.85	5,276	4.15	39	0	0	0	0	0
North America	4,674	.31	172	.14	37	0	0	0	0	0
Alaska	9,946	.65	280	.22	28	0	0	0	0	0
Caribbean	58,534	3.82	2,121	1.67	36	259	.32	0	0	0
South Atlantic										
Europe										
North Africa										
Africa-Middle East										
Persian Gulf										
China-Burma-India										
Total Pacific areas	62,378	4.07	2,703	2.12	43	0	0	0	0	0
Southwest Pacific Area	22,493	1.47	1,158	.91	51	0	0	0	0	0
Pacific Ocean Areas	40,214	2.63	1,545	1.21	38	0	0	0	0	0
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										
Commanding General, Army Service Forces										
War Department Groups										

See footnotes at end of table.

TABLE 31.—*Oversea strength of the Medical Department and oversea Negro medical strength, by area,*[1] *31 July 1941–30 September 1945*—Continued

Area	Army		Medical Department			Negroes—Army		Negroes—Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	30 November 1941									
Worldwide	1,644,210	100.00	131,586	100.00	81	98,664	100.00	0	0	0
Overseas	165,155	10.04	7,992	7.36	48	939	.95	0	0	0
En route	904	.05	0	0	0	0	0	0	0	0
Foreign	164,251	9.99	7,992	7.36	49	939	.95	0	0	0
North America	11,051	.67	1,352	1.03	122	0	0	0	0	0
Alaska	21,461	1.31	1,124	.85	52	0	0	0	0	0
Caribbean	57,467	3.50	2,379	1.81	41	939	.95	0	0	0
South Atlantic										
Europe										
North Africa										
Africa-Middle East										
Persian Gulf										
China-Burma-India										
Total Pacific areas	74,272	4.52	3,137	2.38	42	0	0	0	0	0
Southwest Pacific Area	31,030	1.89	1,623	1.23	52	0	0	0	0	0
Pacific Ocean Areas	43,059	2.62	1,514	1.15	35	0	0	0	0	0
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										

Commanding General, Army Service Forces										
War Department Groups										
	31 March 1942									
Worldwide	2, 386, 138	100. 00	201, 162	100. 00	84	143, 556	100. 00	3, 812	100. 00	1. 89
Overseas	328, 113	13. 75	19, 093	9. 49	58	3, 324	2. 32	20	. 52	. 10
En route	4, 306	. 18	41	. 02	10	0	0	0	0	0
Foreign	323, 807	13. 57	19, 052	9. 47	59	3, 324	2. 32	20	. 52	. 10
North America	23, 261	. 97	1, 880	. 93	81	0	0	0	0	0
Alaska	33, 221	1. 39	1, 364	. 68	41	0	0	0	0	0
Caribbean	86, 828	3. 64	4, 466	2. 22	51	1, 161	. 81	0	0	0
South Atlantic	11, 495	. 06	119	. 06	80	0	0	0	0	0
Europe	13, 811	. 58	1, 624	. 81	118	1	. 00	0	0	0
North Africa										
Africa-Middle East										
Persian Gulf										
China-Burma-India	3, 216	. 13	119	. 06	37	0	0	0	0	0
Total Pacific areas	161, 875	6. 78	9, 480	4. 71	59					
Southwest Pacific Area	62, 500	2. 62	3, 330	1. 66	53	884	. 62	0	0	0
Pacific Ocean Areas	97, 970	4. 11	6, 150	3. 06	63	1, 278	. 89	20	. 52	. 33
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										
Commanding General, Army Service Forces										
War Department Groups										

See footnotes at end of table.

TABLE 31.—*Oversea strength of the Medical Department and oversea Negro medical strength, by area,*[1] *31 July 1941–30 September 1945*—Continued

Area	Army		Medical Department			Negroes—Army		Negroes—Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	30 June 1942									
Worldwide	3,074,184	100.00	253,707	100.00	83	178,708	100.00	5,939	100.00	2.95
Overseas	601,777	19.58	42,770	16.86	71	33,869	18.95	626	10.54	1.46
En route	81,056	2.64	4,536	1.79	56	10,254	5.74	201	3.38	4.43
Foreign	520,721	16.94	38,234	15.07	73	23,615	13.21	425	7.16	1.11
North America	45,573	1.48	2,702	1.07	59	3,685	2.06	77	1.30	2.85
Alaska	50,845	1.65	2,218	.87	44	1,159	.65	37	.62	1.67
Caribbean	103,403	3.36	5,726	2.26	55	3,631	2.03	95	1.60	1.66
South Atlantic	1,623	.05	117	.05	73	0	0	0	0	0
Europe	54,667	1.78	3,856	1.52	71	754	.42	0	0	0
North Africa										
Africa-Middle East	217	.01	0	0	0	0	0	0	0	0
Persian Gulf										
China-Burma-India	7,474	.24	620	.24	82	439	.25	0	0	0
Total Pacific areas	256,929	8.36	22,995	9.06	89	13,947	7.80	216	3.64	.94
Southwest Pacific Area	92,668	3.01	10,238	4.04	110	6,944	3.89	78	1.31	.76
Pacific Ocean Areas	165,649	5.39	12,757	5.02	77	7,003	3.92	138	2.32	1.08
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										

Commanding General, Army Service Forces										
War Department Groups										
	30 September 1942									
Worldwide	3, 971, 016	100. 00	349, 253	100. 00	88	255, 545	100. 00			
Overseas	822, 962	20. 72	58, 827	16. 84	71	45, 300	17. 72	991		1. 68
En route	52, 719	1. 33	3, 926	1. 12	74	1, 431	. 56	66		1. 68
Foreign	770, 243	19. 40	54, 901	15. 72	71	43, 869	17. 16	925		1. 69
North America	65, 554	1. 65	4, 391	1. 26	67	4, 938	1. 93	120		2. 73
Alaska	76, 005	1. 91	3, 010	. 86	40	0	0	0		0
Caribbean	109, 650	2. 76	5, 962	1. 71	55	3, 610	1. 41	66		1. 11
South Atlantic	2, 012	. 05	159	. 05	79	0	0	0		0
Europe	186, 195	4. 69	13, 031	3. 73	70	11, 406	4. 46	156		1. 20
North Africa	0	0	0	0	0	0	0	0		0
Africa-Middle East	9, 273	. 23	517	. 15	56	1, 376	. 54	114		22. 05
Persian Gulf	456	. 01	21	. 006	46	0	0	0		0
China-Burma-India	13, 453	. 34	1, 100	. 31	82	2, 434	. 95	46		4. 18
Total Pacific areas	307, 421	7. 74	26, 707	7. 64	87	20, 105	7. 87	423		1. 58
Southwest Pacific Area	105, 295	2. 65	11, 399	3. 26	108	8, 157	3. 19	168		1. 47
Pacific Ocean Areas	202, 126	5. 09	15, 308	4. 38	76	11, 948	4. 68	255		1. 67
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										
Commanding General, Army Service Forces										
War Department Groups	224	. 06	3	0	13	0	0	0		0

See footnotes at end of table.

TABLE 31.—*Oversea strength of the Medical Department and oversea Negro medical strength, by area,*[1] *31 July 1941–30 September 1945*—Continued

Area	Army		Medical Department			Negroes—Army		Negroes Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	31 January 1943									
Worldwide	5, 824, 517	100. 00	497, 252	100. 00	86	435, 487	100. 00	18, 279	100. 00	3. 68
Overseas	1, 119, 903	19. 23	88, 041	17. 71	79	63, 357	14. 55	1, 311	7. 17	1. 49
En route	28, 602	. 49	3, 703	. 74	129	1, 504	. 35	38	. 20	1. 03
Foreign	1, 091, 301	18. 73	84, 338	16. 96	77	61, 853	14. 20	1, 273	6. 97	1. 51
North America	70, 214	1. 21	4, 622	. 93	66	3, 995	. 92	96	. 53	2. 08
Alaska	97, 985	1. 68	4, 975	1. 00	51	1, 202	. 28	0	0	0
Caribbean	118, 829	2. 04	6, 583	1. 32	55	2, 335	. 54	50	. 27	. 76
South Atlantic	3, 270	. 06	202	. 04	62	0	0	0	0	0
Europe	120, 372	2. 07	10, 738	2. 16	89	9, 541	2. 19	114	. 62	1. 06
North Africa	260, 771	4. 48	20, 836	4. 19	80	10, 697	2. 46	245	1. 34	1. 18
Africa-Middle East	25, 405	. 44	2, 506	. 50	99	1, 879	. 43	204	1. 12	8. 14
Persian Gulf	10, 949	. 19	1, 072	. 22	98	2, 559	. 59	17	. 09	1. 59
China-Burma-India	18, 796	. 32	1, 276	. 27	68	2, 644	. 61	12	. 07	. 94
Total Pacific areas	364, 451	6. 26	31, 525	6. 34	86	27, 001	6. 20	535	2. 93	1. 70
Southwest Pacific Area	118, 005	2. 03	12, 994	2. 61	110	7, 884	1. 81	137	. 75	1. 05
Pacific Ocean Areas	246, 446	4. 23	18, 531	3. 73	75	19, 117	4. 39	398	2. 18	2. 15
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										

Commanding General, Army Service Forces										
War Department Groups	259	0	3	0	12	0	0	0	0	0
	30 April 1943									
Worldwide	6, 719, 827	100. 00	588, 330	100. 00	87	534, 496	100. 00	26, 330	100. 00	4. 48
Overseas	1, 399, 643	20. 83	113, 213	19. 24	81	102, 670	19. 20	2, 126	8. 07	1. 88
En route	100, 648	1. 50	9, 080	1. 54	90	9, 953	1. 86	238	. 90	2. 62
Foreign	1, 298, 995	19. 33	104, 133	17. 70	80	92, 717	17. 33	1, 888	7. 17	1. 81
North America	75, 719	1. 13	5, 153	. 88	68	2, 707	. 51	72	. 27	1. 40
Alaska	104, 878	1. 56	5, 700	. 97	54	1, 888	. 35	33	. 13	. 58
Caribbean	115, 771	1. 72	6, 855	1. 17	59	2, 326	. 43	47	. 19	. 69
South Atlantic	4, 908	. 07	453	. 08	92	0	0	0	0	0
Europe	111, 506	1. 66	10, 855	1. 86	97	5, 188	. 97	57	. 22	. 53
North Africa	395, 461	5. 88	31, 164	5. 30	79	35, 269	6. 59	657	2. 50	2. 11
Africa-Middle East	37, 272	. 55	3, 447	. 59	92	2, 099	. 39	321	1. 22	9. 31
Persian Gulf	18, 513	. 28	1, 812	. 31	98	5, 152	. 96	55	. 21	3. 04
China-Burma-India	30, 110	. 45	4, 286	. 73	142	4, 143	. 77	47	. 19	1. 09
Total Pacific areas	404, 385	6. 02	34, 404	5. 80	85	33, 945	6. 35	599	2. 27	1. 74
Southwest Pacific Area	140, 577	2. 09	14, 276	2. 43	101	9, 148	1. 71	159	. 60	1. 11
Pacific Ocean Areas	263, 808	3. 93	20, 128	3. 42	76	24, 797	4. 64	440	1. 67	2. 19
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										
Commanding General, Army Service Forces										
War Department Groups	472	0	4	0	8	0	0	0	0	0

See footnotes at end of table.

TABLE 31.—*Oversea strength of the Medical Department and oversea Negro medical strength, by area,*[1] *31 July 1941–30 September 1945*—Continued

Area	Army		Medical Department			Negroes—Army		Negroes—Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	31 July 1943									
Worldwide	7, 126, 818	100. 00	628, 360	100. 00	88	576, 886	100. 00	29, 403	100. 00	4. 68
Overseas	1, 779, 688	24. 97	139, 564	22. 21	78	135, 150	23. 41	2, 401	8. 17	1. 72
En route	50, 925	. 71	5, 881	. 94	115	6, 670	1. 16	116	. 40	1. 97
Foreign	1, 728, 763	24. 26	133, 683	21. 27	77	128, 480	22. 25	2, 285	7. 77	1. 71
North America	80, 688	1. 13	4, 683	. 75	58	2, 766	. 48	75	. 26	1. 60
Alaska	138, 882	1. 95	8, 663	1. 38	62	3, 406	. 59	36	. 12	. 42
Caribbean	114, 191	1. 60	6, 063	. 96	53	2, 296	. 40	48	. 16	. 79
South Atlantic	5, 707	. 08	452	. 07	79	0	0	0	0	0
Europe	239, 254	3. 36	18, 278	2. 91	76	17, 730	3. 07	286	. 97	1. 56
North Africa	528, 608	7. 42	42, 092	6. 70	80	44, 953	7. 79	742	2. 52	1. 76
Africa-Middle East	39, 163	. 55	2, 882	. 46	74	2, 240	. 39	192	. 65	6. 66
Persian Gulf	27, 320	. 38	2, 636	. 42	96	5, 246	. 91	31	. 11	1. 18
China-Burma-India	34, 902	. 54	4, 999	. 80	143	4, 110	. 71	57	. 19	1. 14
Total Pacific areas	519, 514	7. 29	42, 929	6. 80	83	45, 733	7. 92	818	2. 78	1. 91
Southwest Pacific Area	200, 841	2. 82	19, 408	3. 09	97	12, 653	2. 19	177	. 60	. 91
Pacific Ocean Areas	318, 673	4. 47	23, 521	3. 74	74	33, 080	5. 73	641	2. 18	2. 73
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										

Commanding General, Army Service Forces										
War Department Groups	534	0	6	0	11	0	0	0	0	0
	31 October 1943									
Worldwide	7, 333, 474	100. 00	615, 102	100. 00	84	610, 687	100. 00	25, 976	100. 00	4. 22
Overseas	2, 238, 799	30. 53	179, 914	29. 25	80	181, 450	29. 71	3, 388	12. 85	1. 86
En route	100, 589	1. 37	5, 474	. 89	54	4, 171	. 68	115	. 44	2. 10
Foreign	2, 138, 210	29. 16	174, 440	28. 36	82	177, 279	29. 03	3, 273	12. 60	1. 88
North America	61, 023	. 83	3, 867	. 63	63	254	. 04	0	0	0
Alaska	127, 976	1. 75	8, 517	1. 39	67	4, 447	. 73	36	. 14	. 42
Caribbean	106, 953	1. 46	5, 562	. 91	52	2, 264	. 37	41	. 16	. 74
South Atlantic	6, 940	. 09	453	. 07	65	0	0	0	0	0
Europe	460, 502	6. 28	38, 084	6. 19	83	40, 252	6. 59	915	3. 53	2. 40
North Africa	632, 744	8. 63	54, 425	8. 85	86	56, 448	9. 24	867	3. 35	1. 59
Africa-Middle East	25, 488	. 35	2, 490	. 41	98	2, 145	. 35	223	. 86	8. 96
Persian Gulf	29, 545	. 40	2, 774	. 45	94	4, 824	. 79	55	. 21	1. 98
China-Burma-India	70, 661	. 96	7, 303	1. 19	103	12, 434	2. 04	205	. 79	2. 81
Total Pacific areas	615, 338	8. 39	50, 946	8. 28	83	54, 211	8. 88	931	3. 60	1. 11
Southwest Pacific Area	263, 120	3. 59	25, 034	4. 07	95	18, 485	3. 03	279	1. 08	2. 52
Pacific Ocean Areas	352, 218	4. 80	25, 912	4. 21	74	35, 726	5. 85	652	2. 52	1. 83
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										
Commanding General, Army Service Forces										
War Department Groups	1, 040	. 01	19	0	18	0	0	0	0	0

See footnotes at end of table.

TABLE 31.—*Overseа strength of the Medical Department and overseа Negro medical strength, by area,[1] 31 July 1941–30 September 1945*– Continued

Area	Army		Medical Department			Negroes–Army		Negroes–Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	31 January 1944									
Worldwide	7, 556, 157	100. 00	628, 758	100. 00	83	646, 800	100. 00	26, 229	100. 00	4. 17
Overseas	2, 814, 658	37. 25	238, 914	38. 00	85	243, 503	37. 65	5, 246	20. 00	2. 20
En route	84, 435	1. 12	5, 730	. 91	68	8, 851	1. 37	542	2. 07	9. 46
Foreign	2, 730, 223	36. 13	233, 184	37. 08	85	234, 652	36. 28	4, 704	17. 93	0
North America	54, 584	. 72	3, 264	. 52	60	0	0	0	0	0
Alaska	114, 225	1. 51	7, 681	1. 22	67	4, 727	. 73	71	. 27	. 92
Caribbean	89, 727	1. 19	5, 266	. 84	59	0	0	0	0	0
South Atlantic	7, 890	. 10	601	. 09	76	0	0	0	0	0
Europe	935, 346	12. 38	81, 616	12. 98	87	77, 580	11. 99	1, 586	6. 05	1. 94
North Africa	621, 831	8. 23	51, 692	8. 22	83	59, 394	9. 18	949	3. 62	1. 84
Africa-Middle East	16, 411	. 22	1, 811	. 29	110	788	. 12	152	. 58	8. 39
Persian Gulf	29, 445	. 32	2, 700	. 43	92	4, 020	. 62	46	. 18	1. 70
China-Burma-India	107, 595	1. 42	9, 945	1. 58	92	15, 711	2. 43	248	. 95	2. 49
Total Pacific areas	752, 056	9. 95	68, 590	10. 91	91	72, 432	11. 04	1, 652	6. 30	2. 41
Southwest Pacific Area	329, 372	4. 36	33, 186	5. 28	100	27, 695	4. 28	395	1. 51	1. 19
Pacific Ocean Areas	422, 684	5. 59	35, 404	5. 63	84	44, 737	6. 92	1, 257	4. 79	3. 55
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										

Commanding General, Army Service Forces										
War Department Groups	1, 113	. 01	18	0	0	0	0	0	0	0
	30 April 1944									
Worldwide	7, 848, 172	100. 00	651, 162	100. 00	83	686, 220	100. 00	25, 556	100. 00	3. 92
Overseas	3, 552, 485	45. 27	300, 502	46. 15	85	325, 960	47. 50	9, 875	38. 64	3. 29
En route	78, 664	1. 00	4, 916	. 75	62	3, 770	. 55	672	2. 63	13. 29
Foreign	3, 473, 821	44. 26	295, 586	45. 39	85	322, 190	46. 95	9, 203	36. 01	3. 11
North America	47, 908	. 61	3, 024	. 46	63	0	0	0	0	0
Alaska	91, 546	1. 17	4, 762	. 73	52	5, 922	. 86	143	. 56	4. 73
Caribbean	84, 013	1. 07	5, 024	. 77	60	0	0	0	0	0
South Atlantic	6, 991	. 09	567	. 09	81	0	0	0	0	0
Europe	1, 421, 908	18. 12	125, 729	19. 31	88	114, 691	16. 75	3, 087	12. 08	2. 45
North Africa	697, 785	8. 89	55, 211	8. 48	79	77, 686	11. 32	1, 506	5. 89	2. 73
Africa-Middle East	15, 951	. 20	1, 396	. 21	88	722	. 11	83	. 32	5. 95
Persian Gulf	29, 300	. 37	2, 468	. 38	84	3, 987	. 58	45	. 18	1. 82
China-Burma-India	150, 101	1. 91	11, 344	1. 74	76	16, 910	2. 46	270	1. 06	2. 38
Total Pacific areas	927, 045	11. 81	86, 036	13. 21	93	102, 272	14. 90	4, 069	15. 92	2. 70
Southwest Pacific Area	448, 165	5. 71	47, 259	7. 26	105	37, 781	5. 51	1, 277	5. 00	4. 73
Pacific Ocean Areas	478, 880	6. 10	38, 777	5. 96	81	64, 491	9. 40	2, 792	10. 93	7. 20
Commanding General, Army Air Forces										
Commanding General, Army Ground Forces										
Commanding General, Army Service Forces										
War Department Groups	1, 273	. 02	25	0	20	0	0	0	0	0

See footnotes at end of table.

TABLE 31.—*Oversea strength of the Medical Department and oversea Negro medical strength, by area,*[1] *31 July 1941–30 September 1945*—Continued

Area	Army		Medical Department			Negroes—Army		Negroes—Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	31 July 1944									
Worldwide	8, 049, 770	100. 00	679, 561	100. 00	84	699, 666	100. 00	21, 902	100. 00	3. 22
Overseas	4, 095, 129	50. 87	343, 931	50. 61	84	382, 999	54. 74	10, 228	46. 70	2. 97
En route	107, 716	1. 34	6, 301	. 93	58	9, 712	1. 39	17	. 07	. 27
Foreign	3, 987, 413	49. 53	337, 630	49. 68	85	373, 287	53. 35	10, 211	46. 62	3. 02
North America	26, 815	. 33	1, 696	. 25	63	0	0	0	0	0
Alaska	71, 181	. 88	4, 055	. 60	57	4, 141	. 59	98	. 45	2. 42
Caribbean	72, 172	. 90	4, 265	. 63	59	0	0	0	0	0
South Atlantic	3, 462	. 04	529	. 08	153	0	0	0	0	0
Europe	1, 770, 614	22. 00	159, 282	23. 40	90	154, 157	22. 03	3, 510	16. 03	2. 20
North Africa	724, 057	8. 96	55, 998	8. 24	77	77, 017	11. 01	1, 247	5. 69	2. 28
Africa-Middle East	9, 603	. 12	1, 190	. 18	124	752	. 11	94	. 43	7. 90
Persian Gulf	28, 296	. 35	2, 218	. 33	78	3, 998	. 57	45	. 21	2. 03
China-Burma-India	142, 640	1. 77	12, 524	1. 81	86	17, 190	2. 46	269	1. 23	2. 18
Total Pacific areas	1, 056, 804	13. 13	94, 437	13. 90	89	114, 282	16. 33	4, 948	22. 59	5. 24
Southwest Pacific Area	664, 508	8. 26	60, 140	8. 85	91	73, 078	10. 44	3, 184	14. 54	5. 29
Pacific Ocean Areas	392, 296	4. 87	34, 297	5. 05	87	41, 204	5. 89	1, 764	8. 05	5. 14
Commanding General, Army Air Forces	80, 160	1. 00	1, 600	. 24	20	1, 750	. 25	0	0	0
Commanding General, Army Ground Forces										

Commanding General, Army Service Forces										
War Department Groups	1, 609	. 02	36	0	22	0	0	0	0	0
	31 October 1944									
Worldwide	8, 103, 376	100. 00	687, 501	100. 00	84	701, 660	100. 00	21, 245	100. 00	3. 09
Overseas	4, 635, 763	57. 21	391, 120	56. 89	84	438, 407	62. 48	12, 742	59. 98	3. 26
En route	132, 710	1. 64	11, 681	1. 70	88	14, 878	2. 12	455	2. 14	3. 90
Foreign	4, 503, 053	55. 57	379, 439	55. 19	84	423, 529	60. 36	12, 287	57. 83	3. 24
North America	22, 180	. 27	1, 254	. 18	57	0	0	0	0	0
Alaska	58, 654	. 72	3, 523	. 51	60	4, 207	. 60	106	. 50	3. 01
Caribbean	69, 266	. 85	3, 720	. 54	54	4, 075	. 58	34	. 16	. 91
South Atlantic	2, 711	. 03	458	. 07	169	0	0	0	0	0
Europe	2, 203, 583	27. 19	198, 410	28. 86	90	178, 866	25. 49	4, 382	20. 63	2. 21
North Africa	712, 218	8. 79	55, 500	8. 07	80	85, 306	12. 16	1, 922	9. 05	3. 46
Africa-Middle East	9, 286	. 11	1, 156	. 17	124	776	. 11	92	. 43	7. 96
Persian Gulf	27, 710	. 34	2, 031	. 30	73	3, 895	. 56	61	. 29	3. 00
China-Burma-India	159, 414	1. 97	15, 275	2. 22	96	18, 502	2. 64	384	1. 81	2. 51
Total Pacific areas	1, 116, 983	13. 78	95, 896	13. 95	86	125, 174	17. 84	5, 306	24. 97	5. 53
Southwest Pacific Area	701, 035	8. 65	61, 625	8. 96	88	76, 559	10. 91	3, 359	15. 81	5. 45
Pacific Ocean Areas	415, 948	5. 13	34, 271	4. 99	82	48, 615	6. 93	1, 947	9. 16	5. 68
Commanding General, Army Air Forces	119, 235	1. 47	2, 169	. 32	18	2, 728	. 39	0	0	0
Commanding General, Army Ground Forces										
Commanding General, Army Service Forces										
War Department Groups	1, 813	. 02	47	. 00	26	0	0	0	0	0

See footnotes at end of table.

TABLE 31.—*Oversea strength of the Medical Department and oversea Negro medical strength, by area,[1] 31 July 1941–30 September 1945*—Continued

Area	Army		Medical Department			Negroes—Army		Negroes—Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	31 January 1945									
Worldwide	8, 070, 929	100. 00	667, 188	100. 00	83	683, 338	100. 00	20, 410	100. 00	3. 06
Overseas	5, 122, 748	63. 47	429, 823	64. 42	84	481, 092	70. 40	14, 150	69. 33	3. 29
En route	81, 402	1. 01	5, 020	. 75	62	7, 419	1. 09	140	. 69	2. 79
Foreign	5, 041, 346	62. 46	424, 803	63. 67	84	473, 673	69. 32	14, 010	68. 64	3. 30
North America	19, 085	. 24	1, 108	. 17	58	0	0	0	0	0
Alaska	47, 685	. 59	2, 652	. 40	56	4, 410	. 65	100	. 49	3. 77
Caribbean	70, 231	. 87	3, 828	. 57	55	3, 571	. 52	28	. 14	. 73
South Atlantic	2, 653	. 03	369	. 06	139	0	0	0	0	0
Europe	2, 829, 039	35. 05	255, 599	38. 31	90	231, 249	33. 84	5, 739	28. 12	2. 25
North Africa	507, 668	6. 29	38, 539	5. 78	76	70, 996	10. 39	1, 982	9. 71	5. 14
Africa-Middle East	9, 330	. 12	1, 147	. 17	123	720	. 11	91	. 45	7. 93
Persian Gulf	26, 082	. 32	1, 958	. 29	75	2, 721	. 40	25	. 12	1. 28
China-Burma-India	187, 256	2. 32	18, 095	2. 71	97	23, 380	3. 42	715	3. 50	3. 95
Total Pacific areas	1, 170, 251	14. 50	97, 678	14. 64	83	133, 700	19. 56	5, 330	26. 11	5. 46
Southwest Pacific Area	749, 454	9. 29	62, 662	9. 39	84	81, 261	11. 89	3, 444	16. 87	5. 50
Pacific Ocean Areas	420, 797	5. 21	35, 016	5. 25	83	52, 439	7. 67	1, 886	9. 24	5. 39
Commanding General, Army Air Forces	165, 468	2. 05	3, 781	. 57	23	2, 926	. 43	0	0	0
Commanding General, Army Ground Forces										

Commanding General, Army Service Forces										
War Department Groups	6, 598	. 08	49	0	74	0	0	0	0	0
	30 April 1945									
Worldwide	8, 248, 780	100. 00	671, 967	100. 00	82	700, 304	100. 00	19, 752	100. 00	2. 94
Overseas	5, 455, 076	66. 13	463, 488	68. 97	85	511, 493	73. 04	13, 429	67. 99	2. 90
En route	50, 237	. 61	3, 392	. 50	68	6, 002	. 86	62	. 31	1. 83
Foreign	5, 404, 839	65. 52	460, 096	68. 47	85	505, 491	72. 18	13, 367	67. 67	2. 92
North America	16, 935	. 20	1, 014	. 15	60	0	0	0	0	0
Alaska	38, 806	. 47	2, 177	. 32	56	5, 401	. 77	118	. 60	5. 42
Caribbean	67, 169	. 81	3, 706	. 55	55	3, 895	. 56	28	. 14	. 76
South Atlantic	2, 763	. 03	372	. 06	135	0	0	0	0	0
Europe	3, 065, 505	37. 16	268, 798	40. 00	88	258, 050	36. 85	5, 482	27. 75	2. 04
North Africa	493, 876	5. 99	37, 704	5. 61	76	68, 458	9. 78	1, 943	9. 84	5. 15
Africa-Middle East	11, 618	. 14	1, 634	. 24	141	799	. 11	107	. 54	6. 55
Persian Gulf	15, 793	. 19	974	. 14	62	1, 072	. 15	8	. 04	. 82
China-Burma-India	198, 830	2. 41	19, 819	2. 95	100	25, 360	3. 62	713	3. 61	3. 60
Total Pacific areas	1, 257, 098	15. 24	105, 022	15. 63	84	139, 450	19. 91	4, 947	25. 04	4. 71
Southwest Pacific Area	806, 128	9. 77	66, 416	9. 88	82	82, 513	11. 78	3, 161	16. 00	4. 76
Pacific Ocean Areas	450, 970	5. 47	38, 606	5. 75	86	56, 937	8. 13	1, 786	9. 04	4. 63
Commanding General, Army Air Forces	197, 670	2. 40	4, 688	. 70	24	3, 006	. 43	21	. 10	. 45
Commanding General, Army Ground Forces	25	. 00	0	0	0	0	0	0	0	0
Commanding General, Army Service Forces	31, 609	. 38	14, 121	2. 10	446	0	0	0	0	0
War Department Groups	7, 142	. 09	67	0	94	0	0	0	0	0

See footnotes at end of table.

693076°—63——25

TABLE 31.—*Oversea strength of the Medical Department and oversea Negro medical strength, by area,*[1] *31 July 1941–30 September 1945*—Continued

Area	Army		Medical Department			Negroes—Army		Negroes—Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	31 May 1945									
Worldwide	8, 291, 336	100. 00	666, 710	100. 00	80	694, 379	100. 00	19, 693	100. 00	2. 95
Overseas	5, 406, 779	65. 21	455, 068	68. 26	84	510, 326	73. 49	13, 426	68. 11	2. 95
En route	44, 373	. 54	1, 367	. 21	31	3, 313	. 48	62	. 31	14. 54
Foreign	5, 362, 406	64. 67	453, 701	68. 05	85	507, 013	73. 02	13, 364	67. 80	2. 95
North America	15, 465	. 19	872	. 13	56	0	0	0	0	0
Alaska	38, 423	. 46	2, 008	. 30	52	5, 357	. 77	116	. 59	5. 78
Caribbean	63, 132	. 76	3, 499	. 52	55	3, 312	. 48	26	. 13	. 74
South Atlantic	2, 789	. 03	369	. 06	132	0	0	0	0	0
Europe	3, 021, 483	36. 44	264, 487	39. 67	88	254, 154	36. 60	5, 354	27. 19	2. 02
North Africa	445, 373	5. 37	34, 729	5. 21	78	64, 807	9. 33	1, 858	9. 43	5. 35
Africa-Middle East	12, 255	. 15	1, 565	. 23	128	675	. 10	92	. 47	5. 88
Persian Gulf	16, 063	. 19	975	. 15	61	1, 059	. 15	10	0	1. 03
China-Burma-India	199, 035	2. 40	20, 025	3. 00	100	25, 217	3. 63	652	3. 31	3. 26
Total Pacific areas	1, 296, 005	15. 63	106, 270	15. 94	82	148, 711	21. 42	5, 233	26. 57	4. 92
Southwest Pacific Area	840, 171	10. 13	69, 276	10. 39	82	86, 259	12. 42	3, 408	17. 31	4. 92
Pacific Ocean Areas	455, 834	5. 50	36, 994	5. 55	81	62, 452	8. 99	1, 825	9. 26	4. 93
Commanding General, Army Air Forces	212, 909	2. 57	4, 766	. 71	22	3, 714	. 53	21	. 11	. 44
Commanding General, Army Ground Forces	27	. 00	0	0	0	0	0	0	0	0

Commanding General, Army Service Forces	31, 939	. 39	14, 057	2. 11	440	7	0	2	0	. 01
War Department Groups	7, 508	. 09	79	. 01	11	0	0	0	0	0
	30 June 1945									
Worldwide	8, 266, 373	100. 00	663, 898	100. 00	80	694, 818	100. 00	19, 674	100. 00	2. 96
Overseas	5, 239, 722	63. 38	443, 696	66. 83	85	510, 376	73. 45	12, 803	65. 08	2. 89
En route	81, 588	. 99	5, 301	. 80	65	12, 395	1. 78	72	. 37	1. 36
Foreign	5, 158, 134	62. 40	438, 395	66. 03	85	497, 981	71. 67	12, 731	64. 71	2. 90
North America	12, 211	. 15	776	. 12	64	0	0	0	0	0
Alaska	37, 923	. 46	1, 935	. 29	51	5, 247	. 76	116	. 59	5. 99
Caribbean	64, 343	. 78	3, 525	. 53	55	3, 580	. 52	26	. 13	. 74
South Atlantic	2, 816	. 03	369	. 06	131	0	0	0	0	0
Europe	2, 811, 820	34. 02	250, 280	37. 70	89	242, 412	34. 89	4, 712	23. 95	1. 88
North Africa	404, 242	4. 89	33, 196	5. 00	82	61, 957	8. 92	1, 798	9. 14	5. 42
Africa-Middle East	11, 352	. 14	1, 385	. 21	122	807	. 12	84	. 43	6. 06
Persian Gulf	13, 547	. 16	698	. 11	52	167	. 02	1	0	. 14
China-Burma-India	194, 558	2. 35	19, 424	2. 93	100	23, 369	3. 36	573	2. 91	2. 95
Total Pacific areas	1, 328, 114	16. 07	107, 181	16. 14	81	156, 376	22. 51	5, 400	27. 45	5. 04
Southwest Pacific Area	866, 214	10. 48	69, 665	10. 49	80	89, 587	12. 89	3, 692	18. 77	5. 30
Pacific Ocean Areas	461, 900	5. 59	37, 516	5. 65	81	66, 789	9. 61	1, 708	8. 68	4. 55
Commanding General, Army Air Forces	237, 386	2. 87	5, 345	. 81	23	4, 066	. 59	21	. 11	. 39
Commanding General, Army Ground Forces	29	. 00	0	0	0	0	0	0	0	0
Commanding General, Army Service Forces	32, 694	. 40	14, 202	2. 14	434	0	0	0	0	0
War Department Groups	7, 099	. 09	79	. 01	11	0	0	0	0	0

See footnotes at end of table.

TABLE 31.- *-Oversea strength of the Medical Department and oversea Negro medical strength, by area,*[1] *31 July 1941–30 September 1945*—Continued

Area	Army		Medical Department			Negroes—Army		Negroes—Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	31 July 1945									
Worldwide	8, 186, 444	100. 00	659, 853	100. 00	81	702, 758	100. 00	19, 995	100. 00	3. 03
Overseas	4, 922, 309	60. 13	423, 120	64. 12	86	505, 279	71. 90	13, 028	65. 16	3. 07
En route	59, 746	. 73	4, 260	. 64	71	5, 619	. 80	206	1. 03	4. 84
Foreign	4. 862, 563	59. 40	418, 860	63. 48	86	499, 660	71. 10	12, 822	64. 13	3. 06
North America	9, 952	. 12	630	. 10	63	0	0	0	0	0
Alaska	39, 022	. 48	1, 959	. 30	50	4, 780	. 68	112	. 56	5. 72
Caribbean	66, 873	. 82	3, 479	. 53	52	3, 431	. 49	28	. 14	. 80
South Atlantic	2, 753	. 03	394	. 06	143	0	0	0	0	0
Europe	2, 509, 719	30. 66	230, 058	34. 87	92	229, 050	32. 59	4, 730	23. 66	2. 06
North Africa	351, 761	4. 30	29, 866	4. 53	85	55, 927	7. 96	1, 583	7. 92	5. 30
Africa-Middle East	11, 086	. 14	1, 336	. 20	121	770	. 11	85	. 43	6. 36
Persian Gulf	9, 173	. 11	496	. 08	54	134	. 02	0	0	0
China-Burma-India	189, 225	2. 31	18, 678	2. 83	99	23, 778	3. 38	575	2. 88	3. 08
Total Pacific areas	1, 389, 010	16. 97	112, 725	17. 08	81	178, 062	25. 34	5, 687	28. 44	5. 05
Southwest Pacific Area										
Pacific Ocean Areas										
Commanding General, Army Air Forces	242, 363	2. 96	5, 725	. 87	24	3, 728	. 53	22	. 11	. 38
Commanding General, Army Ground Forces	28	. 00	0	0	0	0	0	0	0	0

Commanding General, Army Service Forces	34, 519	. 42	13, 441	2. 04	389	0	0	0	0	0
War Department Groups	7, 081	. 09	73	. 01	10	0	0	0	0	0
31 August 1945										
Worldwide	8, 023, 304	100. 00	637, 684	100. 00	79	695, 264	100. 00	20, 285	100. 00	3. 18
Overseas	4, 623, 365	57. 62	377, 072	59. 14	82	475, 950	68. 46	12, 702	62. 62	3. 37
En route	134, 054	1. 67	5, 444	. 85	41	6, 879	. 99	150	. 74	2. 76
Foreign	4, 489, 311	55. 95	371, 628	58. 28	83	469, 071	67. 47	12, 552	61. 88	3. 38
North America	7, 440	. 09	450	. 07	60	0	0	0	0	0
Alaska	37, 785	. 47	1, 896	. 30	50	4, 726	. 68	106	. 52	5. 59
Caribbean	63, 992	. 80	3, 592	. 56	56	2, 763	. 40	27	. 13	. 75
South Atlantic	2, 866	. 04	398	. 06	139	0	0	0	0	0
Europe	2, 164, 161	26. 97	188, 488	29. 56	87	181, 620	26. 12	4, 131	20. 36	2. 19
North Africa	244, 656	3. 05	20, 456	3. 21	84	43, 747	6. 29	1, 301	6. 41	6. 36
Africa-Middle East	11, 103	. 14	1, 291	. 20	116	585	. 08	74	. 36	5. 73
Persian Gulf	6, 922	. 09	395	. 06	57	80	. 01	0	0	0
China-Burma-India	195, 840	2. 44	19, 642	3. 08	100	23, 892	3. 44	552	2. 72	2. 81
Total Pacific areas	1, 458, 911	18. 18	116, 208	18. 22	80	206, 512	29. 70	6, 330	31. 21	5. 45
Southwest Pacific Area										
Pacific Ocean Areas										
Commanding General, Army Air Forces	253, 949	3. 17	5, 805	. 91	23	5, 146	. 74	31	. 15	5. 34
Commanding General, Army Ground Forces	23	. 00	0	0	0	0	0	0	0	0
Commanding General, Army Service Forces	34, 991	. 44	12, 939	2. 03	369	0	0	0	0	0
War Department Groups	6, 672	. 08	68	0	10	0	0	0	0	0

See footnotes at end of table.

TABLE 31.—*Oversea strength of the Medical Department and oversea Negro medical strength, by area,*[1] *31 July 1941–30 September 1945*—Continued

Area	Army		Medical Department			Negroes—Army		Negroes—Medical Department		
	Strength [2]	Percent of worldwide strength	Strength [3]	Percent of worldwide strength	Strength per 1,000 troops	Strength [4]	Percent of worldwide strength	Strength [5]	Percent of worldwide strength	Percent of Medical Department strength
	30 September 1945									
Worldwide	7, 564, 514	100. 00	593, 644	100. 00	79	653, 563	100. 00	19, 328	100. 00	3. 26
Overseas	4, 158, 810	54. 98	331, 261	55. 80	80	417, 948	63. 95	11, 411	59. 04	3. 44
En route	44, 456	. 59	2, 205	. 37	50	2, 343	. 36	147	. 76	6. 67
Foreign	4, 114, 354	54. 39	329, 056	55. 43	80	415, 605	63. 59	11, 264	58. 28	3. 42
North America	4, 869	. 06	335	. 06	69	2	0	0	0	0
Alaska	36, 345	. 48	1, 825	. 31	50	4, 774	. 73	104	. 54	5. 70
Caribbean	62, 580	. 83	3, 491	. 59	56	2, 763	. 42	27	. 14	. 77
South Atlantic	1, 748	. 02	233	. 04	133	0	0	0	0	0
Europe	1, 790, 817	23. 67	152, 700	25. 72	86	137, 428	21. 03	3, 783	19. 57	2. 48
North Africa	189, 994	2. 51	15, 967	2. 69	84	36, 047	5. 52	1, 009	5. 22	6. 32
Africa-Middle East	10, 734	. 14	1, 266	. 21	118	591	. 09	74	. 38	5. 85
Persian Gulf	6, 922	. 09	395	. 07	57	80	. 01	0	0	0
China-Burma-India	181, 338	2. 40	16, 865	2. 84	93	21, 874	3. 35	350	1. 81	2. 08
Total Pacific areas	1, 552, 303	20. 52	120, 300	20. 26	77	206, 477	31. 59	5, 917	30. 61	4. 92
Southwest Pacific Area										
Pacific Ocean Areas										
Commanding General, Army Air Forces	240, 613	3. 18	5, 340	. 90	22	5, 540	. 85	0	0	0
Commanding General, Army Ground Forces	20	. 00	0	0	0	0	0	0	0	0

Commanding General, Army Service Forces	29, 641	. 39	10, 280	1. 73	346	29	0	0	0	0
War Department Groups	6, 430	. 09	59	. 00	9	0	0	0	0	0

[1] For a statement of the territory within the areas shown, see appendix to this table.

[2] For all dates other than 31 March 1942, area strengths are from "Monthly Foreign Strength of the Army by Command," in "Strength of the Army," 1 Oct. 1945, pp. 62–63, except for Southwest Pacific and Pacific Ocean Areas, which are from "Strength of the Army" for dates shown or dates approximate thereto. This accounts for such failure of the strength of these two areas to equal total Pacific strength as occurs. Strength on 31 March 1942 for the Pacific (including both areas) from "Areas of Strategic Responsibility and U.S. Army Overseas Deployment, 2 April 1942"—*in* Matloff, Maurice, and Snell, Edwin M.: The War Department: Strategic Planning for Coalition Warfare. 1941–1942. United States Army in World War II: Washington: U.S. Government Printing Office, 1953. For other areas on the same date from "Strength of the Army" or strength returns (Strength Returns by Grade, WD AGO Form No. 323) from departments and bases for the same date (records of AGO Statistical and Control Branch). These have been used because of double counting of certain personnel and other errors in data for 31 March 1942 shown in the time series mentioned. Worldwide strength from "Monthly Strength of the Army Continental United States" and "Monthly Foreign Strength of the Army Foreign and In Route" in "Strength of the Army," 1 Oct. 1945, except for 31 March 1942 which has been corrected in accordance with the changes made with respect to oversea areas. (The strength on the same date as reported in "Strength of the Army," 1 Jan. 1947 was 2,387,746.)

[3] Worldwide strength for 31 July 1941 based on data of The Adjutant General's Office supplied by the Army Comptroller's Office, January 1956; based on table for 30 November 1941–30 September 1945, from table 1. Data for China-Burma-India for March 1942 represent the troop and Medical Department strength of the 7th Bombardment Group and the 51st Fighter Group, Army Air Forces, which arrived in Karachi on 12 March 1942; all other area strengths prior to October 1943 as well as, partly, for April 1944 from strength returns (Strength Returns by Grade, WD AGO Form No. 323, 1 July 1941, No. 323, 1 Nov. 1941, and No. 323A, 1 Jan. 1943) from departments and bases (records of the AGO Statistical and Control Branch) for corresponding dates; for October 1943–September 1945, except as noted, from "Strength of the Army." Since, in virtually all instances, the oversea strengths shown are those used by the Office of The Adjutant General in compiling its worldwide figures, the differences between the worldwide strengths of the Medical Department as stated by the Office of The Surgeon General and The Adjutant General's Office (table 1) are attributed almost exclusively to the Zone of Interior. This is justified by the fact that the variation between the two sets of figures arose primarily through differences in methods of recording movement in and out of the Army, a process which mainly affected the continental United States. It should be noted, nevertheless, that the medical strengths credited to the oversea areas by the Office of The Adjutant General rarely agreed with the strengths as stated by the oversea Medical Department authorities, who charged that the War Department was wont to credit them with a strength greater than that which they actually possessed. (Unrecorded interview, Medical Department historian with Ralph Casteel, Veterans' Administration, April 1953.)

[4] Worldwide strength for 31 July and 30 November 1941 from "Strength of the Army" for corresponding dates. Strengths for other dates from "Monthly Negro Strength of the Army," "Strength of the Army," 1 Jan. 1945, p. 47; and "Quarterly and Monthly Negro Strength of the Army," "Strength of the Army," 1 Jan. 1946. Area strengths from "Strength of the Army" and other sources of area strength shown in footnote 3.

[5] From sources of area strengths shown in footnote 3.

APPENDIX TO TABLE 31

From the geographic point of view, the data in this table are organized for the most part in accordance with the scheme used in the time series entitled "Monthly Foreign Strength of the Army by Command," in "Strength of the Army," 1 Oct. 1945, pp. 62-63. This time series purports to show the troop strength of each major geographic command, except the China and India-Burma theaters, existing at that time from a date which, in a number of cases, is as early as July 1941. This disregards the fact that some of the commands listed were not even in existence at certain periods in which a strength is attributed to them; in other words, the strength shown, with some exceptions, is that of the area later covered by the command in question. The Persian Gulf Command, although it was once part of the Middle East theater is always treated separately, and the strength of the Africa-Middle East theater is correspondingly reduced for the period when the Persian Gulf was within its jurisdiction. Similarly, Iceland is credited to the Eastern Service Command for all dates despite the fact that for a time it was in the European Theater of Operations. However, China and India-Burma, although separate commands at the time of publication of the time series, nevertheless are grouped together therein. Furthermore, the principle of geographic consistency had not been uniformly observed. For example, contrary to the practice adopted in the case of Iceland, southern France, although credited to the Mediterranean theater for the period prior to 1 November 1944, is subsequently allotted to the European theater. Similarly, North Africa is attributed to the North African-Mediterranean theater before 1 March 1945 and, thereafter, to the Africa-Middle East theater.

To the categories as established in the time series, a breakdown of the Pacific into Southwest Pacific Area and Pacific Ocean Areas has been added to take account of the fact that throughout almost the entire period covered, the Pacific area was divided among more than one command. As used in this and other tables, the Southwest Pacific Area includes the Philippines before the entrance of the United States into the war as well as the territory subject to the jurisdiction of U.S. Army Forces in the Far East subsequent to that event. The Pacific Ocean Areas include all commands of the Pacific independent of the Southwest Pacific Area. Under this arrangement, the strength of certain commands subject to the South Pacific command which were transferred to the Southwest Pacific in 1944 is first credited to the Pacific Ocean Areas and subsequently to the Southwest Pacific. In contrast to the handling of the Pacific, personnel in Iceland and areas subject to some commands in the Western Hemisphere have been combined into a North American group which contains, besides elements in the Northwest Service and Eastern Defense Commands not serving in the continental United States, personnel in every part of that hemisphere outside Alaska, the Caribbean, and the South Atlantic. (As used in the tables, the Caribbean comprehends the Antilles, Trinidad, Aruba, British Guiana, Panama, Venezuela, and Peru, and the South Atlantic includes not only Brazil but also Ascension. Both Bermuda and the Bahamas are counted as part of North America.)

In accordance with the time series noted above and other sources used in the preparation of table 40, certain of the personnel stationed in oversea areas are credited in the table to commands existing in the Zone of Interior; that is, the War Department as a whole, the Army Service Forces, the Army Air Forces. The War Department groups, consisting of members of military missions as well as other personnel, are so credited from the earliest date shown. In the case of the Air Forces, on the other hand, the practice was not adopted until May 1944. As a result of the change, some of the figures shown in the table for the period beginning with 31 July 1944 are not entirely comparable with corresponding figures for earlier dates. Beginning with that date, the Air Transport Command and a much smaller group of other personnel are charged to the Commanding General, Army Air Forces; whereas, at earlier dates, they are included in the strength of the areas where they were stationed. Their subtraction from the strength of these areas increases the medical troop ratios of each area, since Air Forces troops contained a lower proportion of medical troops than did the Army in general (see table 39). While the change has only a negligible effect on the rates of large theaters, it results in marked alterations of the rates of small theaters such as the South Atlantic and Africa-Middle East where the number of troops lost sometimes exceeds those that remain. Much can be done to restore the comparability of the data by adding for each date after April 1944 shown above the strength of the Air Transport Command in each area to the Army strength for that area. This has been done in the table entitled "Adjusted Medical Department Strength in Individual Oversea Areas" below, and the result is there referred to as "Adjusted Strength-Total." To compute a medical ratio for

this adjusted strength-total, the medical strength of each area as reported above also must be increased by the amount of medical personnel among the Air Transport Command troops. This in most cases is unknown. For the sake of adjustment, however, it has been assumed that it is the same proportion of the Air Transport Command strength as the medical strength under the Commanding General, Army Air Forces shown in the table above for the particular date is of the entire oversea personnel under his command. Considerable justification for this procedure exists in the fact that the Air Transport Command constituted a very substantial proportion of this strength. Although the proportion declined, the rate did not change materially. The percentages of the total strength held by the Air Transport Command were as follows:

1944:		1945—Continued	
July	62	May	47
October	60	June	48
1945:		July	47
January	52	August	40
April	46	September	41

Based on data from "Strength of the Army" for relevant dates.

It is of course entirely arbitrary to assume that the ratio of medical personnel to Air Transport Command strength was the same in every area, but the fact that these rates were generally low reduces the amount of influence that errors arising as a result of the procedure followed may have on the adjusted rates shown below. Nevertheless, neither these rates nor the medical strengths on which they are based can be assumed to be more than approximations to the true ones. For example, the medical strength of the Air Transport Command in the South Atlantic on 31 August 1945 is known to have been 191, whereas the figure reached by the procedure described here is 140. The medical strength ratio of the area, using the figure 191, therefore is 66 per 1,000 troops rather than 60 per 1,000 as shown below. On 31 March 1945, the medical strength of the Air Transport Command in the same theater was 72 per 1,000, and if the same total existed on 30 April 1945, the strength ratio on that date was 88 per 1,000; the figure stated below is 84 per 1,000. (For the medical strength of the Air Transport Command in the South Atlantic *see* Medical History World War II, U.S. Army Forces, South Atlantic, p. 56. [official record.])

Personnel outside the Zone of Interior who were under the direct jurisdiction of the Commanding General of the Army Service Forces or the Army Ground Forces are reported separately beginning in April 1945. In the case of the former, at least, the personnel so reported were not hitherto reported as part of the strength of any oversea area. They consisted of the personnel operating hospital ships and troop transports navigating between oversea areas and the Zone of Interior. As may be seen, medical personnel constituted a very substantial proportion of this group. In order to make the oversea strength of the Army and the Medical Department for the period after March 1945 comparable with the strength prior to that time, the following adjustments of the percentages of each group overseas are necessary:

Date	*Army*	*Medical Department*	Date	*Army*	*Medical Department*
30 Apr. 1945	65.75	66.87	31 July 1945	59.71	62.09
31 May 1945	64.82	66.15	31 Aug. 1945	57.19	57.10
30 June 1945	62.99	64.69	30 Sept. 1945	54.59	54.07

Appendix to Table 31—Continued

Adjusted Medical Department strength in individual oversea areas, 31 July 1944–30 September 1945

Area	Adjusted strength			Air Transport Command strength		
	Total	Medical		Total [2]	Medical	
		Number	Rate [1]		Number	Rate [1]
	31 July 1944					
North America	36,494	1,344	52	9,679	194	5.0
Alaska	74,749	4,126	55	3,568	71	.9
Caribbean	72,803	4,278	59	631	13	.2
South Atlantic	6,063	581	96	2,601	52	9.0
Europe	1,773,891	159,348	90	3,277	66	.04
North Africa	729,084	56,099	77	5,027	101	.1
Africa-Middle East	15,746	1,313	83	6,143	123	8.0
Persian Gulf	28,774	2,228	77	478	10	.3
China-Burma-India	157,540	12,622	80	14,900	298	2.0
Southwest Pacific Area	666,568	60,181	90	2,060	41	.06
Pacific Ocean Areas	395,854	34,368	87	3,558	71	.2
	31 October 1944					
North America	33,004	1,449	44	10,824	195	6.0
Alaska	62,502	3,592	57	3,848	69	1.0
Caribbean	69,836	3,730	53	570	10	.1
South Atlantic	5,035	500	99	2,324	42	8.0
Europe	2,208,756	198,503	90	5,173	93	.04
North Africa	719,324	55,628	77	7,106	128	.2
Africa-Middle East	16,839	1,292	77	7,553	136	8.0
Persian Gulf	28,572	2,047	71	862	16	.6
China-Burma-India	182,562	15,692	86	23,148	417	2.0
Southwest Pacific Area	705,529	61,706	87	4,494	81	.1
Pacific Ocean Areas	422,482	34,389	81	6,534	118	.3
	31 January 1945					
North America	29,847	1,355	45	10,762	247	8.0
Alaska	51,542	2,741	53	3,857	89	2.0
Caribbean	70,787	3,841	54	556	13	.2
South Atlantic	4,907	421	86	2,254	52	11.0
Europe	2,836,481	255,770	90	7,442	171	.06
North Africa	517,470	38,764	75	9,802	225	.4
Africa-Middle East	17,263	1,329	77	7,933	182	11.0
Persian Gulf	27,409	1,989	73	1,327	31	1.0
China-Burma-India	216,358	18,864	87	29,102	769	4.0
Southwest Pacific Area	753,816	62,762	83	4,362	100	.1
Pacific Ocean Areas	427,086	35,160	82	6,289	144	.3

See footnotes at end of table.

Appendix to Table 31—Continued

Adjusted Medical Department strength in individual oversea areas, 31 July 1944–30 September 1945

Area	Adjusted strength			Air Transport Command strength		
	Total	Medical		Total [2]	Medical	
		Number	Rate [1]		Number	Rate [1]
	30 April 1945					
North America	26,882	1,253	47	9,947	239	9.0
Alaska	42,415	2,264	53	3,609	87	2.0
Caribbean	67,750	3,720	55	581	14	.2
South Atlantic	5,039	427	84	2,276	55	11.0
Europe	3,073,133	269,161	87	7,628	183	.06
North Africa	496,083	37,757	76	2,207	53	.1
Africa-Middle East	27,353	2,012	74	15,735	378	14.0
Persian Gulf	17,213	1,008	59	1,420	34	2.0
China-Burma-India	231,597	20,605	89	32,767	786	3.0
Southwest Pacific Area	811,505	66,545	82	5,377	129	.2
Pacific Ocean Areas	458,757	38,793	85	7,787	187	.4
	31 May 1945					
North America	26,406	1,113	42	10,941	241	9.0
Alaska	41,947	2,086	50	3,524	78	2.0
Caribbean	63,301	3,613	57	5,169	114	2.0
South Atlantic	5,096	420	82	2,307	51	10.0
Europe	3,029,589	264,665	87	8,106	178	.06
North Africa	447,690	34,780	78	2,317	51	.1
Africa-Middle East	30,547	1,967	64	18,292	402	13.0
Persian Gulf	17,487	1,006	58	1,424	31	2.0
China-Burma-India	231,495	20,739	90	32,460	714	3.0
Southwest Pacific Area	845,756	69,398	82	5,585	122	.1
Pacific Ocean Areas	463,945	37,172	80	8,111	178	.4
	30 June 1945					
North America	23,598	1,038	44	11,387	262	11.0
Alaska	41,104	2,008	49	3,181	73	2.0
Caribbean	74,997	3,770	50	10,654	245	3.0
South Atlantic	8,998	511	57	6,182	142	16.0
Europe	2,821,012	250,491	89	9,192	211	.07
North Africa	406,534	32,249	79	2,292	53	.1
Africa-Middle East	27,455	1,755	64	16,103	370	13.0
Persian Gulf	15,048	733	49	1,501	35	2.0
China-Burma-India	228,485	20,204	88	33,927	780	3.0
Southwest Pacific Area	872,070	69,800	80	5,856	135	.2
Pacific Ocean Areas	470,547	37,715	80	8,647	199	.4

See footnotes at end of table.

Appendix to Table 31—Continued

Adjusted Medical Department strength in individual oversea areas, 31 July 1944–30 September 1945

Area	Adjusted strength			Air Transport Command strength		
	Total	Medical		Total [2]	Medical	
		Number	Rate [1]		Number	Rate [1]
	31 July 1945					
North America	20,935	892	43	10,983	262	13.0
Alaska	42,321	2,038	47	3,299	79	2.0
Caribbean	76,625	3,689	48	9,572	230	3.0
South Atlantic	9,064	545	60	6,311	151	17.0
Europe	2,517,653	230,248	91	7,934	190	.08
North Africa	354,092	29,922	85	2,331	56	.2
Africa-Middle East	31,374	1,823	58	20,288	487	16.0
Persian Gulf	10,686	523	50	1,513	36	3.0
China-Burma-India	223,433	19,499	87	34,210	821	4.0
Total Pacific	1,404,140	113,088	81	15,130	363	.3
	31 August 1945					
North America	18,637	708	38	11,197	258	14.0
Alaska	40,755	1,964	47	2,970	68	2.0
Caribbean	72,842	3,778	52	8,850	186	3.0
South Atlantic	8,969	538	60	6,103	140	16.0
Europe	2,172,100	188,671	87	7,939	183	.08
North Africa	247,020	20,510	83	2,364	54	.2
Africa-Middle East	28,918	1,701	59	17,815	410	14.0
Persian Gulf	8,198	424	52	1,276	29	4.0
China-Burma-India	231,470	20,461	88	35,630	819	4.0
Total Pacific	1,473,868	116,552	79	14,957	344	.2
	30 September 1945					
North America	14,035	520	37	9,166	185	13.0
Alaska	38,166	1,865	49	1,821	40	1.0
Caribbean	67,021	3,589	54	4,441	98	1.0
South Atlantic	5,518	316	57	3,770	83	15.0
Europe	1,798,244	152,863	85	7,427	163	.09
North Africa	192,326	16,018	83	2,332	51	.3
Africa-Middle East	23,993	1,566	65	13,619	300	13.0
Persian Gulf	7,809	415	53	887	20	3.0
China-Burma-India	214,732	17,600	82	33,394	735	3.0
Total Pacific	1,573,170	120,759	77	20,867	459	.3

[1] Per 1,000 troops adjusted strength.

[2] From Personnel Handbook, Headquarters, Air Transport Command, Army Air Forces, for dates shown.

Distribution by Corps and Groups

Overall percentage statistics for Medical Department personnel serving overseas in nowise give a true picture of Medical Department activities overseas inasmuch as percentages varied widely among corps and between officers and enlisted men (charts 5, 6, and 7, and tables 31 and 32). For example, enlisted men constituted more than 80 percent of the strength of the medical service overseas (table 5); whereas, the maximum percentage of Medical Department officers stationed overseas at any time was only about 56 percent, in January and April 1945, making the percentage of the entire Medical Department approximately 58 percent (April 1945). And in the officer corps, the percentage of medical officers and nurses was considerably higher than that of Medical Department officers as a whole, being 60.8 percent in the case of medical officers (April 1945) and 63.3 percent in case of nurses (January 1945). The corresponding percentage of the Medical Administrative Corps was about equal to that of the entire officer group, but in all the remaining officer components, the percentage was lower. In the Dental Corps, the maximum was 48.3 percent reached in May 1945, a percentage that reflected both an actual increase in the number of dentists overseas and a decline in their worldwide strength (tables 1 and 32). As for the Veterinary Corps, its oversea strength failed to reach 35 percent.

CHART 5.—*Percent of total Army and Medical Department strength, in oversea areas, on selected dates, 1941–45*

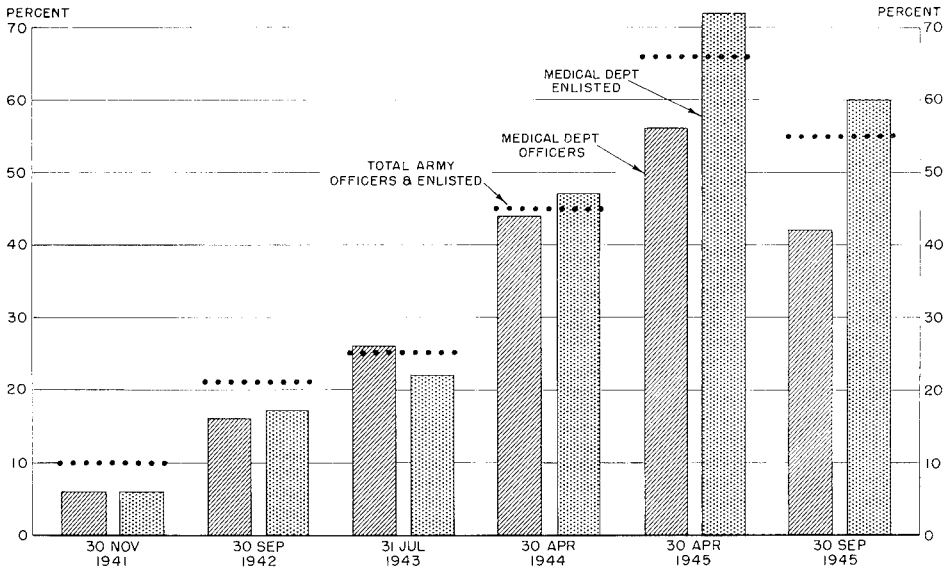


CHART 6.—*Percent of total Army strength and Medical Department officers, by corps (Medical, Dental, Veterinary, and Medical Administrative), in oversea areas, on selected dates, 1941–45*

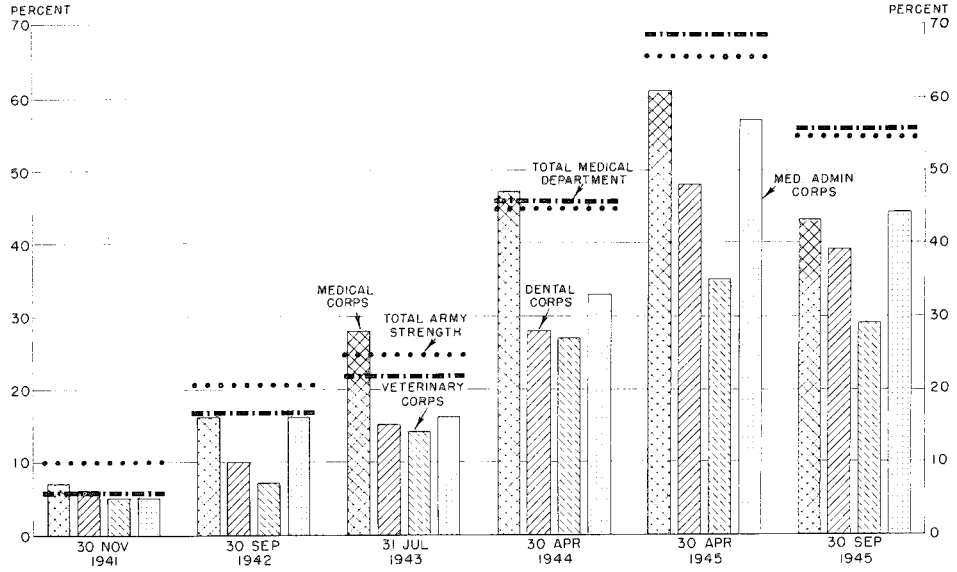
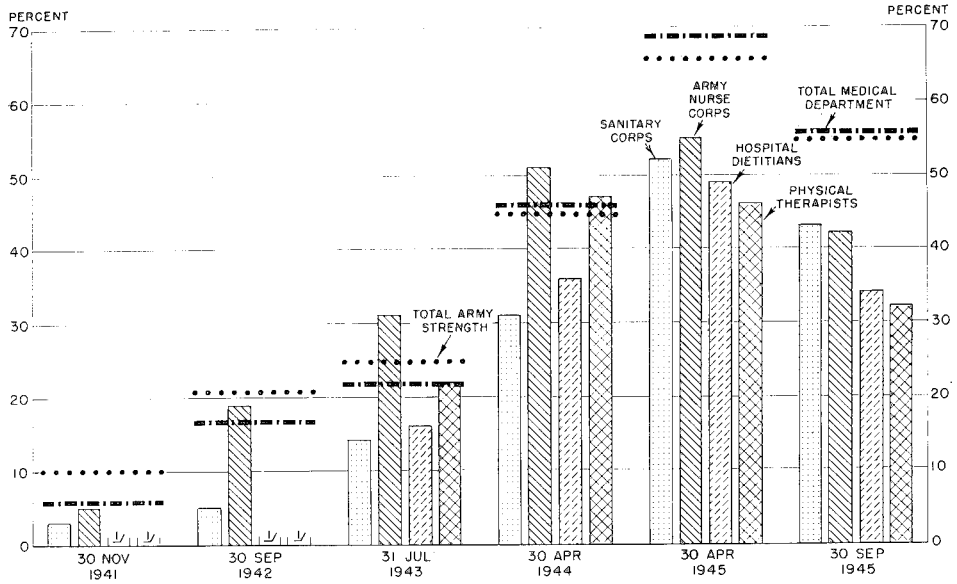


CHART 7.—*Percent of total Army strength and Medical Department officers, by corps (Sanitary and Army Nurse), and Hospital Dietitians and Physical Therapists, in oversea areas, on selected dates, 1941–45*



[1] Corps not existent on this date.

TABLE 32.—*Oversea strength of the Medical Department corps and other officer components, 31 July 1941–30 September 1945*

Date	Strength [1]	Percent of worldwide corps strength [2]	Rate per 1,000 troops [3]
	Medical Corps		
1941			
31 July	521	----------	3. 84
30 November	779	6. 9	4. 72
1942			
31 March	1, 804	14. 5	5. 50
30 June	3, 611	20. 1	6. 00
30 September	4, 945	15. 8	6. 01
1943			
31 January	7, 462	20. 6	6. 66
30 April	9, 424	25. 6	6. 73
31 July	11, 068	28. 3	6. 22
31 October	13, 209	32. 9	5. 90
1944			
31 January	16, 631	39. 7	5. 91
30 April	20, 393	47. 0	5. 74
31 July	22, 648	51. 4	5. 53
31 October	24, 835	54. 1	5. 36
1945			
31 January	26, 456	56. 3	5. 16
30 April	28, 457	60. 8	5. 22
31 May	27, 639	50. 0	5. 11
30 June	26, 849	57. 6	5. 12
31 July	24, 790	51. 6	5. 04
31 August	21, 755	46. 3	4. 71
30 September	19, 135	42. 5	4. 60
	Dental Corps		
1941			
31 July	135	----------	0. 99
30 November	175	5. 6	1. 06
1942			
31 March	286	8. 3	. 87
30 June	535	11. 2	. 89
30 September	798	9. 5	. 97

See footnotes at end of table.

TABLE 32.—*Oversea strength of the Medical Department corps and other officer components, 31 July 1941–30 September 1945*—Continued

Date	Strength [1]	Percent of worldwide corps strength [2]	Rate per 1,000 troops [3]
	Dental Corps—Continued		
1943			
31 January	1,273	12.8	1.14
30 April	1,642	15.3	1.17
31 July	1,910	15.0	1.07
31 October	2,556	18.5	1.14
1944			
31 January	3,301	23.3	1.17
30 April	4,167	28.2	1.17
31 July	4,858	32.5	1.19
31 October	5,577	36.8	1.20
1945			
31 January	6,264	42.0	1.22
30 April	7,080	48.0	1.30
31 May	7,103	48.3	1.31
30 June	6,919	46.8	1.32
31 July	6,576	45.9	1.34
31 August	6,190	43.9	1.34
30 September	5,334	38.8	1.28
	Veterinary Corps		
1941			
31 July	38	----------	0.30
30 November	37	5.3	.22
1942			
31 March	45	5.6	.14
30 June	64	6.7	.11
30 September	97	6.9	.12
1943			
31 January	152	9.7	.14
30 April	250	14.3	.18
31 July	298	16.0	.18
31 October	338	17.2	.15

See footnotes at end of table.

TABLE 32.—*Oversea strength of the Medical Department corps and other officer components, 31 July 1941–30 September 1945*—Continued

Date	Strength [1]	Percent of worldwide corps strength [2]	Rate per 1,000 troops [3]
	Veterinary Corps—Continued		
1944			
31 January	471	24. 1	. 17
30 April	542	26. 9	. 15
31 July	594	28. 7	. 15
31 October	602	30. 2	. 13
1945			
31 January	675	33. 0	. 12
30 April	707	34. 7	. 12
31 May	705	34. 4	. 13
30 June	693	34. 0	. 13
31 July	657	32. 0	. 13
31 August	629	30. 4	. 14
30 September	594	29. 1	. 14
	Sanitary Corps		
1941			
31 July	2	----------	0. 01
30 November	8	3. 0	. 05
1942			
31 March	11	3. 5	. 03
30 June	25	3. 9	. 04
30 September	47	4. 8	. 06
1943			
31 January	79	6. 4	. 07
30 April	167	10. 7	. 12
31 July	263	14. 6	. 15
31 October	394	18. 7	. 18
1944			
31 January	538	23. 9	. 19
30 April	718	31. 4	. 20
31 July	1, 080	42. 9	. 26
31 October	1, 071	43. 8	. 23

See footnotes at end of table.

TABLE 32.—*Oversea strength of the Medical Department corps and other officer components, 31 July 1941–30 September 1945*—Continued

Date	Strength [1]	Percent of worldwide corps strength [2]	Rate per 1,000 troops [3]
	Sanitary Corps—Continued		
1945			
31 January	1,233	49.2	0.24
30 April	1,321	51.6	.24
31 May	1,288	50.3	.24
30 June	1,272	50.0	.24
31 July	1,253	49.7	.25
31 August	1,163	46.7	.25
30 September	1,039	43.4	.25
	Medical Administrative Corps		
1941			
31 July	43	----------	0.32
30 November	64	5.1	.39
1942			
31 March	129	7.4	.39
30 June	403	18.4	.67
30 September	590	16.2	.72
1943			
31 January	1,037	13.8	.93
30 April	1,539	15.0	1.10
31 July	2,003	15.9	1.13
31 October	2,921	21.1	1.30
1944			
31 January	3,746	24.9	1.33
30 April	4,980	33.4	1.40
31 July	6,296	41.8	1.54
31 October	7,782	50.2	1.68
1945			
31 January	9,250	51.5	1.81
30 April	10,768	56.5	1.97
31 May	10,936	56.4	2.02
30 June	10,828	55.3	2.07
31 July	10,426	52.5	2.12
31 August	9,708	48.9	2.10
30 September	8,692	44.4	2.09

See footnotes at end of table

TABLE 32.—*Overseas strength of the Medical Department corps and other officer components, 31 July 1941–30 September 1945*—Continued

Date	Strength [1]	Percent of worldwide corps strength [2]	Rate per 1,000 troops [3]
	Pharmacy Corps		
1941			
31 July			
30 November			
1942			
31 March			
30 June			
30 September			
1943			
31 January			
30 April			
31 July			
31 October	4	6. 9	0. 001
1944			
31 January	6	10. 3	. 002
30 April	9	15. 5	. 002
31 July	6	10. 7	. 001
31 October	10	16. 7	. 002
1945			
31 January	16	23. 9	. 003
30 April	25	35. 7	. 004
31 May	21	35. 0	. 003
30 June	22	37. 9	. 004
31 July	23	40. 4	. 004
31 August	22	32. 4	. 004
30 September	21	34. 4	. 005
	Army Nurse Corps		
1941			
31 July	236		1. 74
30 November	349	5. 1	2. 11
1942			
31 March	1, 306	10. 2	3. 98
30 June	2, 880	16. 7	4. 79
30 September	3, 803	19. 0	4. 62

See footnotes at end of table.

TABLE 32.—*Oversea strength of the Medical Department corps and other officer components, 31 July 1941–30 September 1945*—Continued

Date	Strength [1]	Percent of worldwide corps strength [2]	Rate per 1,000 troops [3]
	Army Nurse Corps—Continued		
1943			
31 January	5,778	24.5	5.16
30 April	7,647	27.7	5.46
31 July	9,649	31.4	5.42
31 October	13,203	37.0	5.90
1944			
31 January	16,958	44.3	6.02
30 April	20,958	51.1	5.90
31 July	22,735	56.8	5.55
31 October	25,433	61.5	5.49
1945			
31 January	27,170	63.3	5.30
30 April	28,546	54.9	5.23
31 May	28,842	53.3	5.33
30 June	27,966	51.5	5.34
31 July	28,127	50.5	5.71
31 August	25,499	45.6	5.52
30 September	22,445	42.4	5.40
	Hospital Dietitians		
1941			
31 July	----------	----------	----------
30 November	----------	----------	----------
1942			
31 March	----------	----------	----------
30 June	----------	----------	----------
30 September	----------	----------	----------
1943			
31 January	----------	----------	----------
30 April	64	11.2	0.05
31 July	117	15.9	.07
31 October	185	19.2	.08
1944			
31 January	326	29.6	0.12
30 April	432	36.2	.12
31 July	552	43.0	.13
31 October	631	44.9	.14

See footnotes at end of table.

TABLE 32.—*Oversea strength of the Medical Department corps and other officer components, 31 July 1941–30 September 1945*—Continued

Date	Strength [1]	Percent of worldwide corps strength [2]	Rate per 1,000 troops [3]
	Hospital Dietitians—Continued		
1945			
31 January	680	46. 3	. 13
30 April	749	49. 3	. 14
31 May	757	48. 8	. 14
30 June	782	50. 3	. 15
31 July	698	44. 2	. 14
31 August	628	39. 7	. 14
30 September	538	34. 3	. 13
	Physical Therapists		
1941			
31 July	----------	----------	----------
30 November	----------	----------	----------
1942			
31 March	----------	----------	----------
31 June	----------	----------	----------
30 September	----------	----------	----------
1943			
31 January	----------	----------	----------
30 April	48	15. 3	0. 03
31 July	93	21. 5	. 05
31 October	145	29. 2	. 06
1944			
31 January	241	43. 1	. 09
30 April	300	46. 6	. 08
31 July	371	47. 4	. 09
31 October	468	50. 6	. 10
1945			
31 January	512	47. 4	0. 10
30 April	539	46. 4	. 10
31 May	546	45. 9	. 10
30 June	521	43. 7	. 10
31 July	514	40. 2	. 10
31 August	431	32. 9	. 09
30 September	414	32. 4	. 10

[1] From sources for oversea data shown in table 31, footnote 3. Revised oversea strength data for nurses published by the Office of The Adjutant General ("Monthly Strength of the Army Foreign and En Route," Strength of the Army, 1 Oct. 1945, p. 59) show the following variations from corresponding strengths stated here: July 1941, 253; November 1941, 463; March 1942, 2,689; June 1942, 4,406; and July 1944, 22,807. Since the same source reveals a decline between June 1942 and July 1942 to 2,608 and a failure to equal the June figure until 30 November 1942, at least some of these figures may be regarded with considerable skepticism.

[2] Worldwide corps strength on 31 July 1941 from "Strength of the Army"; available for nurses only. Worldwide strength for subsequent dates is strength stated in table 1.

[3] For troop strength, see table 31.

A major factor in the variation of oversea strength was the changing of requirements, both in the Zone of Interior and overseas, as the war progressed. During the middle part of the war, specifically, much of 1943, the proportion of Medical Department officers overseas was higher than the proportion of the Department strength as a whole. Toward the end of the conflict, when large numbers of battle casualties began to be concentrated in the Zone of Interior, this situation was reversed. This was particularly true after V–E Day as the numbers of bed patients overseas decreased rapidly.

In addition, the Zone of Interior was responsible for the final, definitive type of treatment for many patients which required highly trained professional personnel and for rendering the new inductees physically fit for military duty. Since the Zone of Interior was the source of most of the manpower supply, it presumably had more control over distribution, particularly the movement of Medical Department officers abroad. When the dental standards were lowered after Pearl Harbor, a higher proportion of its personnel was retained in the Zone of Interior.[1] (See tables 1 and 32.)

The inspection activities pertinent to food procurement also were largely confined to the continental United States, this area being the major source of food for the Army. Although more animals were used overseas than in the Zone of Interior for transporting supplies, the theaters did not require enough veterinary officers for animal care to counterbalance the domestic need for these same officers in food inspection work.[2] As a result, the oversea contingent of the Veterinary Corps, proportionately speaking, was smaller than that of any other Medical Department group.

The extent to which various elements could be sent overseas also was controlled to some degree by the number of replacements available. In the case of enlisted personnel, civilians, prisoners of war, and other military personnel could release many for oversea assignments. However, uncertainties in the supply of local extra-Army labor made it impossible to withhold shipments of enlisted men to the oversea areas to the extent that the actual use of substitute labor might have permitted. Furthermore, it is unlikely that savings in enlisted men would have redounded very much to the benefit of the Zone of Interior medical service; the men probably would have been transferred to other branches of the Army.

Civilian registered nurses, cadet nurses, nurses' aides, members of the Women's Army Corps, and enlisted personnel made possible the oversea shipments of nurses to care for the rapidly increasing number of bed patients. The availability of Medical Administrative Corps officers as battalion surgeon's assistants and executive officers for certain types of medical units and installa-

[1] Foster, William B.: History of the Medical Department, World War II, Physical Standards, 1946. [Official record.]

[2] Information from Lt. Col. E. B. Miller, VC, 22 Dec. 1953.

tions may explain similar phenomena in the Medical Corps.[3] Medical Administrative Corps members, on the other hand, also were in demand in oversea areas, and when the Zone of Interior was unable to supply these areas with such officers late in the war, direct commissioning overseas proved to be one solution.

The groups which remained most closely bound to the Zone of Interior were those for which replacements probably were most difficult to find. This is perhaps especially true in the case of dentists and sanitary engineers. Yet, this is not the sole explanation for their failure to move abroad to a greater extent. The feasibility of utilizing female personnel in certain oversea areas was seriously questioned at times.[4] In the European and North African theaters, nurses habitually moved with their units into forward areas. In certain others, however, the theater commanders were reluctant to permit women either in combat areas or in those wherein material comforts were few. Such opposition does not seem to have reduced the percentage of nurses overseas to a marked degree, for even if they did not accompany their units into the more forward positions, they generally were permitted to enter the theaters.

In the case of physical therapists and dietitians, the difficulties of getting overseas were greater. They were assigned mainly to rear areas (that is, in general and station hospitals and, in the case of dietitians, a few evacuation hospitals). Again, the utilization of this personnel overseas was questioned at times.

The buildup overseas of Sanitary Corps officers was slow in some theaters due to lack of appreciation of the need for men of their skills.[5] About 60 percent of the entomologists and 50 percent of the sanitary engineers served in oversea theaters at sometime during the war.[6]

The inability of the Zone of Interior authorities to furnish medical officers in sufficient numbers forced table-of-organization changes which were mainly responsible for the increasing use of Medical Administrative Corps officers overseas during the course of the war.[7] Although some opposition to such use

---

[3] The proportion of medical officers to troops in oversea areas began to exceed the corresponding worldwide ratio when Medical Administrative Corps officers emerged in great numbers from the officer candidate schools.

[4] (1) Vogel, Emma E.: Physical Therapists of the Medical Department, United States Army. [Official record.] (2) Medical Department Dietitians, Middle Pacific and Pacific Ocean Areas. [Official record.] (3) Physical Therapy History of Pacific Ocean Areas and Middle Pacific. [Official record.] (4) Berger, Florence M.: History of the Medical Department Dietetics Service in the Mediterranean Theater of Operations, U.S. Army, 1942–45. [Official record.] (5) Stone, James H.: History of the Army Nurses, Physical Therapists, and Hospital Dietitians in India and Burma. [Official record.] (6) Letters, Col. Emma E. Vogel, USA (Ret.) to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 28 Mar. 1956, and November 1957.

[5] (1) Annual Report, Surgeon, 1st Infantry Division, 1944. (2) Hardenbergh, William A.: Water Purification. *In* Medical Department, United States Army. Preventive Medicine in World War II. Volume II. Environmental Hygiene. Washington: U.S. Government Printing Office, 1955.

[6] Hardenbergh, W. A.: Organization and Administration of Sanitary Engineering Division. [Official record.] (This may indicate a greater appreciation of the need for Sanitary Corps men in malaria control than in other phases of Medical Department work.)

[7] Letter, Col. David E. Liston, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 5 Jan. 1956.

was encountered, the employment of members of this corps in many positions, including that of battalion surgeon's assistant, gained widespread approbation in oversea areas.[8] Indeed, the Fifth U.S. Army surgeon was instrumental in having the use of Medical Administrative Corps officers as battalion surgeon's assistants extended to infantry regimental medical detachments and to medical detachments of tank battalions, rather than confining the use of these officers to units less exposed to battle losses.[9] The fact that commanders overseas were able to promote enlisted men to commissioned status in the corps also tended to increase the number of such officers overseas.

In the final analysis, therefore, it would appear that the strength overseas of these groups was largely limited by their basic overall numbers and by the fixed requirements in the Zone of Interior. The nonacceptance of certain groups, such as female personnel, was in all probability only a minor contributing factor to the size of the oversea shipments.

Regional Strength Overseas

By and large, Medical Department personnel were assigned overseas in the same proportion as Army personnel in general (table 31). In fact, the difference between the percentages of the total Army strength and the total Medical Department strength in an area rarely equaled 4 points and ordinarily was no more than 1 point. The largest concentration of Medical Department strength outside the continental United States existed in the great combat theaters—the North African-Mediterranean theater, the Central and South Pacific or Pacific Ocean Areas, the Southwest Pacific, and, above all, the European theater. Each of these major combat theaters had at least 5 percent of the entire Medical Department strength; in the case of the European theater, it was 40 percent. The China-Burma-India theater obtained no more than 3.08 percent, and no other region attained more than 2 percent. This was true even though that area as well as Alaska and the Africa-Middle East region had some combat history.

Respecting the relation of Medical Department strength to total troop strength, the pattern among the oversea areas was much less simple. Three small theaters, all in the Western Hemisphere—North America, Alaska, and the Caribbean—were consistently fairly low in the proportion of medical

[8] (1) Report, Lt. Col. Stewart F. Alexander, Personnel Officer, Surgeon's Office, Seventh U.S. Army, of Medical Department Activities in Mediterranean Theater of Operations, 14 July 1945. (2) See footnote 5(1), p. 381. (3) Annual Report, Surgeon, 44th Infantry Division, 1944. (4) Semiannual Report, 515th Clearing Company, January–June 1945. (5) Unfavorable reactions are contained in (a) Letter, Brig. Gen. F. A. Blesse, Surgeon, North African Theater of Operations, U.S. Army, to Maj. Gen. N. T. Kirk, The Surgeon General, 17 Nov. 1943; (b) Letter, Maj. Gen. M. C. Stayer, Surgeon, North African Theater of Operations, U.S. Army, to Maj. Gen. N. T. Kirk, The Surgeon General, 3 Sept. 1944; and (c) Annual Report, 54th Medical Battalion, 1944.

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

personnel. On the other hand, the China-Burma-India region frequently maintained a high percentage during most of 1943, the proportion being far in excess of that characterizing any other area.[10]

In 1943 and the first part of 1944, the proportions in two other small theaters, that is, Africa-Middle East and the Persian Gulf, generally were among the higher ones, and in January 1944, the proportion in the former theater was highest among those in all theaters. Even the small South Atlantic theater attained high proportions of medical personnel at times; in mid-1944 it probably had a higher proportion than that of any other region. The major theaters seldom had the highest ratios of medical personnel to troop strength but the Southwest Pacific was an exception to this rule. For most of the earlier war period it held the leadership in this respect. In the earlier part of 1943 the proportion of medical troops in the European theater increased greatly as a result of the shipment of combat forces. This proportion was not long maintained but was approached again as the preparations for the invasion of the Continent were accelerated. After the middle of 1944, the European theater replaced the Southwest Pacific in having the highest ratio of medical personnel to troop strength in a major combat theater. This was the result not only of an increase in the European theater, but also of a decline in that of the Southwest Pacific. The primary reason for the decline in that theater was a shift in jurisdiction over personnel in the Northern Solomons and in Emirau from the South Pacific to the Southwest Pacific.[11] The shift involved a much greater proportion of the general troop strength of the South Pacific than of the medical strength of that area.

The North African theater, except in the early stages of the Italian campaign, almost invariably had a lower proportion than the general oversea rate until after hostilities ceased in Europe. The shift of jurisdiction over southern France from the North African to the European theater in November 1944 helped to keep the proportion down, for it involved the transfer of a greater proportion of medical than of nonmedical personnel. On the other hand, the Mediterranean theater gained slightly when it lost control over North Africa to the Africa-Middle East theater as of 1 March 1945.[12] At that time, it gave up proportionately more nonmedical than medical personnel with a resultant sharp decline in the proportion in the theater which acquired the most personnel.

Like the Mediterranean theater, the Pacific Ocean Areas rarely attained a proportion of medical troops which was as high as that maintained by the oversea regions combined. The proportion, however, was considerably greater in 1944 and in 1945 than it had been earlier; this partly resulted from the

[10] This percentage rate was in relation to the strength of U.S. troops alone. The American forces also were supporting a large body of Chinese troops.

[11] Monthly Summary of Operations, June 1944, General Headquarters, Southwest Pacific Area.

[12] Vickery, Eugene L.: History of the Medical Section, Africa-Middle East Theater, September 1941–September 1945.

TABLE 33.—*Authorized allotment of Medical Department officers to oversea areas (less Reserve officers assigned to duty with the Air Corps) for the fiscal year 1942*

Area	Medical Corps	Dental Corps	Veterinary Corps	Sanitary Corps	Medical Administrative Corps
Alaska	124	20	2	0	2
Puerto Rico	76	20	4	2	2
Panama	176	37	9	2	6
Hawaii	130	39	6	2	14
Philippines	114	28	12	2	11

Source: Letter, The Adjutant General, War Department, to the Commanding Generals, All Overseas Departments and Alaskan Defense Command, 16 Aug. 1941, subject: Allotment of Officers for Overseas Departments and Alaska, Fiscal Year 1942.

transfer of some of its personnel to the jurisdiction of the Southwest Pacific already noted (table 31).[13]

At no time did anyone in the Zone of Interior or in the oversea areas either attempt to establish a quota for medical officers in the theaters or determine the proper proportion of medical strength to overall troop strength. Prior to Pearl Harbor, officers were assigned overseas by the War Department General Staff or, in the case of Air Corps personnel, by the Chief of the Army Air Corps.[14] Throughout the war, Medical Department officers were assigned to the Panama Canal, Puerto Rican, Hawaiian, and Philippine Departments and the Alaskan Defense Command on much the same basis (table 33), but in the combat theaters, the strength of the Medical Department components was based directly on the number and types of table-of-organization units which in turn determined the overall strength of the theater. Basically, therefore, the medical strength of each theater depended on decisions of the Zone of Interior authorities and the theater commander as to how many units containing medical personnel should be allocated to it. These decisions were largely controlled by the demands of the missions of the armies in the areas and the medical needs created by the local environment in competition with requirements of other areas. To some extent, however, willingness of the War Department to provide units was dependent upon the arguments and powers of persuasion of the theater Medical Department authorities themselves.[15]

[13] The unadjusted rate of the Pacific Ocean Areas was 82 per 1,000 on 31 May 1944. (Basic data from "Strength of Foreign Commands by Arms and Services as of 31 May 1944," in "Strength of the Army," 31 May 1944, p. 15.) By 31 July 1944, it had increased to 87.

[14] Memorandum, War Department General Staff, G–1, for The Adjutant General, 28 July 1941, subject: Allotment of Officers for Oversea Departments and Alaska, Fiscal Year 1942.

[15] These factors are more germane to the volumes on oversea medical service now in preparation in the Historical Unit, U.S. Army Medical Service, than to the present work and will be scarcely more than alluded to here.

TABLE 34.—*Estimated table-of-organization strength of attached medical personnel and divisional medical battalions in oversea areas, 30 September 1944* [1]

Area	Total		Ground Forces		Service Forces		Air Forces	
	Strength	Rate per 1,000 troops	Strength	Rate per 1,000 troops	Strength	Rate per 1,000 troops	Strength	Rate per 1,000 troops
North America	172	5	0	0	55	2	117	3
Alaska	988	15	586	9	238	4	164	2
Caribbean	983	14	763	1	14	0. 2	206	3
South Atlantic	15	3	0	0	15	3	0	0
Europe	41, 507	20	29, 560	14	5, 088	2	6, 859	3
North Africa	14, 274	20	11, 351	16	1, 572	2	1, 351	2
Africa-Middle East	30	2	0	0	0	0	30	2
Persian Gulf	199	7	23	0. 8	176	6	0	0
China-Burma-India	2, 376	14	669	4	260	2	1, 447	8
Southwest Pacific Area	18, 558	27	14, 906	21	1, 447	2	2, 205	3
Pacific Ocean Areas	10, 554	25	9, 343	22	531	1	680	2
Total	89, 656	21	67, 201	16	9, 396	2	13, 059	3

[1] Data are based on the summaries of various types of units in the theaters on 30 September 1944 shown in "Troop List for Operations and Supply, 1 October 1944." In ascertaining the medical strength, it was not always possible to discover a table-of-organization corresponding to that shown on the list; therefore, another table (prior to 30 September 1944) was used in such cases. This probably resulted in some errors, but it is believed that the errors were on the side of conservatism. Rates are based on adjusted troop strength as shown in table 31.

The theater medical authorities had nothing to say about the nonmedical units having medical troops, that is, attached medical personnel and, in the case of combat divisions, organic medical battalions, as well as the attached medical personnel. Naturally, this element of strength was greatest in the combat zones (table 34), where ground force troops predominated (table 35).[16] At the height of the war, this personnel constituted a quarter of the entire oversea medical strength.

The medical units that were not an organic part of the combat units accounted for the majority of the medical strength in virtually all theaters (table 36). In certain theaters, at times, these units were larger proportionately than all units containing medical personnel in other theaters.

While surgeons at various levels of command had considerable latitude in obtaining Medical Department personnel, they were influenced to a large extent by the requirements for medical service created by the mission of the

[16] As of 30 September 1944, in oversea areas, medical troops accounted for 15 per 1,000 Air Forces, 11 per 1,000 Service Forces, and 37 per 1,000 Ground Forces troops. (For the medical strength, see table 34; for the troop strength of the various major commands, see "Troop List for Operations and Supply, 1 Oct. 1945." The troop strengths exclude personnel of the Air Transport Command and other personnel not subject to the jurisdiction of the theater commanders.)

TABLE 35.—*Percentage distribution of Army strength among ground-, air-, and service-type units and overhead in theaters of operations, 30 September 1944*

Area	Air Forces	Ground Forces	Service Forces	Overhead
North America	24	30	24	23
Alaska	22	37	24	18
Caribbean	22	53	14	11
South Atlantic	35	12	16	37
Europe	22	50	22	6
North Africa	25	48	23	5
Middle East	24	11	49	17
Persian Gulf	2	30	63	5
China-Burma-India	45	23	23	9
Southwest Pacific Area	25	52	20	3
Pacific Ocean Areas	15	58	21	6

Source: Troop List for Operations and Supply, 1 Oct. 1944.

Army in each area and the environment of that area. In this connection, the amount of hospital service that the Medical Department was expected to provide in a particular region was of utmost importance. The personnel assigned to hospital establishments constituted the vast bulk of the strength of Medical Department units. This accounted for the high proportion of medical personnel in the South Atlantic and the China-Burma-India areas in the late war period, and for the increase in the proportion in the European theater (table 36).

Hospital strength was influenced in turn by such factors as combat missions, anticipated disease rates, and the presence of special groups for which the Medical Department was required to provide medical care. Hence, it is not difficult to see why most of the American theaters, with low disease rates and limited combat duties or none at all, were consistently low in their total medical strength.[17] The high disease rates in the China-Burma-India area and the obligations of the Medical Department to personnel of the Chinese military forces also explain the high proportion in that region.[18]

[17] Although Alaska was a combat theater until the middle of 1943, both the preparations for combat in that region and the hospitalization of casualties were handled to a large extent in the Zone of Interior. See McNeil, Gordon H.: History of the Medical Department in Alaska in World War II. [Official record.] In September 1944, nevertheless, Alaska had an unusually large proportion of hospital personnel (table 36).

[18] (1) Smith, Robert S.: A History of the Attempt of the U.S. Army Medical Department To Improve the Efficiency of the Chinese Army Medical Service. [Official record.] (2) Medical Department, United States Army. Organization and Administration in World War II. Washington: U.S. Government Printing Office, 1963.

TABLE 36.—*Operating strength of Medical Department units in oversea areas,*[1] *30 April 1943–31 August 1945*

Theater	Aggregate	Type			Function										
					Hospitalization			Preventive			Animal care	Miscellaneous			
		Air	Ground	Service	Supply	Fixed	Mobile	Total	Malaria	Food inspection		Total	Air	Ground	Service
	30 April 1943														
Total overseas [2]															
Strength	67, 015	905	16, 078	50, 032	1, 920	46, 257	10, 843	38	18	20	320	7, 684	410	4, 989	2, 285
Rate	52	0. 7	12	39	1	36	8	0. 03	0. 01	0. 02	0. 2	6	0. 3	4	2
North America:															
Strength	3, 002	0	0	3, 002	47	2, 941	0	20	0	20	0	41	0	0	41
Rate	40	0	0	40	0. 6	39	0	0. 3	0	0. 3	0	0. 5	0	0	0. 5
Alaska:															
Strength	3, 493	82	206	3, 205	18	3, 146	0	0	0	0	0	329	64	206	59
Rate	33	0. 8	2	31	0. 2	30	0	0	0	0	0	3	0. 6	2	0. 6
Caribbean:															
Strength	2, 394	0	415	1, 979	9	1, 970	0	0	0	0	0	415	0	415	0
Rate	21	0	4	17	0. 08	17	0	0	0	0	0	4	0	4	0
South Atlantic:															
Strength	328	0	0	328	0	328	0	0	0	0	0	0	0	0	0
Rate	67	0	0	67	0	67	0	0	0	0	0	0	0	0	0
Europe:															
Strength	7, 734	156	430	7, 148	401	6, 370	0	0	0	0	0	963	0	430	533
Rate	69	1	4	64	4	57	0	0	0	0	0	9	0	4	5
North Africa-Mediterranean theater:															
Strength	19, 833	345	8, 625	10, 863	743	8, 808	6, 444	0	0	0	0	3, 838	261	2, 181	1, 396
Rate	50	87	22	27	2	22	16	0	0	0	0	10	0. 7	6	4

See footnotes at end of table.

TABLE 36.—*Operating strength of Medical Department units in oversea areas,*[1] *30 April 1943–31 August 1945*—Continued

Theater	Aggregate	Type			Function										
					Hospitalization			Preventive			Animal care	Miscellaneous			
		Air	Ground	Service	Supply	Fixed	Mobile	Total	Malaria	Food inspection		Total	Air	Ground	Service
	30 April 1943—Continued														
Total overseas [2]															
Africa-Middle East:															
Strength	2, 424	40	0	2, 384	40	2, 377	0	0	0	0	0	7	0	0	7
Rate	65	1	0	64	1	64	0	0	0	0	0	0. 2	0	0	0. 2
Persian Gulf:															
Strength	1, 529	45	101	1, 383	45	1, 383	0	0	0	0	0	101	0	101	0
Rate	83	2	5	75	2	75	0	0	0	0	0	5	0	5	0
China-Burma-India:															
Strength	3, 324	131	1, 271	1, 922	208	1, 824	655	0	0	0	102	535	0	514	21
Rate	110	4	42	64	7	61	22	0	0	0	3	17	0	17	0. 7
Southwest Pacific Area:															
Strength	11, 996	21	3, 598	8, 377	285	7, 974	2, 954	18	18	0	144	621	0	500	121
Rate	85	0. 2	26	60	2	57	21	0. 1	0. 1	0	1	4	0	4	0. 9
Pacific Ocean Areas:															
Strength	10, 958	85	1, 432	9, 441	124	9, 136	790	0	0	0	74	834	85	642	107
Rate	42	0. 3	5	36	0. 5	35	3	0	0	0	0. 3	3	0. 3	2	0. 4
	30 September 1944														
Total overseas [2]															
Strength	237, 079	5, 413	53, 370	78, 296	5, 733	161, 863	22, 462	2, 560	2, 230	330	700	43, 793	3, 816	25, 800	13, 577
Rate	55	1	12	42	1	38	5	0. 6	0. 5	0. 08	0. 2	10	0. 9	6	3

North America:															
Strength	879	0	0	879	0	839	0	0	0	0	0	40	0	0	40
Rate	25	0	0	25	0	24	0	0	0	0	0	1	0	0	1
Alaska:															
Strength	2, 860	38	0	2, 822	46	2, 736	0	0	0	0	0	17	17	0	0
Rate	43	0. 6	0	43	1	41	0	0	0	0	0	0. 3	0. 3	0	0
Caribbean:															
Strength	1, 910	0	0	1, 910	0	1, 805	0	0	0	0	0	105	0	0	105
Rate	27	0	0	27	0	25	0	0	0	0	0	1	0	0	1
South Atlantic:															
Strength	432	43	0	389	0	364	0	25	25	0	0	43	43	0	0
Rate	79	8	0	71	0	67	0	5	5	0	0	8	8	0	0
Europe:															
Strength	121, 076	2, 759	27, 759	90, 558	2, 913	83, 828	9, 461	122	0	122	0	24, 732	2, 259	15, 743	6, 730
Rate	59	1	13	44	1	41	5	0. 06	0	0. 06	0	12	1	8	3
North Africa-Mediterranean theater:															
Strength	38, 587	884	10, 714	26, 989	762	25, 160	5, 020	367	282	85	154	7, 124	632	5, 250	1, 242
Rate	54	1	15	38	1	35	7	0. 5	0. 4	0. 1	0. 2	10	0. 9	7	2
Africa-Middle East:															
Strength	1, 093	0	0	1, 093	0	917	0	111	111	0	0	65	0	0	65
Rate	67	0	0	67	0	56	0	7	7	0	0	4	0	0	4
Persian Gulf:															
Strength	1, 657	0	123	1, 534	33	1, 498	0	36	36	0	0	90	0	90	0
Rate	58	0	4	54	1	52	0	1	1	0	0	3	0	3	0
China-Burma-India:															
Strength	12, 360	485	3, 533	8, 342	670	7, 843	1, 855	306	306	0	264	1, 422	380	869	173
Rate	72	3	21	49	3	46	9	1	1	0	1	8	2	4	0. 8
Southwest Pacific Area:															
Strength	35, 245	344	8, 628	26, 273	760	21, 667	4, 946	1, 296	1, 183	113	167	6, 409	174	2, 902	3, 333
Rate	51	0. 5	12	38	1	31	7	2	2	0. 2	0. 2	9	0. 3	4	5
Pacific Ocean Areas:															
Strength	20, 980	860	2, 613	17, 507	549	15, 206	1, 160	297	287	10	115	3, 146	311	946	1, 889
Rate	50	2	6	42	1	37	3	0. 7	0. 7	0. 02	0. 3	8	0. 7	2	5

See footnotes at end of table.

TABLE 36.—*Operating strength of Medical Department units in oversea areas,*[1] *30 April 1943–31 August 1945*—Continued

Theater	Aggregate	Type			Function										
					Hospitalization			Preventive			Animal care	Miscellaneous			
		Air	Ground	Service	Supply	Fixed	Mobile	Total	Malaria	Food inspection		Total	Air	Ground	Service
	31 December 1944														
Total overseas [2]															
Strength	273, 133	4, 056	65, 200	203, 877	7, 250	183, 654	28, 382	2, 784	2, 355	419	925	50, 238	2, 978	30, 680	16, 580
Rate	57	0. 8	14	43	2	38	6	0. 6	0. 5	0. 09	0. 2	10	0. 6	6	3
North America:															
Strength	822	0	0	822	0	782	0	0	0	0	0	40	0	0	40
Rate	33	0	0	33	0	32	0	0	0	0	0	2	0	0	2
Alaska:															
Strength	1, 856	15	0	1, 841	46	1, 747	0	0	0	0	0	63	15	0	48
Rate	33	0. 3	0	33	0. 8	31	0	0	0	0	0	1	0. 3	0	0. 9
Caribbean:															
Strength	1, 735	0	0	1, 735	0	1, 593	0	12	12	0	0	130	0	0	130
Rate	25	0	0	25	0	23	0	0. 2	0. 2	0	0	2	0	0	2
South Atlantic:															
Strength	288	0	0	288	0	263	0	25	25	0	0	0	0	0	0
Rate	58	0	0	58	0	53	0	5	5	0	0	0	0	0	0
Europe:															
Strength	165, 173	2, 001	42, 631	120, 541	4, 052	109, 050	17, 282	124	24	100	154	34, 511	1, 553	21, 863	11, 095
Rate	61	0. 7	16	45	1	40	6	0. 05	0. 01	0. 04	0. 06	13	0. 6	8	4
North Africa-Mediterranean theater:															
Strength	24, 226	784	5, 366	18, 076	563	16, 932	2, 553	328	258	70	0	3, 850	542	2, 668	640
Rate	48	2	11	36	0. 5	33	5	0. 7	0. 5	0. 1	0	8	1	5	1

Africa-Middle East:															
Strength	1, 054	0	0	1, 054	0	884	0	111	111	0	0	59	0	0	59
Rate	49	0	0	49	0	41	0	5	5	0	0	3	0	0	3
Persian Gulf:															
Strength	1, 638	0	123	1, 515	33	1, 479	0	36	36	0	0	90	0	90	0
Rate	59	0	4	54	1	53	0	1	1	0	0	3	0	3	0
China-Burma-India:															
Strength	15, 176	540	4, 393	10, 243	545	9, 567	1, 751	485	365	120	451	2, 377	370	1, 816	191
Rate	74	3	21	50	3	46	8	2	2	0. 6	2	12	2	9	0. 9
Southwest Pacific Area:															
Strength	39, 941	500	10. 343	29, 098	1, 519	25, 128	5, 779	1, 378	1, 249	119	90	6, 047	324	3, 366	2, 357
Rate	53	0. 7	14	39	2	34	8	2	2	0. 2	0. 1	8	0. 4	4	3
Pacific Ocean Areas:															
Strength	21, 224	216	2, 344	18, 664	492	16, 229	1, 017	285	275	10	230	3, 071	174	877	2, 020
Rate	51	0. 5	6	45	1	39	2	0. 7	0. 7	0. 02	0. 6	7	0. 4	2	5
	30 April 1945														
Total overseas [2]															
Strength	295, 351	4, 295	71, 877	219, 179	7, 764	199, 580	31, 189	3, 216	2, 622	414	1, 025	53, 941	3, 301	34, 184	16, 456
Rate	56	0. 8	14	42	1	38	6	0. 6	0. 5	0. 08	0. 2	10	0. 6	7	3
North America:															
Strength	672	0	0	672	0	632	0	0	0	0	0	40	0	0	40
Rate	25	0	0	25	0	24	0	0	0	0	0	1	0	0	1
Alaska:															
Strength	1, 354	15	0	1, 339	44	1, 194	0	0	0	0	0	116	0	15	101
Rate	32	0. 35	0	31	1	28	0	0	0	0	0	3	0	0. 3	2
Caribbean:															
Strength	1, 679	0	0	1, 679	0	1, 539	0	12	12	0	0	128	0	0	128
Rate	25	0	0	25	0	23	0	0. 2	0. 2	0	0	2	0	0	2

See footnotes at end of table.

663076°—63——27

TABLE 36.—*Operating strength of Medical Department units in oversea areas,*[1] *30 April 1943–31 August 1945*—Continued

Theater	Aggregate	Type			Function										
					Hospitalization			Preventive			Animal care	Miscellaneous			
		Air	Ground	Service	Supply	Fixed	Mobile	Total	Malaria	Food inspection		Total	Air	Ground	Service
	30 April 1945—Continued														
Total overseas[2]															
South Atlantic:															
Strength	271	0	0	271	0	246	0	25	25	0	0	0	0	0	0
Rate	54	0	0	54	0	49	0	5	5	0	0	0	0	0	0
Europe:															
Strength	181, 914	2, 018	49, 307	130, 589	4, 220	120, 227	20, 557	66	24	30	154	36, 636	1, 594	25, 120	9, 922
Rate	59	0. 7	16	42	1	39	7	0. 02	0. 01	0. 01	0. 05	12	0. 5	8	3
North Africa-Mediterranean theater:															
Strength	25, 038	831	5, 936	18, 271	529	16, 781	2, 979	366	133	65	86	4, 297	622	2, 749	926
Rate	50	2	12	37	1	34	6	0. 7	0. 3	0. 1	0. 1	9	1	6	2
Africa-Middle East:															
Strength	1, 343	0	0	1, 343	0	1, 105	0	136	111	25	0	102	0	0	102
Rate	49	0	0	49	0	40	0	5	4	0. 9	0	4	0	0	4
Persian Gulf:															
Strength	841	0	27	814	27	778	0	36	36	0	0	0	0	0	0
Rate	49	0	2	47	2	45	0	2	2	0	0	0	0	0	0
China-Burma-India:															
Strength	16, 154	681	4, 237	11, 236	568	10, 116	1, 918	641	496	145	643	2, 267	510	1, 422	335
Rate	70	3	18	49	2	44	8	3	2	0. 6	3	10	2	6	1
Southwest Pacific Area:															
Strength	42, 629	447	9, 269	32, 913	1, 605	30, 038	4, 700	1, 419	1, 295	124	90	6, 196	314	3, 359	2, 523
Rate	53	0. 6	11	41	2	37	6	2	2	0. 2	0. 1	8	0. 4	4	3

Pacific Ocean Areas:															
Strength	23, 456	303	3, 101	20, 052	771	16, 924	1, 035	515	490	25	52	4, 159	261	1, 519	2, 379
Rate	51	0. 7	7	44	2	37	2	1	1	0. 5	0. 1	9	0. 6	3	5
	31 August 1945														
Total overseas[2]															
Strength	247, 295	2, 715	62, 139	182, 441	6, 162	163, 845	28, 224	3, 549	2, 686	689	862	44, 653	2, 081	28, 620	13, 952
Rate	57	0. 6	14	42	1	38	7	0. 8	0. 6	0. 2	0. 2	10	0. 5	7	3
North America:															
Strength	348	0	0	348	0	308	0	0	0	0	0	40	0	0	40
Rate	19	0	0	19	0	17	0	0	0	0	0	2	0	0	2
Alaska:															
Strength	1, 339	0	0	1, 339	44	1, 194	0	0	0	0	0	101	0	0	101
Rate	33	0	0	33	1	29	0	0	0	0	0	2	0	0	2
Caribbean:															
Strength	1, 641	0	0	1, 641	0	1, 481	0	12	12	0	0	148	0	0	148
Rate	23	0	0	23	0	20	0	0. 2	0. 2	0	0	2	0	0	2
South Atlantic:															
Strength	271	0	0	271	0	246	0	25	25	0	0	0	0	0	0
Rate	30	0	0	30	0	27	0	3	3	0	0	0	0	0	0
Europe:															
Strength	139, 446	1, 217	40, 718	97, 511	2, 559	89, 398	17, 730	128	37	91	149	29, 482	1, 011	20, 797	7, 674
Rate	64	0. 6	19	45	1	41	8	0. 06	0. 02	0. 04	0. 07	14	0. 5	10	4
North Africa-Mediterranean theater:															
Strength	16, 808	132	3, 886	12, 790	308	12, 047	2, 121	275	72	35	86	1, 971	56	1, 557	358
Rate	68	0. 5	16	52	1	49	9	1	0. 3	0. 1	0. 3	8	0. 2	6	1
Africa-Middle East:															
Strength	1, 143	0	0	1, 143	9	869	0	129	98	25	0	136	0	0	136
Rate	40	0	0	40	0. 3	30	0	4	3	0. 7	0	5	0	0	5

See footnotes at end of table.

TABLE 36.—*Operating strength of Medical Department units in oversea areas,*[1] *30 April 1943–31 August 1945*—Continued

Theater	Aggregate	Type			Function										
					Hospitalization			Preventive			Animal care	Miscellaneous			
		Air	Ground	Service	Supply	Fixed	Mobile	Total	Malaria	Food inspection		Total	Air	Ground	Service
	31 August 1945—Continued														
Total overseas[2]															
Persian Gulf:															
Strength	301	0	0	301	0	289	0	12	12	0	0	0	0	0	0
Rate	37	0	0	37	0	35	0	1	1	0	0	0	0	0	0
China-Burma-India:															
Strength	15, 176	737	2, 841	11, 598	740	9, 950	1, 513	814	559	255	487	1, 672	566	431	675
Rate	66	3	12	50	3	42	7	4	2	1	2	7	2	2	3
Pacific Ocean Areas:															
Strength	70, 822	629	14, 694	55, 499	2, 502	48, 063	6, 860	2, 154	1, 871	283	140	11, 103	448	5, 835	4, 820
Rate	48	0. 4	10	38	2	33	5	1	1	0. 2	0. 09	8	0. 3	4	3

[1] Basic data for April 1943 from Troop Section, Logistics Group, Operations Division, War Department General Staff, Overseas Troop Basis, 1 May 1943: for all other dates from Troop List for Operations and Supply for dates approximate thereto; all data include non-Medical Department personnel. Data for April 1943 comprise actual strength; data for all other periods comprise "operating strength" which is either table-of-organization strength or strength authorized within the theater. April 1943 data also include non-table-of-organization organizations, and Air Transport Command personnel. Divisional medical units are not included at any time. All rates greater than unity are rounded to the nearest whole number. Rates for April 1943 are per 1,000 troop strength for that date as shown in table 31 and rates for April and August 1945 are per 1,000 adjusted troop strengths shown for these dates in table 31, appendix. Rates for September and December 1944 are based on adjusted strengths, determined in a manner similar to that used in determining April and August 1945 rates, as follows:

Area	Army			Medical Department			Rate [e]
	Unadjusted strength [a]	Air Transport Command [b]	Adjusted strength	Unadjusted strength [c]	Air Transport Command [d]	Adjusted strength	
	30 September 1944						
North America	24,290	10,216	34,506	1,334	184	1,518	44
Alaska	63,495	3,727	67,222	3,563	67	3,630	54
Caribbean	70,556	577	71,133	4,008	10	4,018	56
South Atlantic	2,989	2,453	5,442	479	44	523	96
Europe	2,053,417	3,698	2,057,115	183,634	67	183,701	89
North Africa	712,915	6,675	719,590	54,932	120	55,052	77
Africa-Middle East	9,354	7,026	16,380	1,159	126	1,285	78
Persian Gulf	27,739	855	28,594	2,009	15	2,024	71
China-Burma-India	149,014	22,866	171,880	13,052	412	13,464	78
Southwest Pacific Area	689,804	3,871	693,675	60,895	70	60,965	88
Pacific Ocean Areas	412,618	3,748	416,366	34,388	67	34,455	83
	31 December 1944						
North America	19,223	5,458	24,681	1,140	120	1,260	51
Alaska	52,024	3,630	55,654	3,112	80	3,192	57
Caribbean	70,070	567	70,637	3,816	12	3,828	54
South Atlantic	2,715	2,291	5,006	432	50	482	96
Europe	2,699,467	7,516	2,706,983	247,377	165	247,542	91
North Africa	498,675	9,182	507,857	36,972	202	37,174	73
Africa-Middle East	9,321	12,092	21,413	1,147	266	1,413	66
Persian Gulf	26,647	1,214	27,861	1,980	27	2,007	72
China-Burma-India	180,405	25,642	206,047	17,892	564	18,456	90
Southwest Pacific Area	744,373	4,668	749,041	63,473	103	63,576	85
Pacific Ocean Areas	408,085	5,948	414,033	33,789	131	33,920	82

[a] From source of area data reported in table 31, footnote 2.

[b] From source shown in table 31, appendix, footnote 2.

[c] From "Strength of the Army," for dates approximate to those shown.

[d] 1.8 percent of Air Transport Command general strength for 30 September 1944. 2.2 percent of Air Transport Command general strength for 31 December 1944.

[e] Ratio of adjusted medical strength per 1,000 troops of adjusted Army strength.

[2] Total "Oversea" strength is the aggregate of strengths shown for individual areas.

The veterinary care of animals was a more important function of the Medical Department in the China-Burma-India area than elsewhere, but even there it did not increase the proportion more than a few points (table 36). The prevention of disease is one of the major functions of the Medical Department yet, in terms of special personnel for the purpose, it too increased the proportion only slightly in most areas. In certain small theaters, however, it was of considerable significance primarily because of the malaria control and survey teams which were stationed there. This results from the fact that the need for antimalaria personnel is more a matter of geography than of the troop strength to be served.

Besides the organizations directly concerned with hospitalization, most theaters possessed Medical Department units whose functions were accessory to the provision of hospital service. Among such units were dispensaries of various types, ambulance companies, medical depots, medical laboratories, clearing companies, collecting companies, medical gas treatment battalions, and sanitary companies. In the European theater in the latter part of the war, they constituted a substantial element of medical strength which helped to give that area its preeminent position in this respect among the major theaters and its high position among all of them. The European theater utilized more types of Medical Department units (including hospitals) than any other theater (table 37), distributed among air, ground, and service force units.

For the most part, Medical Department personnel in oversea areas were assigned to and served in table-of-organization units. Some medical personnel were in units that had been set up overseas under the non-table-of-organization allotments of the various theaters. Although the maximum number of medical officers who might come under the allotment was fixed by the War Department,

TABLE 37.—*Types of Medical Department units in use in the various theaters of operations, by area, 30 September 1944*

Area	Total	Air	Ground	Service
North America	3	1	0	2
Alaska	4	2	0	2
Caribbean	2	0	0	2
South Atlantic	4	1	0	3
Europe	35	4	14	17
North Africa	33	3	14	16
Africa-Middle East	2	0	0	2
Persian Gulf	5	0	2	3
China-Burma-India	21	3	12	6
Southwest Pacific Area	29	4	15	10
Pacific Ocean Areas	21	3	10	8

Source: Troop List for Operations and Supply, 1 Oct. 1944.

TABLE 38.—*Estimated additions by Air Transport Command to theater medical strength per 1,000 troops, 1944* [1]

Area	30 September 1944	31 December 1944
North America	5	5
Alaska	1	1
Caribbean	.1	.2
South Atlantic	8	10
Europe	.03	.06
North Africa	.2	.4
Africa-Middle East	8	12
Persian Gulf	2.5	1
China-Burma-India	.6	3
Southwest Pacific Area	.1	.1
Pacific Ocean Areas	.1	.3

[1] For the estimated medical strengths of the Air Transport Command on the dates shown and the adjusted theater strengths on the same date, see table 36, footnote 1.

other types of officers could be substituted. In the case of nurses, no substitutes could be made. In either case, the theater surgeon could make representations concerning the size of these allotments, and this was one of the few opportunities he had to deal directly with strength; that is, strength consisting of individuals rather than strength composed of units. Thus, the chief surgeon of U.S. Army Forces, Far East, dispatched an emissary after V–E Day on a successful mission to obtain a large increase in the overhead allotment of medical officers for the Southwest Pacific.[19] Yet, it does not appear that the theater surgeons materially augmented the medical strength ratios of the areas under their jurisdiction through increases in medical allotments. In the larger theaters, especially, it would have been difficult to do so because of the relatively small role played by overhead in the strength of such theaters.

The medical personnel of the Air Transport Command, the Airways Communication System, and certain other troops under the command of the Army Air Forces were counted as part of the strength of the individual theaters only in the early part of the war. From the limited statistics available, it would appear that they contributed a substantial proportion of the strength in the South Atlantic and Africa-Middle East theaters and to a lesser degree in the North America and China-Burma-India areas. In the major theaters, on the other hand, they were of infinitesimal importance (table 38).[20]

[19] (1) Memorandum, Maj. Gen. G. B. Denit, Surgeon, U.S. Army Forces, Far East, to Colonel Pincoffs, 22 May 1945. (2) Memorandum, Brig. Gen. R. W. Bliss, Assistant Surgeon General, for Assistant Chief of Staff for Operations, 23 June 1945, subject: Revised Authorization of Medical Corps Officers for Army Forces Pacific Overhead. (3) Memorandum, Maj. Gen. B. M. Fitch, Adjutant General, U.S. Army Forces, Pacific, for The Adjutant General, 11 Aug. 1945, subject: Theater Overhead Authorized Grades and Strengths.

[20] See appendix to table 31 for further discussion of this matter.

Distribution of Oversea Strength by Major Commands

At the end of September 1944, approximately 5.7 percent of all oversea medical personnel excluding overhead were serving with the Air Forces, 36.9 percent with the Ground Forces, and 57.8 percent with the Service Forces or in communications zone installations.[21] The percentage of medical strength actually assigned to the Air Forces but 1 month earlier was 7.74, but this included overhead personnel (table 39). It represented a decline from a higher percentage prevalent in 1943. At all times, however, the percentage was lower than the Air Forces fraction of the worldwide Medical Department strength. The ratio of medical Air Forces strength to total Air Forces strength was always lower than the ratio of medical strength to general Army strength both worldwide and overseas, but because of the lack of Air Forces hospitals abroad, the strength of the Medical Department personnel assigned to Air Forces organizations in oversea areas was always lower proportionately than the like strength in the Zone of Interior.

While the majority of oversea medical personnel served in the Services of Supply or communications zones, the proportionate strength of such personnel fluctuated greatly. For example, in the European theater in September and October 1942, during the buildup for the North African invasion, medical personnel comprised approximately 30 percent of total personnel in the Services of Supply. After the invasion of North Africa, the total Services of Supply strength in the theater declined approximately 20 percent while Medical Department Services of Supply strength increased by nearly 60 percent (table 35). During November, a number of medical units had landed in the United Kingdom because, although they were destined for North Africa, port facilities which would have made possible their debarkation in the Mediterranean area had not yet become available, and were therefore probably counted as part of the European theater strength.[22]

As 1943 progressed, however, emphasis was placed on supplying Air Forces and Engineer troops to the British Isles. The result was a decline of the percentage of medical troops in the Services of Supply from the peak attained in February 1943. Despite resumption of shipments of medical units in the latter part of the year, the influx of ground troops in preparation for invasion of the Continent led to a continued decline of the percentage of medical personnel under the Services of Supply.[23] Before the end of the year, it had fallen below 50 percent.

---

[21] The percentages are based on the strength of Medical Department units shown in table 36 and the strength of attached and divisional medical personnel shown in table 34. These statistics are based on authorized strengths since actual strength figures for oversea areas by major commands are lacking.

[22] Information from Col. James B. Mason, 6 Oct. 1942.

[23] Ruppenthal, Roland G.: Logistical Support of the Armies, Volume I. United States Army in World War II. The European Theater of Operations. Washington: U.S. Government Printing Office, 1953, table 5, p. 232.

663076°—63——28

TABLE 39.—*Strength of Medical Department personnel assigned to Air Forces,*[1] *30 September 1942–31 May 1945*

Date	Army: Total strength [2]	Army: Air Forces: Strength [3]	Army: Air Forces: Percent of total strength	Army: Air Forces: Rate per 1,000 Air Forces troops	Medical Department: Total [4] strength	Medical Department: Air Forces: Strength [5]	Medical Department: Air Forces: Percent of total strength	Medical Department: Air Forces: Rate per 1,000 Air Forces troops
30 September 1942:								
Worldwide	3, 971, 016	1, 122, 208	28. 26		349, 253	38, 260	10. 95	34. 10
Overseas	822, 962	186, 843	22. 70		58, 827	2, 914	4. 95	15. 60
30 June 1943:								
Worldwide	6, 993, 102	2, 114, 175	30. 23		619, 020	86, 714	14. 01	41. 00
Overseas	1, 637, 419	421, 763	25. 76		129, 955	11, 208	8. 62	26. 60
31 January 1944:								
Worldwide	7, 556, 157	2, 310, 673	30. 58		628, 758	89, 159	12. 50	42. 90
Overseas	2, 814, 658	740, 605	26. 31		238, 914	19, 508	8. 17	26. 30
31 August 1944:								
Worldwide	8, 102, 545	2, 392, 364	29. 53		688, 537	86, 076	12. 50	36. 00
Overseas	4, 262, 247	1, 066, 240	25. 02		354, 379	27, 446	7. 74	25. 70
31 May 1945:								
Worldwide	8, 291. 336	2, 316, 805	27. 94		666, 710	71, 179	10. 68	30. 72
Overseas	5, 406 779	1, 181, 804	21. 86		455, 068	27, 627	6. 07	23. 38

See footnotes at end of table.

TABLE 39.—*Strength of Medical Department personnel assigned to Air Forces,*[1] *30 September 1942–31 May 1945*—Continued

Date	Total strength [2]	Air Forces			Total strength [4]	Air Forces		
		Strength [3]	Percent of total strength	Rate per 1,000 Air Forces troops		Strength [5]	Percent of total strength	Rate per 1,000 Air Forces troops
	Medical Department officers [4 5]				Medical Corps [4 6]			
30 September 1942:								
Worldwide	65, 922	6, 627	10. 05	5. 91	31, 309			
Overseas	10, 280	466	4. 53	2. 49	4, 945	342	6. 92	1. 80
30 June 1943:								
Worldwide	93, 994	13, 402	14. 26	6. 34	37, 189			
Overseas	23, 882	2, 136	8. 94	5. 06	10, 302	1, 509	14. 65	3. 60
31 January 1944:								
Worldwide	113, 634	21, 644	19. 05	9. 37	41, 859	8, 686	20. 75	3. 80
Overseas	42, 218	3, 748	8. 88	5. 06	16, 631	2, 236	13. 44	3. 00
31 August 1944:								
Worldwide	121, 269	20, 844	17. 19	8. 71	44, 726	8, 480	18. 96	3. 50
Overseas	60, 739	5, 583	9. 19	5. 24	23, 522	3, 186	13. 57	3. 00
31 May 1945:								
Worldwide	142, 378	18, 797	13. 20	8. 11	46, 750	7, 711	16. 49	3. 33
Overseas	77, 837	6, 005	7. 71	5. 08	27, 639	3, 092	11. 19	2. 62
	Dental Corps [4 6]				Veterinary Corps [4 6]			
30 September 1942:								
Worldwide	8, 432				1, 408			
Overseas	798	92	11. 53	0. 50	97	6	6. 19	0. 03

30 June 1943:								
Worldwide	12,048				1,839		0	0
Overseas	1,859	322	17.32	.80	289	19	6.57	.05
31 January 1944:								
Worldwide	14,193	3,845	27.09	1.70	1,957	44	17.83	.20
Overseas	3,301	552	16.72	.70	471	349	9.34	.06
31 August 1944:								
Worldwide	15,121	3,960	26.19	1.70	2,024	355	17.54	.10
Overseas	4,980	928	18.63	.90	572	47	8.22	.04
31 May 1945:								
Worldwide	14,705	3,826	26.02	1.65	2,050	352	16.15	.14
Overseas	7,103	1,089	15.33	.92	705	58	8.23	.05
	Sanitary Corps [4 6]				Medical Administrative Corps [4 6]			
30 September 1942:								
Worldwide	983				3,646			
Overseas	47	2	4.26	0.01	590	14	2.37	0.07
30 June 1943:								
Worldwide	1,755				11,630			
Overseas	242	9	3.72	.02	1,843	126	6.84	.30
31 January 1944:								
Worldwide	2,246	207	9.22	.10	14,990	2,060	13.74	.90
Overseas	538	16	2.97	.02	4,746	289	7.71	.40
31 August 1944:								
Worldwide	2,350	271	11.53	.10	14,902	2,029	13.62	.80
Overseas	995	69	6.93	.06	6,695	477	7.12	.40
31 May 1945:								
Worldwide	2,560	292	11.41	.13	19,385	2,318	11.96	1.00
Overseas	1,288	89	6.91	.08	10,936	821	7.51	.69

See footnotes at end of table.

TABLE 39.—*Strength of Medical Department personnel assigned to Air Forces,*[1] *30 September 1942–31 May 1945*—Continued

Date	Total strength [2]	Air Forces			Total [4] strength	Air Forces		
		Strength [3]	Percent of total strength	Rate per 1,000 Air Forces troops		Strength [5]	Percent of total strength	Rate per 1,000 Air Forces troops
	Army Nurse Corps [4 5]				Hospital Dietitians [4 6]			
30 September 1942:								
Worldwide	20, 144	1, 733	8. 60	1. 54	----------	----------	----------	----------
Overseas	3, 803	10	. 26	. 05	----------	----------	----------	----------
30 June 1943:								
Worldwide	28, 423	4, 633	16. 30	2. 20	666	96	15. 97	0. 05
Overseas	9, 189	151	1. 64	. 35	93	0	0	0
31 January 1944:								
Worldwide	36, 672	6, 286	17. 14	2. 70	1, 100	176	16. 00	. 007
Overseas	16, 958	604	3. 56	. 80	326	5	1. 53	. 08
31 August 1944:								
Worldwide	39, 970	5, 519	13. 81	2. 30	1, 312	183	13. 95	. 005
Overseas	22, 970	868	3. 78	. 80	569	5	. 88	. 08
31 May 1945:								
Worldwide	54, 128	4, 028	7. 44	1. 74	1, 550	148	9. 55	. 06
Overseas	28, 842	755	2. 62	. 64	757	1	. 13	. 00

	Physical Therapists [4] [6]				Medical Department enlisted [4] [6]			
30 September 1942:								
Worldwide					282, 331	31, 633	11. 16	13. 1
Overseas					48, 547	2, 448	5. 04	28. 2
30 June 1943:								
Worldwide	403	20	4. 96	0. 009	525, 026	73, 312	13. 97	21. 5
Overseas	65	0	0	0	106, 073	9, 072	8. 55	34. 7
31 January 1944:								
Worldwide	559	35	6. 26	. 02	515, 124	67, 515	13. 11	20. 50
Overseas	241	2	. 83	. 003	196, 696	15, 760	8. 01	29. 20
31 August 1944:								
Worldwide	807	47	5. 82	. 02	567, 268	65, 232	11. 50	20. 50
Overseas	427	3	. 70	. 003	293, 640	21, 863	7. 45	27. 30
31 May 1945:								
Worldwide	1, 190	50	4. 20	. 02	524, 332	52, 382	9. 99	22. 61
Overseas	546	0	. 00	. 00	377, 231	21, 622	5. 73	18. 30

[1] No Pharmacy Corps personnel were assigned to Air Forces organizations on any date shown except May 1945, when there were two in the Zone of Interior.

[2] Worldwide strength from tables 5 and 45. Oversea strength from source shown in table 31, footnote 2.

[3] Oversea strength from "Officers and Enlisted Men Strength of the Departments and Bases. Recapitulation by Arm or Service. Assigned to Air Corps and Other Than Air Corps" (records of AGO Statistical and Control Branch, Office of The Adjutant General), for all dates shown prior to 1945 or dates approximate thereto; from "Personnel Assigned to Air Forces Organizations by Arms and Services by Command," in "Strength of the Army," 1 June 1945, pp. 24-25, for 31 May 1945. Worldwide strength equals oversea strength plus continental United States strength as shown in "Strength of the Army" for dates listed or dates approximate thereto.

[4] Worldwide strength (including personnel assigned to Veterans' Administration) from tables 1 and 27. Oversea strength from sources stated under this heading in footnote 3.

[5] Oversea strength from sources for oversea strength shown in footnote 3. Worldwide strength equals oversea strength plus continental United States strength as shown in "Strength of the Army" for dates listed or dates approximate thereto.

[6] From sources shown in footnote 5. However, no data on continental United States strength for September 1942 and June 1943 are available. Consequently, it is not possible to state worldwide strengths on these dates.

After the invasion of Normandy began, however, it was necessary to increase the rear echelon medical support of the campaign and more fixed hospital installations were brought into the theater.[24] The percentage ascended somewhat above the 50 percent mark although it may have been held down by the reduction of table-of-organization strength of fixed hospital units. By mid-March of 1945, the Medical Department strength in the communications zone of the European theater was less than 45 percent of the total medical strength in the theater. This was exclusive of headquarters personnel, but it is unlikely that even with such personnel it reached 50 percent.[25] By that time, the theater had returned much of its patient load to the Zone of Interior.[26] Use

[24] Data from monthly "Troop Lists for Operations and Supply."

[25] Computations based upon communications zone strength (122,100) as shown in "Unit Strength—ComZ—ETOUSA. Comparison of Actual and T/O—15 Mar. 1945", *in* Progress Report, Communications Zone, ETO—USA, 31 March 1945, p. 4. Theater medical strength used here equals the mean of strengths shown in "Strength of the Army" for 1 Mar. and 1 Apr. 1945.

[26] See footnote 9, p. 382.

TABLE 40.—*Strength of Medical Department by Army components,*

Group	Worldwide		Total		Alaska		North America		Caribbean	
	January	August	January	August	January	August	January	August	January	August
Regular Army										
Male personnel, Army:										
Strength	543,954	577,423	108,275	194,407	10,884	14,790	10,559	20,118	48,389	47,337
Percent of Army male	29.4	16.5	58.5	26.6	46.9	20.7	80.8	31.7	64.4	44.6
Male personnel, Medical Department:										
Strength	33,638	34,302	5,333	9,558	653	858	836	1,302	1,897	1,899
Percent of Medical Department male	24.0	11.8	57.7	19.1	64.2	29.5	83.7	32.4	48.9	33.5
Officers, Army:										
Strength	14,759	14,312	2,768	3,308	193	241	153	309	843	690
Percent of Army officers	12.1	5.9	21.1	7.8	17.3	7.6	22.2	10.7	18.8	10.8
Officers, Medical Department:										
Strength	1,668	1,692	285	397	15	16	14	31	109	106
Percent of Medical Department Officers	10.5	4.8	19.9	6.8	11.7	5.5	12.2	6.5	19.1	12.9
Enlisted men, Army:										
Strength	529,195	563,111	105,507	191,099	10,691	14,549	10,406	19,809	47,546	46,647
Percent of Army enlisted	30.6	17.3	61.3	27.8	48.5	21.4	84.0	32.7	67.4	46.7
Enlisted men, Medical Department:										
Strength	31,970	32,610	5,048	9,161	638	842	822	1,271	1,788	1,793
Percent of Medical Department enlisted	25.7	12.8	64.7	20.8	71.7	32.1	93.0	35.9	54.0	37.0
Nurses:										
Strength	-------	8,670	-------	1,229	-------	15	-------	176	-------	111
Percent of all nurses	-------	60.0	-------	40.0	-------	22.1	-------	64.9	-------	34.7

See footnotes at end of table.

of civilians and prisoners of war also may have reduced the proportion of military personnel in the Communications Zone medical service.

COMPOSITION OF THE MEDICAL DEPARTMENT OVERSEAS

Army Components

For some time after mobilization began in 1940, the majority of U.S. troops overseas were Regular Army due to the time element necessary to train the other components. At the same time, the proportion of Regulars in the Army as a whole was greater than it was in the Medical Department. This was true overseas in the early part of 1942 although the reverse had been the case in the middle of 1941 (tables 40 and 41). But as the relative strength of the Regular Army declined in the Medical Department overseas, that of every other component increased, at least for a time.

worldwide and overseas, 31 January and 31 August 1942 [1]

Overseas											
South Atlantic	Europe		Africa-Middle East	Persian Gulf	China-Burma-India	Pacific Ocean Areas		Southwest Pacific Area		War Department groups	En route
August	January	August	August	August	August	January	August	January	August	August	August
445	102	37,460	1,538	105	5,165	4,637	43,869	33,704	20,982	101	2,497
24.1	3.0	24.0	17.6	38.6	38.7	17.2	23.0	77.6	20.7	45.3	14.0
60	26	1,704	65	5	253	1,239	2,192	682	1,182	1	37
37.7	8.5	14.9	14.0	25.0	25.1	65.5	15.8	59.5	11.8	33.3	9.0
7	2	842	43	8	100	670	574	907	368	101	25
6.0	2.0	7.9	7.1	8.0	9.1	21.0	6.0	25.7	5.8	45.3	2.3
0	1	85	6	0	9	61	83	85	60	1	0
.0	10.0	6.7	9.1	.0	6.3	20.5	5.8	27.7	4.7	33.3	.0
438	100	36,618	1,495	97	5,065	3,967	43,295	32,797	20,614	0	2,472
25.3	3.0	25.1	18.4	56.4	41.3	16.7	23.8	82.3	21.7	.0	14.8
60	25	1,619	59	5	244	1,178	2,109	597	1,122	0	37
42.8	8.4	15.9	14.9	62.5	28.2	73.8	17.0	71.1	12.8	.0	10.4
0	----------	0	35	0	36	---------	269	---------	587	0	0
.0	----------	.0	100.0	.0	39.6	---------	30.5	---------	55.6	.0	.0

TABLE 40.—*Strength of Medical Department by Army components,*

Group	Worldwide		Total		Alaska		North America		Caribbean	
	January	August	January	August	January	August	January	August	January	August
National Guard										
Male personnel, Army:										
Strength	214,480	213,520	19,283	78,455	5,258	11,697	48	2,716	6,317	7,072
Percent of Army male	11.6	6.1	10.4	10.7	22.7	16.4	.4	4.3	8.4	6.7
Male personnel, Medical Department:										
Strength	13,167	11,859	680	4,989	105	402	2	116	237	309
Percent of Medical Department male	9.4	4.1	7.4	10.0	10.3	13.8	.2	2.9	6.1	5.5
Officers, Army:										
Strength	17,468	14,570	1,304	4,351	286	583	3	137	430	529
Percent of Army officers	14.4	6.0	9.9	10.3	25.6	18.3	.4	4.7	9.6	8.3
Officers, Medical Department:										
Strength	1,428	1,163	64	420	10	27	0	9	30	38
Percent of Medical Department officers	9.0	3.3	4.5	7.2	7.8	9.2	.0	1.9	5.3	4.6
Enlisted men, Army:										
Strength	197,012	198,950	17,979	74,104	4,972	11,114	45	2,579	5,887	6,543
Percent of Army enlisted	11.4	6.1	10.5	10.8	22.6	16.3	.4	4.3	8.3	6.6
Enlisted men, Medical Department:										
Strength	11,739	10,696	616	4,569	95	375	2	107	207	271
Percent of Medical Department enlisted	9.4	4.2	7.9	10.3	10.7	14.3	.2	3.0	6.3	5.6
Reserves										
Male personnel, Army:										
Strength	134,107	211,416	9,491	38,169	638	3,280	519	3,884	3,669	5,224
Percent of Army male	7.2	6.0	5.1	5.2	2.8	4.6	4.0	6.1	4.9	4.9
Male personnel, Medical Department:										
Strength	16,443	27,035	1,094	5,264	103	280	98	523	441	647
Percent of Medical Department male	11.7	9.3	11.8	10.5	10.1	9.6	9.8	13.0	11.4	11.4
Officers, Army:										
Strength	87,029	138,984	8,887	29,370	638	2,206	519	2,136	3,089	1,419
Percent of Army officers	71.5	56.9	67.8	64.6	57.1	69.2	75.2	74.1	68.8	69.0
Officers, Medical Department:										
Strength	12,565	20,135	1,076	4,488	103	244	98	392	432	631
Percent of Medical Department officers	78.8	56.9	75.3	76.7	80.5	83.6	85.2	82.4	75.6	76.8
Enlisted men, Army:										
Strength	47,078	72,432	604	8,799	0	1,074	0	1,748	580	805
Percent of Army enlisted	2.7	2.2	.4	1.3	.0	1.6	.0	2.9	.8	.8
Enlisted men, Medical Department:										
Strength	3,878	6,900	18	776	0	36	0	131	9	16
Percent of Medical Department enlisted	3.1	2.7	.2	1.8	.0	1.4	.0	3.7	.3	.3

See footnotes at end of table.

worldwide and overseas, 31 January and 31 August 1942 [1]—Continued

Overseas											
South Atlantic	Europe		Africa-Middle East	Persian Gulf	China-Burma-India	Pacific Ocean Areas		Southwest Pacific Area		War Department groups	En route
August	January	August	August	August	August	January	August	January	August	August	August
313	1,688	11,773	137	16	441	4,277	27,288	1,695	15,479	0	1,523
17.0	49.0	7.5	1.6	5.9	3.3	15.9	14.3	3.9	15.3	.0	8.5
14	121	982	3	1	16	119	1,824	96	1,288	0	34
8.8	39.4	8.6	.6	5.0	1.6	6.3	13.2	8.4	12.8	.0	8.3
16	49	828	11	4	23	310	1,319	226	851	0	50
13.7	50.0	7.8	1.8	4.0	2.1	9.7	13.8	6.4	13.4	.0	4.6
2	1	124	2	0	1	15	103	8	112	0	2
10.5	10.0	9.8	3.0	.0	.7	5.0	7.2	2.6	8.8	.0	3.7
297	1,639	10,945	126	12	418	3,967	25,969	1,469	14,628	0	1,473
17.2	49.1	7.5	1.6	7.0	3.4	16.7	14.3	3.7	15.4	.0	8.8
12	120	858	1	1	15	101	1,721	88	1,176	0	32
8.6	40.4	8.4	.3	12.5	1.7	6.5	13.9	10.5	13.4	.0	9.0
97	51	7,101	408	71	1,039	2,199	8,969	2,415	7,163	110	823
5.3	1.5	4.5	4.7	26.1	7.8	8.2	4.7	5.6	7.1	49.3	4.6
16	15	902	46	8	146	221	1,374	216	1,275	2	45
10.1	4.9	7.9	9.9	40.0	14.5	11.7	9.9	18.8	12.7	66.7	11.0
81	44	6,391	344	91	930	2,197	7,288	2,400	4,867	110	527
69.2	44.9	60.3	57.0	71.0	84.6	68.8	76.3	67.9	76.5	49.3	48.2
16	88	810	45	8	124	221	1,185	214	998	2	33
84.2	80.0	64.1	68.2	66.7	86.7	74.2	83.3	69.7	78.6	66.7	61.1
16	7	710	64	0	109	2	1,681	15	2,296	0	296
.9	.2	.5	.8	.0	.9	.0	.9	.0	2.4	.0	1.8
0	7	92	1	0	22	0	189	2	277	0	12
.0	2.4	.9	.3	.0	2.5	.0	1.5	.3	3.2	.0	3.4

TABLE 40.—*Strength of Medical Department by Army components,*

Group	Worldwide		Total		Alaska		North America		Caribbean	
	January	August	January	August	January	August	January	August	January	August
Reserves—Continued										
Nurses:										
Strength	-------	5,158	-------	1,843	-------	53	-------	95	-------	209
Percent of all nurses	-------	35.7	-------	60.0	-------	77.9	-------	35.1	-------	65.3
Army of United States[2]										
Male personnel, Army:										
Strength	130,748	395,089	885	39,780	153	3,269	175	2,509	172	9,487
Percent of Army male	7.1	11.3	.5	5.4	.7	4.6	1.3	3.9	.2	8.9
Male personnel, Medical Department:										
Strength	3,913	30,813	29	2,051	2	68	4	164	10	314
Percent of Medical Department male	2.8	10.6	.3	4.1	.2	2.3	.4	4.1	.3	5.5
Officers, Army:										
Strength	2,448	76,007	160	5,206	1	157	15	303	126	758
Percent of Army officers	2.0	31.2	1.2	12.3	.0	4.9	2.2	10.5	2.8	11.9
Officers, Medical Department:										
Strength	288	12,383	4	542	0	5	3	44	0	47
Percent of Medical Department officers	1.8	35.0	.3	9.3	.0	1.7	2.6	9.2	.0	5.7
Enlisted men, Army:										
Strength	128,300	319,082	725	34,574	152	3,112	160	2,206	46	8,729
Percent of Army enlisted	7.4	9.8	.4	5.0	.7	4.6	1.3	3.6	.0	8.7
Enlisted men, Medical Department:										
Strength	3,625	18,430	25	1,509	2	63	1	120	10	267
Percent of Medical Department enlisted	2.9	7.2	.3	3.4	.2	2.4	.1	3.4	.4	5.5
Nurses:										
Strength	-------	613	-------	0	-------	0	-------	0	-------	0
Percent of all nurses	-------	4.3	-------	.0	-------	.0	-------	.0	-------	.0
Selectees										
Army:										
Strength	828,207	2,103,315	47,180	381,248	6,222	38,263	1,767	34,319	16,622	37,080
Percent of Army male	44.7	60.1	25.5	52.1	26.9	53.7	13.5	54.0	22.1	34.9
Percent of Army enlisted	47.9	64.6	27.4	55.3	28.2	56.1	14.3	56.5	23.5	37.2
Medical Department:										
Strength	73,079	186,303	2,103	28,133	155	1,305	59	1,916	1,291	2,500
Percent of Medical Department male	52.1	64.2	22.8	56.3	15.2	44.8	6.7	47.6	33.3	44.1
Percent of Medical Department enlisted	58.9	73.1	26.9	63.7	17.4	49.8	5.9	54.0	39.1	51.6

[1] Basic data from "Strength of the Army" for dates shown.
[2] Includes all personnel not shown under another heading.

worldwide and overseas, 31 January and 31 August 1942 [1]—Continued

Overseas											
South Atlantic	Europe		Africa-Middle East	Persian Gulf	China-Burma-India	Pacific Ocean Areas		Southwest Pacific Area		War Department groups	En route
August	January	August	August	August	August	January	August	January	August	August	August
0	----------	351	0	0	55	----------	612	----------	468	0	0
.0	----------	100.0	.0	.0	60.4	----------	69.5	----------	44.4	.0	.0
120	4	7,469	2,344	25	528	305	6,845	76	4,855	12	2,317
6.5	.2	4.8	26.9	9.2	4.0	1.1	3.6	.2	4.8	5.4	13.0
23	0	452	94	4	32	13	477	0	381	0	42
14.5	.0	3.9	26.3	20.0	3.2	.7	3.4	.0	3.8	20.0	10.2
13	3	2,552	206	17	46	15	376	0	275	12	491
11.1	3.1	24.0	34.1	17.0	4.2	.5	3.9	.0	4.3	5.4	44.9
1	0	246	13	4	9	1	53	0	101	0	19
5.3	.0	19.4	19.7	33.3	6.3	.3	3.73	.0	7.9	.0	35.2
107	1	4,917	2,138	8	482	290	6,469	76	4,580	0	1,826
6.2	.0	3.4	26.3	4.7	3.9	1.2	3.6	.2	4.8	.0	16.9
22	0	206	81	0	23	12	424	0	280	0	23
15.7	.0	2.0	20.4	.0	2.7	.8	3.4	.0	3.2	.0	6.5
----------	0	----------	----------	0	----------	0	----------	0	----------	0	----------
----------	.0	----------	----------	.0	----------	.0	----------	.0	----------	.0	----------
871	1,591	92,449	4,298	55	6,179	15,489	104,044	5,489	53,003	0	10,687
47.1	46.3	59.2	49.2	20.2	46.2	57.6	54.4	12.7	52.1	.0	59.9
50.4	47.7	63.5	52.9	31.9	50.5	65.4	57.4	13.8	55.7	.0	63.7
46	145	7,408	255	2	562	301	7,977	152	5,910	0	252
28.9	47.2	64.7	55.1	10.0	55.6	15.9	57.7	13.3	58.9	.0	61.5
32.9	48.8	72.8	64.1	25.0	64.0	18.7	64.2	18.1	67.4	.0	70.7

TABLE 41.—*Strength of male personnel by Army components, worldwide and overseas, on 31 July 1941* [1]

Component	Total Army		Medical Department	
	Number	Percent	Number	Percent
Worldwide	1, 524, 375	100. 0	120, 914	100. 0
Regular Army	508, 383	33. 3	32, 255	26. 7
National Guard	[2] 280, 333	18. 4	[3] 17, 261	14. 3
Reserves	65, 143	4. 3	11, 567	9. 6
Selectees	670, 516	44. 0	59, 831	49. 5
Overseas	122, 913	100. 0	4, 761	100. 0
Regular Army	100, 534	81. 8	3, 919	82. 3
National Guard	[4] 7, 472	6. 1	[5] 154	3. 2
Reserves	4, 118	3. 4	490	10. 3
Selectees	10, 789	8. 9	198	4. 2

[1] Basic data from "Strength of the Army," 31 July 1941.

[2] Includes approximately 22,000 Army of the United States enlisted men or 1.4 percent of the worldwide Army male strength. See table 12, footnote 18.

[3] Includes approximately 750 Army of the United States enlisted men or 0.6 percent of the worldwide Medical Department male strength. See table 12, footnote 18.

[4] It is uncertain whether Army of the United States enlisted men are included. Since in January 1942 the number of such enlisted men serving overseas was only 725 (see table 40), the number on 31 July 1941 could not have been large.

[5] It is uncertain whether Army of the United States enlisted men are included. In January 1942, the total oversea strength of such personnel was 25 (see table 40); hence, they could hardly have been more than a handful in July 1941.

The actual size of the components, however, cannot be traced beyond the early part of 1943 except in the case of Regular Army officers. In April 1944, Regular Army officers, numbering 618, constituted 2.01 percent of the male Medical Department officer strength in foreign areas. The corresponding figure for all male officers (6,323) was 2.37 percent.[27]

It can be said with certainty, however, that by the closing days of the war at least 80 percent of the oversea medical enlisted strength comprised selectees and not less than half of the male Medical Department officers abroad were so-called Army of the United States personnel; that is, neither Regulars, National Guardsmen, nor reservists.

The trend of Army components among nurses probably was the same as that among male officers until about the middle of 1942. At that time, a large reclassification of members of the Army Nurse Corps took place, and many who had been considered reservists were given Regular Army status. Some delay occurred, however, in the reclassification of those nurses who were abroad or at least in the recording of this reclassification. Thus, on 31 August 1942,

[27] On 30 April 1944, the Regular Army strength of the male Medical Department officer corps overseas and the percentage of Regulars in the total oversea strength of each corps were as follows: Medical Corps, 509 (2.5 percent); Dental Corps, 66 (1.6 percent); Veterinary Corps, 35 (6.5 percent); Pharmacy Corps, 9 (88.8 percent). Basic data are from AG Machine Records Branch, Military Strength of Bases. Recapitulation by Arm or Service by Station, Officers and Enlisted Men, 30 Apr. 1944.

the proportion of nurses serving in oversea areas and who were reported to be in the Regular Army was considerably smaller than the corresponding world-wide ratio (table 32). By the end of October, this situation had changed, and by 30 April 1944, the proportion of Regular Army personnel among nurses serving in foreign areas was not much different from the corresponding ratio among other personnel.

Negroes

In the early part of the war, proportionately fewer Negroes were shipped overseas by the Medical Department than whites, partially because of the reluctance of theater authorities to utilize such personnel. Manpower shortages together with the War Department policies to better utilize Negro personnel and to ship abroad personnel that had not seen foreign service reversed the proportion of Negro and white Medical Department personnel overseas.[28] For much of the period between October 1944 and the end of hostilities, the number of Medical Department Negroes overseas was proportionately greater than the oversea portion of the Medical Department as a whole. Contributing to this change was a decline in the Medical Department's overall Negro strength, a decline which was relatively greater than the corresponding loss to the Army as a whole.

While every Negro table-of-organization hospital unit organized in the Zone of Interior eventually went overseas,[29] the number of such units did not exceed five. The increasing use of Negro medical personnel outside the United States was perhaps primarily manifested in regard to sanitary companies. As late as June 1943, only two of these companies were abroad; one, the 708th, had gone overseas in 1942 and was operating in the North African Theater of Operations, U.S. Army, and the other, 716th, had arrived on Guadalcanal in the spring of 1943. Between August and December 1943, only five more sanitary companies were shipped abroad, three to the European theater and two to the Pacific. In 1944, however, at least 35 medical sanitary companies were moved overseas; in January 1945, one additional company was activated in Hawaii. Thus, if January 1945 be taken as the month marking the peak oversea Negro medical strength (14,150), it may be assumed that at least 5,000, or more than one-third of this oversea strength, were allotted to sanitary companies (tables 31 and 42). Virtually all of the companies were concentrated in the European theater and the Pacific (table 42). These were the areas which were receiving the largest number of personnel of all types and this at a time when the War Department policies to promote oversea use of Negroes were becoming effective.

The sanitary companies were trained primarily for the purposes of malaria control, but even in the Pacific, many were occupied in hospital construction and some were used as pools of Medical Department common labor.[30]

[28] Information from Mr. Ulysses G. Lee, Jr., 24 July 1953.
[29] See footnote 9, p. 382.
[30] Quarterly Report, 714th Medical Sanitary Company, 5 July 1944.

TABLE 42.—*Negro Medical Department units overseas, Pearl Harbor to V–J Day* [1]

Type	TOE [2]	Europe	North Africa	Africa-Middle East [3]	China-Burma-India	Pacific [4]	Authorized strength [5]	
							Officers	Enlisted men
Medical Sanitary Company	8–117	17	1	0	0	26	132	4, 928
Station Hospital [6]	8–560	0	0	1	2	1	130	244
Medical Prophylactic Platoon	8–500	0	1	0	0	0	0	6
Medical Battalion [7]	8–15	0	1	0	0	1	[8] 72	858
Motor Ambulance Company	8–317	10	2	0	0	3	60	1, 275
Malaria Survey Unit	8–500	0	0	1	0	1	2	24
Malaria Control Unit	8–500	0	0	2	0	0	2	22
Veterinary Company	8–99	[9] 1	[9] 1	0	3	0	20	236
Veterinary Animal Service Detachment	8–500	0	0	0	0	1	1	4
Medical Supply Platoon (Aviation)	8–497	0	1	0	0	0	2	17

[1] Compiled chiefly from copies of unit cards, W.D., A.G.O. Form 016, 1 Feb. 1942.

[2] A 1944 TOE has been selected, if published in that year. In all other cases, a TOE prior to 1944 was used. In many cases—particularly in the 8–500 series—the T/O was totally changed during the war.

[3] All units listed in this column were in Liberia.

[4] Certain units saw service in both the Pacific Ocean Areas and in the Southwest Pacific. However, the one station hospital and the three malaria control units served exclusively in the Southwest Pacific and the veterinary animal service detachment operated only in the Pacific Ocean Areas. Some of the other units also may have served in only one of the theaters.

[5] T/O strength times number of units. Totals therefore are merely approximations to actual strength, particularly in view of changing T/O's, the undetermined number of white officers utilized, and overstrengths.

[6] The 168th Station Hospital, with white officers and enlisted men, is not included in the unit tabulation, but the Negro nurses in that unit are counted in the "Authorized strength" column.

[7] The medical battalions were the largest medical units staffed with Negro personnel in World War II. The 318th supported the 93d Infantry Division in the Pacific; the 317th supported the 92d Infantry Division in Italy.

[8] Includes 4 warrant officers.

[9] One Negro veterinary company moved from the North African to the European theater with the invasion of southern France in August 1944.

In the absence of a serious malaria problem in the European theater the personnel of the sanitary companies serving therein, though used principally as litter bearers, were also used to guard prisoners of war occupied as Medical Department labor, to perform elementary carpentry and masonry tasks, to handle mail, and to pack supplies as well as operate small dispensaries and carry out basic sanitary measures in the vicinity of Medical Department units.[31] Among other Negro Medical Department organizations that served overseas, the most important from a numerical point of view were the motor ambulance companies. Many of these units were employed in the European theater and lesser numbers in the North African theater and in the Southwest Pacific (table 42).

[31] (1) Annual Report, 726th Medical Sanitary Company, 30 June 1945. (2) Periodic Report (1 Apr.–10 May 1945), 274th Medical Sanitary Company, 23 May 1945. (3) Annual Report, Surgeon, Normandy Base Section, European Theater of Operations, U.S. Army, for 1944, dated 31 Jan. 1945. (4) Periodic Report (1 Jan.–30 June 1945), 703d Medical Sanitary Company, 15 Aug. 1945.

Distribution by Sex

For much of the period of hostilities, female personnel of the Medical Department serving in oversea areas constituted a larger percentage of total Medical Department strength in such areas than they did of total Medical Department strength worldwide (tables 43 and 44). This situation existed until the threat of a draft brought the Army Nurse Corps up to authorized strength. Furthermore, Medical Department female personnel constituted the large majority by far of military female personnel in oversea areas during World War II. In the Zone of Interior, this ceased to be true as early as January 1943 (table 43).

TABLE 43.—*Proportion of Army female personnel in the Medical Department* [1]

Date	Total Army female [2] personnel	Medical Department [3]		Total Army female [5] personnel	Medical Department percent of total Army female personnel [6]
		Percent of total Army female personnel	Percent of total Medical Department personnel [4]		
	Worldwide			Overseas	
1942					
30 September	23, 841	84	5. 8	3, 803	100
1943					
31 January	45, 126	52	4. 7	5, 978	97
30 April	79, 059	35	4. 7	8, 033	97
31 July	92, 146	33	4. 9	10, 796	91
31 October	89, 485	40	5. 8	15, 716	86
1944					
31 January	98, 932	39	6. 1	19, 872	88
30 April	109, 822	37	6. 3	26, 566	82
31 July	121, 341	35	4. 3	32, 464	73
31 October	132, 697	33	6. 4	39, 947	66
1945					
31 January	137, 929	33	6. 8	42, 644	66
30 April	153, 991	36	8. 1	45, 876	65
31 July	152, 882	38	8. 9	46, 374	63
30 September	141, 306	39	9. 4	37, 161	63

[1] Female strength is that of the female components and excludes the small number of women who served in the Medical Corps. For worldwide strength of women doctors, see table 1, footnote 3. In oversea areas, probably no more than 18 women doctors saw service.

[2] Aggregate of worldwide Medical Department female personnel as shown in table 1 and WAAC and WAC personnel as shown in "Strength of the Army," 1 Jan. 1947, pp. 44–45.

[3] For basic data on Medical Department strength, see table 1.

[4] For Medical Department strength, see table 1.

[5] Aggregate oversea Medical Department female personnel as shown in table 44 and oversea WAAC and WAC personnel as reported in "Strength of the Army," 1 Jan. 1947.

[6] For basic data on Medical Department female personnel overseas and the percentage of Medical Department oversea strength in female components, see table 44.

TABLE 44.—*Oversea strength of Medical Department—male and female officer components, 30 September 1942–30 September 1945*

Date	Male officer corps		Female officer corps	
	Strength [1]	Percentage of total Medical Department strength [2]	Strength [1]	Percentage of total Medical Department strength [2]
1942				
30 September	6, 477	11. 0	3, 803	6. 5
1943				
31 January	10, 003	11. 4	5, 779	6. 6
30 April	13, 008	11. 5	7, 759	6. 9
31 July	15, 543	11. 1	9, 859	7. 1
31 October	19, 422	10. 8	13, 533	7. 5
1944				
31 January	24, 693	10. 3	17, 525	7. 3
30 April	30, 809	10. 3	21, 690	7. 2
31 July	35, 482	10. 3	23, 658	6. 9
30 September	37, 884	10. 3	24, 360	6. 6
31 October	39, 877	10. 2	26, 532	6. 8
1945				
31 January	43, 894	10. 2	28, 362	6. 6
30 April	48, 358	10. 4	29, 834	6. 4
31 May	47, 692	10. 5	30, 145	6. 6
30 June	46, 583	10. 5	29, 269	6. 6
31 July	43, 725	10. 3	29, 339	6. 9
31 August	39, 467	10. 5	26, 558	7. 0
30 September	34, 815	10. 5	23, 397	7. 1

[1] From table 32.
[2] Medical Department strength from table 31.

Officer Strength

Overseas, as in the Zone of Interior, the Medical Department contained a greater proportion of officers than did the Army in general, and between 16 and 19 of every 100 officers serving overseas were members of the Medical Department. For reasons already set forth, however, officers ordinarily constituted a somewhat smaller percentage of the Medical Department's strength overseas than they did of its worldwide strength. The year 1943 witnessed an exception to this rule (table 45).

Table 45.—*Medical Department officer strength, worldwide and overseas, 30 November 1941–30 September 1945*

Date and area	Number [1]	Percentage of total Army strength [2]	Number [3]	Percentage of worldwide Medical Department officer strength	Rate per 1,000 troops [2]	Percentage of Army officer strength	Percentage of total Medical Department strength [4]
	Army officer strength		Medical Department officer strength				
30 November 1941:							
Worldwide	121,094	7.4	23,484		14	19.4	17.8
Overseas	10,217	6.2	1,412	6.0	9	13.8	17.7
31 March 1942:							
Worldwide	157,867	6.6	31,535		13	20.0	15.7
Overseas	21,475	6.5	3,581	11.4	11	16.7	18.8
30 June 1942:							
Worldwide	214,151	7.0	43,755		14	20.4	17.2
Overseas	36,393	6.0	7,518	17.2	12	20.7	17.6
30 September 1942:							
Worldwide	307,009	7.7	65,922		17	21.5	18.9
Overseas	54,797	6.7	10,280	15.6	13	18.8	17.5
31 January 1943:							
Worldwide	438,499	7.5	79,948		14	18.2	16.1
Overseas	83,384	7.4	15,782	19.7	14	18.9	17.9
30 April 1943:							
Worldwide	525,669	7.8	88,673		13	16.9	15.1
Overseas	110,474	7.9	20,767	23.4	15	18.8	16.1
31 July 1943:							
Worldwide	602,831	8.5	99,000		14	16.4	15.8
Overseas	143,911	8.1	25,402	25.7	14	17.6	18.2
31 October 1943:							
Worldwide	660,892	9.0	107,491		15	16.3	17.4
Overseas	182,209	8.1	32,955	30.7	15	18.1	18.3
31 January 1944:							
Worldwide	707,828	9.4	113,634		15	16.1	18.1
Overseas	231,610	8.2	42,218	37.2	15	18.2	17.7
30 April 1944:							
Worldwide	743,075	9.5	118,391		15	15.9	18.2
Overseas	296,141	8.3	52,499	44.3	15	17.7	17.5
31 July 1944:							
Worldwide	784,726	9.7	120,748		15	15.4	17.8
Overseas	352,850	8.6	59,140	49.0	14	16.8	17.2
30 September 1944:							
Worldwide	815,691	10.1	122,532		15	15.0	18.0
Overseas	383,590	8.1	62,244	50.8	14	16.2	16.9
31 October 1944:							
Worldwide	815,709	10.1	124,712		15	15.3	18.1
Overseas	397,547	8.6	66,409	53.3	14	16.7	17.0
31 January 1945:							
Worldwide	844,646	10.5	129,904		16	15.4	19.5
Overseas	431,299	8.4	72,256	55.6	14	16.8	16.8
30 April 1945:							
Worldwide	879,775	10.7	139,938		17	15.9	20.8
Overseas	465,932	8.5	78,192	55.9	14	16.8	16.9
31 May 1945:							
Worldwide	892,167	10.8	142,378		17	16.0	21.4
Overseas	465,636	8.6	77,837	54.7	14	16.7	17.1

See footnotes at end of table.

TABLE 45.—*Medical Department officer strength, worldwide and overseas, 30 November 1941–30 September 1945*—Continued

Date and area	Number [1]	Percentage of total Army strength [2]	Number [3]	Percentage of worldwide Medical Department officer strength	Rate per 1,000 troops [2]	Percentage of Army officer strength	Percentage of total Medical Department strength [4]
	Army officer strength		Medical Department officer strength				
30 June 1945:							
Worldwide	890,798	10.8	142,616		17	16.0	21.5
Overseas	440,311	8.4	75,852	53.2	14	17.2	17.1
31 July 1945:							
Worldwide	896,611	10.9	145,342		18	16.2	22.0
Overseas	415,205	8.4	73,064	50.3	15	17.6	17.3
31 August 1945:							
Worldwide	897,929	11.2	144,475		18	16.1	22.7
Overseas	393,943	8.5	66,025	45.7	14	16.8	17.5
30 September 1945:							
Worldwide	879,542	11.6	138,655		18	15.8	23.4
Overseas	357,131	8.6	58,212	42.0	14	16.3	17.6

[1] Includes all commissioned officers as well as warrant officers, flight officers, and WAAC officers. Worldwide strength except for March 1942 is worldwide officer strength as shown in "Strength of the Army," for 1 October 1945, minus worldwide Medical Department officer strength as shown in table 1 plus worldwide Medical Department officer strength as shown here. Worldwide strength for March 1942 consists of Medical Department officer strength shown here plus worldwide non-Medical Department officer strength as determined in accordance with procedures for determining all strengths on that date described in table 31, footnote 2. Oversea strength for all months except March 1942 from "Strength of the Army," 1 October 1945. Oversea strength for March 1942 determined in accordance with procedure for ascertaining all oversea strength on that date described in table 31, footnote 2.

[2] For worldwide total Army strength, see table 1; for the same strength overseas, see table 31.

[3] Oversea strength is the sum of the oversea strength of the individual officer corps as shown in table 32. Worldwide data from table 1.

[4] For worldwide Medical Department strength, see table 1; for the same strength overseas, see table 31.

Quality

Medical Corps

By the middle of 1945, the great majority of Medical Corps officers—amounting to at least 69 percent of the peak strength of the corps—had seen service overseas. The early shipment overseas of medical officers in affiliated units resulted in a decided improvement in the professional quality of medical care in those areas. Medical officers in these units were by experience and professional training highly skilled physicians. At the same time, the gains obtained in oversea theaters by the acquisition of these officers were a loss to Zone of Interior installations. Many older specialists who had served long in the Zone of Interior as specialists were transferred by their own request to oversea assignments. In mid-1945, about half the medical officers over the age of 50 who were not Regular Army personnel were overseas. A sizable majority of this age group serving in the Zone of Interior were assigned to the Veterans' Administration. In the entire medical service, including both Regulars and non-Regulars, the majority of the group in the over-50 category were overseas.

On the other hand, in the Zone of Interior, as large medical requirements for definitive and specialized care built up during the war, it was necessary concurrently to retain highly qualified specialists in the United States and, in fact, to return some from oversea theaters.

In the early part of the war, despite the departure of affiliated units, the Zone of Interior retained more specialists than it released for oversea shipments. As the war progressed and the Zone of Interior installations were stripped of their specialists, the oversea theaters were considerably better staffed. Toward the end of the war, with the return of some specialists to the Zone of Interior and the induction of others, the two areas became approximately equal in quality. After V–E Day, the Zone of Interior again was better staffed. A greater proportion of its doctors were specialists than was the case overseas, and a greater proportion of these also had proficiency ratings above the minimum of D. What was more significant was the fact that this advantage was centered in the A and B categories (table 46).

TABLE 46.—*Strength and proficiency ratings of Medical Corps specialists, worldwide and overseas, 20 June 1945* [1]

Group	Worldwide	Overseas
Medical Corps strength [2]	47, 938	25, 449
Total specialists	26, 525	12, 679
Percent of specialists in total strength	55. 33	49. 82
Specialists rated A:		
Number	197	79
Percent of total specialists	. 74	. 62
Specialists rated B:		
Number	4, 989	2, 033
Percent of total specialists	18. 81	16. 03
Specialists rated C:		
Number	9, 124	4, 559
Percent of total specialists	34. 40	35. 96
Specialists rated D:		
Number	12, 215	6, 008
Percent of total specialists	46. 05	47. 39

[1] Basic data from "Summary Sheet, Specialists Inventory Report Form as of 20 June 1945" in "Classification Count" (prepared in the Personnel Service, Military Personnel Division, Office of The Surgeon General).

[2] Strengths vary considerably from those shown for approximate dates in tables 1 and 32.

It is very difficult to compare with any degree of accuracy the overall quality of the medical officers in the individual theaters. In the early part of the war, because of the military strategy adopted, the Mediterranean and European theaters were favored from a qualitative point of view. But as the war progressed, efforts were made to raise the level of professional quality in the Pacific and in China-Burma-India as those theaters gained in military importance.

Dental Corps

In the early part of the war, the distribution of dental personnel according to quality probably resembled that of the Medical Corps. The affiliated units which went overseas early contained highly skilled dentists as well as doctors. But the dental service overseas was never augmented to the same degree that the medical service was. One reason for this may be the fact that the Dental Corps never had as much as half its strength abroad, with the consequent likelihood that a great many of its members failed to see oversea service. It is also possible that the need for high quality dental personnel in oversea areas was relatively limited. Thus, the Zone of Interior managed to retain more of its highly qualified dental personnel than it sent overseas.[32]

Enlisted personnel

There may have been a tendency for a brief period early in the war to retain the better type of Medical Department enlisted man in the Zone of Interior and to send abroad the misfits and other less desirable persons. One observer, at least, found that in the Southwest Pacific certain station hospitals activated just before departure for that area in 1942 contained what he considered an "abnormally high proportion" of problem cases.[33] The same observer noted, however, that many other units were not staffed in this manner and that the personnel authorities in the Office of The Surgeon General made vigorous efforts to prevent the objectionable practice. The various regulations covering oversea service of enlisted men issued after the beginning of 1944 increased the difficulty of retaining higher quality medical enlisted personnel in Zone of Interior installations. It is significant that The Surgeon General stated in October 1944 that the personnel most suited to be commissioned in the Medical Administrative Corps were warrant officers and Medical Department noncommissioned officers serving overseas.[34]

Late in the war, conditions overseas leading to a large-scale exchange of enlisted personnel between the Medical Department and the combat branches served to lower the quality of the enlisted personnel in the oversea medical service. A similar exchange and like deterioration also was taking place in the continental United States. Hence, it is difficult to determine whether, at the end of the war, the quality was higher at home or abroad. The later stages of the war also witnessed a tendency to send limited-service men overseas, particularly as members of communications zone units. Thus, in the communications zone of the European theater, there were 36,042 Medical Department

[32] Letters, to Col. C. H. Goddard, Office of The Surgeon General, from (1) Brig. Gen. L. H. Tingay, DC, Brooke Army Medical Center, 20 Sept. 1952; (2) Col. E. W. Cowan, DC, 15 Sept. 1952; (3) D. J. Holland, D.D.S., Boston, Mass., 18 Sept. and 21 Oct. 1952; and (4) Col. T. A. McFall, DC, 4 Oct. 1952.

[33] Letter, M. C. Pincoffs, M.D., Baltimore, Md., to Col. C. H. Goddard, Office of The Surgeon General, 29 Aug. 1952.

[34] Memorandum, The Surgeon General, for War Department, Assistant Chief of Staff, G–1, 9 Oct. 1944, subject: Medical Officer Requirements and Availabilities.

enlisted men who, as of 15 March 1945, were so classified and who constituted nearly 38 percent of the total strength of such personnel in the zone. The corresponding percentage for all the theater personnel was somewhat under 22 percent.[35] It need not be assumed, however, from the fact that large numbers of Medical Department enlisted men were regarded as unable to perform general duty, that they could not accomplish the tasks assigned to them in a satisfactory manner. Furthermore, it is likely that the limited-assignment Medical Department enlisted personnel in the communications zone constituted the great bulk of such personnel in the theater; in relation to the total Medical Department enlisted strength in the broader area, they were less than 16 percent.

Non-Medical Department Personnel Overseas

As in the Zone of Interior, chaplains, engineers, and other officer specialists worked in Medical Department installations overseas although, as already indicated, it is difficult to state the strength of such personnel with the precision possible in the case of Medical Department personnel proper.[36] A similar group comprised the workers of the American Red Cross Hospital Service—field directors, assistant field directors, medical social workers, recreation workers, staff aides, and their assistants—who were assigned to or worked with Army medical units in virtually every oversea area. As in the continental United States, the Red Cross personnel handled patients' communications with their homes, aided soldiers with their financial and personal problems, and, in general, did all kinds of welfare work for members of the Army. They not only set up recreation programs in the hospitals, but also obtained social histories of the patients for their own or the medical officers' use.

It was originally planned that Red Cross personnel assigned to the Army for service overseas should be placed only in general and station hospitals, but the importance of field, evacuation, and convalescent hospitals made it desirable to assign workers to these units too, and this at least in the case of evacuation hospitals was done within the theaters. Normally, Red Cross personnel were assigned to Army hospitals as follows: 5 workers per 1,000-bed general hospital, with 3 more for each additional 500 beds; 3 per station hospital (between 500 and 1,000 beds); 10 per convalescent center (in the European theater); and 2 for each field and 400-bed evacuation hospital. In cases where more workers were available, more might be assigned. Smaller medical units were usually covered by Red Cross field directors.

Available statistics do not differentiate Red Cross personnel working in Army hospitals from those employed overseas in Navy and civilian medical

[35] "Unit Strength—ComZ—ETOUSA. Comparison of Actual and T/O—15 Mar. 1945," *in* Progress Report, Communications Zone, ETO—USA, 31 March 1945, p. 4.

[36] The number of table-of-organization positions for chaplains in oversea hospitals on 30 April 1945 was 1,050. (Data from "Troop List for Operations and Supply, 1 May 1945.") This was a figure in excess of the number of veterinary officers, dietitians, or physical therapists serving abroad on that date (table 32).

installations, but it is safe to assume that the bulk of oversea hospital workers of the American Red Cross worked in Army establishments. The total number of these workers increased from 73 in mid–1942 to 2,197 in the middle of 1945 (table 47).[37]

TABLE 47.—*The American National Red Cross: Oversea hospital workers on duty and en route, 1942–45*

Type of worker	1942	1943	1944	1945
Supervisory and administrative field staff	0	0	24	24
Field director and assistant field director	0	78	165	231
Staff aide and assistant to field director	0	0	260	568
Medical social worker	5	86	192	190
Recreation worker	47	183	557	711
Recreation consultant	0	0	0	7
Hospital visitor	0	34	0	0
Clerical, stenographic, secretarial	21	114	366	466
Total	73	495	1, 564	2, 197

Source: "Oversea Hospital Workers on Duty and Enroute as of June 30 (or nearest comparable date) 1943 through June 30, 1949," enclosure to letter, C. H. Whelden, Jr., Chief Statistician, The American National Red Cross, National Headquarters, to Historical Unit, Office of The Surgeon General, 6 June 1952.

Members of the Women's Army Corps, civilians, and prisoners of war also swelled the strength of the medical service overseas beyond the figures revealed by statistics of Medical Department elements proper.

PERMANENT LOSSES OF PERSONNEL

Influences Affecting the Rate of Loss

Factors tending to reduce the Medical Department's temporary as well as permanent losses, in comparison with those of the Army at large, were the location of the great bulk of medical personnel overseas in Army service areas, various communications zones, and base sections where the hazards of combat, though not absent, were minor, and the location of large numbers of personnel in the Zone of Interior. The extent to which these factors operated to reduce the dangers of combat is indicated by a comparison of the battle-casualty rates of the Medical Department with that of the Army as a whole (table 48). For officers, the Army rate was 36.6, while the Medical Department rate was 3.2; for enlisted personnel, the Army rate was 32.6, the Medical Department rate, 11.6; for officers and enlisted men combined, the Army rate was 32.6, the Medical Department rate, 10.1. (See also tables 49, 50, and 51.)

[37] (1) Letter, D. C. Smith, American National Red Cross, Washington, to the Office of The Surgeon General (attention: Lt. Col. Markowitz), 16 June 1952, with enclosures thereto. (2) Annual Report, Personnel Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1943.

TABLE 48.—*Battle casualties of the Medical Department, officers and enlisted men:*[1] *Total battle casualties, deaths among battle casualties, and killed in action, 7 December 1941–31 December 1946*

Area and group	Strength[2]		Total battle casualties		Deaths among battle casualties[3]		Killed in action	
	Median	Number of months of exposure	Number	Annual rate per 1,000[4]	Number	Annual rate per 1,000[4]	Number	Annual rate per 1,000[4]
Total overseas								
Total Army	2, 526, 729	46	936, 259	96. 7	234, 874	24. 2	189, 696	19. 6
Officers	206, 910	46	95, 998	121. 0	35, 984	45. 4	30, 157	38. 0
Enlisted	2, 319, 819	46	840, 261	94. 5	198, 890	22. 4	159, 539	17. 9
Medical Department	209, 414	46	23, 962	29. 3	4, 922	6. 1	3, 690	4. 6
Officers	37, 587	46	1, 339	9. 3	321	2. 2	196	1. 4
Enlisted	171, 828	46	22, 623	34. 3	4, 601	7. 0	3, 494	5. 3
Regional								
Alaska:								
Total Army	64, 918	46	1, 875	7. 5	877	3. 5	853	3. 4
Officers	4, 007	46	290	18. 9	175	11. 4	170	11. 1
Enlisted	60, 297	46	1, 585	6. 9	702	3. 0	683	3. 0
Medical Department	3, 267	46	74	5. 9	30	2. 4	29	2. 3
Officers	480	46	5	2. 7	2	1. 1	2	1. 1
Enlisted	2, 825	46	69	6. 4	28	2. 6	27	2. 5
Caribbean and South Atlantic:								
Total Army	89, 669	46	57	. 2	38	. 1	36	. 1
Officers	6, 474	46	10	. 4	5	. 2	5	. 2
Enlisted	83, 824	46	47	. 1	33	. 1	31	. 1
Medical Department	4, 690	46	3	. 2	2	. 1	2	. 1
Officers	1, 051	46	0	0	0	0	0	0
Enlisted	4, 098	46	3	. 2	2	. 1	2	. 1
European theater:								
Total Army	935, 346	44	586, 628	171. 0	135, 576	39. 5	116, 991	34. 1
Officers	79, 897	44	56, 804	193. 9	19, 152	65. 4	17, 393	59. 4
Enlisted	855, 449	44	529, 824	168. 9	116, 424	37. 1	99, 598	31. 8

See footnotes at end of table.

TABLE 48.—*Battle casualties of the Medical Department, officers and enlisted men:*[1] *Total battle casualties, deaths among battle casualties, and killed in action, 7 December 1941–31 December 1946*—Continued

Area and group	Strength [2]		Total battle casualties		Deaths among battle casualties [3]		Killed in action	
	Median	Number of months of exposure	Number	Annual rate per 1,000 [4]	Number	Annual rate per 1,000 [4]	Number	Annual rate per 1,000 [4]
European theater—Continued								
Medical Department	81,616	44	14,589	48.8	2,763	9.2	2,265	7.6
Officers	14,359	44	618	11.7	128	2.4	99	1.9
Enlisted	67,257	44	13,971	56.7	2,635	10.7	2,166	8.8
Mediterranean theater:								
Total Army	518,138	34	175,107	119.3	40,455	27.6	35,313	24.1
Officers	47,428	34	19,079	142.0	6,371	47.4	5,638	42.0
Enlisted	473,361	34	156,028	116.3	34,084	25.4	29,675	22.1
Medical Department	38,122	34	3,755	34.8	608	5.6	517	4.8
Officers	7,104	34	191	9.5	43	2.1	38	1.9
Enlisted	33,212	34	3,564	37.9	565	6.0	479	5.1
Africa-Middle East:								
Total Army	11,352	39	3,959	107.3	1,031	27.9	930	25.2
Officers	1,097	39	1,636	458.9	462	129.6	407	114.2
Enlisted	9,989	39	2,323	71.6	569	17.5	523	16.1
Medical Department	1,396	38	9	2.0	3	.7	3	.7
Officers	311	38	1	1.0	0	0	0	0
Enlisted	1,085	38	8	2.3	3	.9	3	.9
China-Burma-India:								
Total Army	107,595	42	6,925	18.4	3,727	9.9	2,723	7.2
Officers	12,530	42	2,295	52.3	1,480	33.7	1,106	25.2
Enlisted	95,065	42	4,630	13.9	2,247	6.8	1,617	4.9
Medical Department	9,945	42	95	2.7	42	1.2	17	.5
Officers	1,869	42	20	3.1	11	1.7	1	.2
Enlisted	8,076	42	75	2.7	31	1.1	16	.6
Pacific:								
Total Army	683,697	46	157,938	60.3	50,385	19.2	30,538	11.7
Officers	51,239	46	14,512	73.9	7,260	37.0	4,536	23.1

Enlisted	632, 458	46	143, 426	59. 2	43, 125	17. 8	26, 002	10. 7
Medical Department	59, 768	46	5, 405	23. 6	1, 427	6. 2	812	3. 5
Officers	9, 858	46	502	13. 3	136	3. 6	55	1. 5
Enlisted	49, 911	46	4, 903	25. 6	1, 291	6. 7	757	4. 0
U.S. Army Strategic Air Forces:								
Total Army	61, 900	15	2, 897	37. 4	2, 148	27. 8	1, 795	23. 2
Officers	8, 285	15	1, 289	124. 5	1, 016	98. 1	857	82. 8
Enlisted	53, 615	15	1, 608	24. 0	1, 132	16. 9	938	14. 0
Medical Department	(5)	(5)	1	(5)	1	(5)	1	(5)
Officers	(5)	(5)	1	(5)	1	(5)	1	(5)
Enlisted	(5)	(5)	0	0	0	0	0	0
En route:								
Total Army	(5)	(5)	725	(5)	491	(5)	475	
Officers	(5)	(5)	53	(5)	33	(5)	33	(5)
Enlisted	(5)	(5)	672	(5)	458	(5)	442	(5)
Medical Department	(5)	(5)	56	(5)	41	(5)	41	(5)
Officers	(5)	(5)	1	(5)	0	0	0	0
Enlisted	(5)	(5)	55	(5)	41	(5)	41	(5)
Theater Unknown:								
Total Army			148		146		42	
Officers			30		30		12	
Enlisted			118		116		30	
Medical Department			5		5		3	
Officers			5		5		3	
Enlisted			0		0		0	

[1] Basic data, unless otherwise noted, from "Battle Casualties by Duty, Branch, Type, and Disposition: 7 December 1946" *in* Department of the Army "Army Battle Casualties and Nonbattle Deaths in World War II. Final Report 7 December 1941–31 December 1946," pp. 48–69. A full explanation of the categories of casualties is found in the same document pp. 1 to 4, inclusive. Although casualty data, as reported in this source, are cumulative, 7 December 1941–31 December 1946, it is here assumed that all casualties were incurred prior to 1 October 1945, since the number reported as having occurred subsequent to that date is negligible. (*See* pp. 10–11 of the report.)

[2] Median strength is based on end-of-month strength on the following dates: 30 November 1941; 31 March, 30 June, and 30 September 1942; 31 January, 30 April, 31 July, and 31 October 1943; 31 January, 30 April, 31 July, and 31 October 1944; and 31 January, 30 April, 31 July, and 30 September 1945. In determining the median strength for any group or area, the first of these dates chosen was the first to show a strength for such group or area in the following sources: For the Army in general and the Medical Department, both in oversea areas as a whole and in individual theaters, table 31 (unadjusted data); for Medical Department officers and enlisted men in oversea areas as a whole, tables 5 and 45, for Army officers and enlisted men in oversea areas as a whole, tables 5 and 45, with the addition, in the case of officers, of WAAC officers and, in the case of enlisted personnel, of WAAC and WAC enlisted women, as shown in "Strength of the Army," and for officers and enlisted men in individual oversea areas, including the Army as a whole and the Medical Department, the sources for the corresponding total (unadjusted) strengths in such areas reported in table 31. The final date for the median strength in all cases was 30 September 1945. Time of exposure was dated from the first month following the date on which a strength was first shown for the group or area involved in "Strength of the Army" or the sources thereof. The terminal date in each instance is 30 September 1945.

[3] All persons killed in action, dead as a result of wounds or injuries received in action declared dead from missing in action, and dead of nonbattle causes while in a battle casualty status of captured, interned, or missing in action.

[4] Rate per 1,000 of median strength. [5] Information not readily available.

TABLE 49.—*Battle casualties of the Medical Department, officers and enlisted men:* [1] *Wounded and injured in action,* [2] *7 December 1941–31 December 1946*

Area and Group	Total		Died of wounds and injuries		Evacuated to the United States					Returned to duty in theater	
					Total			Died of wounds			
	Number	Annual rate per 1,000 [3]	Number	Percent of wounded in action	Number	Percent of wounded in action	Annual rate per 1,000 [3]	Number	Percent of evacuation	Returned to duty (number)	Number	Percent of wounded in action
Total overseas												
Total Army	592, 170	61. 1	26, 225	4. 43	182, 749	30. 86	18. 9	84	0. 05	182, 665	383, 196	64. 71
Officers	38, 504	48. 5	2, 109	5. 48	12, 648	32. 85	15. 9	11	. 09	12, 637	23, 747	61. 67
Enlisted	553, 666	62. 3	24, 116	4. 36	170, 101	30. 72	19. 1	73	. 04	170, 028	359, 449	64. 92
Medical Department	15, 977	19. 9	723	4. 53	4, 909	30. 73	6. 1	0	0	4, 909	10, 345	64. 75
Officers	703	4. 9	43	6. 12	246	34. 99	1. 7	0	0	246	414	58. 89
Enlisted	15, 274	23. 2	680	4. 45	4, 663	30. 53	7. 1	0	0	4, 663	9, 931	65. 02
Regional												
Alaska:												
Total Army	933	3. 7	16	1. 71	179	19. 19	. 7	0	0	179	738	79. 10
Officers	91	5. 9	2	2. 20	36	39. 56	2. 3	0	0	36	53	58. 24
Enlisted	842	3. 6	14	1. 66	143	16. 98	. 6	0	0	143	685	81. 35
Medical Department	45	3. 6	1	2. 22	3	6. 67	. 2	0	0	3	41	91. 11
Officers	3	1. 6	0	0	0	0	0	0	0	0	3	100. 00
Enlisted	42	3. 9	1	2. 36	3	7. 14	. 3	0	0	3	38	. 48
Caribbean and South Atlantic:												
Total Army	9	. 0	2	22. 22	1	11. 11	. 0	0	0	1	6	66. 67
Officers	3	. 1	0	0	0	0	0	0	0	0	3	100. 00
Enlisted	6	. 0	2	33. 33	1	16. 67	. 0	0	0	1	3	50. 00
Medical Department	0	0	0	0	0	0	0	0	0	0	0	0
Officers	0	0	0	0	0	0	0	0	0	0	0	0
Enlisted	0	0	0	0	0	0	0	0	0	0	0	0
European theater:												
Total Army	381, 350	111. 2	16, 264	4. 26	125, 417	32. 89	36. 6	0	0	125, 417	239, 669	62. 85
Officers	23, 808	81. 3	1, 287	5. 41	8, 238	34. 60	28. 1	0	0	8, 238	14, 283	59. 99

Enlisted	357, 542	114. 0	14, 977	4. 19	117, 179	32. 77	37. 4	0	0	117, 179	225, 386	63. 04	
Medical Department	10, 016	33. 5	452	4. 51	3, 208	32. 03	10. 7	0	0	3, 208	6, 356	63. 46	
Officers	391	7. 4	28	7. 16	140	35. 81	2. 7	0	0	140	223	57. 03	
Enlisted	9, 625	39. 0	424	4. 41	3, 068	31. 88	12. 4	0	0	3, 068	6, 133	63. 72	
Mediterranean theater:													
Total Army	111, 125	75. 7	3, 993	3. 59	26, 279	23. 65	17. 9	0	0	26, 279	80, 853	72. 76	
Officers	7, 770	57. 8	342	4. 40	2, 127	27. 37	15. 8	0	0	2, 127	5, 301	68. 22	
Enlisted	103, 355	77. 1	3, 651	3. 53	24, 152	23. 37	18. 0	0	0	24, 152	75, 552	73. 10	
Medical Department	2, 753	25. 5	83	3. 01	693	25. 17	6. 4	0	0	693	1, 957	71. 09	
Officers	129	6. 4	4	3. 10	44	34. 11	2. 2	0	0	44	81	62. 79	
Enlisted	2, 624	27. 9	79	3. 01	649	24. 73	6. 9	0	0	649	1, 876	71. 49	
Africa-Middle East:													
Total Army	536	14. 5	17	3. 17	117	21. 83	3. 2	0	0	117	402	75. 00	
Officers	196	55. 0	6	3. 06	48	24. 49	13. 5	0	0	48	142	72. 45	
Enlisted	340	10. 5	11	3. 24	69	20. 29	2. 1	0	0	69	260	76. 47	
Medical Department	3	. 7	1	33. 33	2	66. 67	. 5	0	0	2	1	33. 33	
Officers	0	0	0	0	0	0	0	0	0	0	0	0	
Enlisted	3	. 9	1	33. 33	2	66. 67	. 6	0	0	2	1	33. 33	
China-Burma-India:													
Total Army	2, 597	6. 9	192	7. 39	617	23. 76	1. 6	0	0	617	1, 788	68. 85	
Officers	407	9. 3	42	10. 32	105	25. 80	2. 4	0	0	105	260	63. 88	
Enlisted	2, 190	6. 6	150	6. 85	512	23. 38	1. 5	0	0	512	1, 528	69. 77	
Medical Department	54	1. 6	4	7. 41	9	16. 67	. 3	0	0	9	41	75. 93	
Officers	6	. 9	0	0	0	0	0	0	0	0	6	100. 00	
Enlisted	48	1. 7	4	8. 33	9	18. 75	. 3	0	0	9	35	72. 92	
Pacific:													
Total Army	95, 021	36. 3	5, 707	6. 01	29, 923	31. 49	11. 4	0	0	29, 923	59, 391	62. 50	
Officers	6, 076	30. 9	422	6. 95	2, 045	33. 66	10. 4	0	0	2, 045	3, 609	59. 40	
Enlisted	88, 945	36. 7	5, 285	5. 94	27, 878	31. 34	11. 5	0	0	27, 878	55, 782	62. 72	
Medical Department	3, 100	13. 5	183	5. 90	990	31. 94	4. 3	0	0	990	1, 927	62. 76	
Officers	173	4. 6	11	6. 36	61	35. 26	1. 6	0	0	61	101	58. 38	
Enlisted	2, 927	15. 3	172	5. 88	929	31. 94	4. 9	0	0	929	1, 826	62. 38	
U.S. Army Strategic Air Forces:													
Total Army	407	5. 3	13	3. 19	102	25. 06	1. 3	0	0	102	292	71. 74	
Officers	129	12. 5	7	5. 43	33	25. 58	3. 2	0	0	33	89	68. 99	
Enlisted	278	4. 1	6	2. 16	69	24. 82	1. 0	0	0	69	203	73. 02	

See footnotes at end of table.

TABLE 49.—*Battle casualties of the Medical Department, officers and enlisted men:*[1] *Wounded and injured in action,*[2] *7 December 1941–31 December 1946*—Continued

Area and Group	Total		Died of wounds and injuries		Evacuated to the United States						Returned to duty in theater	
					Total			Died of wounds		Returned to duty (number)		
	Number	Annual rate per 1,000[3]	Number	Percent of wounded in action	Number	Percent of wounded in action	Annual rate per 1,000[3]	Number	Percent of evacuation		Number	Percent of wounded in action
U.S. Army Strategic Air Forces—Continued												
Medical Department	0	0	0	0	0	0	0	0	0	0	0	0
Officers	0	0	0	0	0	0	0	0	0	0	0	0
Enlisted	0	0	0	0	0	0	0	0	0	0	0	0
En route:												
Total Army	100	(4)	13	13.00	30	30.00	(4)	0	0	30	57	57.00
Officers	12	(4)	0	0	5	41.67	(4)	0	0	5	7	58.33
Enlisted	88	(4)	13	14.77	25	28.41	(4)	0	0	25	50	56.82
Medical Department	6	(4)	0	0	4	66.67	(4)	0	0	4	2	33.33
Officers	1	(4)	0	0	1	100.00	(4)	0	0	1	0	0
Enlisted	5	(4)	0	0	3	60.00	(4)	0	0	3	2	40.00
Theater unknown:												
Total Army	92		8	8.70	84	91.30		0	0	0	0	0
Officers	12		1	8.33	11	91.67		0	0	0	0	0
Enlisted	80		7	8.75	73	91.25		0	0	0	0	0
Medical Department	0		0	0	0	0		0	0	0	0	0
Officers	0		0	0	0	0		0	0	0	0	0
Enlisted	0		0	0	0	0		0	0	0	0	0

[1] For basic data, see footnote 1, table 48.

[2] Comprehends "only those wounded or injured in action personnel requiring hospitalization, except that those who died of wounds or injuries after reaching some type of medical treatment facility but before reaching a hospital are also included."

[3] Rate per 1,000 of median strength.

[4] Information not readily available.

TABLE 50.—*Battle casualties of the Medical Department, officers and enlisted men:*[1] *Captured and interned,*[2] *7 December 1941–31 December 1946*

Area and group	Total		Died								Returned to military control (number)
			Total		Killed in action		Died of wounds		Nonbattle causes		
	Number	Annual rate per 1,000 [3]	Number	Percent of captured and interned	Number	Percent of died in captivity	Number	Percent of died in captivity	Number	Percent of died in captivity	
Total overseas											
Total Army	124, 079	12. 8	12, 653	10. 20	3, 102	24. 52	453	3. 58	9, 098	71. 90	111, 426
Officers	21, 593	27. 2	1, 726	7. 99	900	52. 14	189	10. 95	637	36. 91	19, 867
Enlisted	102, 486	11. 5	10, 927	10. 66	2, 202	20. 15	264	2. 42	8, 461	77. 43	91, 559
Medical Department	3, 748	4. 7	444	11. 85	162	36. 49	29	6. 53	253	56. 98	3, 304
Officers	409	2. 8	79	19. 32	46	58. 23	5	6. 33	28	35. 44	330
Enlisted	3, 339	5. 1	365	10. 93	116	31. 78	24	6. 58	225	61. 64	2, 974
Regional											
Alaska:											
Total Army	48	. 2	0	0	0	0	0	0	0	0	48
Officers	23	1. 5	0	0	0	0	0	0	0	0	23
Enlisted	25	. 1	0	0	0	0	0	0	0	0	25
Medical Department	0	0	0	0	0	0	0	0	0	0	0
Officers	0	0	0	0	0	0	0	0	0	0	0
Enlisted	0	0	0	0	0	0	0	0	0	0	0
Caribbean and South Atlantic:											
Total Army	1	. 0	0	0	0	0	0	0	0	0	1
Officers	1	. 0	0	0	0	0	0	0	0	0	1
Enlisted	0	0	0	0	0	0	0	0	0	0	0
Medical Department	0	0	0	0	0	0	0	0	0	0	0
Officers	0	0	0	0	0	0	0	0	0	0	0
Enlisted	0	0	0	0	0	0	0	0	0	0	0

See footnotes at end of table.

TABLE 50.—*Battle casualties of the Medical Department, officers and enlisted men:* [1] *Captured and interned,*[2] *7 December 1941–31 December 1946*—Con.

Area and group	Total		Died								Returned to military control (number)
			Total		Killed in action		Died of wounds		Nonbattle causes		
	Number	Annual rate per 1,000 [3]	Number	Percent of captured and interned	Number	Percent of died in captivity	Number	Percent of died in captivity	Number	Percent of died in captivity	
European theater:											
Total Army	73, 759	21. 5	950	1. 29	224	23. 58	194	20. 42	532	56. 00	72, 809
Officers	13, 920	47. 5	134	. 96	66	49. 25	43	32. 09	25	18. 66	13, 786
Enlisted	59, 839	19. 1	816	1. 36	158	19. 36	151	18. 50	507	62. 13	59, 023
Medical Department	1, 997	6. 7	30	1. 50	6	20. 00	3	10. 00	21	70. 00	1, 967
Officers	121	2. 3	1	. 83	1	100. 00	0	0	0	0	120
Enlisted	1, 876	7. 6	29	1. 55	5	17. 24	3	10. 34	21	72. 41	1, 847
Mediterranean theater:											
Total Army	20, 182	13. 7	171	. 85	64	37. 43	63	36. 84	44	25. 73	20, 011
Officers	3, 894	29. 0	39	1. 00	10	25. 64	21	53. 85	8	20. 51	3, 855
Enlisted	16, 288	12. 1	132	. 81	54	40. 91	42	31. 82	36	27. 27	16, 156
Medical Department	363	3. 4	2	. 55	2	100. 00	0	0	0	0	361
Officers	22	1. 1	1	4. 55	1	100. 00	0	0	0	0	21
Enlisted	341	3. 6	1	. 29	1	100. 00	0	0	0	0	340
Africa-Middle East:											
Total Army	1, 590	43. 1	3	. 19	2	66. 67	0	0	1	33. 33	1, 587
Officers	668	187. 4	2	. 30	2	100. 00	0	0	0	0	666
Enlisted	922	28. 4	1	. 11	0	0	0	0	1	100. 00	921
Medical Department	2	. 5	0	0	0	0	0	0	0	0	2
Officers	0	0	0	0	0	0	0	0	0	0	0
Enlisted	2	. 6	0	0	0	0	0	0	0	0	2
China-Burma-India:											
Total Army	679	1. 8	337	49. 63	274	81. 31	4	1. 19	59	17. 51	342
Officers	254	5. 8	86	33. 86	59	68. 60	0	0	27	31. 40	168
Enlisted	425	1. 3	251	59. 06	215	85. 66	4	1. 59	32	12. 75	174
Medical Department	19	. 5	18	94. 74	17	94. 44	0	0	1	5. 56	1

Officers	10	1.5	9	90.00	9	100.00	0	6	0	0	1
Enlisted	9	.3	9	100.00	8	88.89	0	0	1	11.11	0
Pacific:											
Total Army	27,465	10.5	11,107	40.44	2,473	22.27	182	1.64	8,452	76.10	16,358
Officers	2,688	13.7	1,431	53.24	737	51.50	121	8.46	573	40.04	1,257
Enlisted	24,777	10.2	9,676	39.05	1,736	17.94	61	17.94	7,879	81.43	15,101
Medical Department	1,365	6.0	392	22.72	135	34.44	26	6.63	231	58.93	973
Officers	256	6.8	68	26.56	35	51.47	5	7.35	28	41.18	188
Enlisted	1,109	5.8	324	29.22	100	30.86	21	6.48	203	62.65	785
U.S. Army Strategic Air Forces:											
Total Army	334	4.3	72	21.56	58	80.56	8	11.11	6	8.33	262
Officers	133	12.8	28	21.05	24	85.72	2	7.14	2	7.14	105
Enlisted	201	3.0	44	21.89	34	77.27	6	13.64	4	9.09	157
Medical Department	0	0	0	0	0	0	0	0	0	0	0
Officers	0	0	0	0	0	0	0	0	0	0	0
Enlisted	0	0	0	0	0	0	0	0	0	0	0
En route:											
Total Army	9	(4)	2	22.22	0	0	0	0	2	100.00	7
Officers	6	(4)	0	0	0	0	0	0	0	0	6
Enlisted	3	(4)	2	66.67	0	0	0	0	2	100.00	1
Medical Department	0	0	0	0	0	0	0	0	0	0	0
Officers	0	0	0	0	0	0	0	0	0	0	0
Enlisted	0	0	0	0	0	0	0	0	0	0	0
Theater unknown:											
Total Army	12	----	11	91.67	7	63.64	2	18.18	2	18.18	1
Officers	6	----	6	100.00	2	66.67	2	33.33	2	33.33	0
Enlisted	6	----	5	83.33	5	100.00	0	0	0	0	1
Medical Department	2	----	2	100.00	2	100.00	0	0	0	0	0
Officers	0	----	0	0	0	0	0	0	0	0	0
Enlisted	2	----	2	100.00	2	100.00	0	0	0	0	0

[1] For basic data, see footnote 1, table 48.
[2] All persons known to have been taken prisoner by opposing forces or taken into custody by the authorities of a neutral country as internees.
[3] Rate per 1,000 of median strength.
[4] Information not readily available.

TABLE 51.—*Battle casualties of the Medical Department, officers and enlisted men:* [1] *Missing in action,* [2] *7 December 1941–31 December 1946*

Area and group	Total		Died				Non-battle causes (number)	Returned to duty (number)
			Total		Declared dead [3]			
	Number	Annual rate per 1,000 [4]	Number	Percent of missing in action	Number	Percent of missing in action		
Total overseas								
Total Army	30,314	3.1	6,216	20.51	6,058	19.98	158	24,098
Officers	5,744	7.2	1,981	34.49	1,974	34.37	7	3,763
Enlisted	24,570	2.8	4,235	17.24	4,084	16.62	151	20,335
Medical Department	547	.7	65	11.88	61	11.15	4	482
Officers	31	.2	3	9.68	3	9.68	0	28
Enlisted	516	.8	62	12.02	58	11.24	4	454
Regional								
Alaska:								
Total Army	41	.2	8	19.51	8	19.51	0	33
Officers	6	.4	3	50.00	3	50.00	0	3
Enlisted	35	.2	5	14.29	5	14.29	0	30
Medical Department	0	0	0	0	0	0	0	0
Officers	0	0	0	0	0	0	0	0
Enlisted	0	0	0	0	0	0	0	0
Caribbean and South Atlantic:								
Total Army	11	0	0	0	0	0	0	11
Officers	1	0	0	0	0	0	0	1
Enlisted	10	0	0	0	0	0	0	10
Medical Department	1	.1	0	0	0	0	0	1
Officers	0	0	0	0	0	0	0	0
Enlisted	1	.1	0	0	0	0	0	1
European theater:								
Total Army	14,528	4.2	1,371	9.44	1,361	9.37	10	13,157
Officers	1,683	5.7	338	20.08	338	20.08	0	1,345
Enlisted	12,845	4.1	1,033	8.04	1,023	7.96	10	11,812
Medical Department	311	1.0	16	5.14	16	5.14	0	295
Officers	7	.1	0	0	0	0	0	7
Enlisted	304	1.2	16	5.26	16	5.26	0	288
Mediterranean theater:								
Total Army	8,487	5.8	978	11.52	978	11.52	0	7,509
Officers	1,777	13.2	352	19.81	352	19.81	0	1,425
Enlisted	6,710	5.0	626	9.33	626	9.33	0	6,084
Medical Department	92	.9	6	6.52	6	6.52	0	86
Officers	2	.1	0	0	0	0	0	2
Enlisted	90	1.0	6	6.67	6	6.67	0	84
Africa-Middle East:								
Total Army	903	124.5	81	8.97	81	8.97	0	822
Officers	365	102.4	47	12.88	47	12.88	0	318
Enlisted	538	16.6	34	6.32	34	6.32	0	504
Medical Department	1	.2	0	0	0	0	0	1
Officers	1	1.0	0	0	0	0	0	1
Enlisted	0	0	0	0	0	0	0	0

See footnotes at end of table.

TABLE 51.—*Battle casualties of the Medical Department, officers and enlisted men:* [1] *Missing in action,*[2] *7 December 1941–31 December 1946*—Continued

Area and group	Total		Died					Returned to duty (number)
			Total		Declared dead [3]		Non-battle causes (number)	
	Number	Annual rate per 1,000 [4]	Number	Percent of missing in action	Number	Percent of missing in action		
China-Burma-India:								
Total Army	926	2.5	475	51.30	473	51.08	2	451
Officers	528	12.0	246	46.59	244	46.21	2	282
Enlisted	398	1.2	229	57.54	229	57.54	0	169
Medical Department	5	.1	3	60.00	3	60.00	0	2
Officers	3	.5	1	33.00	1	33.33	0	2
Enlisted	2	.1	2	100.00	2	100.00	0	0
Pacific:								
Total Army	4,914	1.9	3,033	61.72	2,889	58.79	144	1,881
Officers	1,212	6.2	871	71.86	867	71.53	4	341
Enlisted	3,702	1.5	2,162	5.84	2,022	54.62	140	1,540
Medical Department	128	.6	40	31.25	36	28.13	4	88
Officers	18	.5	2	11.11	2	11.11	0	16
Enlisted	110	.6	38	34.55	34	30.91	4	72
U.S. Army Strategic Air Forces:								
Total Army	361	4.7	268	74.24	267	73.96	1	93
Officers	170	16.4	124	72.94	123	99.19	1	46
Enlisted	191	2.8	144	75.39	144	75.39	0	47
Medical Department	0	0	0	0	0	0	0	0
Officers	0	0	0	0	0	0	0	0
Enlisted	0	0	0	0	0	0	0	0
En route:								
Total Army	141	[5]	1	.71	1	.71	0	140
Officers	2	[5]	0	0	0	0	0	2
Enlisted	139	[5]	1	.72	1	.72	0	138
Medical Department	9	[5]	0	0	0	0	0	9
Officers	0	0	0	0	0	0	0	0
Enlisted	9	[5]	0	0	0	0	0	9
Theater unknown:								
Total Army	2	------	1	50.00	0	0	1	1
Officers	0	------	0	0	0	0	0	0
Enlisted	2	------	1	50.00	0	0	1	1
Medical Department	0	------	0	0	0	0	0	0
Officers	0	------	0	0	0	0	0	0
Enlisted	0	------	0	0	0	0	0	0

[1] For basic data, see footnote 1, table 48.

[2] Persons originally reported as missing in action who have not been classified as killed in action, wounded or injured in action, or captured or interned.

[3] All persons previously reported as missing in action who were no longer presumed to be living and in whose cases a finding of death was made by the Chief of the Casualty Branch, Office of The Adjutant General, pursuant to Section 5 of Public Law 490, 77th Congress, 7 March 1942, as amended. Findings of death were made upon or subsequent to 12 months in a missing-in-action status and were withheld so long as the person was presumed to be living.

[4] Rate per 1,000 of median strength.

[5] Information not readily available.

The battle-casualty rates for individual officer groups of the Medical Department were: Medical Corps, 5.2; Dental Corps, 2.2; Veterinary Corps, 1.3; Sanitary Corps, 0.3; Pharmacy Corps, 0; Medical Administrative Corps, 3.5; Army Nurse Corps, 1.0; Dietitians, 0; Physicial Therapists, 0.

Location in rear areas not only reduced the dangers of combat but the likelihood of diseases and injuries that were more prevalent at the front than elsewhere—for example, malaria and cold injury. Little information is available on the incidence of noncombat injury in the Medical Department, but figures for nonbattle deaths amply bear out this statement (table 52). On the other hand, the Medical Department contained a higher than average proportion of women, limited-service troops, and persons of a high age level, many of whom had waived disabilities, all factors that tended to raise the rate of loss through hospitalization or discharge.

Types of Permanent Loss

Permanent losses of the Army comprised not only persons who were formally relieved from active service but those who, though nominally still in service, were absent from their duties because they were hospitalized, imprisoned for misconduct, captured by the enemy, missing in action, absent without leave, or had deserted. The total numbers of Medical Department personnel who were captured and missing in action have been determined (tables 50 and 51), but how many in either group were restored to the service before the end of hostilities is unknown. No figures are available for those who were permanently hospitalized, imprisoned as deserters, or absent without leave, but it is known that a very considerable number of persons hospitalized remained under treatment until the end of the war.

TABLE 52.—*Nonbattle deaths in the Medical Department:* [1] *Actual, 7 December 1941–31 December 1946; estimated, 7 December 1941–30 September 1945*

Group	Strength		All nonbattle deaths			Accidental deaths						Died of disease			Other causes		
						All accidental deaths				Aircraft							
				Adjusted [5]			Adjusted [5]			Adjusted [5]			Adjusted [5]			Adjusted [5]	
	Median 7 December 1941–30 September 1945 [2]	Number of months of exposure [3]	Total [4]	Number	Rate [6]	Total [4]	Number	Rate [6]	Total [4]	Number	Percent of adjusted accidental	Total [4]	Number	Rate [6]	Total [4]	Number	Rate [6]
Total Army:																	
Worldwide	7, 444, 816	46	92, 656	82, 770	2. 9	56, 852	51, 155	1. 8	27, 628	26, 027	51	26, 518	23, 793	0. 8	9, 286	7, 822	0. 3
Overseas	2, 526, 729	46	52, 758	47, 021	4. 9	31, 885	28, 102	2. 9	12, 835	11, 785	42	15, 290	14, 403	1. 5	5, 583	4, 516	. 5
Officers:																	
Worldwide	684, 360	46	20, 950	18, 886	7. 2	17, 199	15, 987	6. 1	14, 940	14, 044	88	2, 831	2, 548	1. 0	920	773	. 3
Overseas	206, 910	46	9, 984	9, 068	11. 4	8, 208	7, 473	9. 4	6, 892	6, 341	85	1, 201	1, 129	1. 4	575	446	. 6
Enlisted:																	
Worldwide	6, 676, 698	46	71, 706	63, 884	2. 5	39, 653	35, 117	1. 4	12, 688	11, 927	34	23, 687	21, 318	. 8	8, 366	7, 027	. 3
Overseas	2, 319, 819	46	42, 774	38, 019	4. 3	23, 667	20, 719	2. 3	5, 943	5, 468	26	14, 089	13, 244	1. 5	5, 008	4, 056	. 5
Medical Department:																	
Worldwide	621, 731	46	3, 692	3, 215	1. 3	1, 552	1, 348	. 6	227	203	15	1, 668	1, 471	. 6	472	396	. 2
Overseas	209, 414	46	1, 920	1, 690	2. 1	977	845	1. 1	175	158	19	714	658	. 8	229	187	. 2
Officers:																	
Worldwide	110, 563	46	854	715	1. 7	325	276	. 7	142	123	45	425	352	. 8	104	87	. 2
Overseas	37, 587	46	365	310	1. 1	201	173	. 6	99	88	51	123	102	. 4	41	35	. 2
Medical Corps:																	
Worldwide	40, 983	46	463	400	2. 5	161	145	. 9	78	67	46	241	204	1. 3	61	51	. 3
Overseas	14, 920	46	193	168	2. 9	94	84	1. 5	50	43	51	71	60	1. 0	28	24	. 4

See footnotes at end of table.

TABLE 52.—*Nonbattle deaths in the Medical Department:*[1] *Actual, 7 December 1941–31 December 1946; estimated, 7 December 1941–30 September 1945*—Continued

Group	Strength		All nonbattle deaths			Accidental deaths						Died of disease			Other causes		
						All accidental deaths				Aircraft							
				Adjusted [5]			Adjusted [5]			Adjusted [5]			Adjusted [5]			Adjusted [5]	
	Median 7 December 1941–30 September 1945 [2]	Number of months of exposure [3]	Total [4]	Number	Rate [6]	Total [4]	Number	Rate [6]	Total [4]	Number	Percent of adjusted accidental	Total [4]	Number	Rate [6]	Total [4]	Number	Rate [6]
Medical Department—Con.																	
Officers—Continued																	
Dental Corps:																	
Worldwide	13,776	46	91	77	1.5	25	18	0.3	8	6	33	56	49	0.9	10	10	0.2
Overseas	2,929	46	32	27	2.4	13	10	.9	6	5	50	16	14	1.2	3	3	.3
Sanitary Corps:																	
Worldwide	2,178	46	6	5	.6	3	3	.4	2	2	68	3	2	.2	0	0	.0
Overseas	466	46	2	2	1.1	2	2	1.1	1	1	50	0	0	.0	0	0	.0
Veterinary Corps:																	
Worldwide	1,963	46	13	12	1.6	7	7	.9	4	4	57	6	5	.7	0	0	.0
Overseas	405	46	6	6	3.9	4	4	2.6	2	2	50	2	2	1.3	0	0	.0
Medical Administrative Corps:																	
Worldwide	14,385	46	76	59	1.1	27	20	.4	4	3	15	36	31	.6	13	8	.1
Overseas	3,334	46	29	23	1.8	13	10	.8	2	2	20	12	10	.8	4	3	.2
Army Nurse Corps:																	
Worldwide	35,381	46	199	159	1.2	98	81	.6	45	41	51	81	60	.4	20	18	.1
Overseas	15,081	46	101	82	1.4	73	61	1.1	38	35	57	22	16	.3	6	5	.1
Physical Therapists:																	
Worldwide	783	30	5	3	1.9	3	2	1.0	0	0	0	2	1	.5	0	0	.0
Overseas	371	30	2	2	2.2	2	2	2.2	0	0	0	0	0	.0	0	0	.0

Enlisted:																	
Worldwide	511, 061	46	2, 838	2, 500	1. 3	1, 227	1, 072	. 5	85	80	8	1, 243	1, 119	. 6	368	309	. 2
Overseas	171, 828	46	1, 555	1, 380	2. 1	776	672	1. 0	76	70	10	591	556	. 8	188	152	. 2

[1] Basic data, unless otherwise specified, from "All Army Deaths by Duty Branch and Type of Deaths: 7 December 1941-31 December 1946," in Department of the Army, "Army Battle Casualties and Nonbattle Deaths in World War II. Final Report 7 December 1941-31 December 1946," pp. 112, 114. Hospital dietitians incurred but one nonbattle death. This occurred in the Zone of Interior and was caused by an aircraft accident.

[2] For the means of determining median strength, see table 48, footnote 2. Worldwide and oversea strength of the Army at large and the Medical Department based on data in table 31. Worldwide and oversea strength of Army officers at large determined from data in table 45, plus WAAC officers as shown in "Strength of the Army." Worldwide strength of Army enlisted men at large derived from data in table 56, plus WAAC and WAC enlisted personnel as reported in "Strength of the Army." Medical Department officer and enlisted strength, worldwide and overseas, based on strengths shown in tables 45 and 56.

[3] Determined according to criteria stated in table 48, footnote 2.

[4] Number of cases between 7 December 1941 and 31 December 1946.

[5] Deaths from 7 December 1941 to 30 September 1945. Data are from basic source in the following instances: Total Army, worldwide and overseas for all types of deaths; total Army officers; total Army enlisted; Army Nurse Corps; and physical therapists, all worldwide, for the entire number of nonbattle deaths. In all other cases, the figures are estimates. In the case of Medical Department officer groups, the number in each worldwide category has been attained by subtracting from the number of deaths reported in such category in the basic source the number of deaths shown for the corresponding category during the period 1 October 1945-31 December 1946 in monthly reports both current and supplementary (OTM 53 and OTM 55) on file in the Statistics Section, Statistical and Accounting Branch, Office of The Adjutant General. For the oversea categories, the numbers shown in the basic source have been reduced by a percentage equal to the corresponding worldwide percentage as determined by the procedure just described. This results in a very conservative estimate of the number of deaths prior to 30 September 1945 since the reduction of oversea strength of Medical Department officers between that date and the end of 1946 was much more rapid than the worldwide reduction of the same group. However, knowledge available in the Office of The Surgeon General has been used to some extent in determining oversea deaths in the Veterinary Corps and among physical therapists. The total number of nonbattle deaths among Medical Department officers (and the number in the Medical Department as a whole) to 30 September 1945 must be increased by one, which occurred among the Hospital Dietitians in the Zone of Interior as a result of an aircraft accident. (Data from basic source.) In the case of Medical Department enlisted men, the estimates of worldwide losses between 7 December 1941 and 30 September 1945 have been attained by reducing the numbers reported in each category in the basic source by the percentage that losses in the same categories among all Army personnel from 1 October 1945 to 31 December 1946 constitute in relation to corresponding losses between 7 December 1941 and 31 December 1946 as shown in this table. Oversea losses have been estimated by using the equivalent oversea data. To estimate the nonbattle deaths of officers and enlisted men in the Army at large prior to 1 October 1945, the same procedures were utilized. However, while all adjustments pertaining to the Medical Department have been made consistent with the data from the basic source, this procedure has not been followed in the present cases. Nevertheless, no marked variation in rates shown would follow if the procedure were used. The total number of estimated officer nonbattle deaths is 19,308—or 7.4 per 1,000 per annum. The equivalent for enlisted men is 63,462 or 2.5 per 1,000 per annum.

[6] Annual rate per 1,000 of median strength.

Deaths

In the Medical Department, the death rate from enemy action was a little more than one-fourth that in the Army as a whole, although there was a great variation in rate among the several Medical Department components (table 53).

TABLE 53.—*Deaths from enemy action: Medical Department and Army as a whole, 7 December 1941–30 September 1945* [1]

Group	Battle deaths [2]		Killed in action	
	Number	Rate	Number	Rate
Army	225, 618	7. 9	189, 696	6. 7
Officers	35, 340	13. 5	30, 157	11. 5
Enlisted personnel	190, 278	7. 4	159, 539	6. 2
Medical Department	4, 665	2. 0	3, 690	1. 6
Officers	293	. 7	196	. 5
Medical Corps	203	1. 3	129	. 8
Dental Corps	25	. 5	18	. 3
Veterinary Corps	4	. 05	1	. 01
Sanitary Corps	0	0	0	0
Pharmacy Corps	0	0	0	0
Medical Administrative Corps	45	. 8	34	. 6
Army Nurse Corps	16	. 1	14	. 1
Dietitians	0	0	0	0
Physical Therapists	0	0	0	0
Enlisted personnel	4, 372	2. 2	3, 494	1. 8

[1] Basic data on deaths are in tables 50 and 52.

[2] Comprises killed in action, died of wounds and injury, died of wounds while in captivity, and missing in action and declared dead.

Returns to civilian life

The basic reasons for returns to civil life were physical and mental disabilities, the attainment of a certain age, inefficiency or misconduct, hardship and civilian needs, and demobilization in its early stages. Statistics on these causes for the entire war period are available only in the case of male Medical Department officers. A breakdown so far as enlisted men are concerned is available only for the period October 1943–June 1945 (tables 54, 55, 56, and 57).

TABLE 54.—*Returns to civil life: Officers of the Medical Department and of the Army as a whole, 7 December 1941–30 September 1945*

Group	Median strength [1]	Returns	
		Number [2]	Rate [3]
All Officers:			
Army	684, 360	89, 510	33. 8
Medical Department	110, 563	16, 887	40. 1
Male officers:			
Army	641, 188	78, 711	31. 6
Medical Department	73, 602	7, 288	25. 8
Medical Corps	40, 983	4, 060	25. 8
Dental Corps	13, 776	2, 280	43. 2
Veterinary Corps	1, 963	155	20. 6
Medical Administrative Corps	14, 385	655	11. 9
Sanitary Corps and Pharmacy Corps	2, 236	138	16. 1
Female officers:			
WAAC and WAC officers only	5, 754	1, 200	65. 9
Medical Department:			
Army Nurse Corps	35, 381	9, 358	69. 0
Dietitians and Physical Therapists	2, 066	241	46. 7

[1] From table 52 for all officers, Army and Medical Department, as well as for Medical, Dental, Veterinary, Medical Administrative, and Army Nurse Corps, individually. All other median strengths were computed on the basis of the dates used in computing the median strengths of the groups already mentioned. Strength data constituting the course for the determination of the median strengths of the combined male Medical Department personnel, the combined Sanitary and Pharmacy Corps, and the combined Dietitians and Physical Therapists are in table 1. Corresponding data for WAAC and WAC and all Army male officers appear in "Strength of the Army," 1 Jan. 1947.

[2] Basic data for the Medical Department are from table 55; for the nurses, dietitians, physical therapists, and the Army in general, from "Strength of the Army," 1 Oct. 1950. Basic data in this issue of "Strength of the Army" may be more complete than that in table 55; hence, the figures for male Medical Department officers may be somewhat higher than those shown here.

[3] Per 1,000 per annum of median strength.

Physical and mental disability.—The rates of discharge of Medical Department personnel for physical and mental disability were frequently high in comparison with those of the Army as a whole, particularly in the case of officers. The rate for male officers in general was 11.1. The higher rates of discharge were concentrated almost entirely in the Medical and Dental Corps; the Medical Administrative Corps and the combined Sanitary and Pharmacy Corps had rates well below those of male officers in the Army at large (tables 55 and 58).

It will be noted that in the latter part of 1943 the rate of discharge for medical and dental officers was particularly high despite the fact that at that time the regulations authorizing release on physical grounds were less lenient for them than for other Army officers: In July of that year, the General Staff authorized the release of line officers qualified only for limited service, but specifically excepted doctors and dentists from the terms of its directive.[38]

Late in 1943, the rate at which male Medical Department officers of all corps were being granted discharges for physical reasons caused an investigation. At that time, the Assistant Chief of Staff, G–1 (personnel) of the War Department General Staff, called the attention of Army Service Forces headquarters to the fact that in September 1943 the rate of discharge for Medical Department officers on grounds of physical disqualification was almost four times that for the rest of the Army. It was intimated that more careful scrutiny of doctors under consideration for discharge on those grounds might lead to their retention in a limited-service capacity.[39]

At the request of Army Service Forces headquarters, The Surgeon General appointed a board of officers to investigate the matter. The board reported that a careful review of the 143 separations for physical causes in September 1943 showed the action of retiring boards to be justified in 84 percent of the cases and unjustified in the remaining 16 percent. With regard to the latter groups, the board emphasized that, in the review, professional judgment rather than rigid interpretation of existing regulations was used to evaluate the officers' status. In the group of 123 whose separation appeared justified, 49 were retired because of defects which had existed prior to appointment. It was evident, the board declared, that none of the 49 should have been commissioned. "The chief apparent explanation of the acceptance of doctors who later had to be separated from the service lay in the fact that the urgent need for medical officers made it necessary frequently to commission individuals who did not meet the strict physical requirements of Army regulations." [40]

---

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

[39] Memorandum, Maj. Gen. Miller G. White, G–1, for Director of Personnel, Army Service Forces, 12 Oct. 1943, subject: Medical Department Officer Separations.

[40] The board did not mention that examining officers may not always have been familiar enough with the physical standards required for commissions. This was very likely the case with at least some members of the Medical Officer Recruiting Boards, which lacked centralized direction but which had brought in large numbers of officers in 1942.

TABLE 55.—*Returns of male Medical Department officers to civilian life, December 1941–September 1945*[1]

Component	Mean strength[2]	Total returns	Physical disqualifications	Over 38, no suitable assignment	Hardship	Key man in industry and Government	Reclassification[3]	Dishonorable discharge[4]	Others[5]
All male Medical Department officers:									
7 December 1941–30 June 1943	39, 510	1, 311	1, 020		4	7	12	4	264
July–December 1943	70, 737	1, 001	861		2	7	25	8	98
January–June 1944	76, 720	720	509	31	2	1	32	13	132
July–December 1944	80, 241	1, 007	635	179	7	4	22	8	152
January–June 1945	84, 908	2, 196	1, 504	391	35	5	24	14	223
July–September 1945	85, 557	1, 053	627	86	42	20	5	10	263
Total		7, 288	5, 156	687	92	44	120	57	1, 132
Medical Corps:									
7 December 1941–30 June 1943	25, 532	949	755		4	4	7	2	177
July–December 1943	39, 638	703	618		2	3	7	3	70
January–June 1944	42, 960	413	312	1	1	1	10	7	81
July–December 1944	45, 217	388	261	12	5	3	10	5	92
January–June 1945	46, 824	952	723	29	27	2	11	7	153
July–September 1945	46, 930	655	416	10	28	11	2	3	185
Total		4, 060	3, 085	52	67	24	47	27	758
Dental Corps:									
7 December 1941–30 June 1943	7, 135	247	195			2	1		49
July–December 1943	13, 462	199	173				9	4	13
January–June 1944	14, 685	161	130	8	1		7	1	14
July–December 1944	15, 075	424	280	113	1		6		24
January–June 1945	14, 813	1, 000	618	333	8	1	5	2	33
July–September 1945	14, 253	249	145	67	11	1	1	1	23
Total		2, 280	1, 541	521	21	4	29	8	156

See footnotes at end of table.

TABLE 55.—*Returns of male Medical Department officers to civilian life, December 1941–September 1945*[1]—Continued

Component	Mean strength [2]	Total returns	Physical disqualifications	Over 38, no suitable assignment	Hardship	Keyman in industry and Government	Reclassification [3]	Dishonorable discharge [4]	Others [5]
Veterinary Corps:									
7 December 1941–30 June 1943	1, 241	33	20			1	2		10
July–December 1943	1, 929	17	12			3		1	1
January–June 1944	1, 995	28	20	4			1		3
July–December 1944	2, 025	27	11	9	1		2		4
January–June 1945	2, 044	39	24	8			1		6
July–September 1945	2, 053	11	3	1			1		6
Total		155	90	22	1	4	7	1	30
Medical Administrative Corps:									
7 December 1941–30 June 1943	4, 724	67	39				2	2	24
July–December 1943	13, 626	71	48			1	8		14
January–June 1944	14, 947	100	41	11			11	5	32
July–December 1944	15, 468	127	70	23			3	3	28
January–June 1945	18, 640	172	118	13		1	7	5	28
July–September 1945	19, 767	118	50	5	2	7	1	6	47
Total		655	366	52	2	9	32	21	173

Sanitary and Pharmacy Corps:									
7 December 1941–30 June 1943	878	15	11						4
July–December 1943	2, 082	11	10				1		
January–June 1944	2, 133	18	6	7			3		2
July–December 1944	2, 456	41	13	22		1	1		4
January–June 1945	2, 587	33	21	8		1			3
July–September 1945	2, 554	20	13	3	1	1			2
Total		138	74	40	1	3	5		15

[1] From records on file in Personnel Statistics Unit, Statistics Section, Statistical and Accounting Branch, Office of The Adjutant General.

[2] Average of monthly mean strength within the periods shown, obtained by averaging the strength at the end of the month with the strength at the end of the preceding month, both as stated in table 1.

[3] Includes the following categories shown in the sources: Reclassification, honorable; reclassification, other than honorable; and reclassification, honorable or other than honorable. "Other than honorable" probably includes dishonorable discharges.

[4] Additional to those that may be included under "reclassification" and categories covered by "other."

[5] Contains the following separations: 7 December 1941–30 September 1945 as shown in the sources: Medical Corps: retirement, 129; overage, 26; honorable discharge, 53; less than 6 months' service (honorable discharge under AR 605–10), 1; less than 6 months' service (other than honorable discharge, under AR 605–10), 3; resignation, 223; conditions other than honorable, 75; expiration of tour, 6; confidential instruction, 2; convenience of Government, 1; Reserve appointment expired (not reappointed), 2; declination or cancellation of appointment, 2; to enter U.S. Military Academy, 32; by action of service commander (specific cause not reported), 1; unsatisfactory service, 6; necessary to national and community health, 75; relief of retired officer at own request, 70; demobilization under RR 1–5, 49; Dental Corps: retirement, 16; overage, 4; honorable discharge, 5; resignation, 74; conditions other than honorable, 29; confidential instructions, 1; Reserve appointment expired (not reappointed), 1; to enter U.S. Military Academy, 5; by action of service commander (specific cause not reported), 1; unsatisfactory service, 2; necessary to national and community health, 1; relief of retired officer at own request, 10; demobilization under RR 1-5, 6; Veterinary Corps: retirement, 11; overage, 2; resignations, 8; conditions other than honorable, 3; expiration of tour, 1; to enter U.S. Military Academy, 2; relief of retired officer at own request, 3; Medical Administrative Corps: retirement, 2; overage, 2; honorable discharge, 3; less than 6 months' service (other than honorable discharge under AR 605–10), 4; resignation, 90; conditions other than honorable, 21; convenience of Government, 1; necessary to national and community health, 3; relief of retired officer at own request, 8; demobilization under RR 1–5, 30; surplus under Circular No. 290, 1; Sanitary and Pharmacy Corps: retirement, 1; overage, 1; resignation, 7; conditions other than honorable, 3; less than 6 months' service (other than honorable discharge under AR 605–10), 1; relief of retired officer at own request, 1; demobilization under RR 1-5, 1.

TABLE 56.—*Returns of Medical Department enlisted men to civilian life, October 1943–June 1945*[1]

Date[2]	Mean strength[3]	Total releases	Honorable discharges					Transfer to inactive status	Discharges other than honorable
			Physical and mental disqualifications[4]	Overage	Retired[5]	Demobilization	Miscellaneous		
1943									
October–December	510,282	15,586	13,662	136	369	----------	466	[6] 295	658
1944									
January–June	527,048	12,135	8,371	44	678	----------	1,522	578	942
July–December	558,469	25,103	16,857	9	72	----------	7,136	412	617
1945									
January–June	532,729	19,787	11,051	1,980	69	4,942	917	345	483
Total		72,611	49,941	2,169	1,188	4,942	10,041	1,630	2,700

[1] All data from Monthly Progress Reports, Army Service Forces, War Department, November 1943 to July 1945, inclusive, Section 5: Personnel.

[2] Dates are the periods in which processing of the pertinent papers by the Office of the Adjutant General was completed.

[3] Average of monthly mean strength within the periods shown, obtained by averaging the strength at the end of the month with the strength at the end of the preceding month, both as stated in table 1.

[4] Includes releases for inaptitude.

[5] From November 1943 through June 1944 also includes "dropped held for unterminated enlistment" and "dropped from the rolls resulting from AWOL." After June 1944, "dropped held for unterminated enlistment" are included in miscellaneous; "dropped from the rolls resulting from AWOL" are not included at all. Data, which cover the Army as a whole but not the Medical Department specifically, show that during the period when "dropped" were grouped with retired, the retired were only 7.5 percent of the combined categories. (The percentage is determined by comparing the combined figures in the contemporary reports with a revision, published in Monthly Progress Report, Army Service Forces, War Department, December 1944, showing retirements alone.)

[6] November and December only. Transfers to inactive status in October are included in "miscellaneous."

TABLE 57.—*Returns to civil life: Enlisted men of the Medical Department and of the Army as a whole, October 1943–June 1945*

Date	Army[1]		Medical Department	
	Number	Rate	Number	Rate
October–December 1943	195,128	117.1	15,586	123.6
January–June 1944	173,128	50.0	12,135	46.1
July–December 1944	262,902	73.1	25,103	89.9
January–June 1945	288,803	80.0	19,787	74.3

[1] Revised figures exist for the Army, indicating that some revision of the Medical Department figures is also needed The revised Army figures (from "Strength of the Army," 1 Jan. 1950) are as follows: October–December 1943, 190,187 (rate, 114.2); January–June 1944, 159,853 (rate, 46.0); July–December 1944, 262,958 (rate, 73.1); January–June 1945, 340,920 (rate, 94.5). The Army and Medical Department figures in the text are contemporaneous, both being drawn from data in the Monthly Progress Reports, Army Service Forces, for the periods shown. The same data for the Medical Department appear in table 56, where the mean strengths of medical enlisted personnel are shown. The mean strengths of Army male enlisted personnel were: October–December 1943, 6,664,339; January–June 1944, 6,949,670; July–December 1944, 7,193,678; January–June 1945, 7,217,133. Mean strengths are the average of the monthly means for the periods covered. Monthly means are the average of end-of-month strength of the particular month and the strength at the end of the preceding month as shown in "Strength of the Army," 1 Oct. 1945.

TABLE 58.—*Rates of discharge for mental and physical disability: Male officers of the Medical Department and of the Army as a whole, December 1941–September 1945* [1]

Date	All officers (male)	Total Medical Department officers (male)	Medical Corps	Dental Corps	Veterinary Corps	Sanitary Corps and Pharmacy Corps	Medical Administrative Corps
December 1941–June 1943	7. 6	16. 3	18. 7	17. 3	10. 2	7. 9	5. 2
July–December 1943	11. 3	24. 3	31. 2	25. 7	12. 4	9. 6	7. 1
January–June 1944	10. 9	13. 3	14. 5	17. 7	20. 1	5. 6	5. 5
July–December 1944	14. 3	15. 8	11. 5	37. 2	10. 9	10. 6	9. 1
January–June 1945	17. 5	35. 4	30. 9	83. 4	23. 5	16. 2	12. 7
July–September 1945	22. 4	29. 3	35. 5	40. 7	5. 8	20. 4	10. 1

[1] Basic data on disqualifications of all male officers are from "Strength of the Army," 1 Oct. 1950; of Medical Department officers, from table 55. Mean strengths for male officers in general, including warrant and flight officers, were computed from monthly means of end-of-month strengths shown in "Strength of the Army," 1 Jan. 1947. These mean strengths are as follows: December 1941–June 1943, 286,887: July–December 1943, 602,393; January–June 1944, 668,487; July–December 1944, 708,695; January–June 1945, 811,693; July–September 1945, 831,028. For mean strengths of male Medical Department officers, see table 55.

The board report also stated that "the racial distribution of medical officers separated by reason of physical disability may be significant," but it did not explain this statement further. Although admitting it was conceivable that professional relations between members of a disposition board and the officer whose record was under review could have been a factor in the high rate of Medical Department officer separation, the board considered this "highly improbable."

The board also suggested that the high discharge rate of Medical Department officers in general was attributable partly to the fact that they were older, on the average, than other officers. A report on Medical Department officers retired in September, October, and November 1943 added the following points: [41]

There is a relative excess of Medical Corps officers among the Medical Department officers retired.

There is a relative excess of 1st lieutenants in the group * * *.

The average period served by retired Medical Department officers was approximately 14 months.

In nearly 90 percent of cases the disability leading to retirement was judged not contracted in line of duty.

The types of disability leading to retirement and their incidences were similar to those in the retirement of non-Medical Department officers.

The rate of discharge of Medical Corps officers for physical disability was markedly lower in the first half of 1944 than it had been previously. Possible reasons for the decline may have been the influx into the corps of younger men of greater stamina from the medical schools, the elimination

[41] Reports, Brig. Gen. Hugh J. Morgan, Office of The Surgeon General, 15 Nov. 1943 and 31 Dec. 1943.

earlier of some officers who might otherwise have been discharged during this period, and perhaps also a less liberal attitude on the part of reviewing boards in consequence of criticism. The rate of discharge of dental officers declined at the same time, though not so sharply as that of doctors, and in the last half of 1944, it leaped upward while the rate for doctors continued to decline. The policy of discharging dentists to avoid a surplus had been inaugurated as early as April 1944, and in the same month, the authorization to discharge limited-service officers had been extended, under certain conditions, to dentists.

The upward trend in discharges for disability during 1945 among male officers throughout the Army no doubt represented, in part, the effect of physical deterioration as the war was prolonged. The fact that the rate was so much higher in the Medical Department than in the Army as a whole probably reflects the higher age level of the group, as well as its larger proportion of men who had waived disability in entering the Army.

So far as enlisted men were concerned, the disability-discharge rate from October 1943 until June 1945 was not greatly different in the Medical Department from what it was in the Army as a whole (table 59).

Physical and mental disability caused most of the separations of male Medical Department officers from service during the war period. The same is true of separations of Medical Department enlisted men during the period from October 1943 to June 1945; in this case, physical and mental disability caused two-thirds of the discharges (table 56).

Data on discharges resulting from this cause exist for all three women's officer components of the Medical Department for the period 1 September 1944–30 June 1945 and also for the following 3 months. One cause of the great disparity between these two periods in the rates of discharge is the fact that during the first period the reporting was very incomplete. Since pregnancy caused the great majority of disability discharges, the rates for that cause are shown separately in table 60.

TABLE 59.—*Disability-discharge rate: Enlisted men of the Medical Department and of the Army as a whole, October 1943–June 1945*

Date	Rate	
	Army [1]	Medical Department
October–December 1943	107. 1	100. 6
January–June 1944	36. 4	31. 8
July–December 1944	60. 2	60. 4
January–June 1945	41. 2	41. 5

[1] Basic data on Army discharges are from Monthly Progress Reports, Army Service Forces; on Medical Department discharges, from table 53. For mean strengths of Army enlisted men, see footnote to table 54. For mean strengths of Medical Department enlisted men, see table 55. Revised figures for medical discharges of enlisted men of the Army as a whole are given in "Strength of the Army," 1 Oct. 1950, as follows: October–December 1943, 167,148 (rate, 100.3); January–June 1944, 120,570 (rate, 36.4); July–December 1944, 262,958 (rate, 60.2); January–July 1945, 162,022 (rate, 44.9).

TABLE 60.—*Discharges for disability: Army Nurse Corps, Dietitians, and Physical Therapists, 1 September 1944–30 September 1945* [1]

Female officers	1 Sept. 1944–30 June 1945				1 July 1945–30 Sept. 1945			
	Total discharges for disability [2]		Pregnancy discharges		Total discharges for disability [2]		Pregnancy discharges	
	Number	Rate [3]	Number	Rate [3]	Number	Rate [3]	Number	Rate [3]
Army Nurse Corps	318	8. 2	269	7. 1	690	50. 1	615	44. 7
Dietitians	8	6. 6	6	4. 9	17	43. 3	14	35. 5
Physical Therapists	5	5. 8	4	4. 7	9	22. 9	8	20. 4

[1] Basic data are from records in Statistical and Accounting Branch, Statistical Section, Personnel Statistics Unit, Office of The Adjutant General.

[2] Includes pregnancy discharges.

[3] Annual rate per 1,000 of mean strength for the period shown. Mean strengths are the average of monthly mean strengths computed by averaging the end-of-month strength for a particular month with the strength at the end of the preceding month, both as shown in table 1. The mean strengths are as follows: September 1944–June 1945—Army Nurse Corps, 45,560; Dietitians, 1,465; Physical Therapists, 1,030; July–September 1945—Army Nurse Corps, 55,091; Dietitians, 1,571; Physical Therapists, 1,265.

Attainment of a certain age.—Age alone caused the discharge of very few male officers of the Medical Department. Retirements, which also included retirements for physical disability after 20 years' service, occurred at the rate of 0.56 not materially different from the rate of 0.67 for male Army officers in general.[42] Another basis for the discharge of officers was "overage in grade." Of the very few male Medical Department officers released for this reason, the majority came from the Medical Corps (table 55).

In December 1943, the War Department authorized the discharge of all Army officers 45 years of age and over for whom no suitable assignment existed. A month later the age limit was lowered to 38.[43] At the end of 1944, the age limit for discharges on this ground was removed, but it was indicated that persons over 38 would be given more consideration than others.[44] Actually, the great majority discharged afterward under this rule were over 38. In the approximately 21 months of war during which the rule was in operation, more male Medical Department officers were released through its workings than were discharged throughout the war for any other reason except physical and mental disability, and more than 80 percent of those so

[42] Basic data for Medical Department are from table 55, and for Army from "Strength of the Army," 1 Oct. 1950. Data for the Medical Department are not so complete as for the Army at large. If the figures were complete, the Medical Department rate would probably equal or exceed the Army rate. For median strengths, see table 54. Here and in subsequent references, rates are figured on the basis of number per annum per 1,000 median strength for the period of December 1941 to 30 September 1945.

[43] Letters, The Adjutant General, to Divisions of War Department General Staff, 8 Dec. 1943 and 12 Jan. 1944, subject: Relief From Active Duty of Officers for Whom No Suitable Assignment Exists.

[44] War Department Circular No. 485, 29 Dec. 1944.

released were members of the Dental Corps. The rates for the various corps were as follows:

Medical Department male officers	2.44
Medical Corps	.33
Dental Corps	9.87
Veterinary Corps	.29
Sanitary Corps and Pharmacy Corps	.47
Medical Administrative Corps	.97

Nevertheless, the Medical Department rate for most of this period was much lower than that for male officers of the Army at large. Thus, the Medical Department rate for January–June 1944 was 0.8; the Army rate, 9.2; for July–December 1944, the rates were 4.5 and 11.5; and for January–June 1945, 9.2 and 8.0.

The return of enlisted men to civilian life for reasons involving age included retirements. Comparative figures on retirements are available only for the year 1 July 1944–30 June 1945. They show a slightly higher rate for the Medical Department 0.3) than for the Army as a whole (0.2) (table 56).

Beginning in December 1942, the Army permitted the release of enlisted men over 38 years old who were less useful to the Army than to industry and who could show that a job was waiting for them in an essential war industry. Under this rule, men were discharged outright, but at least as early as 1943 they could be transferred to the Enlisted Reserve Corps,[45] although some continued to be discharged. Then, in April and May 1945, when the war in Europe was ending, successive directives[46] permitted the discharge of enlisted personnel, at first over 42 years of age and then over 40, almost without restriction. Figures for the Army at large show heavy discharges in the age category for the months following December 1942, and then a decline. In the last few months of 1943, when comparative figures for the Medical Department first became available, the rates for the Army and the Medical Department were on the way to becoming insignificant until they shot upward during the period when the directives of April and May 1945 took effect. Comparative rates for October–December 1943 were: Medical Department 1.07, Army 0.23; for January–June 1944, Medical Department 0.16, Army 0.14; for July–December 1944, Medical Department 0.03, Army 0.04; and for January–June 1945, Medical Department 7.43, Army 7.08.

Meanwhile, the rates of transfer to the Enlisted Reserve Corps, at first much higher than the rate of discharges, descended without a break. In this case, the comparative rates for November–December 1943 were: Medical Department 3.5, Army 5.0; for January–June 1944, Medical Department 2.2, Army 2.4; for July–December 1944, Medical Department 1.5, Army 1.2; and

[45] (1) War Department Circular No. 397, 7 Dec. 1942. (2) War Department Circular No. 92, 3 Apr. 1943.

[46] (1) War Department Circular No. 125, 25 Apr. 1945. (2) War Department Circular No. 151, 23 May 1945.

for January–June 1945, Medical Department 1.3, Army 1.4.[47] The majority were transferred for reasons of age. Among the minority transferred for other reasons, probably most returned to active duty before the end of hostilities.

Inefficiency and misconduct.—Among male officers of the Medical Department, 324 were discharged specifically for inefficiency and misconduct during the course of the war (table 55). Of these, 120 were separated from the service through the action of reclassification boards. Another eight were discharged for unsatisfactory service, presumably without such proceedings. Of the remainder, 139 were given discharges without honor and 57 received dishonorable discharges; as already noted, these are to be understood as separations in addition to those resulting from action by reclassification boards, although the latter could recommend any type of discharge—honorable, dishonorable, or without honor. These boards, which existed throughout the Army, could propose (among other things) the separation of officers brought before them on allegations of inefficiency, misconduct, or undesirable habits and traits of character. The person involved might be returned to his command for trial by court martial. A board was to recommend honorable discharge if it found the officer to be merely incompetent; it could recommend a dishonorable discharge or one without honor in case of misconduct or undesirable habits or traits.[48]

For both officers and enlisted men, the rates of discharge for misconduct in the Medical Department were lower than those for the Army as a whole, reflecting, in part, a greater degree of professionalism and a higher age and maturity level; in part, the psychological effect of feeling that they were saving rather than taking lives. Another important factor was the fact that Medical Department personnel were less subject to the hazards and strains of combat.

Hardship and civilian needs.—Very few male Medical Department officers were separated from the service because of "undue hardship" to themselves or their families, the pertinent annual rate being only 0.3 per 1,000. Somewhat more were discharged on the score of their importance to the Government or the community in a civilian capacity. Provision was made for releasing individuals who were "keymen in industry and Government" or who were essential to "the national health, safety, or interest." Both provisions applied to enlisted personnel as well as officers. Only 19 male officers of the Medical Department were released under them up to the end of 1944. Well before that time, the Procurement and Assignment Service had advocated releasing physicians who came from communities where there was a shortage, but this plan failed to obtain tangible results. After a conference in January 1945 between representatives of the Army and the Procurement and Assignment Service, the Army announced its new policy: Medical officers over 39

[47] Basic data for the Army are from Monthly Progress Reports, Army Service Forces; for the Medical Department, from table 56.

[48] Army Regulations No. 605–230, 25 Aug. 1941, 24 Dec. 1942, and 9 June 1943.

years of age who were qualified for general service or who were practicing a specialty in the Medical Department, who were deemed "worthy cases" could be discharged. This procedure resulted in virtually no discharges before the end of June 1945, but by 30 September of that year, a total of 75 medical officers and 4 other male Medical Department officers had been discharged under the "National and community health" provision. By the same date, 44 male Medical Department officers, mostly members of the Medical and Medical Administrative Corps, had obtained release as "keymen." These factors produced an annual rate of loss among male Medical Department officers amounting to 0.5 per 1,000. The number of enlisted men discharged for the same reasons is not available.

Demobilization.—Among the permanent losses of the Medical Department during the war must be counted that group of personnel discharged in accordance with established demobilization procedures, limited as they were, between May 1945, when these regulations went into effect, and the end of hostilities. The regulations apparently had no effect on the discharges of male Medical Department officers before July 1945, and by the end of September had caused the release of less than 90 officers. For nurses, on the other hand, the demobilization regulations were operative as early as May; up to the end of September, somewhat more than 200 nurses had been discharged under them.[49] The number of Medical Department enlisted men demobilized before the end of the war is available only through June 1945; by that date, it amounted to 4,942 (table 56).

Transfers to other branches of the Army

Transfers of Medical Department personnel to other branches of the Army represented another type of Medical Department loss. Although figures on this point are lacking, transfers of officers from the Medical Department were necessarily less than that of Medical enlisted personnel, the highly specialized training of most of the Department's officers and the fact that a large proportion of them were women made it difficult and inadvisable to transfer them. The majority of those transferred were Medical Administrative Corps officers who were transferred to combat or other service branches of the Army.

Transfer of enlisted men, on the other hand, was considerably more important numerically; the repeated efforts of medical authorities to stop the flow of medically trained enlisted men out of the Department are an indication that the loss was substantial. This was particularly true toward the end of the war when personnel were desperately short. In the Mediterranean theater in November 1944 to February 1945, 25 percent of general-assignment enlisted men in station and general hospitals were replaced by limited-service men.

---

[49] Data on male officers are from table 55; on nurses, from records in Statistical and Accounting Branch, Statistics Section, Personnel Statistics Unit, Office of The Adjutant General.

This impression is confirmed by the experience of the European theater. There the number of enlisted men scheduled to be given up in the latter part of 1944 and in 1945 was in excess of 12,000, and even though by special arrangements the great majority of these eventually were retained in the medical service, more than 4,000 were transferred out of it.[50]

[50] (1) Administrative and Logistical History of Medical Service, Communications Zone, European Theater of Operations. Chapter X. [Official record.] (2) Report, Operations Division, Office of the Chief Surgeon, European Theater of Operations, U.S. Army, 1 Jan.–30 June 1945. (3) Annual Report, Surgeon, Third U.S. Army, 1944.

CHAPTER XII

Rank, Promotion, and Pay

The Surgeon General was keenly aware of the morale factors involved in problems of rank, promotion, and pay. He understood, also, that in such matters he could not hope to win the approval of everybody in the Medical Department. Policies concerning rank and promotion necessarily varied somewhat from corps to corps. The way in which these policies were applied or took effect might also vary to a certain extent from one command to another. Personnel in oversea areas, for example, did not always fare the same in matters of promotion as did their opposite numbers in the Zone of Interior. Pay increased with length of service, and extra compensation came to be given for service overseas. But for the most part, pay followed rank, and promotion therefore was of vital interest to Army personnel not only because of the added prestige but because of the higher pay that went with it.

ZONE OF INTERIOR

Emergency Period

Officers

In the early part of the emergency period, when selective service had not yet been introduced, and even reservists could not be compelled to accept active duty, many physicians resigned from the Reserve, the reason given being the disparity between civilian income and Army pay. It must be assumed, too, that some resigned for other reasons, notably an unwillingness to accept active duty, but gave the insufficiency of pay and allowances as an excuse. Whatever their real reasons, in the year ending on 30 June 1941, 1,937 Medical Corps Reserve officers resigned.[1] No raise in base pay was granted until 1942, and even then only second lieutenants and enlisted personnel received an increase. Since doctors entered the Army as first lieutenants or higher, the increase did not affect them.

The commissioning of men in the Reserve directly from civilian life in the same grade or even higher than that held by members who had belonged to the Reserve for a period of time did not sit very well with the Reserve officers, particularly those on active duty. Men had spent time and effort in the Reserve during peacetime expecting that in an emergency or war they would receive higher recognition than those who were newcomers. The Gen-

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

eral Staff resisted any change in the existing system on the ground that it was protecting the interest of reservists. The Medical Department, therefore, had to point out that there was then a need for more professional specialists than were available from the Reserve or National Guard and as most of those in civilian life had advanced themselves professionally by postgraduate study, in order to obtain their services, it was necessary to offer the inducement of higher rank. The General Staff acquiesced in this line of reasoning so far as to permit a certain number of appointments of the kind desired, but it was not until after Pearl Harbor that a sizable group of civilians was brought in with advanced rank.[2] That these new men were specialists (most of them members of affiliated units) did not lessen the dissatisfaction of other reservists.[3]

It would also appear that promotions came more readily to National Guard officers in Federal service than to medical officers in the Regular Army. Objections to this policy were expressed by Reserve officers, who were being called to active duty without a comparable promotion policy.

Meanwhile, a promotion had been authorized in 1940 for Reserve officers who had been on active duty for a year, but only the relatively small number who had been placed on active duty in 1939 were affected. In August 1941, the Secretary of War listed certain temporary promotions, but again, as with the promotion of 1940, relatively few benefited from this action. The authority covered Reserve officers with at least a year's service ending not later than 1 August 1941, and on the date nearest the beginning of that period for which figures are available (30 August 1940), only 646 Reserve officers of the Medical Department were either on active duty or had had orders requested for them by The Surgeon General. Of these, 450 were in the Medical, 121 in the Dental, 52 in the Veterinary, 17 in the Medical Administrative, and 6 in the Sanitary Corps. By 30 June 1941, however, a month before the authority became effective, 11,477 were on active duty,[4] and undoubtedly, the number was larger by 1 August 1941.

After careful consideration, the Secretary of War on 26 December 1941 directed The Surgeon General to submit a list of not to exceed 360 captains and 1,620 first lieutenants of the Medical Corps, without regard to component, whom The Surgeon General recommended for a temporary, one-grade promotion.[5] On this basis, The Surgeon General recommended and the General Staff approved the promotion of 351 captains and 1,277 first lieutenants.[6]

---

[2] (1) Committee to Study the Medical Department, 1942. (2) Letter, The Surgeon General, to The Adjutant General, 24 Aug. 1940, subject: Appointment in Medical Department Reserve, with 1st endorsement thereto, 9 Sept. 1940.

[3] Letter, Lt. Col. Laurence Mickel, to Executive Officer, Ohio Military Area, 25 Mar. 1941, subject: Medical Reserve Officers.

[4] See footnote 1, p. 451.

[5] Disposition Slip, G–1, to The Surgeon General, 26 Dec. 1941, subject: Promotion of Captains and First Lieutenants of Medical Corps.

[6] Memorandum, Lt. Col. Paul A. Paden, Military Personnel Division, Office of The Surgeon General, for Col. A. G. Love, Director, Historical Division, Office of The Surgeon General, 14 Mar. 1944.

Since by that time new regulations had been issued, conferring on local commanders the right to promote, The Surgeon General suggested that these authorities handle further promotions.

The Surgeon General had not recommended, nor did the Secretary of War grant, the authority to promote officers other than those of the Medical Corps. The advent of war somewhat dulled the edge of the question, but the War Department's new policies after Pearl Harbor did not change the feeling of many physicians, that they were not receiving their due. Nevertheless, this action began a process of removing restrictions on promotion that had had the effect of lowering morale among Medical Corps officers.

Nurses

During the emergency period, Army pay was no greater inducement for Reserve nurses to go on active duty than it was for many doctors. At this time, those in the grade of "nurse," which included the great majority of reservists, were paid only $840 a year plus maintenance. Although nurses who had served 3 or more years on active duty received more, few of those brought on duty beginning in 1940 could have qualified for the higher rates, as there had been little or no opportunity for active duty in the preceding years. The low pay of nurses was emphasized by a War Department plan to use male nurses with noncommissioned rank in theater of operations hospitals during wartime. These men were to be paid substantially more than female nurses were receiving in 1941. The Surgeon General called attention to this inequality, even though no action on the plan was taken.[7]

On 13 June 1941, in answer to a letter of complaint from a nurse on active duty, The Surgeon General stated that he had recommended to the War Department an increase in nurses' pay "on several occasions." [8] The following day, he repeated the recommendation.[9] A representative of the Surgeon General's Office reported that in many Army hospitals "third-rate civilian ward employees" were receiving $85 a month as against the Army nurse's $70.[10] The Superintendent of the Army Nurse Corps believed that personnel requirements could not be met without an increase in pay.[11] But efforts to secure an increase did not succeed until June 1942 when Congress approved an upward revision for all members of the Armed Forces.[12]

---

[7] Letter, The Surgeon General, to Hon. Charles A. Clason, U.S. House of Representatives (Mass.), 23 June 1941.

[8] Letter, The Surgeon General, to 2d Lt. Birdie B. Daigle, ANC, 13 June 1941.

[9] Memorandum, The Surgeon General, for The Adjutant General, 14 June 1941.

[10] Report, Perrin Long, M.D., of Visit to Station Hospital No. 3, Fort Bragg, N.C., 30 Aug. 1941.

[11] Memorandum, Maj. Julia O. Flikke, Superintendent, Army Nurse Corps, for The Surgeon General, 2 Dec. 1941. Cited by Blanchfield, Florence A., and Standlee, Mary W.: Organized Nursing and the Army in Three Wars. [Official record.]

[12] 56 Stat. 359.

Early War Years, 1941–43

Officers

The outbreak of war brought with it a need for temporary promotions in the Army of the United States for all officers, medical and otherwise. Hence, an Army regulation, dated 1 January 1942, one of the basic orders affecting promotion that were issued during the war, suspended most peacetime promotion regulations; advancement was thereafter based on (1) completion of a minimum of 6 months in grade except for second lieutenants, who could be promoted sooner; (2) recommendations from superiors, attesting to the officer's qualifications; and (3) existence of a vacancy in the desired grade. The regulation stipulated that "normally" no officer except a second lieutenant would be recommended for promotion until he had been assigned to a position calling for the higher grade and had actually performed the duties of the higher grade for a period of at least 6 months. This regulation, applying to officers of the Army of the United States, governed temporary promotions only; Regular Army Medical Department officers continued throughout the war to receive their permanent promotions in the Regular Army under conditions laid down in peacetime. As promotion in the Army of the United States was more rapid than in its Regular component, the vast majority of Regular officers held two different grades throughout the war and for some time afterward—a temporary one in the Army of the United States (the higher one) and a permanent one in the Regular Army. They wore the insignia, had the command powers and duties, and drew the pay of the higher grade. National Guard and Reserve officers did not receive permanent promotions in those components during the war.

This January 1942 regulation gave the power to recommend promotions for personnel under their command to the commanding generals of armies, defense commands, corps areas, chiefs of services, and similar major elements of the Army. The Surgeon General thereby lost the power to control promotions of all Medical Department officers except those (relatively few) who were serving in one of the installations under his command.[13] At that time, these included the named general hospitals, the Army Medical Center, the Medical Field Service School, and medical replacement training centers. He later lost command of the medical replacement training centers and the general hospitals, except Walter Reed, which was part of the Army Medical Center. This order was one of the first if not the very first of many that decentralized the control of personnel, taking much of it from The Surgeon General and giving it to the corps area, army, and defense command commanders.[14]

---

[13] A similar measure affecting the promotion of enlisted men deprived The Surgeon General of all power to make such promotions, vesting it in local medical authorities (War Department Circular No. 17, 22 Jan. 1942). A year earlier, his power in that respect had already been limited to promotions in the two highest noncommissioned grades (War Department Circular No. 5, 7 Jan. 1941).

[14] (1) War Department Circular No. 1, 1942. (2) See footnote 6, p. 452.

Meanwhile, in July 1942, Congress raised the limit of rank in the Medical Administrative Corps from that of captain to temporary ranks as high as colonel.[15] During the war, at least one officer of this corps—Edward Reynolds, chief of The Surgeon General's Supply Service—was appointed a brigadier general. Before the law was passed, a few Medical Administrative Corps officers had received temporary promotions to the grade of major, although they were not permitted to draw a major's pay until the passage of the act, which made this pay retroactive to 9 September 1940.

In March 1943, at the suggestion of The Surgeon General, the Deputy Chief of Staff issued an order revising the tables of organization which increased the possibility of promoting members of the Medical and Dental Corps from first lieutenant to captain.[16] This provided an opportunity to promote approximately 8,082 medical and dental lieutenants then authorized; the troop basis for the remainder of 1943 called for an additional 4,065 first lieutenant positions in the two corps which were thereupon changed to captain or first lieutenant positions. The Surgeon General meanwhile had proposed extending the policy to all medical units and detachments. At the same time, he recommended that all first lieutenants of the Medical and Dental Corps be promoted to the rank of captain upon the completion of 6 months' satisfactory service. The Army Service Forces, without rejecting these ideas entirely, postponed consideration of them until promotions had been made under the policy already adopted.[17]

An extension of this policy to all table-of-allotment units[18] took place 2 months later (July 1943).[19] First lieutenants of the Veterinary Corps in table-of-organization units or in table-of-allotment or manning-table organizations were given the same opportunity for promotion later in the war.[20]

The effect of this new policy on table-of-organization units was immediate, but some difficulty seems to have been encountered in installations working under manning tables or tables of allotment since service commands were restricted to certain numbers of officers in each grade, and they hesitated to advance Medical Department officers when such action would prevent promotions desired for qualified officers of other branches of service.[21]

The new policy gave members of the Medical and Dental (and later the Veterinary) Corps a better chance of promotion to the grade of captain than

---

[15] 56 Stat. 663.

[16] Memorandum, Deputy Chief of Staff, for Commanding General, Services of Supply, 10 Mar. 1943, subject: Availability of Physicians.

[17] (1) Memorandum, The Surgeon General, for General Somervell, 22 Apr. 1943. (2) Memorandum, Army Service Forces, for The Surgeon General, 10 May 1943, subject: Promotion for Medical Corps and Dental Corps Officers.

[18] Since all or nearly all units and activities were operating under either a table of organization, a table of allotment, or a manning table, these two orders made all but a negligible percentage of Medical and Dental Corps lieutenants eligible for promotion.

[19] War Department Circular No. 169, 24 July 1943.

[20] Army Regulations No. 605-12, 3 Feb. 1944.

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

that possessed by officers of other corps. But officers in the grade of captain or higher in many table-of-organization units still found themselves blocked from promotion. Whenever the table of organization was filled and all officers had the maximum grade allowed by it, there could be no further promotion without transfer to a new unit in which an opportunity for promotion existed. Transfer could and did solve the problem for some officers. For example, the Chief of Personnel in the Surgeon General's Office was able to arrange a number of promotions for Medical Corps officers, particularly in the grades of lieutenant colonel and colonel by permitting the Surgeon, Army Ground Forces, to suggest commanding officers for new units being activated. By selecting competent and deserving officers whose rank was lower than that called for by the new position, a promotion could be effected. Thus, many able men who came to the Army Ground Forces as division surgeons and organic medical battalion commanders, and were frozen in the grade of lieutenant colonel in consequence, achieved their colonelcies by being named hospital commanders.

Aside from inequalities in the promotion policy so far as it affected individuals, there was a lack of uniformity, if not of equity, in the distribution of rank among the several Medical Department corps (table 61).

The percentage distribution of field grades in the Medical and Veterinary Corps differed markedly from that in the Dental Corps. In each of these three grades (colonel, lieutenant colonel, and major), the Medical and Veterinary Corps had a much higher percentage of officers than the Dental Corps. Possibly, the high percentage of Veterinary Corps officers in field grades is accounted for by their holding a staff position in numerous headquarters. At each headquarters, as one might expect, a Medical Corps officer served as the senior Medical Department representative in that headquarters. Commanders of most Medical Department units and installations were also Medical Corps officers.

The distribution of general officers in the expanding Medical Department was also heavily weighted in favor of the Medical Corps. As of 30 June 1942, The Surgeon General was the only major general in the Department, and the three brigadier generals included the chiefs of the Dental and Veterinary Corps. A year later, there was still only 1 major general, and only the 2 nonmedical brigadier generals, but the number of Medical Corps brigadiers had jumped from 1 to 33. The chief of the Dental Corps won an additional star in September 1943, but by 30 June 1944, there were eight additional Medical Corps major generals and three more brigadier generals, including in the latter category an Assistant Surgeon General of the U.S. Public Health Service. There were thus altogether 47 general officers in the Medical Department as of 30 June 1944, an increase of 43, or more than 1,000 percent in 2 years.[22]

[22] (1) Annual Report, Commissioned and Enlisted Division, Personnel Service, Office of The Surgeon General, U.S. Army, 1942. (2) Annual Report, Military Personnel Division, Personnel Service, Office of The Surgeon General, U.S. Army, 1944.

TABLE 61.—*Rank of Medical Department officers, 1939–45*[1]

Date	Colonel		Lieutenant colonel		Major		Captain		First lieutenant		Second lieutenant	
	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component
30 June 1939[2]												
Total Army:												
Male	793	6. 12	1, 605	12. 38	2, 858	22. 04	4, 094	31. 57	2, 146	16. 55	1, 471	11. 34
Female												
Medical Department:												
Male	126	8. 38	556	36. 97	91	6. 05	502	33. 38	205	13. 63	24	1. 60
Medical Corps	109	9. 96	384	35. 10	68	6. 22	402	36. 75	131	11. 97		
Dental Corps	13	5. 91	99	45. 00	14	6. 36	42	19. 09	52	23. 64		
Veterinary Corps	4	3. 17	73	57. 94	9	7. 14	35	27. 78	5	3. 97		
Medical Administrative Corps							23	35. 94	17	26. 56	24	37. 50
Female												
Army Nurse Corps												
30 November 1941[3]												
Total Army:												
Male	2, 380	1. 98	5, 712	4. 75	9, 680	8. 04	21, 194	17. 61	40, 033	33. 26	41, 373	34. 37
Female					1	. 01	35	. 50	365	5. 18	6, 642	94. 31
Medical Department:												
Male	234	1. 41	712	4. 29	1, 214	7. 31	4, 341	26. 14	9, 611	57. 87	495	2. 98
Medical Corps	183	1. 62	536	4. 73	897	7. 92	2, 910	25. 69	6, 801	60. 04		
Dental Corps	30	. 97	106	3. 42	226	7. 29	872	28. 12	1, 867	60. 21		
Veterinary Corps	20	2. 89	62	8. 95	52	7. 50	153	22. 08	406	58. 59		
Sanitary Corps	1	. 44	8	3. 54	21	9. 29	70	30. 97	126	55. 75		
Medical Administrative Corps					18	1. 43	336	26. 67	411	32. 62	495	39. 29
Female					1	. 01	35	. 50	365	5. 18	6, 642	94. 31
Army Nurse Corps					1	. 01	35	. 50	365	5. 18	6, 642	94. 31

See footnotes at end of list.

TABLE 61.—*Rank of Medical Department officers, 1939–45* [1]—Continued

Date	Colonel		Lieutenant colonel		Major		Captain		First lieutenant		Second lieutenant	
	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component
28 February 1943												
Total Army:												
Male	6,553	1.55	13,895	3.29	31,628	7.49	78,629	18.62	117,068	27.73	174,417	41.31
Female [4]	2	.007	1	.004	9	.03	182	.64	1,528	5.35	26,833	93.97
Medical Department:												
Male	765	1.38	1,803	3.24	6,796	12.22	18,059	32.48	22,765	40.95	5,408	9.73
Medical Corps	603	1.73	1,459	4.18	5,325	15.27	13,903	39.87	13,577	38.94	----	----
Dental Corps	112	1.14	234	2.39	920	9.40	2,442	24.94	6,082	62.12	----	----
Veterinary Corps	48	3.27	59	4.02	223	15.18	414	28.18	725	49.35	----	----
Sanitary Corps	2	.17	26	2.20	116	9.82	357	30.23	680	57.58	----	----
Medical Administrative Corps	0	0	25	.30	212	2.56	943	11.38	1,701	20.52	5,408	65.24
Female	1	.004	1	.004	9	.035	90	.35	1,048	4.02	24,905	95.59
Army Nurse Corps [4]	1	.004	1	.004	7	.027	90	.35	1,048	4.13	24,250	95.48
Physical Therapists [4]	0	0	0	0	1	.48	0	0	0	0	208	99.52
Hospital Dietitians [4]	0	0	0	0	1	.22	0	0	0	0	447	99.78
30 September 1943												
Total Army:												
Male	7,681	1.31	17,569	3.00	42,086	7.20	110,925	18.97	161,625	27.64	244,784	41.87
Female	2	.005	18	.047	75	.2	567	1.48	2,734	7.12	34,997	91.15
Medical Department:												
Male	900	1.28	2,374	3.38	8,648	12.30	26,785	38.09	23,268	33.09	8,350	11.87
Medical Corps	734	1.84	1,967	4.94	6,811	17.11	19,171	48.15	11,130	27.96	----	----
Dental Corps	102	.78	262	2.00	1,049	8.02	4,910	37.56	6,750	51.63	----	----
Veterinary Corps	59	3.18	66	3.56	288	15.53	566	30.53	875	47.20	----	----
Sanitary Corps	4	.20	37	1.84	163	8.09	657	32.62	794	39.42	359	17.82
Pharmacy Corps	1	2.94	12	35.29	18	52.94	3	8.82	----	----	----	----
Medical Administrative Corps	----	----	30	.22	319	2.36	1,478	10.92	3,719	27.47	7,991	59.03

Female	1	.003	18	05	48	.14	202	.58	1,736	4.95	33,069	94.28
Army Nurse Corps [5]	1	.003	18	.05	46	.14	195	.58	1,551	4.59	31,945	94.64
Physical Therapists [6]					1	.23	4	.92	73	16.74	358	82.11
Hospital Dietitians [6]					1	.11	3	.34	112	12.70	766	86.85
31 December 1943												
Total Army:												
Male	7,861	1.27	19,076	3.08	46,752	7.54	124,963	20.16	175,069	28.24	246,148	39.71
Female	2	.005	22	.05	101	.23	712	1.65	3,670	8.52	38,555	89.53
Medical Department:												
Male	951	1.30	2,566	3.50	9,511	12.98	30,842	42.08	21,076	28.76	8,340	11.38
Medical Corps	770	1.91	2,129	5.28	7,405	18.38	21,310	52.90	8,673	21.53		
Dental Corps	113	.80	290	2.06	1,215	8.63	6,338	45.03	6,118	43.47		
Veterinary Corps	61	3.15	61	3.15	305	15.77	652	33.71	855	44.21		
Sanitary Corps	5	.23	38	1.73	191	8.70	763	34.76	738	33.62	460	20.96
Pharmacy Corps	2	3.08	21	32.31	33	50.77	4	6.15	2	3.08	3	4.62
Medical Administrative Corps			27	.18	362	2.46	1,775	12.05	4,690	31.84	7,877	53.47
Female	1	.003	22	.06	56	.15	222	.60	2,320	6.24	34,585	92.96
Army Nurse Corps	1	.003	22	.06	54	.15	215	.60	2,056	5.76	33,363	93.42
Physical Therapists					1	.20	4	.80	109	21.80	386	77.20
Hospital Dietitians					1	.10	3	.30	155	15.58	836	84.02
31 May 1944												
Total Army:												
Male	8,405	1.25	21,952	3.26	54,273	8.06	147,925	21.97	193,529	28.74	247,368	36.73
Female	2	.004	46	.10	176	.37	1,223	2.59	7,499	15.88	38,286	81.06
Medical Department:												
Male	1,066	1.37	3,188	4.09	10,938	14.02	36,814	47.18	18,958	24.30	7,041	9.03
Medical Corps	876	2.01	2,673	6.12	8,609	19.70	24,270	55.55	7,262	16.62		
Dental Corps	114	.76	346	2.31	1,305	8.72	8,479	56.64	4,727	31.57		
Veterinary Corps	66	3.31	69	3.46	333	16.71	786	39.44	739	37.08		
Sanitary Corps	7	.31	45	1.97	212	9.27	879	38.42	643	28.10	502	21.94
Pharmacy Corps	2	3.77	19	35.85	28	52.83	3	5.66			1	1.89
Medical Administrative Corps	1	.01	36	.24	451	3.00	2,397	15.97	5,587	37.22	6,538	43.56

See footnotes at end of table.

TABLE 61.—*Rank of Medical Department officers, 1939–45* [1]—Continued

Date	Colonel		Lieutenant colonel		Major		Captain		First lieutenant		Second lieutenant	
	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component	Number	Percentage of component
31 May 1944—Continued												
Medical Department—Con.												
Female	1	.003	38	.09	117	.28	607	1.47	5,573	13.47	35,045	84.69
Army Nurse Corps	1	.003	38	.10	115	.29	596	1.51	5,133	12.98	33,659	85.12
Physical Therapists					1	.16	5	.78	171	26.64	465	72.43
Hospital Dietitians					1	.08	6	.50	269	22.47	921	76.93
31 December 1944												
Total Army:												
Male	9,690	1.32	25,534	3.47	63,947	8.69	174,327	23.69	238,172	32.37	224,158	30.46
Female	2	.003	68	.13	281	.56	1,899	3.76	13,128	25.97	35,178	69.58
Medical Department:												
Male	1,224	1.47	3,647	4.37	12,209	14.64	40,924	49.06	18,633	22.34	6,781	8.13
Medical Corps	1,017	2.18	3,058	6.54	9,501	20.32	25,703	54.98	7,468	15.98		
Dental Corps	124	.82	372	2.46	1,439	9.52	9,815	64.96	3,360	22.24		
Veterinary Corps	73	3.58	73	3.58	355	17.42	1,018	49.95	519	25.47		
Sanitary Corps	5	.21	43	1.80	198	8.30	919	38.52	591	24.77	630	26.40
Pharmacy Corps	2	3.03	22	33.33	26	39.40	4	6.06	2	3.03	10	15.15
Medical Administrative Corps	3	.02	79	.46	690	4.04	3,465	20.30	6,693	39.21	6,141	35.97
Female	1	.002	58	.13	168	.38	1,045	2.34	10,449	23.49	32,928	73.67
Army Nurse Corps	1	.002	58	.14	166	.39	1,014	2.40	9,871	23.37	31,138	73.70
Physical Therapists					1	.10	11	1.11	245	24.75	733	74.04
Hospital Dietitians					1	.07	20	1.37	383	26.21	1,057	72.35

31 August 1945												
Total Army:												
Male	11, 027	1. 42	29, 356	3. 79	70, 958	9. 16	197, 495	25. 49	305, 989	39. 49	159, 958	20. 64
Female	3	. 005	116	. 18	463	. 73	2, 933	4. 63	33, 884	53. 46	25, 980	40. 99
Medical Department:												
Male	1, 404	1. 62	4, 256	4. 90	13, 818	15. 92	43, 483	50. 09	18, 002	20. 74	5, 842	6. 73
Medical Corps	1, 186	2. 48	3, 547	7. 41	10, 622	22. 21	26, 597	55. 60	5, 882	12. 30	----------	----------
Dental Corps	131	. 91	426	2. 97	1, 618	11. 26	10, 167	70. 75	2, 028	14. 11	----------	----------
Veterinary Corps	69	3. 26	84	3. 97	397	18. 76	1, 169	55. 25	397	18. 76	----------	----------
Sanitary Corps	9	. 37	52	2. 12	269	10. 95	1, 010	41. 12	708	28. 83	408	16. 61
Pharmacy Corps	4	5. 88	22	32. 35	24	35. 30	4	5. 88	3	4. 41	11	16. 18
Medical Administrative Corps	5	. 02	125	. 63	888	4. 45	4. 536	22. 72	8, 984	45. 01	5, 423	27. 17
Female	1	. 002	96	. 17	301	. 52	1, 803	3. 13	30, 175	52. 36	25, 251	43. 82
Army Nurse Corps	1	. 002	96	. 18	299	. 55	1, 704	3. 11	28, 695	52. 38	23, 984	43. 78
Physical Therapists	----------	----------	----------	----------	1	. 08	41	3. 23	550	43. 38	676	53. 31
Hospital Dietitians	----------	----------	----------	----------	1	. 06	58	3. 67	930	58. 86	591	37. 41

[1] Unless otherwise specified, basic data are from issues of "Strength of the Army" corresponding to the dates shown. Percentage distributions by rank therefore are based on The Adjutant General's figures rather than those of The Surgeon General (table 1). In accordance with the principles governing the preparation of these tables, general officers are not covered by any of the figures presented here. Figures for male officers include the female members of the Medical Corps, whose distribution by rank was:

	Colonel		*Lieutenant colonel*		*Major*		*Captain*		*First lieutenant*	
Date	*Number of women*	*Percent of doctors*	*Number of women*	*Percent of doctors*	*Number of women*	*Percent of doctors*	*Number of women*	*Percent of doctors*	*Number of women*	*Percent of doctors*
31 December 1943	0	0	0	0	3	7. 14	18	42. 86	21	50. 00
31 May 1944	0	0	0	0	3	5. 88	26	50. 98	22	43. 14
31 December 1944	0	0	0	0	5	6. 67	38	50. 67	32	42. 67
31 August 1945	0	0	1	1. 39	4	5. 56	51	70. 83	16	22. 22

[2] Basic data on Medical Department ranks from Annual Report of The Surgeon General, U.S. Army, 1939. Basic data on rank of male officers in general are from Annual Report of the Secretary of War, 1939. Only Regular Army personnel are covered in either figure.

[3] Approximate date. Basic data for the entire Army and for nurses are for 31 December 1941 and were provided by Statistics and Accounting Branch, Statistics Section, Office of The Adjutant General, on 21 February 1958. Basic data on Medical Department male officers cover Regular Army and Reserve personnel on active duty as of 5 December 1941 and Army of the United States and National Guard personnel as of 1 November 1941. Memorandum, F. M. Fitts, for Colonel Lull, 29 Oct. 1942, subject: Status of Medical Department Officers as of 7 Dec. 1941, addendum to History of Military Personnel Division, Personnel Service, 1939–April 1944.

[4] Figures for 31 March 1943, from "Strength of the Army," 1 Feb. 1947.

[5] Basic data from Annual Report, Nursing Branch, Military Personnel Division, Office of The Surgeon General, 1944.

[6] "Strength of the Army," 1 Feb. 1947.

Nurses

In the Nurse Corps, the percentage of personnel in the grade of second lieutenant was far higher than in either of the male officer corps having members in that grade—the Medical Administrative Corps and the Sanitary Corps; of these three corps, the percentage was lowest in the Sanitary Corps (table 61). Up to December 1942, the grades of colonel, lieutenant colonel, and major in the Nurse Corps were not authorized as a general rule, although exception had been made in the cases of the superintendent and her chief assistant, who had been granted the grade of colonel and lieutenant colonel, respectively. In December 1942, Public Law 828 authorized appointments in the grades of lieutenant colonel and major. During the remainder of the war, however, no appreciable percentage reached a higher rank than that of captain.

After Congress had granted the dietitians and physical therapists relative rank (December 1942), the War Department on the recommendation of The Surgeon General established the following table of grade distribution for each group: In addition to one major, the number of captains was not to exceed 1 percent; the number of first lieutenants not to exceed 15 percent; the remainder were to be second lieutenants.[23] During the rest of the war, each group possessed an actual percentage in the grade of first lieutenant much larger than that authorized; during most of the period, the percentage in the grade of captain was also larger (table 61).

In the early war years, Congress increased the pay of most members of the Armed Forces, and male personnel of the Medical Department received the same increases, rank for rank, that were simultaneously accorded to those in other branches of the Army. In March 1942, Congress passed a law which included, among other provisions, extra compensation for oversea or sea duty amounting to 10 percent of base pay for commissioned officers and 20 percent for warrant officers, enlisted men, and female nurses.[24] Another law, enacted in June 1942, raised the pay of all enlisted men; privates, for example, whose base pay had been increased from $21 to $30 a month by the Selective Training and Service Act of 1940,[25] received a further increase to $50. The base pay of warrant officers was also raised.

The new scale for commissioned officers involved partly a readjustment of base pay and partly added compensation for subsistence and rental of quarters. In the case of most Medical, Dental, and Veterinary Corps officers, the increase took the form of higher allowances for subsistence and quarters. In no case did the increase accorded Army officers amount to more than a few hundred dollars a year,[26] an addition which, so far as doctors in particu-

[23] Letter, Col. Emma E. Vogel, USA (Ret.), to Col. C. H. Goddard, Office of The Surgeon General, 5 June 1952.

[24] 56 Stat. 143.

[25] 54 Stat. 885.

[26] 56 Stat. 359.

lar were concerned, did little or nothing to close the gap between Army pay and income from civilian practice.

Members of the Army Nurse Corps, although their compensation was gradually increased, did not achieve the full pay and allowances of Army officers until they attained full commissioned rank. Nevertheless, their compensation was high enough so that the majority of nurses were not reluctant to accept it until the establishment of the more highly paid Women's Auxiliary Army Corps in May 1942.[27]

As nurses entered the Army or were induced by higher wages to take nonnursing jobs in industry, fewer remained in civilian practice, so that wages rose there too (until they were frozen in 1942). A slight rise in pay for Army nurses came from the Pay Readjustment Act of 1942, effective on 1 June 1942. Nurses also received monthly quarters and subsistence allowances equal to those of a second lieutenant, but unlike male officers, they did not receive increased allowances as their rank increased.[28] In spite of improvements, the pay still seemed inequitable, for the same act set enlisted men's pay rates at such levels that an intelligent soldier with little or no civilian training might in the course of a year be earning as much as a nurse who had spent 3 years in nursing school.[29]

The increase in pay did not satisfy all Army nurses or civilian nurses who considered entering the service. To add to their belief that the Army was not only underpaying but actually discriminating against nurses were the provisions in the act creating the Women's Auxiliary Army Corps in May 1942 which fixed a generally more liberal pay scale.[30] When questioned by members of the Committee to Study the Medical Department in the fall of 1952, the Superintendent of Nurses answered that the nurses were not properly paid, and mentioned the salary of the Women's Auxiliary Army Corps as a "hindrance," presumably to the procurement of nurses.

The dissatisfaction of the nurses, coupled with support by their friends outside the corps, was partly responsible for further improvements in the position of Army nurses. These [31] included a pay increase in December 1942, which gave nurses a remuneration substantially equal to that of commissioned officers.[32] By its terms, nurses received the same military base- and longevity-pay and allowances for subsistence, rental of quarters, mileage and other travel allowances as commissioned officers were receiving. Subsistence and quarters allowances increased according to rank, and they henceforth received only a 10-percent increase in base pay (not 20 as previously) for oversea or sea duty, the same increase as that given to commissioned officers. Thus, although

---

[27] Memorandum, Colonel Blanchfield (Ret.), for Col. C. H. Goddard, Office of The Surgeon General, 14 July 1952, subject: Medical Department History in World War II.

[28] See footnote 26, p. 462.

[29] Memorandum, Chief, Military Personnel Division, Office of The Surgeon General, for Colonel Nugent, G–1, 6 Oct. 1942.

[30] 56 Stat. 278.

[31] For other concessions to the nurses at this time, see chapter VIII, pp. 247–266.

[32] 56 Stat. 1072.

663076°— 63——32

they held only relative rank, Army nurses had now attained the same pay schedule as commissioned officers, except for the allowance for dependents. They received that allowance and other privileges when in June 1944 they were accorded full commissioned rank in the Army of the United States.

Dietitians and physical therapists

The act of December 1942 raising the pay of Army nurses, "militarized" two other groups of women, the hospital dietitians and the physical therapists, giving them, along with "relative rank," the same pay as nurses. Before they were given military status, women in these two groups received a salary of $1,800 to $2,300 a year, while the two superintendents each received $3,200.[33]

As before the war, the pay of civilian employees of the Medical Department conformed to the wage scales of all employees of the Federal Government, except that for a time certain Medical Department civilian personnel did not receive the higher pay for overtime work which, after 1940, some of those scales had allowed.[34] The reason was that, since not all classes of civilian workers were entitled to such a rate, the commanders of hospitals, in order to avoid a morale problem and also because only a few members of their civilian staffs were entitled to it, did not request this rate for them. In May 1943, however, Congress granted almost all Federal employees higher pay in lieu of specific pay for overtime work.[35]

Later War Years, 1943–45

Officers

Inequalities (or inequities) in the system of promotion and in the distribution of rank among Medical Department officers caused concern and criticism during the later war years. At the same time, some progress was made toward removing the basis for complaint.

As regards promotion, there was a tendency to restrict it at this period, both by lengthening the time an officer must spend in his current rank and by preventing his promotion above the rank authorized for his job. The War Department in 1942 made officers' promotions to each grade possible after 6 months had been spent in the lower grade; the only exception was in favor of second lieutenants, who could be promoted in less than 6 months. This regulation applied throughout the Army, as did succeeding regulations during 1943–46 which increased the waiting time in all grades. It will be observed that the increases in waiting time struck the higher grades first and were greater in them than in the lower grades. In July 1944, however, the

[33] Memorandum, Maj. Helen B. Gearin, for Col. C. H. Goddard, Office of The Surgeon General, 23 June 1952, subject: Draft of Material To Be Included in History of World War II.

[34] (1) 54 Stat. 1205. (2) 55 Stat. 241.

[35] 57 Stat. 75.

War Department granted extra credit to all officers overseas; it stipulated that for time-in-grade purposes, service outside the United States would be counted as time and a half.[36]

Working within the confines of these Army-wide policies, Army Service Forces likewise tended to restrict promotions, particularly in the higher grades, within its own domain. On 26 February 1944, Army Service Forces headquarters, under whose jurisdiction fell a large percentage of Medical Department officers stationed in the United States, published Circular No. 59 which showed its desire to prevent indiscriminate promotions of officers. It stated at that time that the two principal considerations in promoting an officer were the importance of the position and the merits of the individual. The promotion of any group or individual at a rate faster than was prevalent throughout the Army, especially in combat units, could be justified only in the most exceptional circumstances. Medical Department authorities believed that existing regulations did not give medical and dental officers enough opportunities for promotion, and during the later war years, they succeeded in having special instructions issued to favor members of those corps.[37]

In June 1945, the General Staff declared its desire and intent to be that all first lieutenants of the Medical, Dental, Veterinary (and Chaplains) Corps occupying positions established for an officer of these services in the grade of captain or first lieutenant should be promoted to captain—providing, of course, that the officer was qualified for and deserving of promotion and had served the required time in grade and position. For this purpose, the order authorized each command concerned a larger number of captains' ratings in each of the corps just mentioned—a number equal to the combined total of hitherto authorized captains' and first lieutenants' ratings in the corps. The order applied to ratings established both by tables of organization and from bulk allotment sources.[38]

Surgeon General Kirk had already complained that the promotion of medical officers of higher as well as lower rank had not kept pace with their responsibilities, as indicated by the growing patient load. Many outstanding specialists from civilian life who were chiefs of services in general hospitals, he declared, were only majors or lieutenant colonels. Many officers had been in company grade for 2 or 3 years without promotion. Pointing out the amount of time that medical, dental, and veterinary officers had spent in getting their education, he said that many of these men after 3 years of Army service were still in the grade of lieutenant, despite the provisions of Army regulations. Actually, although changes in regulations had made lieutenants

---

[36] Army Regulations No. 605–12, 3 Feb. 1944, with Changes No. 1, 24 July 1944.

[37] (1) Memorandum, Surgeon General Kirk, for General Styer, Army Service Forces, 24 Nov. 1943, subject: Failure to Promote 1st Lieutenants of the Medical and Dental Corps. (2) The Surgeon General's Conference With Service Command Surgeons, commencing 10 Dec. 1943. (3) Army Regulations No. 695–12, 17 Aug. 1944.

[38] Letter, The Adjutant General, to Commanding General, Army Service Forces, 30 June 1945, subject: Temporary Promotions in the Army of the United States of 1st Lieutenants, Medical, Dental, Veterinary, and Chaplains Corps.

eligible for promotion to captain, they had not made such promotions mandatory, and presumably not all commanding officers had recommended their Medical and Dental Corps lieutenants for these promotions.[39]

Shortly afterward, The Surgeon General initiated a move to have the chiefs of services and sections of Zone of Interior general hospitals promoted. Stating that these officers had a big workload and grave responsibilites, he pointed out that if the chiefs of services in hospitals having a capacity of 1,500 beds or more had been so assigned in table-of-organization hospitals of the same size they would, without exception, have been authorized to hold the rank of colonel. He showed that only 29 chiefs of medical and surgical services in these Zone of Interior hospitals were colonels, whereas 87 were lieutenant colonels, and 16 were only majors. (At the end of April 1945, a few months before The Surgeon General furnished this information, only about 6 of the 65 general hospitals in this country had capacities of less than 1,500 beds.) Moreover, a table showing the grade of chiefs of sections in such hospitals listed 3 colonels, 66 lieutenant colonels, 114 majors, 35 captains, and 5 first lieutenants. The chiefs of the larger sections, such as laboratory, neuropsychiatry, X-ray, and eye, ear, nose, and throat would rank, he asserted (presumably referring again to table-of-organization general hospitals), either as majors or lieutenant colonels, depending upon the workload of the hospital. Somewhat later, he submitted a list of officers who were chiefs of services in Zone of Interior general hospitals and urged that they be promoted as rapidly as possible to a grade commensurate with their professional assignments.[40]

In this effort, The Surgeon General, besides invoking justice for these highly trained officers, was endeavoring to correct a situation which, he stated, would inevitably result in hard feelings toward the Army in the future on the part of individuals whose work was not rewarded. Undoubtedly, many of those concerned wielded considerable influence in the medical profession, and he may have feared the effects of their criticism based on the Medical Department's failure to obtain promotions for them. The War Department finally granted his request. General Kirk was then able to recommend a one-grade promotion for many of the medical officers who were serving as chiefs of services and sections in Zone of Interior hospitals.[41] He did not secure this authorization, however, until after the end of hostilities, and by that time,

[39] Army Service Forces Seventh Semiannual Service Command Conference, 28-30 June 1945.

[40] (1) Memorandum, Surgeon General Kirk, for General Somervell, Commanding General, Army Service Forces, 4 July 1945. (2) Memorandum, Chief, Personnel Service, Office of The Surgeon General, for Commanding General, Army Service Forces (attention: Director, Military Personnel Division), 10 July 1945, subject: Promotions of Chiefs of Services in Zone of Interior Hospitals. (3) Memorandum, Deputy Surgeon General, for Director, Military Personnel Division, Army Service Forces, 16 Oct. 1945, subject: Promotion of Chiefs of Services in Zone of Interior General Hospitals.

[41] (1) Memorandum, Surgeon General Kirk, for G–1, 28 Feb. 1946, subject: Promotion of Selected Officers. (2) Letter, Office of The Surgeon General (Col. H. W. Doan), to Commanding General, Army Service Forces (attention: Military Personnel Division), 19 Apr. 1946, subject: Promotion of Certain Medical Officers.

undoubtedly, some of the officers for whose promotion he had worked so diligently had returned to civilian life.

In November 1945, The Surgeon General recommended that about 100 specialists needed in hospitals in this country be retained on active duty regardless of their eligibility for separation from the Army and that all of them who were not already colonels be given a one-grade promotion. These men were promoted.[42]

Nurses

Some complaints were made about the delay or lack of promotion not only for male Medical Department officers but also for nurses—in the case of the latter, promotions from second to first lieutenant in particular. Pressure originated from nurses' families, from nursing and allied organizations, and from the press. The critics alleged that nurses were dispirited at their own lack of promotion in comparison to the rise of at least some members of the Women's Army Corps, of whom less formal training was required than of nurses; that some nurses served long periods overseas in the same grades as recent graduates or remained second lieutenants while others at home were promoted.

Partly, no doubt, in order to placate so many critics, the Medical Department increased its exertion, in the later war years, to get higher grades for its nurses. In November 1943, revisions of many tables of organization for various kinds of hospitals and for certain other types of medical units raised the number of nurse first lieutenants in those units while lowering the number of second lieutenants.[43] As with other regulations concerning rank or promotion, this one did not make the new proportions of grades mandatory, and it is possible that for one reason or another many of the first lieutenant vacancies created by it were filled slowly, if at all. In any case, as late as November 1944, 31,116 nurses—75 percent of the total Nurse Corps strength—were still in the grade of second lieutenant.[44]

A move to increase the opportunity for promotion of second lieutenants, not only of the Army Nurse Corps but of all other components of the Army, took shape at the end of 1944. In December of that year, the War Department announced that any second lieutenant who had completed 18 months of service in that grade might be promoted to the grade of first lieutenant without table-of-organization or table-of-allotment vacancies in that grade, provided he (or she) was qualified for and worthy of promotion. This authorization was not to be used for the automatic promotion of all second lieutenants who had served 18 months in that grade, but was reserved for those denied

[42] (1) Information from Military Personnel Division, Office of The Surgeon General, 17 Mar. 1947. (2) Letter, Acting Chief, Personnel Service, Office of The Surgeon General (Col. Francis F. Mintz), to Commanding Officer, Valley Forge General Hospital, Pa., 11 Dec. 1945, subject: Promotion of Officers.

[43] War Department Circular No. 306, 22 Nov. 1943.

[44] Strength of the Army, 1 Dec. 1944. Prepared for War Department General Staff by Machine Records Branch, Office of The Adjutant General, under direction of Statistical Branch.

TABLE 62.—*Army Nurse Corps first lieutenants and second lieutenants: Numbers in grade and numbers of promotions, September 1944–August 1945*

Date	Second lieutenants [1]	First lieutenants [1]	Promotions to grade of first lieutenant [2]
1944			
September	31, 468	7, 753	213
October	31, 653	8, 565	636
November	31, 116	9, 276	622
December	31, 138	9, 871	632
1945			
January	30, 810	10, 790	973
February	29, 601	13, 752	2, 350
March	30, 871	16, 528	3, 126
April	30, 870	19, 490	3, 670
May	29, 497	22, 826	3, 723
June	26, 013	26, 330	4, 369
July	25, 629	28, 028	1, 914
August	23, 984	28, 695	1, 388

[1] "Strength of the Army" for dates approximate to those shown.
[2] "Strength of the Army," 1 Sept. 1945.

merited advance solely because they were not in positions established for the higher grade.[45] In the Medical Department, the directive applied to all officer components except the three which contained no second lieutenants—that is, the Medical, Dental, and Veterinary Corps. It meant ultimate promotion for large numbers of nurses, dietitians, physical therapists, and Medical Administrative Corps officers, and for smaller numbers of the Sanitary and Pharmacy Corps. By the early part of 1945, the change of policy was beginning to stimulate the promotion of sizable numbers of Army-nurse second lieutenants (table 62).

Dental Corps

At the urgent recommendation of the American Dental Association, and of the dental profession generally, The Surgeon General agreed in September 1943 to promote the chief of his Dental Division from brigadier general

[45] (1) Army Regulations 605–12, 17 Aug. 1944, with Changes No. 1, 9 Dec. 1944. The same regulations also permitted a promotion without regard to position vacancies for officers returned to the United States from a status of missing in action, evading capture in enemy controlled territory, internee, or prisoner of war, provided the officer's case presented unusually meritorious or exceptional circumstances justifying waiver of the normal requirements for promotion. This permitted one-grade promotion of the 66 nurses, 3 dietitians, and 1 physical therapist who had been prisoners of the Japanese in the Philippine Islands and who were returned to this country in early 1945 after their recovery by the forces under General MacArthur. (2) History of Nursing Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1 Jan.–31 May 1945. (3) Quarterly History of Medical Department Dietitians, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1 Mar.–31Mar. 1945. (4) Quarterly History of Physical Therapy Branch, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1 Apr.–31 May 1945.

to major general, and to consider recommending the appointment of one or more brigadier generals in the Dental Corps. Only one was actually appointed, in February 1945; and he was reduced to the rank of colonel some months after the end of the war. There was also some improvement in rank so far as the mass of dental officers was concerned, as a comparison of the situation in late 1943 with that in 1945 (table 61) will show. Nevertheless, their position continued to lag behind that of Medical Corps officers.[46]

Medical Corps

In the Medical Corps, a problem of rank was sometimes involved when an officer had as his subordinate a man of lower rank but of higher proficiency rating, and therefore presumably of greater professional ability, in the specialty to which both were assigned. By virtue of his rank, the man of higher grade could give orders in technical as well as administrative matters to his subordinate and could either accept or refuse his advice. In cases such as these, it would have been better from the professional standpoint if the positions had been reversed, but under existing Army practices, there was no way this could be accomplished. Sometimes the purpose was achieved, however, in the case of specialists when the ranking officer accepted his subordinate's advice or permitted him virtually to issue the orders. If this was not done voluntarily, informal means were occasionally used to overcome the difficulty; ranking officers were asked to accept orders and advice from subordinates of superior competence. The Surgeon General's Military Personnel Division reported at the end of the war that success had occurred only in cases where the ranking officers recognized that the ability of those under them completely surpassed their own.[47] The problem might also have been solved by relieving certain ranking officers from active duty, but since the procurement of medical officers was still going on, the War Department did not permit such action.

Sanitary Corps

During the war, members of the sanitary engineering profession exerted great pressure on The Surgeon General to promote members of the corps to rank commensurate with their experience. In June 1943, a bill was introduced in Congress providing for an Assistant to The Surgeon General in the person of a Sanitary Corps officer with the rank of brigadier general. The Secretary of War, however, contended that such a promotion should be made only when the War Department considered the duties and responsibilities of a Sanitary Corps officer justified it. He furthermore stated that permanent

---

[46] For a detailed discussion of the reasons for this discrepancy, see publication cited in footnote 21, p. 455.

[47] Report, Military Personnel Division, Office of The Surgeon General, to Historical Division, autumn 1945, subject: Medical Department Personnel.

legislation affecting the peacetime Army should not be enacted in time of war.[48] The bill did not pass.

Enlisted personnel

Late in the war, the War Department took steps to promote privates—Medical Department as well as others—who through no fault of their own had not received a promotion—just as it did second lieutenants. In May 1945, regulations provided that commanding officers who were authorized to appoint privates, first class, might waive the requirement of an authorized vacancy to appoint enlisted men or women to that grade if they had completed one year of satisfactory service or had served outside the United States (a few exceptions were listed in the latter case). The War Department admonished that this authority was not to be used for the automatic promotion of all privates in those categories but was to be reserved for those who were qualified for promotion but were denied it because of lack of position vacancies. At the same time, oversea commanders and the commanding generals of the Army Air Forces, Army Ground Forces, and Army Service Forces were authorized to waive the requirements of an authorized vacancy to appoint to the next higher grade any persons below the grade of first or master sergeant who was returned to U.S. military control after having evaded capture by the enemy or after having been missing in action, interned, or taken prisoner. Such promotions were limited, however, to those who presumably would have been promoted except for their absence from the Army.[49]

PROMOTION OVERSEAS

Officers

During the early part of the war, the rank held by Medical Department officers[50] overseas was the rank they had acquired before leaving the Zone of Interior. For one thing, the oversea theaters were limited as to the number of high-ranking positions they could set up. The theaters throughout the war lacked the function of supervising the worldwide medical service

---

[48] (1) Letter, Arthur D. Weston, Chief Sanitary Engineer, Department of Public Health, Boston, Mass., to Abel Wolman, Professor of Sanitary Engineering, The Johns Hopkins University, 22 Apr. 1943. (2) Letter, Deputy Surgeon General, to Abel Wolman, 30 June 1943. (3) Letter, Secretary of War, to Robert R. Reynolds, Chairman, Committee on Military Affairs, U.S. Senate, 31 May 1944.

[49] Army Regulations No. 615–5, Changes No. 6, 23 May 1945.

[50] In the section which follows, the term "Medical Department officers," unless qualified, includes nurses. On the other hand, officers above the rank of colonel are not included in the term. Probably not more than 20 general officers of the Medical Department were overseas at any time. Sixteen (3 major generals and 13 brigadier generals) are listed in "The Surgeon General's Notebook," vol. I, under date of 28 July 1945.

that characterized the Surgeon General's Office, nor did they have the responsibility to the same degree of definitiveness, of providing specialized treatment, as did medical facilities in the continental United States. Both of these functions formed the basis for positions with the highest ranks. Thus, it was only on rare occasions that any Medical Department corps had a percentage of its oversea strength in the rank of colonel equal to or greater than that which it possessed in the Zone of Interior (table 63). In the Dental Corps, this inherent advantage of the Zone of Interior extended down into ranks as low as that of major, for the concentrations of dental officers necessitated by a large amount of remedial work on new recruits was lacking in oversea areas.[51]

However, even had the higher positions existed, the possibilities of promotion into them would have been few and far between in the earlier years. Promotions at the time were greatly dependent upon the existence of vacancies. Conditions overseas, however, were not such as to give rise to a great many vacancies that could be filled by promotion. In the Zone of Interior, until the middle of the war, units were constantly activated with personnel recently drawn from civilian life; fresh jobs were continuously established, and many of the new posts could be filled by promotion. In the theaters, on the other hand, such organizations as were activated generally were staffed with the personnel of units that had been disbanded or reorganized, and the total number of jobs remained substantially unchanged. Nor did the establishment of non-table-of-organization units provide many vacancies to be filled by promotion since many casuals arrived from the Zone of Interior with grades appropriate to the positions which arose in this fashion. Casuals also could be used to replace losses which, moreover, were fairly low particularly because the U.S. Forces were not yet fully committed to combat. Finally, transfers between units often were carried out on a grade-for-grade basis. Though promotions as a rule depended on the existence of vacancies, a possibility of advancement also existed when a man held a position for which the table of organization of his unit authorized a higher rank than the one he possessed. Overseas, as in the Zone of Interior, however, some commanders both in the line as well as in the Medical Department, who had spent many years in the military service without advancement in grade, frequently were unwilling to accord their juniors rapid promotion.[52]

---

[51] (1) Letter, Brig. Gen. L. H. Tingay, DC, Brooke Army Medical Center, to Col. C. H. Goddard, Office of The Surgeon General, 20 Sept. 1952. (2) As late as 31 May 1944, no hospital dietitian or physical therapist was serving abroad in any grade above that of first lieutenant (table 63).

[52] (1) Report, Maj. John B. West, 14 Apr. 1944, on Medical Department Activities in Liberia. (2) King, Arthur G.: Medical History of Espíritu Santo (New Hebrides) Service Command, pp. 55–56. [Official record.] (3) Letter, Brig. Gen. Robert P. Williams, to Col. John B. Coates, Jr., MC, Director, Historical Unit, U.S. Army Medical Service, 22 Dec. 1955. (4) Information from Col. Florence A. Blanchfield, USA (Ret.), 13 Mar. 1952.

TABLE 63.—*Rank of Medical Department officers overseas (excluding general officers), 31 July 1941–31 May 1944* [1]

Component and date	Colonel		Lieutenant colonel		Major		Captain		First lieutenant		Second lieutenant	
	Number	Percent of component in rank	Number	Percent of component in rank	Number	Percent of component in rank	Number	Percent of component in rank	Number	Percent of component in rank	Number	Percent of component in rank
31 July 1941												
Total Army officers	128	1. 85	465	6. 70	640	9. 22	1, 228	17. 69	2, 023	29. 15	2, 455	35. 38
Total Medical Department officers	15	1. 54	47	4. 82	69	7. 08	276	28. 32	336	34. 46	232	23. 79
Male Medical Department officers	15	2. 03	47	6. 36	69	9. 34	273	36. 94	328	44. 38	7	. 95
Medical Corps	9	1. 73	35	6. 72	51	9. 79	194	37. 24	232	44. 52		0
Dental Corps	2	1. 48	8	5. 93	11	8. 15	47	34. 81	67	49. 63		0
Veterinary Corps	4	10. 53	4	10. 53	4	10. 53	16	42. 11	10	26. 32		0
Sanitary Corps		0		0	1	50. 00	1	50. 00		0		0
Medical Administrative Corps		0		0	2	4. 65	15	34. 88	19	44. 19	7	16. 28
Female Medical Department officers [2]		0		0		0	3	1. 27	8	3. 39	225	95. 34
30 November 1941												
Total Army officers	135	1. 38	522	5. 35	735	7. 55	1, 843	18. 89	3, 305	33. 87	3, 216	32. 96
Total Medical Department officers	14	. 99	44	3. 12	87	6. 16	402	28. 47	518	36. 69	347	24. 57
Male Medical Department officers	14	1. 32	44	4. 14	87	8. 18	400	37. 63	506	47. 60	12	1. 13
Medical Corps	8	1. 03	32	4. 11	71	9. 11	289	37. 10	379	48. 65		0
Dental Corps	3	1. 74	8	4. 57	11	6. 29	74	42. 29	79	45. 14		0
Veterinary Corps	3	8. 11	4	10. 8	3	8. 11	17	45. 95	10	27. 02		0
Sanitary Corps		0		0	1	12. 50	2	25. 00	5	62. 50		0
Medical Administrative Corps		0		0	1	1. 56	18	28. 13	33	51. 56	12	18. 75

Female Medical Department officers		0		0		0	2	.57	12	3.44	335	95.98
30 September 1942												
Total Army officers	921	1.83	1,800	3.57	4,009	7.95	11,039	21.90	16,726	33.18	15,914	31.57
Total Medical Department officers	66	.64	229	2.23	859	8.36	2,584	25.14	2,492	25.27	2,944	38.37
Male Medical Department officers	66	1.02	229	3.54	858	13.2	2,575	39.76	2,598	38.47	257	3.97
Medical Corps	56	1.13	196	3.96	751	15.2	2,120	42.87	1,822	36.84		0
Dental Corps	4	.50	21	2.63	70	8.77	272	34.09	431	54.01		0
Veterinary Corps	6	6.18	9	9.28	25	25.8	36	37.11	21	21.65		0
Sanitary Corps		0	2	4.26	6	12.8	13	27.66	26	55.32		0
Medical Administrative Corps		0	1	.17	6	1.02	134	22.71	192	32.54	257	43.55
Female Medical Department officers		0		0	1	.03	9	.24	106	2.79	3,687	96.95
28 February 1943												
Total Army officers	1,463	1.73	2,889	3.41	6,498	7.68	17,962	21.22	26,237	30.99	29,598	34.96
Total Medical Department officers	122	.73	390	2.34	1,434	8.61	4,329	25.98	3,860	23.16	6,529	39.18
Male Medical Department officers	122	1.17	390	3.73	1,434	13.72	4,318	41.32	3,638	34.81	548	5.24
Medical Corps	109	1.41	354	4.59	1,250	16.20	3,492	45.26	2,511	32.54		0
Dental Corps	6	.47	21	1.65	111	8.71	502	39.40	634	49.76		0
Veterinary Corps	7	3.54	12	6.06	41	20.71	55	27.78	83	41.92		0
Sanitary Corps		0	3	3.19	11	11.70	28	29.78	51	54.26	1	1.06
Medical Administrative Corps		0		0	21	1.80	241	20.63	359	30.74	547	46.83
Female Medical Department officers		0		0		0	11	.18	222	3.57	5,981	96.25

See footnotes at end of table.

TABLE 63.—*Rank of Medical Department officers overseas (excluding general officers), 31 July 1941–31 May 1944* [1]—Continued

Component and date	Colonel		Lieutenant colonel		Major		Captain		First lieutenant		Second lieutenant	
	Number	Percent of component in rank	Number	Percent of component in rank	Number	Percent of component in rank	Number	Percent of component in rank	Number	Percent of component in rank	Number	Percent of component in rank
31 December 1943												
Total Army officers	2, 474	1. 21	6, 186	3. 03	14, 747	7. 21	43, 529	21. 29	61, 734	30. 19	75, 805	37. 07
Total Medical Department officers	263	. 67	893	2. 26	3, 297	8. 34	12, 621	31. 91	5, 595	14. 15	16, 878	42. 67
Male Medical Department officers	263	1. 13	891	3. 82	3, 293	14. 13	12, 551	53. 86	4, 672	20. 05	1, 631	7. 00
Medical Corps	241	1. 54	791	5. 05	2, 884	18. 40	9, 503	60. 63	2, 254	14. 38	----	0
Dental Corps	10	. 31	66	2. 05	212	6. 59	2, 146	66. 70	774	24. 07	----	0
Veterinary Corps	12	2. 65	17	3. 75	89	19. 65	168	37. 09	167	36. 86	----	0
Sanitary Corps	----	0	8	1. 69	32	6. 78	199	42. 16	178	37. 71	55	11. 65
Medical Administrative Corps	----	0	9	. 26	70	2. 01	534	15. 36	1, 298	37. 34	1, 565	45. 02
Pharmacy Corps	----	0	----	0	6	50. 00	2	16. 66	1	8. 33	3	28. 00
Female Medical Department officers	----	0	2	. 01	4	. 02	70	. 43	923	5. 68	15, 247	93. 85
Army Nurse Corps	----	0	2	. 01	4	. 03	70	. 44	849	5. 38	14, 862	94. 14
Hospital Dietitians	----	0	----	0	----	0	----	0	39	14. 66	227	88. 33
Physical Therapists	----	0	----	0	----	0	----	0	35	18. 13	158	81. 87

31 May 1944												
Total Army officers	3,495	1.13	9,594	3.11	22,252	7.21	68,455	22.19	96,669	31.33	108,077	35.03
Total Medical Department officers	382	.71	1,375	2.54	4,722	8.74	18,558	34.34	8,143	15.07	20,860	38.60
Male Medical Department officers	382	1.19	1,372	4.26	4,686	14.55	18,250	56.68	5,451	16.93	2,055	6.36
Medical Corps	346	1.63	1,197	5.65	4,096	19.34	13,431	63.41	2,111	9.97	--------	0
Dental Corps	13	.29	118	2.65	288	6.46	3,323	74.54	716	16.06	--------	0
Veterinary Corps	20	3.77	31	5.84	109	20.56	218	41.13	152	28.68	--------	0
Sanitary Corps	3	.40	12	1.61	55	7.36	348	46.58	222	29.72	107	14.32
Medical Administrative Corps	--------	0	11	.21	135	2.56	929	17.62	2,250	42.67	1,948	36.94
Pharmacy Corps	--------	0	3	42.85	3	42.85	1	14.29	--------	0	--------	0
Female Medical Department officers	--------	0	3	.01	36	.16	308	1.41	2,692	12.32	18,805	86.09
Army Nurse Corps	--------	0	3	.01	36	.17	308	1.46	2,546	12.06	18,219	86.30
Hospital Dietitians	--------	0	--------	0	--------	0	--------	0	76	17.31	363	82.68
Physical Therapists	--------	0	--------	0	--------	0	--------	0	70	23.89	223	76.11

[1] Basic data from sources shown in table 31 footnote.
[2] Comprises Army Nurse Corps only.

It is true that Regular Army promotions continued, and it can be assumed that in this respect the oversea areas had an advantage owing to the fact that they had a greater proportion of regulars in their officer strength than did the Zone of Interior (table 41). When special regulations to permit promotions in the Army of the United States were issued, the oversea areas also had an advantage in view of the greater seniority of their officers. Such regulations, however, were of extremely limited scope in the emergency and especially in the early war period.

Thus it is that the arrival of large numbers of second lieutenants from the Zone of Interior in 1942 caused the first significant wartime alteration in the distribution of rank among Medical Department officers overseas; that is, a general lowering of the level of grades. Most of the second lieutenants who came were members of the Army Nurse Corps, whose numbers overseas increased tenfold between Pearl Harbor and 30 September 1942, while those of male Medical Department officers grew less than seven times. A considerable increment of Medical Administrative Corps officers also helped to account for the increase in the proportion of second lieutenants (tables 32 and 64). Whereas the proportion of the oversea membership of this corps in the lowest rank had been less than 20 percent in November 1941, it was 43.55 percent in September 1942. The change was of such proportions that it reversed the relationship with regard to the grade of second lieutenant that had prevailed prior to Pearl Harbor between Medical Department officers and officers in general. The Medical Department overseas now had, and continued to have until at least May 1944, a ratio of second lieutenants that was larger than that possessed by the entire Army abroad. Among male Medical Department officers alone, the proportion of second lieutenants also increased, but it is clear that overseas as at home the proportion continued to be smaller than was the case among the other male officers until the end of the war. The fact that the Medical Corps, Dental Corps, and Veterinary Corps had no members in the grade of second lieutenant accounts for this situation.

A similar process was taking place in the Zone of Interior. Intensive commissioning of Medical Administrative Corps officers beginning in 1942 and heavy recruiting of the professional corps during the same period accounts for the substantially greater proportions of worldwide strength in second and first lieutenants as compared with oversea strength.

The latter part of the war witnessed a very marked improvement in promotion rates among oversea Medical Department officers. This development began to manifest itself among the male components of the group toward the middle of 1943. During 1944, the pace slackened, but in 1945 rates were attained which surpassed the levels reached in 1943 (table 65). Although

pressure by Surgeon General Kirk upon oversea authorities in mid-1944 gave some impetus to promotions of members of the Army Nurse Corps, the monthly rate of these promotions abroad even during the third quarter of that year was 0.1 per 1,000, whereas the worldwide rate was 3.4 (table 65).[53]

In 1945, however, great promotion activity was manifested among the members of the female components in the Medical Department overseas. The most important factors in the improvement of the promotion rates of Medical Department officers were the special regulations making possible advancements in grade regardless of the existence of vacancies. However, a directive of October 1943 authorizing promotion of second lieutenants of the Nurse Corps to the rank of first lieutenant irrespective of openings in the higher grade was of little influence at least until the invasion of Normandy since they were applicable only to personnel serving with combat forces engaged in foreign areas.[54]

Promotions through the creation of vacancies also increased in the later war period. Higher attrition rates, rotations, arrival of units from the Zone of Interior without qualified incumbents in highly specialized jobs, and changes in tables of organization to permit replacement of medical officers by members of the Medical Administrative Corps all swelled the number of vacancies in oversea areas, although in many cases obstacles were raised to filling these vacancies by promotion. Among such obstacles was the requirement that an officer rotated to the Zone of Interior be replaced by an officer from that area holding the same rank. In the North African theater, regulations issued in August 1944 provided that a replacement for a Medical Department officer be requisitioned in the same grade as the individual to be replaced and that when a vacancy was to be filled by promotion no action to that effect be taken until a replacement was obtained for the officer to be promoted. In the Southwest Pacific, medical officers transferred to headquarters in order to serve as consultants, remained on the rolls of their parent units, thus blocking promotion opportunities in such units.[55]

---

[53] (1) Letter, Maj. Gen. Kirk, to Maj. Gen. M.C. Stayer, Chief Surgeon, North African Theater of Operations, U.S. Army, 30 Nov. 1944. (2) Letter, Maj. Gen. Kirk, to Maj. Gen. P. R. Hawley, Chief Surgeon, European Theater of Operations, U.S. Army, 30 May 1944.

[54] Promotions under the regulation were subject to demonstration of the fitness of the subject for advancement. She must also have served at least 6 months as a second lieutenant, no less than 3 months of this being in a theater of operations. Moreover, the number of first lieutenants in a table-of-organization unit might not exceed 50 percent of all lieutenants in the unit. Finally, the authorization applied only to specified theaters. Memorandum, The Adjutant General, to Commanding General, Army Ground Forces, 2 Oct. 1943, subject: Promotions of Second Lieutenants, Army Nurse Corps, in Active Theaters. Also Annual Report, Surgeon, U.S. Army Services of Supply, 1943.

[55] (1) Annual Report, Surgeon, Mediterranean Theater of Operations, U.S. Army, 1944. (2) Memorandum, Brig. Gen. G. B. Denit, Chief Surgeon, Headquarters, U.S. Army Forces, Far East, for Colonel Pincoffs, 22 May 1945.

TABLE 64.—*Temporary promotions of Medical Department officers, worldwide and overseas, January 1943–September 1945*

Component	1 January–31 March		1 April–30 June		1 July–30 September		1 October–31 December		1 January–31 March		1 April–30 June		1 July–30 September		1 October–31 December		1 January–31 March		1 April–30 June		1 July–30 September	
	Number	Rate [1]	Number	Rate [1]	Number	Rate [1]	Number	Rate [1]	Number	Rate [1]	Number	Rate [1]	Number	Rate [1]	Number	Rate [1]	Number	Rate [1]	Number	Rate [1]	Number	Rate [1]
	1943								1944								1945					
All Army officers [2]																						
Worldwide													80,029	34.7	66,693	28.2	93,540	38.3	99,858	39.8	56,395	22.7
Overseas													49,775	43.3	45,059	35.9	61,595	44.4	75,632	57.3	34,651	32.3
Male Army officers: [3]																						
Worldwide	56,427	41.5	70,653	45.2	66,330	37.7	65,578	35.2	63,969	32.4	74,151	35.7	78,885	36.5	64,096	29.0	85,566	37.7	86,812	37.5	51,549	36.9
Overseas	334	1.3	18,133	51.0	15,575	35.2	18,871	33.1	25,481	34.6	36,862	41.4	49,704	48.6	43,469	39.4	57,261	46.9	65,953	56.9	31,710	33.7
Female Army officers: [4]																						
Worldwide													1,444	7.9	2,597	17.1	7,974	46.4	13,046	69.2	4,846	25.7
Overseas													71	.9	1,590	18.2	4,334	47.0	9,679	106.6	2,941	40.0
Women's Army Corps: [5]																						
Worldwide									557	31.8	553	31.5	737	41.4	544	31.0	1,178	67.8	710	41.3	469	27.5
Overseas									10	14.5	29	17.6	64	30.8	89	35.4	187	66.8	186	61.4	92	27.7
Medical Department officers [6]																						
Worldwide													5,511	15.0	7,141	18.6	13,302	32.5	18,994	44.4	9,213	22.1
Overseas													2,298	12.3	4,232	19.9	8,919	38.3	14,484	63.7	5,213	29.9
Male, excluding Pharmacy Corps: [7]																						
Worldwide	4,936	27.1	5,639	29.2	8,032	37.5	8,009	36.3	7,782	33.2	5,711	24.0	5,149	21.1	5,088	19.9	6,506	25.0	6,658	25.4	4,836	19.0
Overseas	35	1.0	795	18.2	1,783	33.8	2,007	28.6	2,176	24.7	2,340	23.3	2,291	20.2	2,731	21.4	4,772	33.3	4,991	35.7	2,364	22.6
Medical Corps: [7]																						
Worldwide	3,239	29.3	4,058	36.4	4,210	35.1	4,244	35.1	4,080	31.3	2,819	21.4	2,260	16.9	2,231	15.9	2,744	19.5	3,218	23.0	2,721	20.1
Overseas	26	1.0	628	20.3	1,279	35.9	1,460	31.0	1,328	22.7	1,349	20.5	1,238	17.1	1,296	16.6	2,254	26.7	2,576	32.0	1,125	19.6

Dental Corps: [7]																				
Worldwide	901	28.9	1,059	29.3	2,008	49.3	1,824	42.4	1,813	40.8	1,201	26.9	961	21.4	846	18.7	737	16.6	718	16.2	738	20.0
Overseas	5	1.2	105	18.8	422	61.2	416	43.1	357	30.1	360	26.8	281	18.0	330	18.3	412	19.3	467	22.4	369	23.1
Veterinary Corps: [7]																				
Worldwide	212	43.3	152	27.6	135	23.6	138	22.9	159	26.7	176	28.8	140	23.1	121	19.8	106	17.3	124	20.3	210	34.3
Overseas	3	4.5	16	18.5	15	15.4	30	22.2	41	26.3	60	35.8	69	40.4	49	25.1	73	35.6	74	36.1	51	28.6
Sanitary Corps: [7]																				
Worldwide	176	40.5	151	29.2	105	17.0	180	27.2	220	31.6	185	25.3	206	29.0	202	28.2	336	44.4	340	44.6	192	26.7
Overseas	0	0	5	7.0	18	17.6	28	19.8	41	19.7	62	23.5	58	19.2	102	28.5	226	61.1	234	61.3	126	40.4
Medical Administrative Corps: [7]																				
Worldwide	408	14.8	216	6.2	1,574	37.6	1,623	36.7	1,510	33.6	1,330	29.7	1,582	35.0	1,688	33.0	2,583	45.9	2,258	38.4	975	16.6
Overseas	1	.3	41	7.4	49	6.6	73	7.0	409	29.0	509	30.4	645	30.6	954	36.5	1,807	57.1	1,640	50.5	693	26.6
Army Nurse Corps: [8]																				
Worldwide													407	3.4	2,053	16.2	6,796	46.3	12,336	75.7	4,377	27.6
Overseas													7	.1	1,501	18.4	4,147	48.5	9,493	113.1	2,849	42.3
Physical Therapists: [9]																				
Worldwide															27	9.1	129	39.6	221	62.8		
Overseas															14	9.2	95	59.0	146	93.4		
Hospital Dietitians: [9]																				
Worldwide															36	8.2	215	47.9	372	76.4		
Overseas															18	9.0	120	54.4	249	106.1		

[1] Average monthly rate per 1,000 of the mean strength of the component during the quarter.

[2] Exclusive of physical therapists and hospital dietitians but including Pharmacy Corps. Rates per 1,000 troops based on addition of strength utilized in determining rate for total male Army officers to that used in ascertaining rate for total female Army officers.

[3] Basic data and rates from "Temporary Promotions of Male Officers by Arms and Services," in "Strength of the Army," 1 July 1945, pp. 104–105, for the years 1943 and 1944; from table with same title in "Strength of the Army," 1 November 1945, p. 97, for subsequent dates. No adjustment to take account of revised Medical Department strengths used in this volume (see table 31) was made in determining rates. Includes Pharmacy Corps.

[4] Army Nurse Corps plus Women's Army Corps.

[5] Basic data from "Monthly Summary of Temporary Promotions, Women's Army Corps," in "Strength of the Army," 1 November 1945, pp. 104–105. Rates based on end-of-quarter strengths shown in "Strength of the Army" for actual dates listed or dates approximate thereto.

[6] Male Medical Department officers plus Army Nurse Corps.

[7] Does not include Pharmacy Corps, for which no data are available. Basic data and oversea rates from sources mentioned in footnote 3. Worldwide rates based on strengths shown in table 1 in addition to strength of personnel assigned to Veterans' Administration.

[8] Basic data from "Monthly Summary of Temporary Promotions, Army Nurse Corps," in "Strength of the Army," 1 November 1945, p. 107. Oversea rates based on end-of-quarter strengths reported in "Strength of the Army" for actual dates shown or dates approximate thereto. Worldwide rates based on end-of-quarter strengths shown in table 1.

[9] Basic data from source shown in table 13, footnote 1. Data for October–December 1944 cover November and December only. Rates based on end-of-quarter strengths from sources noted in this table, footnote 8.

TABLE 65.—*Temporary promotions of Medical Department officers by rank,*[1] *by corps, and by other components, worldwide and overseas, November 1944 to June 1945, inclusive*

Components	Total promotions	To colonel		To lieutenant colonel		To major		To captain		To first lieutenant	
		Number	Percent of all promotions	Number	Percent of all promotions	Number	Percent of all promotions	Number	Percent of all promotions	Number	Percent of all promotions
All Army officers:[2]											
Worldwide	238, 854	2, 249	0. 9	8, 111	3. 4	19, 131	8. 0	53, 443	22. 4	155, 920	65. 3
Overseas	168, 986	1, 506	. 9	5, 916	3. 5	14, 048	8. 3	37, 727	22. 3	109, 789	65. 0
Male Army officers:[3]											
Worldwide	215, 095	2, 249	1. 0	8, 067	3. 8	18, 907	8. 8	52, 109	24. 2	133, 763	62. 2
Overseas	153, 184	1, 506	1. 0	5, 891	3. 8	13, 902	9. 1	37, 100	24. 2	94, 785	61. 9
Female Army officers:[4]											
Worldwide	23, 759	-------	0	44	. 2	224	. 9	1, 334	5. 6	22, 157	93. 3
Overseas	15, 802	-------	0	25	. 2	146	. 9	627	4. 0	15, 004	95. 0
Medical Department officers:											
Worldwide	37, 838	288	. 8	1, 104	3. 0	3, 271	8. 6	8, 363	22. 1	24, 812	65. 6
Overseas	26, 961	201	. 7	825	3. 2	2, 358	8. 7	5, 850	21. 7	17, 727	65. 8
Male, excluding Pharmacy Corps:											
Worldwide	16, 322	288	1. 8	1, 070	6. 7	3, 116	19. 1	7, 434	45. 5	4, 414	27. 0
Overseas	11, 605	201	1. 7	802	7. 3	2, 242	19. 3	5, 330	45. 9	3, 030	26. 1
Medical Corps:											
Worldwide	7, 466	249	3. 3	874	11. 4	2, 285	30. 7	4, 058	54. 6	----------	0
Overseas	5, 676	170	3. 0	655	11. 5	1, 620	28. 5	3, 231	56. 9	----------	0
Dental Corps:											
Worldwide	1, 982	27	1. 4	110	5. 5	400	20. 2	1, 437	72. 5	[5] 8	. 4
Overseas	1, 089	22	2. 0	88	8. 1	278	25. 5	700	64. 3	1	. 1

Veterinary Corps:											
Worldwide	310	6	2.0	19	6.1	77	24.8	208	67.1		0
Overseas	182	4	2.2	15	8.2	60	33.0	103	56.6		0
Sanitary Corps:											
Worldwide	806	5	.6	23	2.9	113	14.0	264	32.8	401	49.7
Overseas	525	4	.8	14	2.7	90	17.1	184	35.0	233	44.4
Medical Administrative Corps:											
Worldwide	5, 758	1	.02	44	.8	241	4.2	1, 467	25.5	4, 005	69.6
Overseas	4, 133	1	.02	30	.7	194	4.7	1, 112	26.9	2 796	67.7
Female:											
Worldwide	21, 516		0	34	0.2	155	0.7	929	4.3	20, 398	94.8
Overseas	15, 356		0	23	.1	116	.8	520	3.4	14, 697	95.7
Army Nurse Corps:											
Worldwide	20, 516		0	34	.2	155	.8	862	4.2	19, 465	94.9
Overseas	14, 714		0	23	.2	116	.8	517	3.5	14, 058	95.5
Physical Therapists:											
Worldwide	377		0		0		0	27	7.2	350	92.8
Overseas	255		0		0		0		0	255	100.0
Hospital Dietitians:											
Worldwide	623		0		0		0	40	6.4	583	93.6
Overseas	387		0		0		0	3	.8	384	99.2

[1] Basic data, unless otherwise specified, from "Promotions," Monthly Statistical Summary (processed), prepared in Promotion Section, Officers Branch, Office of The Adjutant General.
[2] All male officers as well as Army Nurse Corps officers, physical therapists, hospital dietitians, and WAC's.
[3] Basic data from "Temporary Promotions of Male Officers by Rank," (April 1943–October 1945), in "Strength of the Army," 1 Nov. 1945, pp. 98–99.
[4] Army nurses, physical therapists, hospital dietitians, and Wacs.
[5] So shown in source. May represent (in part) dental students originally commissioned in Medical Administrative Corps as second lieutenants who became first lieutenants upon commissioning in Dental Corps.

Some commanders also retained their prejudice against rapid promotions. On the other hand, in Espíritu Santo and probably in many other places there were commanders who, upon hearing reports of high initial ranks being granted to men entering the medical service in the United States, went to the opposite extreme and tried, although perhaps with not much success, to fill all vacancies by promotion even before they had an opportunity to observe the beneficiaries in action. For similar reasons, commanders were more willing than formerly to permit individuals to attain the rank authorized for their jobs by tables of organization.

In spite of obstacles, at least 19.4 percent of all Medical Department promotions during the period from November 1944 to June 1945, inclusive, resulted from assignments to vacancies or from advancement to authorized rank. In each of the Medical Department's male officer corps, the percentage was much higher (table 65).

In the latter part of the war, promotion rates of Medical Department officers overseas at times exceeded the corresponding worldwide rates. There were several reasons for this. The special regulations favoring promotion had their initial application in the Zone of Interior and attained their peak effect overseas when their influence at home was waning. Certain regulations, such as the time-and-a-half credit for service abroad, quite rightly favored oversea personnel. Promotion requirements in the continental United States became more stringent. Finally, few new units were being activated in the Zone of Interior, and in those that were activated, the new jobs were given more and more to the former members of disbanded or reorganized establishments or to men who had been rotated home from overseas who already had ranks appropriate to the vacancies created.

Although the rate of promotion of oversea Medical Department officers increased, it exceeded the rate of all officers in the theaters only during the second quarter of 1945. The reason for this generally lower rate was the fact that attrition was a much greater influence in the Army in general than it was in the Medical Department. The contrast is better illustrated when male officers alone are compared. At no time did the promotion rate of male Medical Department officers overseas even closely approach that of the corresponding group in the Army as a whole despite the increased medical losses experienced in 1945 and all the other aids to promotion activity. Indeed, promotion rates of the two groups were closer together in 1943 than they were at later dates.

Even though promotions overseas increased during the latter part of the war, it can be assumed that only about half of all Medical Corps officers who served overseas prior to the end of hostilities received promotions there. Many officers, of course, received promotions before going abroad, but the fact nevertheless remains that considerable numbers of medical officers who

saw service overseas never were promoted at all or not until late in their Army careers. [56]

Decentralization of promotions

Decentralization of promotion in wartime had many advantages. It obviated heaping upon a central headquarters the vast amount of paperwork necessary to the promotion of officers, both of high and of low rank. In removing the necessity of sending all recommendations for promotions through military channels to a central headquarters (for the Medical Department this was the Surgeon General's Office), decentralization speeded promotions greatly. This acceleration tended to foster officers' morale. Undoubtedly, The Surgeon General was content to have others promote officers in the lower grades. Lack of attention in certain instances to qualifications when promoting officers to the grade of colonel overseas, however, posed serious problems for him when men who lacked either the professional or the military experience to justify that rank for assignment to any type of job were returned to the Zone of Interior. Often, particularly in the later war years, he had difficulty in persuading commanding generals of service commands and others to accept young, inexperienced or ineffectual men who held that rank. A centralized control over promotions to the rank of colonel, in the hands of The Surgeon General, might possibly have tended to eliminate such difficulties.[57] But this procedure was unthinkable. Theater commanders had the authority to promote up to and including the rank of colonel. This was based on the recommendations of major commanders and availability of TOE vacancies and the proved competence of the individual concerned.

Enlisted Personnel

Between 31 July 1941 and the end of May 1944, the percentage of Medical Department enlisted men who were in grades above that of private increased from 49 to 68, and above the grade of private, first class, from 19 to 45 percent. Even in ranks above that of corporal, the increase was substantial, being from 15 to 21 percent (table 66). In terms of pay, however, these improvements were less significant than they seem to be. Prior to June 1942, certain Medical Department enlisted men in the grades of private and private, first class, had specialist ratings which made their pay equal to that of soldiers in higher ranks. What proportion of the number in each of these grades they constituted is unknown, but it seems probable that they comprised more than 31 percent of all Medical Department enlisted men

[56] Letters, to Col. C. H. Goddard, Office of The Surgeon General, from (1) T. L. Badger, M.D., 3 Sept. 1952; (2) Col. E. G. Billings, 23 Sept. 1952; (3) Col. H. L. Blumgart, 7 Aug. 1952; (4) Col. G. G. Duncan, 19 Aug. 1952; (5) C. S. Drayer, M.D., 3 Sept. 1952; (6) G. H. Gowen, M.D., 10 Sept. 1952; and (7) Col. George G. Finney, 2 Sept. 1952.

[57] Letter, Col. Paul A. Paden, Percy Jones Army Hospital, to Col. C. H. Goddard, Office of The Surgeon General, 9 June 1952.

TABLE 66.—*Rank of Medical Department enlisted men overseas, 31 July 1941–31 May 1944* [1]

Date	Master sergeant		First sergeant		Technical sergeant		Staff sergeant [2]		Sergeant [3]		Corporal [4]		Private, first class		Private	
	Number	Percent of strength in rank	Number	Percent of strength in rank	Number	Percent of strength in rank	Number	Percent of strength in rank	Number	Percent of strength in rank	Number	Percent of strength in rank	Number	Percent of strength in rank	Number	Percent of strength in rank
31 July 1941																
Total Army	961	0.77	874	0.70	1,762	1.40	4,220	3.36	9,665	7.71	11,554	9.21	33,399	26.63	62,999	50.22
Medical Department	26	.60	9	.21	75	1.74	188	4.37	328	7.63	202	4.70	1,271	29.56	2,201	51.19
30 November 1941																
Total Army	1,136	.74	1,098	.71	1,969	1.28	5,415	3.52	12,637	8.21	14,777	9.60	40,858	26.56	75,962	49.37
Medical Department	45	.68	25	.38	97	1.47	248	3.77	494	7.51	386	5.87	1,888	28.69	3,397	51.63
30 September 1942																
Total Army	4,990	.65	4,115	.54	10,195	1.33	34,261	4.46	82,638	10.76	124,311	16.19	171,803	22.37	335,738	43.71
Medical Department	168	.35	216	.44	533	1.10	2,480	5.11	4,213	8.68	7,391	15.22	11,880	24.47	21,666	44.63
31 January 1943																
Total Army	7,252	.70	5,527	.53	16,175	1.56	55,478	5.35	120,156	11.59	193,408	18.66	236,881	22.86	401,452	38.74
Medical Department	244	.34	319	.44	797	1.10	3,105	4.30	7,409	10.25	13,647	18.89	17,733	24.54	29,005	40.14
31 December 1943																
Total Army	19,536	.81	13,200	.55	48,100	2.00	55,747	6.49	320,695	13.37	517,470	21.57	551,328	22.98	773,383	32.23
Medical Department	673	.37	725	.40	2,174	1.20	10,178	5.60	22,515	12.39	41,440	22.80	43,893	24.15	60,164	33.10
31 May 1944																
Total Army	29,549	.87	18,731	.55	80,443	2.36	246,654	7.22	466,609	13.67	721,718	21.14	796,861	23.34	1,053,584	30.86
Medical Department	1,033	.40	1,065	.41	3,105	1.20	16,565	6.43	33,584	13.03	60,976	23.65	59,852	23.22	81,625	31.66

[1] Basic data from sources shown in table 31, footnote 3.
[2] After 1941 includes technicians, 3d grade.
[3] After 1941 includes technicians, 4th grade.
[4] After 1941 includes technicians, 5th grade.

in oversea areas. After June 1942, the specialist ratings were abolished, and although a minority of the men who had held them remained in the ranks of private and private, first class, the bulk of the specialists were automatically placed in the newly created ranks of technician, 5th grade, and technician, 4th grade. Their rank was thus brought up to the level of their pay rather than vice versa. Despite this immediate monetary limitation, the level of pay of Medical Department troops nevertheless increased considerably over a period of time through gains in the level of grades. Between 30 September 1942, by which time the conversion of the grades of enlisted specialists had been completed, and 31 May 1944, the proportion in grades above that of private increased by nearly one-fourth; above that of private, first class, by about one-half; and above that of corporal by a somewhat smaller ratio.

What proportion of this relative rise in rank of Medical Department enlisted men took place overseas cannot be precisely determined. As in the case of officers, attrition and special regulations favoring oversea personnel undoubtedly had some effect on promotion rates in the late stages of the war, but not enough to put the Medical Department on a par with the Army as a whole in this respect. The medical soldier continued to have less chance of promotion to higher rank, with accompanying increase in pay, than had his enlisted counterpart elsewhere in the Army.

CHAPTER XIII

Redeployment, Retraining, and Demobilization

PERIOD OF PARTIAL DEMOBILIZATION

As early as January 1943, the Army had begun work on demobilization planning.[1] By April, it became obvious that only partial demobilization could follow the defeat of the Axis and that plans for redeployment of troops from the European and Mediterranean theaters to the Pacific would have to be included in the overall demobilization plans.

Criteria for Release of Officers

In deciding which persons should be released as a means of reducing the forces, the intention of the War Department was to consider a number of factors in addition to those already operating to remove personnel from the Army. One of these factors was the adjusted service rating, which might also aid in determining whether, even if a man stayed in the Army, he was to be transferred from one area to another. This rating was a point score to be given each individual shortly after the surrender of Germany. The score was the sum of his credits for length of service in the Army (1 point for each month since 16 September 1940), length of service overseas (1 point for each month), number of combat awards and decorations (5 points each), and number of children he possessed under 18 years of age up to a limit of three (12 points each). The score must reach a certain total (the "critical score") to be considered as a factor working toward his release from the Army.

As part of the plans for redeployment of medical personnel, The Surgeon General, 2 weeks after V–E Day, requested and received authority for the transfer of 1,000 Medical Corps officers from the European and Mediterranean theaters to the United States so as to help care for the expected concentration of patients in the United States after the end of hostilities in Europe. He also obtained approval for certain other policies concerning the redistribution of members of the Medical Department. The War Department planned to send some medical units to the Pacific by way of the United States, and The Surgeon General obtained authority to restaff these units by exchanging their high-score personnel for low-score personnel in the United States before shipping them to the Pacific. To this end, a complete census was taken of all personnel stationed in the United States.

[1] For a detailed account of demobilization Army-wide, *see* Sparrow, John C.: History of Personnel Demobilization in the United States Army. Washington: U.S. Government Printing Office, 1952. (DA Pamphlet 20–210.)

On the basis of this census and in the light of experience to date, criteria were established for withdrawing personnel from units passing through this country and for assigning personnel then in the United States to the units scheduled for the Pacific. Thus, Medical Corps officers in returning units would be withdrawn if they were 45 years of age or over, or had an adjusted service rating of 75 or over, or had had 12 months' service overseas. The age and oversea service criteria for all other Medical Department officers were lower—40 years and 6 months, respectively. The critical figure for the adjusted service rating was also lower, being 50 for all other male Medical Department officers and 30 for all female officers of the Department.

The Surgeon General also planned to speed the exchange of personnel with the Pacific as soon as part of the surplus from the European and Mediterranean theaters should return to the United States. Finally, he recommended that the European theater, which had more low-score specialists than the Mediterranean theater, should exchange them with high-score specialists from the latter. This would enable the Mediterranean theater to send units directly to the Pacific, properly balanced with specialists, and yet avoid keeping high-score men in oversea service. Presumably, the latter would be returned to the United States.[2]

The Surgeon General's Office also developed a method of selecting the Medical Department officers to be separated from the Army in helping to carry out partial demobilization. According to War Department readjustment regulations, which were given the force of directives upon the defeat of Germany, all Medical Department officers who were returned to the United States as surplus from oversea theaters and defense commands were to be placed under the jurisdiction of Army Ground Forces, Air Forces, or Service Forces, depending on which of these commands was responsible for the unit in the troop basis with which the particular officer had last served. If these officers were needed by the Air or Ground Forces, they were to be retained by them. If not, they and other surplus Medical Department officers from those commands were to be turned over to the Commanding General, Army Service Forces, for a decision as to their essentiality to the Army. The regulations stated that in this decision "military necessity must be the controlling factor," but that other considerations should also be weighed—efficiency, the officer's desire as to retention, and his adjusted service rating. The Army was permitted to keep officers otherwise qualified for release if they wished to be retained and had satisfactory records.[3]

On 7 May 1945, the Commanding General, Army Service Forces, delegated his responsibility for determining the essentiality of Medical Department officers to The Surgeon General, although he retained a certain amount of control in that respect. A week before this, The Surgeon General in accord-

[2] Medical Department Redeployment and Separation Policy, as revised, 6 August 1945. *In* Annual Report, Military Personnel Division, Office of The Surgeon General, U.S. Army, 1946.

[3] Readjustment Regulations 1–5, 30 Apr. 1945.

ance with prior planning had established a board of medical officers, composed in part of representatives of Army Ground and Air Forces, to deal with the question.[4]

By the end of July, the Surgeon General's Office had evolved a method of selecting the officers who were to be kept in service and those who were to be released. This method took into consideration the essentiality not of individual officers but of numbers—the number that would be needed and the number that could be dispensed with in each of eight officer [5] components and in each of certain specialties within the Medical Corps.

The Surgeon General's Office adopted age and the adjusted service rating as the factors which might give officers claim to separation. Keeping in mind the number needed in each component and specialty, it set the age or point score at such a figure that the number who could qualify would not exceed the number that could be dispensed with. It might happen, however, that certain persons with "irreplaceable experience," even though they were eligible for release on other grounds, needed to be retained; in such cases, their release could be deferred by applying the principle of military necessity directly to them as individuals.[6] It appears that before the surrender of Japan the point score for release was not arrived at by any very exact calculation as to how many officers would be made eligible for discharge by the figure adopted; in the case of specialists, at any rate, the point score fixed upon was to be retained so long as the number of releases under it "would not endanger the efficiency of the medical service," after which it would presumably be raised or the whole procedure abandoned.

Although The Surgeon General recommended the release of Medical and Dental Corps officers who were 50 years of age or over, Army Service Forces headquarters did not put this provision into effect immediately. Many such men had been retained in the United States throughout their period of service and so had been unable to accumulate many points. The minimum point score required for members of the Medical Corps was 100 (120 for specialists in gastroenterology, ophthalmology, otorhinolaryngology, cardiology, dermatology, allergies, anesthesiology, neuropsychiatry, thoracic surgery, plastic surgery, orthopedic surgery, neurosurgery, clinical laboratory work). The minimum separation ages or point scores required for members of other officer components were as follows: Veterinary Corps, 50 years or 110 points; Medical Administrative and Sanitary Corps, 45 years or 90 points; Nurse Corps, 40 years or 65 points; dietitians and physical therapists, 50 years or 65 points.[7]

---

[4] (1) Army Service Forces Circular No. 175, May 1945. (2) Personnel Service Plan for Period I, Action 66, Office of The Surgeon General. (3) Office Order No. 105, Office of The Surgeon General, U.S. Army, 11 May 1945.

[5] Members of the Pharmacy Corps, all of whom were officers of the Regular Army, did not fall under this program.

[6] See footnote 2, p. 488.

[7] Letter, Chief, Personnel Service, Office of The Surgeon General, to Chief, Historical Division, Office of The Surgeon General, 14 Aug. 1945, subject: Criteria for Separation of Medical Department Officer Personnel.

Criteria for Release of Enlisted Personnel

Few special provisions concerning Medical Department enlisted personnel appeared in the rules governing the release of the Army's enlisted members as a phase of partial demobilization. It will be recalled that shortly after V–E Day the War Department permitted the release of all enlisted persons 40 years of age or over almost without restriction. About the same time, the Secretary of War announced that the critical score for enlisted personnel would be 85 points; military necessity, however, might dictate that men having that score—particularly those possessing special skills—would be held until qualified replacements arrived. The readjustment regulations provided that the essentiality of enlisted personnel would be determined at reception centers where surplus personnel from the United States and overseas were to be collected. There, the liaison officer of the Commanding General, Army Service Forces, would pass upon members of the Medical Department, with the possible exception of personnel assigned to the Air Forces and certain other combat branches of the Army.[8] The regulations permitted persons to remain in the Army if they chose to do so, providing they had satisfactory records.

Problems Encountered in Redeployment and Separation

By the early part of August 1945, 3 months after V–E Day, the carrying out of some of these plans had not gone as far as might have been anticipated. The thousand Medical Corps officers from the European and Mediterranean theaters, authority for whose return The Surgeon General had requested in May, had not yet all arrived in the United States. The remainder were en route, but the peak patient load in the U.S. hospitals had already been reached and passed. The explanation for the delay was that "tremendous personnel shifts in the theaters and the uncertainties regarding individual scores [that is, adjusted service ratings] which were not available until almost 6 weeks after V–E Day, made it difficult for the theater to return personnel as rapidly as desired." [9]

In addition, The Surgeon General's plan to restaff units passing through this country to the Pacific was not too successful, since few units had been shipped back by early August. His efforts to speed replacements to the Pacific in order to relieve personnel who had been there for a long time were achieving more success; arrangements had been made to bring back large numbers of nurses and replace them with fresh members of the Nurse Corps. The policy of exchanging low- for high-score specialists between the European and Mediterranean theaters had also, after some delays, been put into effect.

On the other hand, the separation of Medical Department personnel from the service as a phase of partial demobilization had no more than begun. In

[8] Readjustment Regulations 1–1, 12 Feb. 1945, par. 12, and Changes No. 1, 4 May 1945, par. 12a(1).

[9] See footnote 2, p. 488.

July, the chairman of a Senate subcommittee investigating the Army's use of doctors had charged that surplus Army doctors in Europe were not working "more than an hour or two a day" and declared that they should be brought home to relieve the shortage of civilian doctors.

The Surgeon General's Office gave reasons why few Medical Department personnel were being discharged from the Army. It pointed out that very large numbers of patients continued to come back to the United States even after the fighting ended in Europe, so that the patient load at home might be expected to remain at or near the peak until the fall of 1945. It stated that while Medical Department personnel in Europe no longer had to care for combat casualties they were occupied with closing hospitals, treating displaced persons for sickness and injuries in territories overrun by the American armies, and finally moving toward the United States or the Pacific.[10]

FULL-SCALE DEMOBILIZATION

The capitulation of Japan on 14 August 1945 put an end to redeployment as a shift from a two- to a one-front war. The process of transferring units from Europe to the Pacific either directly or by way of the United States was abandoned. Gradually, a vast movement of men from overseas to the United States set in, with a smaller movement outward of fresh personnel to maintain the occupation forces. Partial demobilization, which had hardly started, gave way to full demobilization.

Reduction of Criteria for Demobilization of Enlisted Personnel

Officers as well as enlisted men who possessed the critical score could no longer be held in the Army on the ground of military necessity, except in special instances. Adjusted service ratings were recomputed as of 2 September 1945. The critical score of enlisted men was then reduced from 85 to 80 points, and enlisted men 35 years of age and over who had had at least 2 years' service were ordered released on their application; the age for automatic release of those with less than 2 years' service remained at 38, having been reduced from 40 earlier. Within the next 3 months, the critical score for enlisted men was brought down by successive cuts from 80 to 55, while new alternatives of 4 years' service or the possession of three dependent children also qualified men for discharge.

Medical Department enlisted technicians in certain specialties were excepted from the rule that men could not be held in the Army for reasons of military necessity if they were otherwise eligible for release. Six months was the maximum length of time for which these technicians could be retained. Orthopedic mechanics were among those so held.[11] In the fall of 1945, the

[10] See footnote 2, p. 488.

[11] Memorandum, Surgeon General Kirk, for Commanding General, Army Service Forces, 22 Oct. 1945, subject: Shortage of Medical Department Enlisted Personnel for Zone of Interior Installations.

Medical Department was training 75 of these technicians; The Surgeon General stated that when they completed their training those being held on duty would be discharged. Expressing his belief that when men were held beyond the date at which they became eligible for discharge their morale went down, he also urged service command surgeons to consider seriously a one-grade promotion for those being retained.[12] In late November, promotions were authorized for orthopedic mechanics.

In early December, The Surgeon General stated that information available to his Office indicated that the situation had improved in the last 2 weeks, but he warned the Army Service Forces headquarters at the same time that additional replacements would have to be forthcoming as the discharge criteria were lowered in the future.[13] A few days later, he reluctantly advised the same headquarters that effective on 1 January 1946 men in four critically needed enlisted specialties might be authorized for discharge—medical and dental laboratory, X-ray, and orthopedic technicians—provided they had 50 points on the adjusted service record or had been in the Army for 3½ years.[14] These same criteria were announced the next day by the War Department as those that would govern the discharge of enlisted men generally after 31 December 1945.

As late as February 1946, the Surgeon General's Office was still trying to make good the losses by recommending that G–1 make enlisted men available to the Medical Department for training to replace scarce category personnel, specifically men in the four critical specialties.[15] All specialists were taken off the list of those critically needed by 1 July 1946 in order to comply with the Chief of Staff's statement that all enlisted personnel with 2½ years' service or 45 points be discharged by 30 April 1946 and all with 2 years' service or 40 points by 2 months later. At the same time, The Surgeon General asserted that the situation had become increasingly worse. He admonished service command surgeons that they must make exceptional effort immediately to employ soldiers as civilians upon their discharge. Furthermore, they were to hold enlisted specialists as long as possible.[16]

---

[12] (1) Memorandum, Chief, Enlisted Branch, Military Personnel Division, Office of The Surgeon General, for Director, Military Personnel Division, Office of The Surgeon General, 14 Nov. 1945, subject: Survey of Medical Department Enlisted Situation, Eighth Service Command, with Comment No. 2, Military Personnel Division, Office of The Surgeon General, to Legislative and Liaison Division, War Department General Staff, 23 Nov. 1945. (2) Letter, The Surgeon General, to Surgeon, each service command, 28 Nov. 1945.

[13] Memorandum, Deputy Surgeon General, for Commanding General, Army Service Forces (attention: Deputy Chief of Staff for Service Commands), 6 Dec. 1945, subject: Medical Department Enlisted Personnel.

[14] Memorandum, Director, Military Personnel Division, Office of The Surgeon General, for Director, Military Personnel Division, Army Service Forces, 18 Dec. 1945, subject: Scarce Categories and Critically Needed Specialists.

[15] Memorandum, Deputy Surgeon General, for G–1, 8 Feb. 1946, subject: Scarce Category Enlisted Personnel, Medical Department.

[16] Letter, Deputy Surgeon General, to Col. John A. Isherwood, Surgeon, First Service Command, 8 Feb. 1946.

Reduction of Criteria for Demobilization of Officers

Following V–J Day, the criteria for demobilizing Medical Department officers also were reduced. The first reduction occurred on 10 September 1945. The new criteria did not entitle certain Medical Corps specialists having an A, B, or C proficiency rating to release; moreover, The Surgeon General could hold individual specialists who were essential to the proper care of patients. For others, the minimum point score was considerably reduced. Age, which had not previously been an alternative for Medical and Dental Corps officers, was now added for them, while length of service became a second alternative for all except female officers (nurses, dietitians, and physical therapists). The criteria for age and length of service were so high, however, that few officers could qualify for separation under them. Consequently, the speed with which doctors were being demobilized met with considerable criticism.

Congressional reaction

On 6 November 1945, Senator Clyde M. Reed of Kansas submitted a resolution to the Senate in which he pointed out that the Army had more doctors on its rolls on 1 September 1945, 2 weeks after fighting had ceased, than on the previous 1 January, when a two-front war was waging. The Senator also charged that "from many sources, testimony of undoubted reliability has come to members of the Senate indicating an incredible degree of incompetency, inefficiency, and general neglect on the part of the Office of The Surgeon General of the Army, in dealing with the return of the doctors and surgeons from the Army service where they are not needed, to communities where the civilian need for proper medical attention is very great." Actually, the number of doctors in the Army was about the same on 1 September as it had been 8 months earlier and by the time the Senator spoke, it had fallen by 8,000. Furthermore, over 11,000 had been discharged between 1 May and 1 November. The Surgeon General might have pointed out that in addition to the medical skills still needed to provide definitive treatment in Army hospitals even though fighting had ceased, some 2,000 doctors had to be stationed in separation centers to perform the final physical examinations so that other troops could be promptly released. Senator Reed's resolution requested the Secretary of War to appoint a board to investigate the situation, fix responsibility, and "take immediate steps to remedy the injury done to the doctors, surgeons, and dentists as individuals and to the communities affected." [17]

The Surgeon General had let it be known that he would welcome such an investigation, as an opportunity to present his own case to the American people. At the same time, he promised to do everything in his power to speed

[17] S. Res. 184, 79th Cong., 6 Nov. 1945 (legislative date, 20 October).

the overall demobilization. The firm position of The Surgeon General, with its implied promise to expose the organized groups then seeking to influence the Congress, strengthened the hand of the Secretary of War, who was able to persuade the senatorial sponsors of the resolution to drop it. In return, the Secretary promised to give his personal attention to the problem of discharging at the earliest possible date all doctors and dentists not actually needed by the Army. In a memorandum of 21 November 1945 to the Chief of Staff, he set forth certain steps to achieve that end; they included determination by the General Staff of the number of doctors and dentists each theater required, the appointment of a mission to the European and Mediterranean theaters to report on ways of speeding the process of returning their surpluses to the United States, priority of transportation for these surpluses, and investigation of the three major commands in the United States to see that their staffs were cut as fast as their workload permitted and that the criteria for discharge were kept adjusted so as to release the surplus without delay. Col. Durward G. Hall, Chief of The Surgeon General's Personnel Service, himself headed the mission to the European and Mediterranean theaters, and took with him Lt. Col. Bolling R. Powell, Jr., Congressional Legislative Liaison Officer, on the War Department Special Staff. The mission traveled on orders from the Secretary of War, with authority to expedite the return of critical category medical personnel.[18] Although much pressure continued to be brought for the release of individual doctors, no further public attacks were made by Senator Reed or his associates.

While the threat of a congressional investigation did not change basic medical demobilization plans, it probably hastened the execution of them. Only a week before the Secretary of War took action, The Surgeon General had informed G–1 that the release of 13,000 doctors by Christmas in fulfillment of a promise made 6 weeks earlier "should relieve undue pressure from Congress and other sources."[19] But by the end of December, 22,000 had been released in an orderly manner. Nevertheless, it was not until then that the criteria were substantially reduced. After that, reductions occurred on 1 February, 1 July, and 1 September 1946. Although the demobilization of critical category personnel, including shipment from oversea theaters, was an outstanding achievement, it was undoubtedly too rapid from the standpoint of good medical care.[20]

Differences in criteria for medical and nonmedical officers

The principal criteria for the discharge of Medical Department officers differed from those for other Army officers, which after V–J Day were for

[18] Statement of Durward G. Hall, M.D., to the editor, 27 May 1961.

[19] The promise of 13,000, or slightly more, separations was made on 31 August. The Deputy Surgeon General later (17 October) promised 14,000 separations and hoped that that figure could be exceeded. (House of Representatives, Hearings before the Committee on Military Affairs, "The Demobilization of the Army of the U.S.," 28 and 31 Aug. 1945; Senate, Hearings before the Committee on Military Affairs, "The Demobilization of the Armed Services," 17 and 18 Oct. 1945.)

[20] See footnote 18.

the most part uniform. As already indicated, the medical authorities were permitted to set their own criteria after as well as before the surrender of Japan, and the function continued to be exercised by The Surgeon General on the advice of a board representing his own Office, the Ground Forces, and the Air Forces.

From early September 1945, at the beginning of the demobilization period, until 31 August 1946, when the point score was abolished as a criterion for release, the minimum score set for doctors, dentists, and veterinarians was always (except for the first 3 weeks in October) lower than that for non-Medical Department officers. The difference varied from 3 to 10 points. When in favor of Medical Department officers, it tended to equalize their situation with that of other officers, since a smaller proportion of the former than of the latter had had the opportunity to serve overseas, and oversea service plus battle decorations counted in the score. Until it was abolished, the minimum point score for the separation of male Medical Department officers was never allowed to fall below 60, a figure reached on 1 February 1946. The Surgeon General's separation board believed that to have reduced it further would have weighted the criterion too much in favor of officers possessing children, and would then have promoted the release of the older professional group.[21]

Length of service (apart from the point score) became an alternative criterion for the release of male Medical Department officers in early September 1945 and for all other Army officers (except dietitians, to whom it was granted on 1 February 1946) at the beginning of December 1945. The criterion was revised downward from time to time, but until 1 September 1946, it was always considerably lower for Medical Department officers than for others. The attainment of a certain age, a third alternative for release under demobilization regulations, was applicable to officers of the Medical Department only. In the case of members of the Medical Corps, it was set at 48 years in early September 1945 and reduced to 45, 2 months later, where it remained until abolished on 1 September 1946.

OFFSETTING FACTORS

Administration of Demobilization

Before making each successive reduction in criteria, authorities in the Surgeon General's Office had of course to compute how many officers would be eligible for separation if criteria were reduced by a certain amount. Whenever possible they would forewarn the service command surgeons, and the commanders of those relatively few installations which were directly under The Surgeon General's jurisdiction, who would then report to the Surgeon General's Office how many officers and what types of specialists they would

[21] Memorandum, unsigned, for Deputy Surgeon General, 5 Jan. 1945 [46], subject: Separation of Medical Corps Officers.

need after the proposed cut. Thus it was that, through close cooperation, the service command surgeons were enabled to make certain that no hospital, post, or body of troops was, through the separation of its Medical Department officers, left without adequate medical and allied attention. One saving clause that tended to keep this task from becoming even more troublesome and demanding was a provision that regardless of a Medical Department officer's eligibility for separation, he could be retained until a replacement became available.[22] Thus, military necessity took precedence over an individual's eligibility for separation.

Likewise, The Surgeon General had to exercise care that, regardless of the level at which the criteria were fixed, the oversea commands always had sufficient Medical Department strength to care for Army personnel remaining there. As the time involved in transporting officers was so great, this aspect of demobilization was probably more difficult than that of keeping service commands in the United States properly manned. During this period, there was also more necessity to juggle personnel than had been needed when whole units were being sent to theaters of operations. The fact that separation criteria were being repeatedly lowered during this period caused difficulty in getting the right men overseas. An officer or enlisted man might be slated for shipment when a lowered set of criteria would make him eligible for separation. As the Chief of Staff pointed out to Congress, the Army had to suffer the inevitable delay between the date of recruiting new personnel and the time it could put them to work.

New Officer Procurement

During the period of demobilization, various factors helped partially to offset the losses produced by it or to prevent it from proceeding as rapidly as possible. One such factor was the continuous procurement of new officers.

Dentists

In the case of dentists, however, the number fell far short of the demand. Unlike the Medical Corps, the Dental Corps could no longer rely on graduates of the Army Specialized Training Program to take up the deficit, for the dental phase of the program had ended in April 1945. The medical phase ran until June 1946 and was the main source of procurement for the Medical Corps during demobilization. Most if not all of the doctors it produced were held for 2 years' service in the Army; those who had spent little of their student career in the program complained that they were compelled to serve as long after graduation as those who had spent much time in it.[23] The case was dif-

[22] Memorandum, Executive Officer, Office of The Surgeon General, for Chiefs of Services, Directors of Divisions, and others, Office of The Surgeon General, 13 Sept. 1945, subject: Criteria for Separation of Medical Department Officer Personnel.

[23] War Department, Information and Education Division, Report No. 12–310, 2 Nov. 1946, subject: Attitudes of A.S.T.P. Medical Officers Toward Service in the Regular Army.

ferent with students who had received part of their education through the program but had not been permitted to continue in it long enough to graduate. They had been relieved of all obligation to serve after finishing their course, and no effort was yet made to compel these men in particular, or even the dentists among them, to come to the relief of the Medical Department. Instead, a more general measure of compulsion was introduced—a draft of dentists—the first time in American history that a professional group had been singled out for conscription. As already stated, such a measure had been agitated before, for doctors and nurses, but it had been avoided even in wartime.

On 17 May 1946, The Surgeon General in a memorandum to the Assistant Chief of Staff, G–1, stated that only 15 dentists had joined the Army in the past 3 months, from which he concluded that volunteering alone would not yield sufficient recruits. Accordingly, he recommended that the Selective Service System be requested to deliver enough dentists to meet the procurement objective of 1,500, preferably, "both from the War Department's point of view and probably from that of the community at large * * * dentists in the youngest age groups who have not yet been firmly established in civilian practice." [24] His advice was accepted and Selective Service issued its call. However, only a very few dentists, probably not more than four, were actually drafted, others who were called preferring to accept commissions instead.[25] Nevertheless, the drafting of dentists had established a precedent for applying conscription to professional groups, a precedent that was followed 4 years later in the case not only of dentists, but of doctors as well.

Physicians

Before this latter event took place, another piece of evidence indicated that it might become necessary to draft physicians. In November 1946, the War Department conducted a poll of Medical Corps officers—former members of the Army Specialized Training Program—to discover the attitude of graduates of the program toward volunteering for the Regular Army Medical Corps. All but 1 of the 385 who answered the questionnaire stated that they were not planning to apply for commissions in the Regular Army. Among the main reasons given were dissatisfaction with assignments, inadequate opportunities for training, insufficient financial compensation, and dissatisfaction with living conditions. Also, 267 of the 385 said they would like to get out of the Army at once, if possible.[26]

Effects of procurement

Procurement for most of the Medical Department officer components did little or nothing to offset losses through demobilization and other factors be-

[24] Memorandum, Surgeon General Kirk, for G–1, subject: Procurement Objective for Dental Corps Officers.

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

[26] See footnote 23, p. 496.

TABLE 67.—*Medical Department officers separated, V–E Day–31 December 1946 (cumulative)*

End of month	Medical Corps	Dental Corps	Veterinary Corps [1]	Sanitary Corps [1]	Medical Administrative Corps	Army Nurse Corps	Hospital dietitians	Physical therapists
1945								
May	230	50	10	10	220	300	10	5
June	570	115	30	30	330	600	20	10
July	1, 140	450	60	60	490	900	30	20
August	2, 170	610	80	100	720	1, 200	40	30
September	4, 220	1, 025	130	195	1, 250	4, 200	80	70
October	11, 750	2, 530	330	565	3, 420	15, 900	310	225
November	17, 630	3, 960	520	905	5, 790	24, 000	530	370
December	22, 590	5, 185	730	1, 265	8, 500	29, 300	680	500
1946								
January	27, 100	7, 375	900	1, 400	11, 140	33, 600	790	685
February	30, 750	8, 950	1, 075	1, 530	13, 230	36, 600	810	765
March	32, 900	9, 750	1, 225	1, 700	15, 370	39, 700	1, 020	835
April	34, 750	10, 290	1, 425	1, 900	17, 200	41, 925	1, 075	875
May	37, 000	10, 825	1, 475	2, 025	17, 290	43, 750	1, 120	930
June	39, 000	11, 500	1, 500	2, 100	17, 500	45, 600	1, 180	1, 030
July	40, 950	12, 100	1, 550	2, 200	17, 800	46, 850	1, 205	1, 080
August	42, 000	12, 540	1, 600	2, 260	18, 100	47, 725	1, 225	1, 110
September	42, 775	13, 175	1, 650	2, 320	18, 400	48, 350	1, 255	1, 130
October	43, 900	13, 450	1, 700	2, 380	18, 600	48, 900	1, 280	1, 150
November	44, 500	13, 850	1, 750	2, 440	18, 800	49, 850	1, 305	1, 170
December	45, 050	14, 200	1, 770	2, 460	18, 900	50, 325	1, 325	1, 190

[1] Figures for Veterinary and Sanitary Corps are estimated.

Source: Chart, "Medical Department Officer Separations since V–E Day–30 June 1947 (cumulative)," Resources Analysis Division, Office of The Surgeon General.

tween August or September 1945 and March 1946, the period when the greatest losses occurred. This is indicated by a comparison of the strength figures (table 1) with the figures for separations, by month, in table 67.[27] The Medical Administrative Corps, however, obtained enough new recruits to make up for most of its losses through November 1945, after which it too lost members more rapidly than it gained them. No figures are available for procurement or losses of Medical Department enlisted personnel after June 1945.

Reference to table 1 will show that the ratio of Medical Department officer strength to Army strength increased markedly during the period of heaviest demobilization. Since procurement was at a very low ebb, this means that Medical Department officers were being discharged more slowly than members of the Army in general. A similar lag occurred in the case of mem-

[27] In comparing these two tables, it will be noticed that in a number of instances the decline in strength shown is greater than the number of separations. As it is unlikely that losses from causes other than separations amounted to any appreciable number, especially after hostilities had ceased, some of the figures must be inaccurate. In fact, those in the table on separations and some of those in the strength table are obviously mere approximations.

TABLE 68.—*Civilians and prisoners of war employed in medical activities within Army Service Forces in the United States, 30 March 1945–30 April 1946*

Month	Civilians [1]	Prisoners of war [2]	Total
1945			
March	72, 690	15, 237	87, 927
April	73, 096	17, 098	90, 194
May	73, 313	20, 322	93, 635
June	[3](75, 258)	[3](20, 528)	[3](95, 785)
July	77, 202	20, 733	97, 935
August	75, 353	20, 485	95, 838
September	72, 714	18, 518	91, 232
October	72, 492	16, 731	89, 223
November	67, 407	14, 767	82, 174
December	61, 021	11, 992	73, 013
1946			
January	60, 337	10, 678	71, 015
February	59, 990	9, 491	69, 481
March	54, 512	6, 054	60, 566
April	51, 354	5, 063	56, 417

[1] Figures obtained by adding figures for civilians in the following tables of Army Service Forces Monthly Progress Reports: (1) "Service Command Operating Personnel and Prisoners of War" (subhead "Hospital and Medical Activities"); (2) "Technical Service ZI Operating Personnel and Prisoners of War, by activity" (subheads "Station Medical at Staging Areas" and "Debarkation Hospital and Station Medical at Ports"); (3) "ASF Personnel Authorizations and Strengths" (subhead "Surgeon General").

[2] Figures obtained by adding figures for prisoners of war in the following tables of Army Service Forces Monthly Progress Reports: (1) "Technical Service ZI Operating Personnel and Prisoners of War" (subhead "Hospital and Station Medical Activities"); (2) "Service Command Operating Personnel and Prisoners of War by Activity" (subhead "Hospital and Medical Activities").

[3] Figures in parentheses indicate the interpolation of a figure halfway between those immediately following and preceding it for one that was obviously incorrect.

Source: Monthly Progress Reports, Army Service Forces, War Department, for the dates indicated.

bers of the individual Medical Department officer components. On the other hand, Medical Department enlisted men, and also officers and enlisted men taken together, were apparently being released more rapidly than members of the Army as a whole, for their ratio to Army strength, which had been declining since November 1944, continued to decline throughout the period of heaviest demobilization.

During the same period, a decline also occurred in the number of civilians and prisoners of war employed in Medical Department activities within Army Service Forces in the United States, as is shown in table 68.

Voluntary Continuance

Another offsetting factor was the choice of various officers and enlisted men to remain in the Army. Since the beginning of demobilization, men of both categories had been permitted to extend their terms of service under

certain conditions if they so chose. In December 1945, the War Department required a statement from each non-Regular Army officer as to whether he wished to be released at once, to be kept on active duty indefinitely, or to remain for a specified time. In the last mentioned case, the stated discharge date was to be 31 December 1946, 30 June 1947, or some other date agreed upon between the individual and his commanding officer that involved a continuance of at least 60 days but would not be later than 30 November 1946.

For medical and dental officers, as we shall see in the following section, one of the inducements to remain in the Army for an additional period was a program of refresher training for those about to return to civilian practice.

PROFESSIONAL RETRAINING

In addition to the technical and military training that was a continuing function of the Medical Department throughout the war, there were two phases of professional training that were carried out primarily by the Personnel Division of the Surgeon General's Office rather than by the Training Division. One of these was the retraining of Army of the United States officers returning to civilian life. The other was the preparation of Regular Army officers, most of whom had been serving in administrative rather than professional capacities, to resume the complete responsibility for the medical care of the Army as a whole that was their peacetime mission. These Regular Army medical officers would also be called upon to care for the thousands of casualties of the war who would remain in Army hospitals long after the specialists who first treated them had returned to civilian practice.

Army of the United States

Even before the attack on Pearl Harbor, The Surgeon General had been faced with the problem of uneven distribution of professional opportunities for Medical Corps officers on active duty for a year or two and its resultant effect on morale. After the declaration of war, he became increasingly concerned about the failure of his efforts to produce an effective rotation system which would permit an exchange of medical officers between hospital and tactical assignments. This was due in large measure to the decentralization of control of military personnel which, while no doubt responsible for the acceleration of the war efforts, posed peculiar problems for the Medical Service.

Tradition and history agree that great scientific advancement occurs during a war between major powers. General Kirk was not alone in believing that the pressures of World War II had advanced medical science out of all proportion to the duration of the conflict. All of this professional advancement did not take place in the large hospitals. Much of it was in the field of preventive medicine, such as the development of Atabrine (quinacrine hydrochloride) and DDT; and some was by way of improvisations on the

field of battle in the treatment of shock or the management of various types of wounds. There were improvements in medical supplies and equipment, and decided advances in the fashioning of artificial eyes and limbs. It was nevertheless the work going on in the large hospitals, and particularly in the specialty centers, that enticed young officers who had been primarily on field duty in the forward areas.

The Surgeon General fully sympathized with the desire of these young doctors to take back with them to civilian practice the best of wartime gains in medicine and surgery and was prepared to give them every encouragement, both to strengthen civilian medicine the country over and to insure for the next emergency a nucleus of men widely experienced in the special requirements of military medicine. With these purposes in mind, various means were explored well before the war was over whereby the professional advances stemming from the conflict might be made available to the largest possible number of Army of the United States officers.[28]

The American Medical Association was also interested in various phases of planning for the return to civil life of the doctors in the military service. Among its recommendations was further education to supplement the training available in the military service and to facilitate reorientation to civilian practice.

On 7 July 1944, The Surgeon General constituted a committee to formulate plans for postwar refresher courses for medical officers scheduled to be separated from the military service. It was understood that at first most of these would be leaving for physical reasons; later, the general demobilization would take place. At the committee's first meeting, Lt. Col. (later Col.) Durward G. Hall, MC, Chief of Personnel, was appointed chairman. Under his leadership, the committee undertook to survey the various possibilities relating to types of courses, where they should be conducted, and the means of financing them. It was later determined that this committee should handle both the inservice refresher courses and the postwar courses.

During the summer of 1944, the Chief of the Personnel Service and a representative of the Training Division worked closely together. By 20 September, they were agreed on who should be eligible for the proposed training, in terms of rank, previous assignments in the Army, and type of work they had done in civil life. Consideration was given both to on-the-job training and to didactic courses, as well as to the feasibility of sending officers still in the service to civilian institutions. Among the numerous problems that arose, one of the most threatening was a requirement that officers could be detailed to the Military District of Washington for duty in excess of 30 days only with the concurrence of the Assistant Deputy Chief of Staff.[29] Be-

[28] One direction of Medical Department thinking along these lines is exemplified by a 4-week refresher course offered to Medical Corps officers of the Army Ground Forces at various general hospitals early in 1944. Designed primarily for junior officers who were scheduled for combat duty after a year or more in training units, the course reviewed the principles of medicine and surgery as they related to battle casualties, including treatment of burns, tropical diseases, and psychiatric cases.

[29] War Department Memorandum W–500–44, 13 Mar. 1944.

cause of this requirement, it was necessary to get special approval to send five officers at a time to Walter Reed Hospital for professional medical training.

On 30 November 1944, in accordance with the recommendations of The Surgeon General, hospitals were designated within each service command at which 12 weeks of on-the-job training would be given. A quota, divided between medical and surgical services, was established for each hospital. The limit was set at six officers for either medical or surgical refresher training at any one hospital at the same time, and it was stipulated that no additional personnel or facilities would be granted for the purpose. Officers returning from overseas were first to participate in this instruction. Applications were processed by the Personnel Service, and selection was made with the advice of one of the professional consultants. Only those officers whose assignments had removed them from responsibility for the professional care of patients for 12 months or longer were considered eligible. After the German surrender, similar refresher courses were set up in the European theater for men awaiting redeployment or return to the United States. Instruction was given in medical and surgical specialties for those who had had little opportunity for hospital practice, while qualified specialists were given an opportunity for furthering their education in their own specific fields.

In March 1945, the Dental Division of the Surgeon General's Office took steps to provide courses for the professional retraining of dental officers whose military assignments had removed them for 12 months or more from the direct practice of dentistry. The program was approved by the Commanding General, Army Service Forces, in April. Courses were approved the following month for the retraining of laboratory officers of both Medical and Sanitary Corps under conditions comparable to those laid down for doctors and dentists.

Regular Army

The Medical Corps of the Regular Army went underground professionally during the war. Its shining hour in that respect was to come later, on 1 January 1947, when the Army Medical Residency Program which has brought so much favorable attention to the Army Medical Service was officially launched. In between is a story of unusual courage and loyalty in response to an almost cruel demand.

Soon after the outbreak of World War II, The Surgeon General had available the cream of the medical profession with which to staff the hospitals of the Army. Outstanding doctors from civilian life were appointed in the Medical Corps by the thousands. This rapid growth brought with it a tremendous demand for Medical Corps officers to fill administrative, command, staff, and training assignments. The almost inevitable decision was made that the Regular Army officers were the best fitted for these positions.

It had been planned that, after a year or two, when Army of the United States officers had had the opportunity to demonstrate their command and

administrative abilities, at least some of the Regular Army officers would be returned to professional assignments in the large hospitals in the Zone of Interior where they could share in the unusual professional opportunities then available, and receive instruction and guidance from some of the outstanding doctors who would then be on duty in these installations. The wisdom of the decision is still debatable. The premise that the Regular Army medical officer would fill the administrative and command positions with credit was amply sustained. On the other hand, there was no question but that a few Regular Army medical officers could have made a much greater contribution to the war effort had they remained on purely professional duty. While leadership can be developed, it must be based on an inherent characteristic. The record does not show that this was an exclusive possession of the Regular Army officer. Many Army of the United States medical officers made outstanding contributions to the war effort in medical staff and command positions. As the theaters became virtually autonomous and the war spread around the globe, it never became possible to reassign any substantial number of Regular Army medical officers to professional work. All those who were physically qualified were used in administrative, tactical, or command assignments throughout the war.

When the decision was made to place all Regular Army medical officers in staff or command assignments, they were given a corresponding primary MOS (military occupational specialty) classification. Even though they were well established professionally, the professional consultants in the Office of The Surgeon General were reluctant to award them a secondary MOS indicating any appreciable degree of proficiency on the theory that, as most of them lacked formal specialty training and there was no opportunity to observe them professionally, they could not be properly evaluated. Only if an officer had been certified by one of the professional specialty boards was he given a "B" prefix to his secondary MOS. Thus, for most of the Regular Army medical officers, there was no official record of professional ability in the Classification Branch. The Surgeon General was able, nevertheless, to convince the various civilian medical organizations concerned that the professional potential of the Regular Army was great enough to justify a graduate program comparable to those offered in the approved civilian teaching hospitals.

It was important that plans be formulated in time to utilize the professional skill then available to the best advantage. Early in the year 1945, the Personnel Service prepared a study for the consideration of The Surgeon General. It was for planning purposes only, designed to show what could be done professionally with the then current Regular Army Medical Corps by way of staffing nine permanent hospitals with a view to training Medical Corps officers for board certification. The study showed both those certified and those who, though not certified, were sufficiently experienced to qualify in a specialty. It also showed the total number of board members needed to staff the hospitals where approval for residency training was desired, and the board-certified officers who might serve within their appropriate specialties. Included in this group were names of men who obviously would remain in admin-

istrative work. The consultants in the office aided in the preparation of the list. It was through the results of this study that The Surgeon General was able to make a rather convincing presentation to the Council of Medical Education and Hospitals of the American Medical Association in seeking approval of Army hospitals for formal training.[30]

Long before V–E Day, it was apparent that considerable preparation would be needed before the Regular Army medical officer would be able to take over completely the professional care of the Army. Necessary deviations from Department of the Army and Army Service Forces policies were authorized, and on 7 July 1945, a Professional Training Committee was appointed by The Surgeon General. Two months later, by Office Order No. 223, The Surgeon General assigned to the various divisions of his Office specific responsibilities for the problem.

In August 1945, a letter was addressed to all Regular Army officers by the Deputy Surgeon General stating that the Chief of Staff had approved a plan for courses of instruction in professional training for Regular Army Medical Corps officers, that the plan called for the assignment of these officers to installations where professional training leading eventually to board certification would be carried out and also for training in outstanding civilian installations.[31] The plan contemplated that those qualified as potential chiefs and assistant chiefs of service would initially be assigned to such positions as understudies, and that officers with less training and experience would receive selected professional assignments based upon their qualifications with the opportunity under competitive selection to receive the training that would eventually lead to board certification. Each Regular Army officer was requested to submit a statement to the Chief of Personnel, Office of The Surgeon General, giving his preference as to either professional or administrative assignment and including specific training.

During the latter part of 1945, those who had indicated a desire for specialized professional training were placed in the program as they returned from overseas. Among the large number still out of the country, however, were many who would have to seek certification by one of the specialty boards at an early date if the formal training program was to start within the next few years. The Surgeon General, early in January 1946, persuaded the Assistant Chief of Staff, G–1, to have radiograms sent to the various theaters, Defense Commands, and Departments asking for the return of certain named officers at the earliest possible date. General Kirk supplemented this radiogram in some instances with direct communication either to the commanding general or to the surgeon concerned. Most of the men requested were returned within the next few months to begin their arduous course of preparation. It was not easy for men in their late 40's and even early 50's, who were long out

[30] Army Regulations No. 350–1010, 11 Feb. 1946.

[31] The date was rubber stamped, and varied somewhat. The actual distribution of the letter was questionable. Certainly, many officers overseas never received it.

of school, to undertake the strenuous study that would be needed to pass searching oral and written examinations before civilian boards.

It should be remembered that the Regular Army officers had not the same economic reasons for seeking certification as civilian specialists. A good many were already in the grade of colonel, so rank was not a factor. They had been separated from their families, some over 3 years, and were weary from their war experience. What they quite honestly needed was some rest and quiet, rather than intensive study with always the fear of failure haunting them. They were some of the unsung heroes of the war, and to their credit, most of them willingly accepted the challenge and came through with flying colors.

In their efforts, they had a tremendous assist from outstanding members of the medical profession—men who not only verbally supported the idea, but stayed on active duty in its interest well beyond the time that they were eligible for discharge and frequently at considerable inconvenience to their families and financial loss to themselves. Several of these later became the nucleus of the consultant group, who from the very beginning lent their knowledge and prestige to the teaching program. Aid and encouragement also came from those Regular Army medical officers who carried the full burden of administrative responsibility while their fellow officers were in training. Needless to say, the graduate professional training program could not have been established nor carried on without the continuing aid and cooperation of civilian medicine. The Council on Medical Education and hospitals of the American Medical Association, the American College of Surgeons, the Advisory Boards of the American Specialty Boards and the various specialty boards, all rendered invaluable service.

POSTWAR PLANNING

Two important aspects of postwar planning, both growing directly out of the needs and the experience of the conflict, properly belong in this volume. These are the program for integrating Reserve officers into the Regular Army, officially called the Regular Army Integration Program, and the establishment of the Career Management Plan for Regular Army officers.

The Integration Program

Realizing that postwar conditions would necessitate an Army considerably larger than that of prewar days, the War Department recommended and Congress authorized late in 1945 an increase in the commissioned strength of the Regular Army to 25,000.[32] The act provided that appointments in the various

[32] (1) 59 Stat. 663. (2) Memorandum, Maj. James H. Mackin, MSC, Office of The Surgeon General, for Chief, Personnel Division, Office of The Surgeon General, 24 June 1948, subject: Commissioning of Male Officers in the Various Corps of the Medical Department During the Integration Period, 1946–47.

corps of the Regular Army were to be made in the grades of second lieutenant, first lieutenant, captain, and major, subject to certain conditions and limitations. One condition was that these appointments were to be made not later than 8 months following the date of the enactment of the act. This limitation of time was placed in order to attract as many officers as possible who had served in World War II before they had returned home and become reestablished in civil life. Their combined experience was invaluable to the military service, gained as it was in fighting all over the world, in every kind of climate from the tropics to the arctic, and under most difficult field conditions.

The War Department moved immediately to implement the new law by establishing eligibility for appointment and setting up rules for determining service credit and grades to which individual appointments would be made. No officer was to be appointed in the Regular Army in a grade higher than that which he held during wartime.[33] Less than 8 months later, on 8 August 1946, Congress authorized the procurement of additional male officers to increase the commissioned strength of the Regular Army to 50,000.[34] It is of interest to note that separate means for determining qualifications for appointment were not established for any corps of the Medical Department, thus doing away with the longstanding requirement that applicants must pass a written or oral professional examination.

The Surgeon General was charged with final responsibility for selecting applicants for the various corps of the Medical Service. To carry out this responsibility, the Central Medical Department Examining Board was designated to make suitable recommendations regarding each applicant.[35] There was also a screening board and review committee in the Surgeon General's Office, and an Integration Section was established in the Procurement Separation and Reserve Branch of the Personnel Division which was responsible for the necessary recordkeeping, processing of cases, and preparation of finalized appointment lists. The Army Service Forces Review Board reviewed the cases of all applicants whose appointments were not recommended by The Surgeon General. This board was appointed by the Secretary of War to assure that the integration program was conducted on a fair and impartial basis. This function was later taken over by the Secretary of War's Personnel Board.

Throughout the integration period, the vast majority of those of the Medical Corps whose age required their appointment in the grade of major were selected because of outstanding professional qualifications and in most cases were required to be diplomates of one of the American specialty boards. This policy undoubtedly resulted in passing over many applicants in the older age groups who, though they had rendered highly satisfactory wartime service, were not established professional specialists.

---

[33] War Department Circular No. 392, 29 Dec. 1945.
[34] 60 Stat. 925. Implemented by War Department Circular No. 289, 24 Sept. 1946.
[35] War Department Special Orders No. 255, 25 Oct. 1945.

Medical and Dental Corps

The last appointments into the Medical Corps of the Regular Army prior to the integration program were made in 1944. The strength of the corps on 1 January 1946 was 1,214. Integration gains amounted to 374, while losses during the period amounted to 367. Thus, the integration period produced a net gain of only seven officers for the Medical Corps. Although 3,000 of the 50,000 officer spaces under the two integration statutes had been allotted to the Medical Corps, only 1,221 had been assigned as of 31 December 1947, leaving 1,779 vacancies.

The last appointments into the Dental Corps, Regular Army, prior to the integration program, were made in January 1944. The strength of the corps on 1 January 1946 was 261. Integration gains amounted to 234, while losses during the period amounted to 60. Thus, the integration period produced a net gain of 174, but left the corps still short by 308 officers of its authorized strength of 743.

The results of the integration program as it related to the Medical and Dental Corps in no way compared with the results for the Regular Army as a whole. Of the more than 45,000 eligible medical officers who had served in World War II, only slightly over 500, hardly more than 1 percent, had seen fit to apply for a Regular Army commission. The program did, however, provide new vigor for this corps as a good many of the losses were retirements for age or physical disability while the new appointees were either professional specialists trained in some of the best medical centers of the United States, or young officers with a high military potential. It served to keep the corps afloat while new legislation to make it more attractive to the medical profession was being planned, and professional training programs established. While the Dental Corps filled a larger percentage of its new authorizations, much of the above discussion is also applicable. Indeed, the situation was not peculiar to the Army. The Navy and the Public Health Service were encountering the same retention and procurement problems. This created an awareness, not only in the top levels of the military service but also among members of Congress, that in order for the military services to maintain Medical and Dental Corps of suitable size and quality, some special provision would have to be made for their members to compensate for the extra time and money invested in their education and training, and permit them to have a standard of living at least closer to that of their civilian counterparts.

On the recommendation of the Secretary of War, the necessary legislation was enacted on 5 August 1947.[36] It increased the pay of doctors of medicine and dentistry in the military services by $100 per month and authorized the procurement of officers in all grades up to and including the grade of colonel.

[36] 61 Stat. 776; War Department Bulletin 21, 1947.

This was the first major legislative breakthrough in the specific interest of these corps.

Veterinary Corps

The Veterinary Corps was in a more favored position than the Medical or Dental Corps in that it experienced an excess of qualified applicants over the number of vacancies available. The strength of the corps as of 1 January 1946 was 113. Integration gains amounted to 118, while losses during the period amounted to 31, producing a net gain of 87. The strength of the corps had been established at 186. In order to permit the integration into the Regular Army of as many qualified veterans of World War II as possible, authority was granted to carry a temporary overstrength of 14 officers, giving a strength of 200 as of 31 December 1947.

Medical Service Corps and its components

While provision was made in the law for appointment in the Medical Administrative Corps up to the grade of captain, Circular 392 authorized the appointment of Medical Administrative and Sanitary Corps officers of the Army of the United States in the Pharmacy Corps, under the provisions stated for that corps. This authority was the result of strong recommendations by The Surgeon General that these officers be given the advantage of the higher ranks available in the Pharmacy Corps. As this was an interim measure pending the securing of legislation authorizing the Medical Service Corps, the special educational requirements for the Pharmacy Corps had to be waived and additional ones added.

This corps was in the most favored position of all. It was considered an extremely good "buy" in relation to the line. Consequently, it attracted the interest of many officers who had served in various corps, other than those in the Medical Department, during the war. Over 2,500 individuals applied for commissions in the Pharmacy Corps, approximately 2½ times the ultimate number of vacancies.

The strength of the corps on 1 January 1946 was 66. Integration gains amounted to 727, while losses during the period amounted to 30, thus producing a net gain of 697. The authorized strength of the corps as of 1 January 1946 was 72. This was increased to 1,022 when the allocation of the 50,000 officers was made. As of 31 December 1947, there were 763 assigned and 259 vacancies. In the meantime, on 4 August 1947, Congress passed the Army-Navy Medical Service Corps Act of 1947 which established the Medical Service Corps and abolished the Medical Administrative Corps, Sanitary Corps, and Pharmacy Corps.[37]

One might wonder why all the vacancies were not filled in view of the large number of qualified applicants. This is accounted for by the fact that

[37] 61 Stat. 734.

the vast number of applicants for commissions in the Medical Service Corps were qualified only for appointment in the Pharmacy, Supply, and Administration Section of the corps, which had been tentatively allocated only 60 percent of the position vacancies, the remaining 40 percent being distributed between the Allied Science Section, Sanitary Engineering Section, and Optometry Section. The vacancies existing at the conclusion of the program were in these three sections. It was not considered desirable to fill these vacancies with individuals who were not qualified for one of these three sections, since should qualified individuals become available later for appointment there would be no position vacancies in which they could be placed. Several attractive programs were then under consideration with a view to procuring officers for these sections. Some involved additional education at Government expense. Most were eventually put into effect.

Career Management Program

All the advances during World War II were not made in the professional or scientific fields. As the war in Europe progressed satisfactorily, and action was being taken toward speeding up the contemplated invasion of Japan, the one alarming shortage that appeared on the horizon was not of arms, food, or strategic material, but of manpower. This shortage was not limited to the military services but was being keenly felt in many of the industries and factories of the country. While some personnel management courses were available in several of the colleges and universities prior to the war, it was considered a new and somewhat untried field. Many large business organizations with modern, streamlined programs in other fields had completely ignored this one or were just becoming aware of its potentialities. The Army's plan, while not archaic, could hardly have been called progressive. During the war, however, many studies were made on various levels which brought out the need for more advanced thinking in this regard. "You're in the Army now" could no longer be accepted as the standard reply to any young officer's request for information concerning his job or its future.

It had been clearly demonstrated that most young Americans really are, as often stated, rugged individualists and that they make a better contribution in a field in which their interests lie, or for which they have a particular aptitude or skill. It also showed that job classification not only improved morale but increased production levels. Consequently, after the MOS system of job descriptions had been published and the success of the classification system seemed assured, the War Department made plans for the establishment of a career management program for the Regular Army. The chiefs of the various arms and services were called upon for assistance in the development of the plan. The Surgeon General welcomed this opportunity. Such a program would fit naturally into the already conceived Professional Training Program for the development of the specialists needed in the Medical Service and would permit The Surgeon General, for the first time, to

give some assurance to the young physician, dentist, or allied scientist that throughout most of his career in peacetime he would continue in the specialty of his choice.

By way of implementation, The Surgeon General prepared and submitted to the War Department a graphic representation of a pattern for each corps under his jurisdiction. Each pattern showed the various types of assignment and training available to the members of that particular corps during specific time intervals within a 30-year period. Later, it was contemplated that a similar personal pattern for each officer would be prepared showing not only the opportunities in his particular field but also those for transfer to broader fields as he advanced in rank and experience. While the program was not officially announced until June 1948 by The Adjutant General, it was one of the better byproducts of the war and, no doubt, was a tremendous factor later in procurement for, and retention in, the Regular Army of many outstanding and especially qualified young officers,[38] who were to prove their worth in Korea.

Thus, well before the end of hostilities, The Surgeon General had turned his attention not only to planning for the orderly return of personnel to civilian life, and for maintaining a large and qualified Reserve group composed of both active and inactive members, but also to strengthening of the Regular Army. All factors were assessed and gains consolidated. The Surgeon General, together with members of his staff and representatives of various echelons of the War Department, had envisioned changes and planned necessary legislation that would result within the next 2 or 3 years in a tremendous increase in the authorized strength of each corps of the Regular Army, and adequate provision for the Reserve Corps, and would give to the Medical Department a large Medical Service Corps, composed of many outstanding administrative and managerial officers as well as those qualified in the allied sciences. The changes brought about also permitted nurses, physical therapists, dietitians, and occupational therapists to become an integral part of the Regular Army. A much closer liaison with civilian medical and allied professions was established, and plans were well underway for excellent and modern professional and military training and career guidance programs.

[38] War Department Technical Manual 20–605, Career Management for Army Officers.

BIBLIOGRAPHICAL NOTE

Although some materials used in the preparation of this volume came from civilian sources and from other Government agencies, the vast bulk of the documentation both in manuscript and in printed form is to be found in Army records located within the Washington, D.C., metropolitan area. For matters pertaining to the Zone of Interior and the determination of broad personnel policies, the best single source was the central files of the Office of The Surgeon General for the war years, now deposited in the National Archives. Here were copies of incoming and outgoing correspondence, reports, memorandums for record (often containing invaluable summaries of long or complex courses of action), and minutes of conferences.

The Historical Division of the Surgeon General's Office (now known as the Historical Unit, U.S. Army Medical Service) collected documents during and after the war which were especially useful in tracing the applications of policy and in following the personnel history of particular areas at home and overseas. This material includes diaries, correspondence, and reports emanating from the various segments of the Surgeon General's Office. Among them are a number of reports to the Historical Division showing the highlights of personnel administration for various periods of the war. The material also includes annual reports of medical units and medical sections of headquarters as well as manuscript histories of some areas prepared, in most cases, under the direction of the surgeons of theaters and field armies; for certain theaters, there is considerable material of other types, such as orders, correspondence, and circular letters. These documents were of special value in the preparation of the chapters dealing with manpower sources.

Also deposited in the Historical Unit are a number of useful manuscript histories of various components of the Medical Department. These include "Organized Nursing and the Army in Three Wars," by Col. Florence A. Blanchfield (Ret.) and Mary E. Standlee; Lt. Col. Everett B. Miller's history of the Veterinary Corps; Col. William A. Hardenbergh's "Organization and Administration of the Sanitary Engineering Division (Office of The Surgeon General)"; Col. Emma Vogel's "Physical Therapists of the Medical Department"; and the work entitled "History of the Army Dietitian." The Historical Unit's file of annual reports of The Surgeon General to the Secretary of War yielded important data concerning personnel administration. These reports ceased to be published after the fiscal year 1941, but during the war years, annual summaries of events prepared by the Historical Division for Army Service Forces headquarters to some extent took the place of the published reports.

The Historical Unit at one time housed histories, reports, and correspondence accumulated in the Office of the Air Surgeon. These are now in the custody of the historical office of the Surgeon General of the Air Force.

The files of The Surgeon General's Resources Analysis Division contained material of value for personnel history during the latter part of the war. They were arranged both chronologically and by subject and since the elimination of that Division have been distributed among The Surgeon General's Personnel Division, Executive Office, and Comptroller's Office. Other extremely useful sources of information were the files of the Adjutant General's Office, the General Staff (particularly G–1), and Army Service Forces headquarters, which contained material regarding medical personnel matters involving those agencies. Manuscript and "processed" histories on file in the Office of the Chief of Military History, Department of the Army, as well as printed volumes of the "official" history, were also used, both to obtain additional data pertaining to the Medical De-

partment and to gain a fuller understanding of developments which affected that Department in common with other branches of the Army.

Statistical materials were obtained in all of the groups of records mentioned, but certain sources of such data deserve special mention. Of particular significance for discussions of strength, promotions, and rank was the series originally prepared in mimeographed form by the Returns Section, Miscellaneous Division, Adjutant General's Office, in 1940 and known as the Quarterly Station Strength Report, Continental and Foreign. This became a monthly publication during the later emergency period and eventually was issued in printed form under the title "Strength of the Army" (STM-30) by the Machine Records Branch, Office of The Adjutant General.

Another important publication of a similar character was issued from October 1942 to May 1946. It was known as Personnel Section No. 5 Monthly Progress Report until August 1945 when the title was changed to Personnel and Training No. 5 Monthly Progress Report. From October 1942 through January 1943, it was prepared by the Control Division, Army Service Forces; from 28 February through 31 August 1943, by The Adjutant General's Office; and from 30 September 1943 through 31 May 1946, by the Director of Personnel, Army Service Forces. It has been used mainly for data concerning strength of civilian personnel of the Medical Department. For authorized strengths of Medical Department units and medical complements of other organizations the "troop bases" and "troop lists" were used; these were published as early as 1941. For the purposes mentioned, the most extensive use was made of the "Troop List for Operations and Supply," prepared monthly, from 1 July 1944 until after the end of hostilities, by the Strength Accounting and Reporting Office of the War Department.

Data pertaining to strength and replacements in the European theater also were obtained from a serial document issued by the theater's Services of Supply (and successor commands) beginning in July 1942. Under the title "Statistical Summary" and later "Progress Report," this appeared several times a month until 1945, when it was issued monthly and renamed "Progress Report, Section 1." Parts of this series are filed in the Record Center at Kansas City and in the Historical Unit, U.S. Army Medical Service.

Additional data on strength and rank were derived from one of the sources of "Strength of the Army," that is, the reports on W.D., A.G.O. Form No. 323 which are now in the custody of the Departmental Records Branch of the Adjutant General's Office. Another source of "Strength of the Army," the monthly statistical summary prepared in processed form by the Promotion Section, Officers Branch, Office of The Adjutant General, from November 1944 to June 1945 also was utilized. This series is on file in the Promotion Section, Personnel Actions Branch, Adjutant General's Office. Finally, considerable use has been made of the Department of the Army's "Army Battle Casualties and Nonbattle Deaths in World War II, Final Report, 7 December 1941–31 December 1946" [Washington, D.C., June 1943].

Records of civilian agencies of the Government were studied primarily for the history of personnel policies. They included printed material; for example, transcripts of Congressional hearings, the Statutes at Large of the United States, and unpublished correspondence and minutes of meetings of the Directing Board and subordinate committees of the Procurement and Assignment Service of the War Manpower Commission. Medical, dental, and similar journals revealed the attitudes taken by professional organizations toward Army and Medical Department personnel policies and, in letters to the editors, the views of individuals who were affected by these policies.

Despite the vast number of War Department records pertaining to medical personnel matters that were produced during World War II, many decisions were made by officers and civilian employees of the Department either in conference or by telephone without a written record of what took place. To help fill the gaps in the record as well

as to reconcile conflicting evidence and to develop proper perspective, many such individuals were interviewed in person or by telephone for their knowledge and opinions concerning various matters. A similar use was made of correspondence, now filed in the Historical Unit. Information obtained in this way has been used especially in the oversea sections of the chapters on strength and utilization of personnel. Finally, the chapters have been circulated in draft form among persons responsible for decisions taken on the subjects discussed in this study and their comments have been taken into account in the preparation of the final version.

Index

ABELL, Dr. IRVIN, 149
Absent without leave, personnel loss to Army due to, 432
Accra, 259
Act of 3 April 1939—122–123
  authorized strength of Regular Army officer corps fixed by, 122
  modification of, 122
Act of 13 December 1941, tour of active duty extended by, 130, 167
Acting Surgeon General, 65, 66, 233
Activation, of field medical units, 59
Active-duty strength, of Medical Department groups, by Army components, 112
Adjusted service rating scores:
  abolishment of, 494
  for enlisted personnel, 491, 492
  for female Medical Department officers, 488
  for male Medical Department officers, 488
  for Medical Department enlisted technicians, 491, 492
  for redeployment, 487, 488
  for release, 487, 488, 499
Adjutant, Medical Administrative Corps officer serving as, 7
Adjutant General, The, 21, 33, 58, 111, 112, 143, 146, 152, 160, 173, 175, 176, 233, 235, 510
  assignments made by, 293, 307
  classification system of, 270, 287
  duty orders issued by, 122, 180
  list of scarce specialists published by, 285–286
  Medical Corps officers relieved from nonprofessional duties by, 79
  reassignment by, 236, 238
Adjutant General's Office, The, 269
  Replacement Section of, 293
Administration:
  for personnel matters, 21–52
    authority for, 21
    in theaters of operations, 47–52
    in Zone of Interior, 21–46
  of demobilization, 495–496
Administrative actions, replacement personnel made available by, 301–303
Administrative Division, Office of The Surgeon General, 23
  See also Office of The Surgeon General.
Administrative duties, medical officers relieved from, 78, 303
Administrative functions:
  for professional groups, 290, 296
  of Medical Department, 1–2
Advance Section, Communications Zone, European theater, 240
Advisory Commission, to Council of National Defense, 156, 161
Advisory Committee, to Nursing Supply and Distribution Service, War Manpower Commission, 226
Affiliated hospital units, 3, 168
  commanding officers of, 144
  deferment of active duty for members of, 146–148
  enlisted personnel for, 143
  In European theater, 208
  in South Pacific, 208
  Medical Corps Reserve officers in, 146
  Medical Department officers in, 147
  organization of, 143–145
  organized for call to service, 168
  problems with:
    delay in activation of, 209
    keeping units intact, 207–208
    morale, 209
  revival of, 62, 141–145
  source of officer personnel, 206
  technicians for, 233
  undermanning of, 307
  use of, 3
  women elements of, 207
Africa, 254
Africa-Middle East theater, 382, 383
  native labor employed in, 259
Age, 490
  as criteria for release, 488, 489
  discharge for, 445–447
  for assignment to Army Nurse Corps, 225
  for induction into military service, 167, 201
  for registration for military service, 167
  for return to civilian life, 437
  limit of, on Medical Department Reserve officers, 123

Age-in-grade, removal of restrictions on, 167
Aides:
nurses', 251, 254, 380
occupational therapy, 165
physiotherapy, 165, 252, 254, 271, 304
Aidmen, Medical Badge for, 337
Air Corps, 21, 38
organization of, for personnel administration, 26–27
See also Army Air Forces.
Air Corps Reserve, 57
Air Forces Station Hospital, Tuskegee, Ala., 319
Air Surgeon, 38, 69, 179, 223, 224
procurement by, 176
Air Surgeon's Office, organization of, 38
See also Office of the Air Surgeon.
Air Transport Command, 397
Airways Communication System, 397
Alaska, 108, 382
Alaskan Defense Command, 384
ALEXANDER, Col. STEWART F., 336
Alien physicians, requirements of, for commission in Army of the United States, 152
Allied assault landing, plans for, 68
Allies, 228
Allocation of Medical Personnel Committee, Directing Board, Procurement and Assignment Service, 170, 172
Allotment:
control of, 37
of enlisted men, 63, 64
of officers, 55
to oversea areas, 1942—384
Allowances, resignation for insufficiency of, 451
Allowances of personnel:
readjustment of, 313–314
oversea units, 313–314
Zone of Interior, 314
system of bulk authorizations for, 43–45
Ambulance companies, 396
American Alumni of British Medical Schools, 149
American Board of Ophthalmology, 267
American College of Hospital Administration, 214
American College of Physicians, 269
American College of Surgeons, 141, 269, 505
American Dental Association, 162, 171, 172, 468
American Institute of Pharmacy, 213
American Jewish Congress, 148
American Medical Association, 141, 148, 159, 160, 162, 170, 171, 172, 176, 177, 269, 273, 297, 501
Bureau of Medical Economics of, 73
Committee on Medical Preparedness of, 149, 156–159, 161, 171, 268
contribution of, to procurement, 156, 158, 159
Council on Education and Hospitals of, 192, 503, 505
American National Red Cross. *See* Red Cross.
American Nurses Association, 164
American Public Health Association, 172
American Red Cross Hospital Service, 419
American specialty boards:
in classification of Medical Corps officers, 273
percent of Medical Corps officers diplomates of, 267
American Surgical Association, 193
American Veterinary Medical Association, 171
"American Women and Our Wounded Men," 229
Animals, veterinary care of, 7, 396
Antilles Department, 266
Applicants:
Cadet nurses, 251
for Army Nurse Corps, 134, 228
for Medical Corps Reserve, 139
Appointment(s):
in Medical Corps Reserve, 148
of The Surgeon General, 4
qualifications for, to—
Army Nurse Corps, 8–9
Sanitary Corps Reserve, 7
suspension of, in Dental Corps Reserve, 57
Arm and Service Assignment Group, 22, 127, 160, 289
Armed Forces, 19, 74, 172, 173, 176, 199, 203, 225, 297, 453
Armed Services Committee, House of Representatives. *See* House Armed Services Committee.
Army Air Corps. *See* Army Air Forces.
Army Air Forces, 26, 33, 43, 98, 99, 175, 181, 203, 223–224, 234, 238, 276, 312, 397, 470, 488
allotments to, 72
classification manual of, 277
classification of medical officers in, 273–274
commanding general of, 47

Army Air Forces—Continued
creation of, 40
doctors recruited by, 315
medical personnel assigned overseas, 398, 399
medical specialists in, 315
Army animals, veterinary care of, 7, 396
Army General Classification Test scores, 235, 286
of medical recruits, 234
of Negroes, 323
Army Ground Forces, 98, 153, 181, 203, 238, 243, 276, 280, 315, 470, 488
allotments to, 72
Commanding General of, 294
creation of, 40
medical specialists in, 315
Office of the Surgeon of, 81
Army hospitals, training in, 503–504
Army Medical Center, 43, 99, 250, 295, 454
Army Medical Library, 250
Army Medical Museum, 43, 250
Army Medical Residency Program, 502
Army-Navy Medical Service Corps Act of 1947, establishes Medical Service Corps, 508
Army Nurse Corps, 1, 56, 84–87, 101, 131, 134–135, 221–231, 225, 277, 413, 476
age for, 225
cadet nurses commissioned in, 251
composition of, 8–9
discharges from, 225
grades in, 462–463
increase in ceiling of, 87
male officers appointed in, 1
marital status for, 225
Negro personnel, 318, 322
pay in, 453
procurement for, 135
measures to speed, 223–225
1942–43—221–231
1944–45—227–231
Procurement and Assignment Service in, 225–231
Red Cross in, 222
promotions in, 467, 468
qualifications for appointment to, 134
ratio of, to—
beds, 86
overall Army strength, 84
Reserves of, 5
separation from:
age, 489
point score, 489
Army Nurse Corps—Continued
strength of, 54, 112, 227, 228, 229, 230
ceiling, 229–230
1939—112
overseas, 371, 373
superintendent of, 84, 222, 225, 228, 230
Technical Information Branch of, 228
uniforms, 221
See also Nurses.
Army of the United States, 5, 9, 17, 47, 102, 111, 130, 151, 152, 155, 174, 181, 202, 215, 464
female physicians commissioned in, 155
Medical Administrative Corps section of, 7
professional students commissioned in, 199–201
professional retraining for medical officers in, 500–502
promotion in, 454
strength of, worldwide and overseas, 404, 405, 410
Army Regulations:
No. 140–33, 30 July 1936, pertaining to candidates for Medical Corps Reserve, 148
No. 615–25, 3 Sept. 1940, on classification of enlisted men, 286
No. 40–2035, 18 Dec. 1942, governing veterinarians, 77
No. 605–95, January 1943, on classification of officers, 270
Army Service Forces, 31, 98, 202, 215, 231, 274, 296, 312–313, 314, 315, 438, 455, 470, 488, 492
Army Air Forces medical officers transferred to, 33
bulk-authorization system established by, 43–45
commanding general of, 34, 40, 41, 42, 84, 87, 236, 316, 490, 502
creation of, 40
directs officers to complete classification forms, 275
directs The Surgeon General to modify plan for utilization of medical officers, 72
jurisdiction over general hospitals, 312
jurisdiction over surplus Medical Department officers, 488
medical specialists in, 315
Military Personnel Division of, 87, 294
Officer Procurement Service of, 231
promotion restrictions of, 465

Army Service Forces—Continued
proper utilization of personnel directed by 238
representative of, on Committee to Study the Medical Department, 3
sets ceiling on Dental Corps strength, 76
survey of military personnel in, 295
Army Service Forces Circular No. 59, 26 Feb. 1944, on promotion of officers, 465
Army Service Forces Review Board, 596
Army Specialist Corps, 79
abolished, 102
Army Specialized Training Program, 8, 195–196, 197, 201–206, 212, 276, 496
curtailment of, 203–206
dental phase, 204
medical phase, 205–206
veterinary phase, 204
discontinuance of veterinary phase of, 197
enrollment of professional students in, 206
establishment of, 201
output of professional students, 206
status of members of, 202
Army War Shows, Inc., 223
Assam, 258, 329
Assignment(s), 289–297
consultants in, 296
decentralization of, 292
during war years, 295–297
enlisted men, 292–297
to Medical Department, 165
factor of classification in, 289
of cadet nurses, 251
of Negro Medical Administrative Corps officers, 321
of personnel, 3
officer replacement pools in, 292
problem of, 289–291
Assistant Chief of Staff, G–1—58, 67, 132, 173, 438
Assistant Chief of Staff, G–2—152
Assistant Chief of Staff, G–3—217
Assistant Civilian Aide, to Secretary of War, 323
Assistant Secretary of War, 153, 189
Assistant Surgeon General, U.S. Public Health Service, 456
Assistants, for The Surgeon General, 4
Association of American Medical Colleges, 192
Association of Collegiate Schools of Nursing, 164
ASTP. *See* Army Specialized Training Program.
Atabrine, 500
Atlantic Refining Corporation, 30
AUS. *See* Army of the United States.
Australia, 254, 256, 257
Authorizations, bulk, system of, 43–45, 314
Authorized officer strength of Medical Department, in 1939—53
Auxiliary surgical group(s), 314
5th—107
Availability, of personnel:
data on supply of, 35
for military service, 173, 185–186, 187, 195
Aviation medical examiner, rating as, 47
Axis Powers, 67
defeat of, 487
Bacteriologists, 212, 242
BAKER, Capt. FRANCIS E., 325
Base K, Leyte, 257
Base Section, United Kingdom, 327
"Basic Curricula," of Army Specialized Training Program, 203
Basic military training, 192
Basis for calculation of nurse requirements, 55
Battalion surgeon's assistant(s), Medical Administrative Corps officers as, 218, 380
Battalions, medical. *See* Field medical units.
Battle casualty rates, of Medical Department, compared with total Army, 420–430
Battle of the Bulge, 107, 302
Biochemists, 212
BLANCHFIELD, Col. FLORENCE A., 228
BLISS, Maj. Gen. RAYMOND W., 36
Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army, 250
BOUSFIELD, Lt. Col. MIDIAN W., 320
"Branch immaterial" officers, 69, 79
Bronze Star Medal, award of, 337
to Medical Department personnel, 337
Bulk authorizations, system of, 43–45, 314
Bureau of Medical Economics, American Medical Association, 73
Bureau of Medicine and Surgery, 156
Bureau of Placement, War Manpower Commission, 169, 226
Burma, 254, 259
BURNS, HELEN C., 16
Cadet nurses, 101, 228, 243, 380
in Army hospitals, 251
induction of, 230
Calcutta, 259
CALDWELL, Col. GEORGE L., 197

Camps. *See* Military installations.
Captains, of Medical Corps, promotion of, 452
Capture, of Medical Department personnel, 427, 432
Cardiologist, 282
Career Management Program, 509–510
Caribbean Defense Command, 266
Carlisle Barracks, Pa., 126
See also Military installations.
CARSTENS, Col. HENRY R., 144
Casuals:
for overseas replacements, 303–305
from Zone of Interior, 471
Catholic nuns, utilized as nurses, 254
Central Medical Department Examining Board, 111, 506
Central Pacific Area, 108, 257, 258, 382
classification system in, 284
Certificate of appreciation, awarded to 61st Station Hospital, 210
Chairman, War Manpower Commission, 74
Chaplains, in Medical Department, 1, 419
Chemical laboratory technicians, 165
Chemical Warfare Service, 234
Chicago College of Medicine, 151
Chief(s), of—
Military Personnel Division, 23
Personnel Service, 27, 30
Preventive Medicine Division, 29
Professional Service Division, 23
Staff, 21, 47, 68, 126, 129, 205
Veterinary Division, 197, 200
Chief Consultant in Medicine, European theater, 282
Chief Consultant in Surgery, European theater, 282
Chief Surgeon:
European theater, 176, 208, 282
Southwest Pacific Area, 284
U.S. Army Forces, Far East, 397
Chief Surgeon's Office, U.S. Army Forces in the Middle East, 245
Children's Bureau, Department of Labor, 172
China, 254, 259
China-Burma-India theater, 382, 383, 386
classification system in, 284
natives utilized in, 258–259
rotation in, 332–333
shortage of Medical Corps officers in, 304
Chinese military forces, medical care for, 386
Chiropractors, 156
Ch'ung-Ch'ing, China, 259
Cincinnati College of Eclectic Medicine, 151
Circulars, War Department, on—
authorizations of personnel, 314
change of table of organization of general hospitals, 303
classification procedures for Medical Department officers, 283
commissions in Sanitary Corps, 212, 213
policy of rotation, 332
proficiency qualifications of officers, 277
See also specific War Department Circular.
Citizenship, in relation to State licensing examinations, 152
Civil Service Commission, 101, 251
Civilian components, of Medical Department, 19
Civilian Conservation Corps, 5–6, 125, 248
Medical Department officers assigned to, 5–6
Civilian Defense, Office of, 251
Civilian employees, in Medical Department installations, 43
Civilian medical profession, survey of, by Committee on Medical Preparedness, 156
Civilian medical service:
medical personnel for, under war conditions, 160
ratio of physicians to population recommended for, 74
Civilian needs:
determination of medical manpower for, 172
discharge for, 447
for return to civilian life, 437
Civilian nurses, 221
Civilian nurses' aides, 101, 254
Civilian occupational classification of enlisted personnel, guide for, 285
Civilian personnel, procurement of, 247–266
Civilian Personnel Division, Office of The Surgeon General, 27, 29
functions of, 29
organization of, 29
See also Office of The Surgeon General.
Civilian Personnel (Field) Subdivision, Finance and Supply Division, Office of The Surgeon General, 23
Civilian physicians, available for military service, roster of, 160
Civilian reaction, to Medical Officer Recruiting Boards, 178–179
Civilian strength, of Medical Department, 1

Civilian workers, utilization of, in Medical Department units, Mediterranean, theater, 260, 261
Civilians, 100–102, 420
  direct commissioning of, for Medical Administrative Corps, 214, 215
  employed by Medical Department, 63, 499
    pay of, 464
  enlisted personnel replaced by, 63, 64
  guide for employment of, in event of mobilization, 65
  problems in hiring of, 63, 64
  saving of military personnel effected by utilization of, 255
  substitutes for military personel, 100
Classification, 3, 267–287
  assistance of Committee on Medical Preparedness in, 159
  directive on procedures of, 283
  enlisted personnel, 284–287
  factor of, in assignment, 289
  female officers, 1943–45—274–284
  improvements in, 1
  male officers, 1943–45—274–284
  measures of, 274–277
    instructions of The Surgeon General, 275–276
    questionnaires, 275
  nurses:
    1939–41—267–270
    1941–43—270–274
  officers:
    1939–41—267–270
    1941–43—270–274
  role of Classification Branch in, 276–277
  role of consultants in, 278
  system of:
    background, 267–268
    development of, overseas, 281–283
    evaluation of, 279–281
    uniformity of, in theaters of operations, 283–284
  uniformity in, 277–278
"Classification Questionnaire of Medical Department Officers," WD AGO Form No. 178–2—129, 273, 275
Clearing companies, 396
Clerical workers, civilian, 254
Code number system, establishment of, in classification of officers, 271
Collecting companies, 396
College training, of officer candidates, 212
Combat divisions, triangular organization of, 313
Combat Infantryman Badge, 337
Combat missions, factor of, in determining hospital personnel strength, 386
Combat Team, 442d Regimental, 153
Command functions, of Medical Corps officers, 2
Commander, Ground Forces Replacement System, 239
Commander in Chief. *See* Roosevelt, Franklin Delano.
Commanders, in oversea theaters, personnel functions of, 47–49
Commanding General:
  Army Air Forces, 47
  Army Ground Forces, 294
  Army Service Forces, 34, 40–42, 84, 87, 236, 316, 488, 490, 502
  Ground Forces Replacement System, European theater, 301
  Services of Supply, 179, 181, 320
Commissioned officers, legislation increasing pay of, 462
Commissioned status:
  for female doctors, 154–155
  for minority groups, 156
  rejected, for women dentists, 155
  See also Military status.
Commissioned Subdivision, Military Personnel Division, Office of The Surgeon General, 22, 27
  renamed as a division, 27
Commissioning, of interns, 138
Commissions:
  direct, 168
  for alien physicians, 152
  for female doctors and dentists, 154–156
  for graduates of foreign schools, 148–150
  for graduates of unapproved American medical schools, 150–152
  for Japanese-American medical personnel, 153–154
Committee on Allocation of Medical Personnel, Procurement and Assignment Service, 73
Committee on Education and Labor, U.S. Senate, report of subcommittee of, on procurement of doctors for armed services, 194
Committee on Medical Preparedness, American Medical Association, 149, 156–159, 161, 171
  classification of physicians, 268–269
  survey of physicians, 156, 268–269

Committee on Sanitary Engineering, National Research Council, 211
Committee to Study the Medical Department of the Army, 154, 178, 222, 225, 273, 463
  appointment of, 3
  complaints to, on misassignment of professional personnel, 291
  critical of procurement activities of Nursing Division, Office of The Surgeon General, 224
  members of, 3
  ratio of doctors for the U.S. Army studied by, 69
  recommendations of, on—
    replacement of Medical Corps officers, 79
    use of Wacs, 99
Communications Zone, European theater, 217, 239, 260, 301
  prisoner-of-war labor in, 327
Company grade officers, Medical Department, Medical Badge authorized for, 337
Components, of U.S. Army, 5, 111
Composition, of Medical Department, 1–19
  civilian components, 19
  introduction, 1–4
  military components, 4–18
  overseas, 405–420
    Army components, 405–411
    by sex, 413
    Negro personnel, 411–412
Comptroller of the United States, 155
Compulsory military service, extension of; to special groups, 1
Congress, 53, 54, 55, 58, 60, 112, 122, 125, 130, 133, 187, 194, 201, 229, 248, 337, 453, 455, 462, 464, 505–506
  on demobilization criteria for Medical Department officers, 493–494
  passes peacetime selective service act, 54
  responsibility of, for Medical Department personnel strength, 53
Congressional Medal of Honor, to Medical Department personnel, 337
Conservation, of manpower, 3
Construction and Repair of Hospitals Fund, 248
Consultant system:
  establishment of, 272
  factor of, in assignment and utilization of personnel, 46
Consultants:
  civilian, 250
  in classification of officers, 278
  role of, in personnel assignment, 296
Continent, the, 261, 304, 327, 328
  invasion, 383
Continental Advance Section, European theater, 264
Continental United States. *See* Zone of Interior.
Contract surgeons, 6, 250
  female doctors serving as, 154
Control Division, Army Service Forces, 31, 79
Convalescent furloughs, period of, 313
Convalescent hospitals:
  creation of, 312
  guide for utilization of personnel in, 312
  in Zone of Interior, 88
Convalescent patients, utilization of, in hospital activities, 239
Corps Area Assignment Group, 22, 127, 289
  strength of, 30 June 1939—26
Corps area commander(s), 24, 25, 55, 123, 158
  applications for commission in Medical Department Reserve Corps submitted to, 111
  authorized to commission professional students in Medical Administrative Corps, Army of the United States, 199–201
  authorized to procure Reserve nurses, 135
  See also Service command commander(s).
Corps area committees, of Procurement and Assignment Service, 170
Corps area headquarters, 268
Corps area surgeon(s), 159, 289
  authority of, to—
    appoint applicants to Reserve Corps, 132
    employ civilians for station hospitals, 248
  responsibility of, for medical personnel functions, 24–25
  See also Service command surgeon(s).
Corps areas, organization of, for personnel administration, 24–26
  See also Service commands.
Corps of Chaplains, 55
Council of Medical Education and Hospitals, American Medical Association, 503, 505
Council of National Defense:
  Advisory Commission to, 156, 161
  Health and Medical Committee of, 161
Council on Education and Hospitals, American Medical Association, 192
County committees, of Procurement and Assignment Service, 170

Criteria, for—
recruitment of professional personnel, 173
release of enlisted personnel, 490
release of officers:
congressional reaction to, 493–494
differences in for medical and nonmedical officers, 494–495
during partial demobilization, 487–489
reduction of, 493–495
Critical score. *See* Adjusted service rating score.
Criticism(s):
of Medical Officer Recruiting Boards, 178
of "9–9–9 plan," 192
on assignment of medical officers, 289
on rotation of nurses, 335
Curtailment, of Army Specialized Training Program, 203–206
CUTLER, Col. ELLIOTT C., 282
DALTON, Brig. Gen. JOSEPH N., 44–45
DANIELSON, Lt. Col. IDA W., 230
D-day, 107, 302, 330, 333
DDT, 500
Death rate, Medical Department personnel, 436
Decentralization, of personnel administration, 40–45, 454
Decorations:
Bronze Star Medal, 337
certificate of appreciation, 210
Combat Infantryman Badge, 337
Congressional Medal of Honor, 337
Expert Infantryman Badge, 337
Medical Badge, 337
Defense Health and Welfare Services, Office of, 162, 169
Demobilization, 4, 437, 487–510
administration of, 495–496
discharges, 448
factor of, in personnel planning, 36
full-scale, 491–495
new officer procurement during, 496–499
partial, 487–491
reduction of criteria for, 493–495
voluntary service continued during, 499
DENIT, Brig. Gen. GUY B., 284
Dental Corps, 1, 4, 56, 59, 75–76, 177, 203, 277
ceiling for, 76
classification in, 279–280
deficits in, 58
discharge rates in, 438
establishment of, 6
field grades in, 456
general officers in, 456
Dental Corps—Continued
Negro personnel in, 318
of Regular Army, integration gains in, 507–508
pay increase in, 507, 508
procurement for, 195–196
sources of, 195–196
promotions in, 455, 469
strength of, 53, 180–181, 196, 204
overseas, 371
vacancies in, 112
Dental Division, Office of The Surgeon General, 7, 23, 28, 132, 296, 502
director of, 75
See also Office of The Surgeon General.
Dental hygienists, 165, 286
for affiliated hospital units, 207
Dental laboratory technicians, 286, 492
Dental mechanics, 165
Dental officers:
assigned to Medical Officer Recruiting Board, 177
duties of, 6–7
morale of, in oversea theaters, 330
pay of, adjustments in, 1
rank of, adjustments in, 1
ratio of, to enlisted strength, 75
refresher courses for, before separation, 502
Dental phase, of Army Specialized Training Program, termination of, 204
Dental students:
commissioned in Medical Administrative Corps, Army of the United States, 199–200
deferment of, for occupational reasons, 139
discontinuance of Army Specialized Training Program for, 196
in Army Specialized Training Program:
commissioning of, upon graduation, 202–203
school costs for, 202
with Reserve commissions, transferred to Medical Administrative Corps Reserve, 137
Dentistry Committee, Directing Board, Procurement and Assignment Service, 170
Dentists, 169, 381
classification of, 279–280
direct commissions for, 180
draft of, 134
induction of, as enlisted men, 132, 133

Dentists—Continued
procurement of, 496–497
See also Dental Corps; Dental officers.
Department of Agriculture, 172
Department of Justice, 152
Department of Labor, 172
Dependents, of Army personnel, medical care for, 2, 282–283, 296
Depots, medical supply, 59
Deputy Chief of Staff, 69, 72, 86, 455
Deputy Surgeon General, 204, 335
Desegregation, in U.S. Army, 1
Desertion, personnel loss to Army due to, 432
Detachments of patients, replacement personnel from, 298
DIEHL, Dr. HAROLD S., 73
Dietitians, 84, 88–90, 155, 165, 271, 304
civilian, 29, 42, 252
for affiliated units, 207
grade distribution for, 462
in World War I, 16
military status of, 154
officer status for, 9–17
pay for, 464
procurement of, 231–232
objective, 232
Officer Procurement Service in, 231
rank of, 17
ratio of, to hospital beds, 88
requirements for, 90
separation of:
age for, 489
point score for, 489
strength of, 90, 232
overseas, 371
student-apprentice program for, 232
Superintendent of, 16
Women's Army Corps members commissioned as, 232
Direct commissions, for—
doctors, 168
Medical Administrative Corps, 214, 215, 215–217
medical personnel, 180
Sanitary Corps, 212
Directing Board, Procurement and Assignment Service, 69, 150, 162, 188, 211
advisory committees of, 170
Chairman of, 169, 176, 184, 187
committees of, 172
members of nursing profession appointed to, 227
proposal of "9–9–9 plan," 192
Director:
Dental Division, Office of The Surgeon General, 75
Military Personnel Division, Army Service Forces, 184
Military Training, Army Service Forces, 202
Selective Service System, instructions of, to Medical Officer Recruiting Boards, 178
War Manpower Commission, 69
Women's Army Corps, 244
"Directory of Medical Specialists," 273
Discharge(s):
civilian needs, 447
demobilization, 448
for age, 445
for disability, 438–444
for hardship, 447
for physical and mental disability, 438
from Army Nurse Corps, 225
inefficiency, 447
misconduct, 447
of dental students, for failure to convert commissions, 200
of medical students, 205
Disease(s):
immunization against, as function of Medical Department, 2
prevention of, as function of Medical Department, 396
Disease rates, factor of, in determining hospital personnel strength, 386
Dispensary(ies), 396
general, 59
Displaced persons, utilized in Medical Department activities, 328, 329
Distribution of personnel:
control of, 37
overseas, 339–405
Zone of Interior, 339–405
District committees, of Procurement and Assignment Service, 170
District of Columbia, 148, 151
Division of Medical Sciences, National Research Council, 161, 273
Doctors, 169
classification of, 279
direct commissions for, 180
draft of, 72, 177, 185, 186–190
ratio of, to Army strength, 72
training of, in military subjects, 219
See also Contract surgeons; Medical Corps; Medical officers; Physicians.

Dorr, Goldthwaite, 229
Draft, of—
dentists, 196
doctors, 72, 184, 185, 186–190
nurses, 229–231
Draft boards, 132
deferments granted by, 138, 139
nurses classified by, 227
See also Selective service boards.
Draft law. *See* Selective Training and Service Act.
Eanes, Col. Richard H., 131
Effect of selective service legislation, on procurement, 131–134
E. I. Dupont de Nemours, 30
Eighth U.S. Army, authorized and actual strength of medical personnel in, 107
Eligibility for separation, criteria of, for—
enlisted personnel, 490
officers, 487–489
Emergency Management, Office for, 169
Emergency measures, for procurement of Medical Department officers, 124
Emirau, 383
Engineer Corps, 234
Engineers, in Medical Department, 1, 419
England, 54, 154
Enlisted Branch, Office of The Surgeon General, 91
Enlisted men, 56, 60–65, 91–98
age for discharge of, 446
assignments of, 293–295
combat recognition for, 337–338
commissions for, 166
direct commissioning of, in Medical Administrative Corps, 214, 215–217
in oversea theaters, 215–217
in Zone of Interior, 215
for affiliated units, 143
in Medical Department, 5
Medical Badge authorized for, 337
of Regular Army, quotas for, 53
pay increase for, 3
legislation for, 462
procurement of:
during emergency period, 164–166
in oversea theaters, 239–242
in Zone of Interior, 233–239
replacement of, by civilians, 63, 64
table-of-organization allotment of, 94
training for, 165
Enlisted personnel:
classification of, 284–287
difficulties encountered in, 286–287
guides for, 285
operation of, 286–287
reevaluations of, 287
criteria for release of, 490
reduction of, 491–492
of Medical Department, 9
procurement of, 233–246
promotion for, 470
Enlisted Reserve, Medical Department, 165
Enlisted Reserve Corps, 201, 205, 207, 446
technicians enrolled in, 233
Enlisted Subdivision, Military Personnel Division, Office of The Surgeon General, 22, 23, 27
Enlisted technicians:
recruitment of, for affiliated units, 207
schools for, 235
Enlisted women, 99
in Medical Department:
oversea theaters, 245–246
Zone of Interior, 242–245
Enlistment, voluntary, in Medical Department, 164
Enrollment:
in Registry of Medical Technologists, 165
of professional students, in Army Specialized Training Program, 206
Entomologists, improper classification as, 281
Espíritu Santo, 482
Essentiality of professional personnel, in civilian community, 173, 185
Europe, 54, 108, 228, 239, 243, 329
cessation of hostilities in, 383, 487
European Theater of Operations, U.S. Army, 48, 83, 105, 217, 239, 240, 255, 279, 298, 301, 303, 316, 317, 382, 383, 386, 487
affiliated units in, 208
cessation of hostilities in, 330
civilians employed in medical installations in 254, 260–261, 262
classification system in, 281–283, 284
general hospitals reorganized in, 301
Ground Forces Reinforcement Command of, 302–303
limited-assignment personnel replacing general-assignment personnel in, 239, 240
Medical Department strength in, 306
non-table-of-organization allotment for, 103–104
Office of the Chief Surgeon of, 52

European Theater of Operations—Con.
organization for personnel administration in, 52
rotation in, 332, 333, 334
shortages of Medical Department officers in, 107
shortage of nurses in, 230–231
station hospitals reorganized in, 301
surplus of medical officers in, 301
Evacuation, 296
Evacuation hospitals, 59
See also Field medical units; Hospitals, evacuation.
EVANS, Lt. Col. ROBERT W. W., 270, 284
Executive Office of the President, 169
Expansion of Medical Department, problems of, 2
Expert Infantryman Badge, 337
Factors, affecting determination of requirements, 58–66
Federalization, of National Guard, 58, 124, 339
Female dentists, 155–156
Female dietetic personnel. *See* Dietitians.
Female doctors, 154–155
service of, as contract surgeons, 154
Female Medical Technicians campaign, 242–243
Female officer components of Medical Department, 3, 17
Female personnel, proportion of, in Medical Department, 413, 414
Field commands, role of, in classification of officers, 272–274
Field medical units:
activation of, 59
ambulance battalion, 61
medical battalions, 59
hospitals:
evacuation, 59, 61
general, 59
station, 59
surgical, 59, 61
laboratory, medical, 59
personnel for, 59
regiments, medical, 59, 61
squadron, medical, 61
See also evacuation hospitals.
FIELDING, Col. FRED J., 83
Fifth U.S. Army, 216, 382
Finance and Supply Division, Office of The Surgeon General, 23
See also Office of The Surgeon General.
Finance Department, 234
First lieutenants, of Medical Corps, promotion of, 452
First Reserve, of the Red Cross, 135, 222, 223
First U.S. Army, 302, 326
First World War. *See* World War I.
FITTS, Col. FRANCIS M., 202
Fixed installations in oversea theaters, civilian clerical workers in, 254
Flight surgeons:
morale of, 330
rating as, 47
Food inspection, as function of Medical Department, 2
Foods, of animal origin, inspection of, by Veterinary Corps officers, 7
Foreign medical schools, graduates of, 148–150
standards for, 1
utilization of, 3
Fourth Service Command, survey of Medical Department officers at, 295
France, 143, 254, 261, 302, 327
Functions, of—
Medical Department, 1–2
Procurement and Assignment Service, 170–173
Resources Analysis Division, 36–37
Furloughs, in effective utilization of personnel, 331
G–1 (personnel), 21, 40, 55, 58, 63, 72, 79, 85, 86, 87, 132, 159, 173, 182, 184, 187, 188, 197, 438, 492
See also War Department General Staff.
G–2 (intelligence), 152
See also War Department General Staff.
G–3 (operations) 63, 64, 84, 204, 217
See also War Department General Staff.
G–4 (logistics), 65
See also War Department General Staff.
General hospitals:
for care of prisoners of war, 324–325
manning tables for, 314
Negro WAC hospital companies in, 322
oversea shipment of, 316
Protective Mobilization Plans for number of, 62
reorganization of, under T/O 8–550, 4 July 1944—301
The Surgeon General employs civilians for, 248
War Department directive on change of table of organization of, 303
See also Hospitals, general.

General Staff. *See* War Department General Staff.
Geneva Convention of 1929—324
German control of Europe, 54
German prisoners of war, for Medical Department activities, 327–329
Germany, 37, 90, 143, 231, 246, 283, 487
  defeat of, 87, 488
GIBSON, TRUMAN, 323
GINZBERG, ELI, 35, 37
Glennan General Hospital, Okmulgee, Okla., 325
GOETHALS, Col. THOMAS R., 144
Governors. *See* State Governors.
Grades, for female medical technicians, 244
Graduates, of—
  foreign medical schools:
    standards for, 1
    utilization of, 3
  unapproved medical schools, commissions for, in Medical Corps, Army of the United States, 150–151
GRANT, LAURA, 227
Great Britain, 2
  ratio of physicians to population in, 68, 261
Ground Forces Reinforcement Command, European theater, 302–303
  Medical Department personnel supplied by, 298
Ground Forces Replacement System, European theater, 239
  commanding general of, 301
Ground Surgeon, 69
Groups, Medical Department, 112
Growth, of Medical Department, before Pearl Harbor, 2
Guam, 331
Guardsmen:
  geographic restriction on use of, 54, 124
    removal of, 167
  induction of, into Federal service, 58
Guides, for—
  classification of enlisted personnel, 285–286
  utilization of personnel. *See* Manning guides.
Gynecologists, 282, 296
HALL, Col. DURWARD G., 30, 229, 494, 501
Hardship:
  discharge for, 447
  return to civilian life for, 437
Hasting Air Base, 245
Hawaiian Department, 384
Hawaiian Islands, 257, 258
Headquarters, Army Service Forces, 33, 203
  elements of:
    Control Division, 31, 79
    Military Personnel Division, 87, 184, 294
    Military Training Division, 202
  See also Army Service Forces.
Health and Medical Committee, Council of National Defense, 161, 162
  National Nursing Council for War Service, 226
  Subcommittee on Medical Education, 161
HOBBY, Col. OVETA CULP, 244
Hollandia, 52
Hospital center(s):
  813th—327, 328
  814th—225
  815th—255
  Protective Mobilization Plans for number of, 62
Hospital Dietitians, 1
  creation of, 3
  oversea strength of, 371
  See also Dietitians.
Hospital Division, Office of The Surgeon General, 35
  See also Office of The Surgeon General.
Hospital internship, 192, 193
Hospital staffs, civilians on, 248
Hospital system:
  changes in, to economize on personnel, 31, 312
  expansion of, 248
Hospitalization:
  personnel loss to Army due to, 432
  reduction of time of, 313
Hospitals:
  Negro personnel for, 318–320
  shipment of, with less than table-of-organization complement, 316–317
  WAC table-of-organization companies in, 244–245
Hospitals, affiliated. *See* Affiliated hospital units.
Hospitals Committee, Directing Board, Procurement and Assignment Service, 170
Hospitals, convalescent, 312
  Red Cross workers assigned to, 419
  table of organization for, 95
Hospitals, evacuation:
  affiliated, 142, 144
  Red Cross workers assigned to, 419
  See also evacuation hospitals; field medical units.

Hospitals, field, Red Cross workers assigned to, 419
Hospitals, general:
affiliated, 142, 144, 208
named:
Gardiner, 322
Glennan, 325
Halloran, 322
Lovell, 322
Percy Jones, 101
Thomas M. England, 322
Tilton, 322
Valley Forge, 325
Wakeman, 322
Walter Reed, 16, 454, 502
numbered:
3d—109
5th—332
6th—144
17th—144
18th—258
19th—144
20th—258
30th—208
42d—239
46th—144
49th—254, 257
71st—208
96th—232
98th—246
116th—246
118th—306
133d—245
203d—261
218th—258
table of organization for, 94
Hospitals, portable surgical, 9th—306
Hospitals, station:
affiliated, 142
manning guides for, 91
numbered:
2d—256
61st—210
67th—259
95th—254, 259
125th—257
159th—259
tables of organization for, 91
Hospitals, surgical, affiliated, 142, 144
House Military Affairs Committee, 230
Housing sanitation, as function of Medical Department, 2
Howard University Medical School, 318
H.R. 227, the nurse draft, 229–231
HUDNALL, Col. JAMES R., 30
HUTTER, Col. CHARLES G., 158
Illiterates, definition of, 234
Immigration and Naturalization Service, Department of Justice, 152
Immunization, as function of Medical Department, 2
Imprisonment, for misconduct, personnel loss to Army due to, 432
Inactive Reserve, 122
India, 258–259, 329
India-Burma theater, 245
Inductees, period of service for, 54
Industrial Health and Medicine Committee, Directing Board, Procurement and Assignment Service, 170
Industrial hygiene engineers, 212
Inefficiency:
discharge for, 447
return to civilian life for, 437
Infantry Division, 93d—320, 321
Infantrymen, combat recognition for, 337
Information Committee, Directing Board, Procurement and Assignment Service, 170
Information forms. *See* Questionnaires.
Insect and rodent control, as function of Medical Department, 2
Inspector General, 85
Inspector General's Office, 314
Instruction(s):
in medical techniques, 165
of Director, Selective Service System, to Medical Officer Recruiting Boards, 178
of The Surgeon General:
on classification of officers, 275–276
to Medical Officer Recruiting Board, 174
Integration program, 505–508
Interns, 139
commissioning of, 138
effect of selective service on military status of, 137
military obligations of, 137
Intratheater rotation of medical officers, 332–334
Ireland, 332
Italian armistice, 326
Italian campaign, 334, 383
Italian service troops, for—
Medical Department activities, 326
Medical Department units, 260
Italy, 260, 304, 329
Japan, 204, 205, 489, 494, 509

663076—63—— 36

Japanese-American medical personnel, 153–154
dentists, 153
nurses, 153–154
physicians, 153
utilization of, in Medical Department, 4
JEFFCOTT, Col. GEORGE F., 76
Job categories, in classification system, 282
Job specifications, for Army jobs, 270–271
Johns Hopkins University, 211
JOHNSON, Senator EDWIN C., 231
Journal of the American Medical Association, 158–159
Judge Advocate General, 129
Karachi, India, 259
KENNER, Maj. Gen. ALBERT W., 30
Kenner Board, 30
KIRK, Maj. Gen. NORMAN T., 31, 37, 80, 82, 84, 465, 466, 501, 504
See also Surgeon General, The.
Korea, 570
KRISTAL, Dr. J. JOHN, 149
K'un-ming, China, 254
Labor, local:
availability of, 255–256
saving of military personnel effected by utilization of, 255
Labor troops, native, for Medical Department activities, 329
Laboratory, medical, 59
See also Field medical units.
Laboratory officers, refresher courses for, before separation, 502
Laboratory technicians, 165
Lae, New Guinea, 256
Lag, in procurement of nurses, 228
LAHEY, Dr. FRANK H., 169, 176, 187
LAWLAH, Dean JOHN W., 318
Leaves, in effective utilization of personnel, 331
Legislation:
active-duty tour extended by, 130, 167
for manpower in the Army, 167
Medical Service Corps established, 508
on Army Nurse Corps grades, 462
on pay increase, 462, 463
on selective service, 131–134
pertaining to commissioning of licensed female physicians, 155
pertaining to reservists, 122, 124
compulsory active duty, 129
proposed, for draft of nurses, 229–231
strength of Regular Army officer corps authorized by, 122
LELAND, Dr. ROSCO G., 73
Leyte, 254
Liaison, between—
Office of The Surgeon General and Committee on Medical Preparedness, 159
Procurement and Assignment Service and Selective Service System, 170
Liaison officers, 158, 162
Liberia, 259
Limited-service personnel, 167, 234–236
Army policy concerning, 235
in oversea theaters, 239–242
transfer of, to Medical Department, 298
with Medical Department, 235
LIPPMANN, WALTER, 229
List, of critically needed specialists, 237, 238, 239
LISTON, Col. DAVID E., 82
Litter bearers, 306
German prisoners of war utilized as, 326
natives utilized as, 256, 259
Local draft boards. *See* Draft boards.
Local labor:
availability of, 255–256
saving of military personnel effected by utilization of, 255
London, 330
LONG, Col. PERRIN H., 282
Losses, 420–449
factors affecting rate of, 420–432
permanent, 432–449
deaths, 436
return to civilian life, 437, 439–442
LOVE, Brig. Gen. ALBERT G., 149
Low Countries, 143
LUETH, Lt. Col. HAROLD C., 158
LULL, Maj. Gen. GEORGE F., 23, 27, 30
Luzon, 254
McCLOY, JOHN J., 189
McINTIRE, Vice Adm. Ross T., Surgeon General of the Navy, 74
McNUTT, PAUL V., 74, 162, 169, 175, 177, 187, 188, 189
on special draft of doctors, 189
MAGEE, Maj. Gen. JAMES C., 17, 37, 61, 62, 63, 64, 65, 67, 69, 74, 142, 143, 144, 184
See also Surgeon General, The.
Malaria control units, natives utilized in, 235, 256, 257, 258, 259
Male nurses, in Army Nurse Corps, 9
Male officer components, of Medical Department, 3

Male officers, appointment of, in Army Nurse Corps, 1
Manning guides, 90
for dietitians, 88
for physical therapists, 88
for Zone of Interior hospitals, 91, 312
Manpower, conservation of, 3
Manpower Board, War Department, 32, 314
Marine Corps, 77
Marital status, for Army nurses, 225
MARSHALL, Gen. GEORGE C., 244
Mayo Clinic, 208
Meat and dairy hygiene inspectors, 165
Medical Administrative Corps, 1, 7, 17, 56, 78–84, 124, 166, 195, 212, 214–220, 277, 462, 476
abolishment of, 508
authorized strength of, 53
discharge rate in, 438
misassignment of officers to, 213
Negro personnel, 318, 321–322
officers of:
assigned as battalion surgeon's assistants, 80
substituted for Medical Corps officers, 70, 80, 81, 82, 218
oversea strength of, 371, 373
procurement for:
by direct commissioning of civilians, 214, 215
by direct commissioning of enlisted men, 214, 215–217
officer candidate schools, 217–219
rank in, 455
reservists of:
response of, to active duty, 126
substitutes for Medical Corps reservists, 60
separation from:
age for, 489
point score for, 489
strength of, 218, 219
training for, 81, 126
transfer of limited-service officers to, 298
vacancies in, 112
Medical aidmen, Medical Badge authorized for, 337
Medical and Health Committee, Office of Defense Health and Welfare Services, Subcommittee on Nursing of, 163–164, 223
Medical and Hospital Department Fund, Army, 248
Medical Badge, authorization of, 337–338
Medical Corps, 1, 6, 56, 58, 67–74, 111, 146, 150–151, 168–195, 205, 277
classification of officers of, 274–275
criteria for release from, reduction of, 493
deficits in, 58
discharge rates in, 438
field grades in, 456
general officers in, 456
Negro personnel, 318
of Regular Army:
appointment of women doctors in, 1
integration gains, 507–508
pay increase in, 507–508
position categories established in, 268
procurement for:
by direct commissions, 180
control of, shifted to service command commanders, 179
in 1944—190–193
increase in, in 1942—180–181
lag in, during first months of the war, 168
lag in, in 1943—182–184
Medical Officer Recruiting Boards in, 173–181
"9–9–9 plan," 192–192
Officer Procurement Service, in 181–182
Procurement and Assignment Service in, 169–173
special draft of doctors proposed, 186–190
the Reynolds Plan, 184–185
promotion in, 453, 455
rank in:
of women doctors, 155
problem of, 469
reservists of, response to active duty, 126
separation from:
age for, 489
point score for, 489
strength of, 180–181
in 1939—53
in 1943—72
maximum, 73
overseas, 371, 373
vacancies in, 112
Medical Corps Reserve, 451, 452
Army regulations pertaining to candidates for, 148
Medical students applying for commissions in, 139
promotions in, 452
resignation from, 451

Medical Department, 132, 137, 151, 155, 156, 163, 166, 168, 171, 212, 215, 232, 268, 270, 274, 290, 294
active-duty strength of, by Army components, 112
additional sources of professional personnel for, 148–156
battle casualty rates of, 420-430
civilian employees of, 101
contract surgeons, 250
contribution of, 102
dietitians, 252
employing agent for, 248
funds for payment of, 248, 249
geographic distribution of, 264–266
nonprofessional personnel, 252
nursing personnel, 250–251
occupational therapists, 251–252
physiotherapy aides, 252
Red Cross workers, 252
strength of, 250
types utilized in oversea theaters, 253–255
components added to, 3
composition of, 1–19
overseas, 405–420
Congressional Medal of Honor awarded to personnel of, 337
enlisted men in, 233
illiterates, 233–234
key technicians, 236–239
limited-service, 234–236
oversea theaters, 239–242
rank of, 483, 485
enlisted personnel of:
criteria for release of, 490
distribution of, 95
ratio of, to total Army strength, 62
specialists, 492
Enlisted Reserve of, 165
enlisted strength of, 54, 164
of total Army strength, 91, 92
enlisted women in:
as technicians, 99
in oversea theaters, 245–246
in Zone of Interior, 242–245
functions of, 1–2, 396
general officers in, 456
increase in supply of officers for, 125
Japanese-Americans in, 4
military components of, 9–18
Negro personnel, 4, 318
non-Medical Department personnel in, 419-420
Medical Department—Continued
officer candidate schools of, 217–219
officer components of, 1, 3, 5
strength of, 53–54
officers of:
allotment of, to oversea areas, 1942—384
assigned to Veterans' Administration, 339
in affiliated medical units, 146
shortages, 58–59
Officers Reserve Corps, procurement objectives for, 55
personnel of field forces utilized in, 64
personnel offices of, 49–52
physical therapists recruited for, 231
Procurement and Assignment Service in personnel procurement program of, 73, 74
professional retraining by, 500–505
rank in, 456
redistribution of officers of, 315–316
Reserve officers allotted to, 55
responsibilities of, 1
retention of trained noncommissioned officers in, 166
specialization restricted in, in peacetime, 267
strength of, 339–449
in 1939—53
in 1944—1
in oversea areas, 105
on 7 Dec. 1941—9
transfer of qualified noncommissioned officers from, 294
units of, 396
Negro, 411, 412
operating strength of, in oversea theaters, 385, 387
Waacs trained for work of, 243
War Department responsibilities for personnel for, 54–57
Medical Department enlisted men. *See* Enlisted men.
Medical depots, 396
Medical Division, Office of Chief of Air Corps, 21, 26
Medical Education Committee, Directing Board, Procurement and Assignment Service, 170
Medical entomologists, 212
Medical Field Service School, 217, 218, 219, 289, 454
Medical gas treatment battalions, 396

Medical installations:
Air Forces Station Hospital, Tuskegee, Ala., 319
Negro Station Hospital, Fort Huachuca, Ariz., 319
Medical laboratories, 59, 396
See also Field medical units.
Medical missionaries, commissioned in Medical Department, 180
Medical Officer Recruiting Boards, 173–181, 191
accomplishment of, 175, 180
Air Forces medical officers on duty with, 176
civilian reaction to, 178–179
closing of, 179
dental officers assigned to duty with, 177
establishment of, 173
instructions of Director, Selective Service System, to, 178
instructions of The Surgeon General to, 174
procedures for, 173–174
Procurement and Assignment Service reaction to, 176–177
testimony of Chairman, War Manpower Commission, on, 178
The Surgeon General's control of, 175
Medical officers:
duties of, 6
morale of, in oversea theaters, 330
pay of, 1
rank of, 1
ratio of, to enlisted strength, 68
refresher courses for, before separation, 501
relieved of administrative duties, 78, 303
transfer of, from Air to Service Forces, 315
Medical Practice Division, Office of The Surgeon General, 28
See also Office of The Surgeon General.
Medical Preparedness Committee, American Medical Association, 149, 156–159, 171
Medical regiments, 59, 61
See also Field medical units.
Medical replacement training centers, 60, 80, 217, 235, 292, 320, 454
establishment of, 165
See also Military installations.
Medical schools, foreign, graduates of, 1, 3
Medical Section, Mediterranean theater, 52
Medical service:
of National Guard, 58
United States standards of, compared with that of Great Britain, 68
Medical Service Corps:
establishment of, 508
integration gains in, 508
Medical Society of New Jersey, 210
Medical specialists training, 193
Medical students, 136–138
commissioned in Medical Administrative Corps, 199
deferred, for occupational reasons, 139
effect of selective service on military status of, 137
in Army Specialized Training Program:
commissioning of, upon graduation, 202–203
school costs for, 202
military obligations of, 137
supply of, 3
with Reserve commissions, transferred to Medical Administrative Corps Reserve, 137
Medical supply depots, 59
Medical supply officer, Medical Administrative Corps officer serving as, 7
Medical technicians, 218, 236, 244, 286, 306, 492
assignment of, 295
channelling of, to Medical Department, 295
Wacs trained as, 243
Medical technologists, 165
Medicine:
consultant in, in—
European theater, 282
North African theater, 282
Office of The Surgeon General, 272
supply of students of, 3
Medicine and Surgery, Bureau of, 156
Mediterranean Theater of Operations, U.S. Army, 47, 240, 382, 487
classification system in, 283–284
limited-assignment personnel replacing general-assignment personnel in, 239–240
organization for personnel administration in, 52
replacements for, 304
rotation in, 334
shortage of nurses in, 230–231
skilled civilian workers for Medical Department in, 254

Memorandums, War Department:
on critically needed specialists, 237
See also specific War Department Memorandum.
Mental disability:
discharge for, 438
for return to civilian life, 437
Mess officer, Medical Administrative Corps officer serving as, 7
Middle Pacific Area, shortages of medical and surgical specialists in, 108
Middlesex University College of Medicine, 151, 152
MIDDLETON, Col. WILLIAM S., 282
Military components, of Medical Department, 4–18
prewar period, 1939–41—5–9
Army Nurse Corps, 8–9
Dental Corps, 6–7
enlisted personnel, 9
Medical Administrative Corps, 7
Medical Corps, 6
Sanitary Corps, 7
Veterinary Corps, 7
Physical Therapists, 9–17
Dietitians, 9–17
Pharmacy Corps, 17–18
Physical Therapists, 9–17
Military District of Washington, 99, 501
Military Establishment, 67, 77
Military installations:
Camp Atterbury, 322
Camp Barkeley, 80, 81, 165, 217, 218, 219, 235, 321
Camp Forrest, 324
Camp Grant, 60, 80, 165
Camp Lee, 60, 165
Camp Livingston, 318
Camp Pickett, 80
Camp Shelby, 153
Carlisle Barracks, 126, 217, 218, 318, 321
Fort Bragg, 318
Fort Devens, 322
Fort Dix, 322
Fort Huachuca, 319, 320, 321
Fort McPherson, 243
Military Intelligence Service, 152
Military necessity, in demobilization, 495–496
Military occupational classification of enlisted personnel, guide for, 285
Military occupational specialty, 270–271, 279, 503
Military Personnel Division, Army Service Forces, 87, 184, 294
Military Personnel Division, Office of The Surgeon General, 32
chief of, 22, 23
organization of, 27
redesignation of, 27
See also Office of The Surgeon General.
Military Personnel Division, Services of Supply, 173, 224
Military Police, 324
Military preparedness program, 54
Military service:
age for, 167
change from voluntary to involuntary, 124–125
deferment of, for—
members of affiliated units, 146–148
reservists, 127–129
extension of compulsory, 1
inventory, 125
Military status, of—
medical students, 137
physical therapists, 154
residents, 137
Military strength, of Medical Department, 1
Milne Bay, 256
Minority groups, commissioned status for, 156
Misassignment(s), 289, 291–295, 296
causes of, 292
of enlisted men, 293
extent of, 294
of officers, 291–292
in Medical Administrative and Sanitary Corps, 213
Misconduct:
discharge for, 447
for return to civilian life, 437
imprisonment for, 432
Missing in action, personnel loss to Army due to, 430, 432
Missionaries, medical, commissioned in Medical Department, 180
Mobilization, beginning of, 405
system of classification, 270
Mobilization guide, for employment of civilians, 65
Mobilization planning, responsibility for health and medical aspects of, 1
Mobilization Regulations 1–10, 5 Mar. 1943—47

Morale:
factor of, in efficient utilization of personnel, 329–337
in affiliated units, 209
Mourmelon, France, 327
Munich, 246
National Association of Colored Graduate Nurses, 164
National Board of Medical Examiners, 148
National Defense Act, of—
1916—7, 53
1920—53, 54, 60, 91, 111
National Guard, 5, 9, 63, 111, 112, 159, 164, 248, 269, 290, 452, 454
call to active duty of physicians in, 168
compulsory active duty for, 129
federalization of, 58, 124, 339
geographic restriction on use of, 54, 125
removal of, 167
Medical Department officer corps in, 5
promotions in, 452
strength of:
changes in, 112
worldwide and overseas, 404, 405, 410
National Guard-Reserve Act of 27 Aug. 1940—54
National Inventory of Nurses, 227
National League of Nursing Education, 164
National Medical Association, 320
National Nursing Council for War Service, 164, 227, 228, 229
organizations represented by, 164
Subcommittee on Nursing of Health and Medical Committee of, 226
Supply and Distribution Committee of, 223
National Organization for Public Health Nursing, 164
National Red Cross, American. *See* Red Cross
National Research Council, 170, 269
Committee on Sanitary Engineering of, 211
Division of Medical Sciences of, 161, 273
in classification of officers, 269
National Roster of Scientific and Specialized Personnel, 170, 171
established, 269
function, 269
in classification of officers, 269
National Survey of Registered Nurses, 164, 171
Native labor troops, for Medical Department activities, 329
Naturalized physicians, requirements of, for commissions in Army of the United States, 152
Naval Reserve, female physicians commissioned in, 155
Navy College Training Program (V–12), 201, 203
Navy Department, 203
Navy Surgeon General, 74
Negro Health Committee, Directing Board, Procurement and Assignment Service, 170
Negro infantry division, 320, 321
Negro personnel:
hospital personnel, 318–320
in Army Nurse Corps, 322
in Medical Administrative Corps, 321–322
in Medical Corps, 318
in sanitary companies, 320–321
in Women's Army Corps, 322–323
strength, 411–412
utilization of, 3, 4, 317–324
Neuropsychiatrists, 291
Neuropsychiatry, consultant in, Office of The Surgeon General, 272
New Caledonia, 220
New Guinea, 52, 254, 256
Newspapers:
article on nurse shortages, 229
criticism in, on rejection of Nisei nurses, 154
"9–9–9 plan," in Medical Corps:
criticism of, 192
procurement, 192–193
Nisei nurses, military duty for, 153–154
Nonaffiliated units, 307
Noncommissioned officers, of Medical Department, 166
Nonprofessional personnel, of Medical Department, 252
"Nonprotected" personnel, category of prisoner of war, 324, 325
See also Prisoners of war.
Non-table-of-organization personnel, for European theater, 303
Normandy campaign, 326
North Africa, 210
medical units for invasion of, 302
North African theater, 48, 216, 217, 331, 382, 383
civilian personnel in medical units of, 260–261
classification system in, 281–283
deactivation of station hospitals in, 301
rotation in, 334

North African theater—Continued
skilled civilian workers for Medical Department in, 254
surplus of Medical Department personnel in, 108
See also Mediterranean Theater of Operations, U.S. Army.
North America, 382
Northern Ireland, 332
Norway, 143
Nuremberg, 246
Nurse Corps. *See* Army Nurse Corps.
Nurses, 155, 169, 207, 304
civilian, 380
classification of:
code number system in, 271
directives on, 270
during 1939–41—267–270
during 1941–43—270–274
distribution of, 88
draft of, 87
proposed legislation, 229–231
duties of, 8
failure of, to volunteer, 228, 229
for affiliated units, 207
full officer status for, 17
morale of, in oversea theaters, 330
of Japanese ancestry, policy for commissioning of, 153–154
of Regular Army, authorization for, 54
pay of:
during emergency period, 453
increase in, 462, 463, 464
rank of, 8
recruitment of, 135
Nurses' aides, 254, 380
quota for, 251
strength, 251
training of, 251
Nursing Advisory Committee, Directing Board, Procurement and Assignment Service, 170
Nursing Council for National Defense, 171
Nursing Division, Directing Board, Procurement and Assignment Service, 170
functions of, 226–227
organization of, 227
Nursing Division, Office of The Surgeon General, 23, 84, 222, 224, 229
See also Office of The Surgeon General.
Nursing profession, organization of, for defense, 163–164
Nursing Service, of the Red Cross, 134
Nursing Supply and Distribution Service, War Manpower Commission, 226
Advisory Committee to, 226
See also Nursing Division, Procurement and Assignment Service.
Nutrition, 2
Obstetricians, 282, 296
Occupational groups, exempted from selective service, 131
Occupational specialists, Medical Department:
bacteriologists, 212, 213, 242–243
biochemists, 212, 213
dental hygienist, 286
dental laboratory technicians, 236, 243, 245, 246, 286, 492
entomologist, 281
industrial hygiene engineers, 212
laboratory officer, 212
laboratory technicians, 218, 236, 243
medical entomologists, 212
medical technicians, 218, 236, 243, 244, 245, 246, 286, 306, 492
optician, 286
optometrists, 242–243
orthopedic mechanic, 242, 286
orthopedic technicians, 492
parasitologists, 212, 213
pharmacists, 242–243, 286
psychiatric social workers, 101
sanitary engineers, 211, 213, 280–281
sanitary technician, 286
serologists, 212
surgical technicians, 218, 236, 243, 244, 286, 306
veterinary surgical technician, 286
X-ray technicians, 243, 286, 492
Occupational therapists, 102, 251–252
Occupational therapy aides, 165
Office for Emergency Management:
Office of Defense Health and Welfare Services of, 169
War Manpower Commission of, 169
Office of Civilian Defense, 251
Office of Defense Health and Welfare Services, 162
Director of, 169
Medical and Health Committee of, 164, 223
Procurement and Assignment Service of, 169
Office of the Air Surgeon:
organization of, for personnel administration, 38

Office of the Air Surgeon—Continued
subordinate elements of:
Nursing Section, 38
Personnel Division, 38, 40, 224
Office of the Chief of Air Corps, Medical Division of, 21, 26
Office of the Chief Surgeon, European theater, 52, 245
Personnel Division of, 302
Professional Services Division of, 282
Office of the Secretary of War, 127
Office of the Surgeon, Antilles Department, 266
Office of the Surgeon, Army Ground Forces, 81
Office of The Surgeon General, 3, 16, 19, 62, 63, 64, 90, 95, 133, 143, 154, 162, 170, 173, 178, 182, 190, 203, 204, 231, 248, 253, 268, 274, 290, 296, 305, 317, 323, 335, 488, 489
civilians in, 247
consultants in:
medicine, 272
neuropsychiatry, 297
surgery, 297
control of medical personnel reestablished in, 45
discontinues direct commissioning of enlisted men, 215
estimates of, on nurse requirements, 84
liaison with Committee on Medical Preparedness, 158
organization of, for personnel administration, 21–24
January 1939—27
August 1942—28
February 1944—37, 38, 39
May 1945—37, 38, 39
reorganization of, 27–37
role of, in classification of officers, 271–272
revision of organization of, 4
subordinate elements of:
Administrative Division, 23
Civilian Personnel Division, 250
Classification Branch, 271–272, 276, 278, 280, 284
Commissioned Division, 27
Dental Division, 7, 23, 28, 75, 132, 296, 502
Enlisted Branch, 91, 323
Finance and Supply Division, 23
General Surgical Branch, 297
Hospital Division, 35
Integration Section, 506
Office of the Surgeon General—Continued
subordinate elements of—continued
Medical Consultants Division, 296
Medical Practice Division, 28
Military Personnel Division, 22, 27, 28, 32, 191, 228, 229, 230, 250, 270, 272, 280, 284, 323, 469
Neuropsychiatry Consultants Division, 296
Nursing Division, 23, 84, 222, 224, 229, 296
Operations Service, 36, 84
Personnel Division, 84, 111, 149, 500, 506
Personnel Planning and Placement Branch, 315
Personnel Service, 75, 86, 171, 221, 228, 250, 279, 283, 291, 294, 324, 493–494, 501, 503–504
Physical Standards Division, 167
Preventive Medicine Service, 28, 296
Procurement Separation and Reserve Branch, 506
Professional Service Division, 23
Reconditioning Consultants Division, 296
Reserve Subdivision, 143
Resources Analysis Division, 35, 36, 37
Sanitary Engineering Division, 281, 320
Strategic and Logistics Planning Unit, 87
Supply Service, 455
Surgical Consultants Division, 296, 297
Training Division, 500, 501
Veterinary Division, 23, 28, 197, 200, 204, 296
Officer candidate schools:
for Medical Administrative Corps, 126, 212
in Zone of Interior, 217–219
Negro graduates of, 321
oversea theaters, 219, 220
"Officer Civilian Classification," Army Regulations No. 605–95—270
Officer components, of Medical Department, 1, 3, 5
"Officer Military Classification and Job Specifications," Army Regulations No. 605–95—270
Officer procurement, during demobilization, 496–499
effects of, 497–499
Officer Procurement Service, 179, 180, 181–185, 212, 270
establishment of, 181

Officer Procurement Service—Continued
in procurement of—
dietitians and physical therapists, 231
nurses, 224
technologists, 243
procedures for, 181–182
Officer replacement pools, 292
Officer strength, overseas, 414, 415
Officers:
classification of:
code number system in, 271
consultants in, 272
directive on, 270
during 1939–41—267–270
during 1941–43—270–274
Office of The Surgeon General in, 271–272
role of field commands in, 272–274
sources of information for, 273
within Air Forces, 273–274
male, appointment of, in Army Nurse Corps, 1
of Medical Department. *See* Army Nurse Corps; Dental Corps; Hospital Dietitians; Medical Administrative Corps; Medical Corps; Pharmacy Corps; Physical Therapists; Sanitary Corps; Veterinary Corps.
of Regular Army, quotas for, 53
pay increase for, 3
Officers' Reserve Corps, 130, 136, 137, 141, 166
changes in strength of, 112
commissions in Medical Department Reserve corps of, 112
procurement objective for sections of, 55
suspension of appointments to, 56
Okinawa, 180
Operation TORCH, 68
Operations Division, War Department General Staff, 317
Operations Service, Office of The Surgeon General, 34, 35, 84
See also Office of The Surgeon General.
Opticians, 286
Optometrists, 156, 242
Ordnance Department, 234
Organization:
for personnel matters, 21–52
changes in, 1
in theaters of operations, 47–52
in Zone of Interior, 4, 21–46
of Procurement and Assignment Service, 169–170
Organized Reserves, 111, 144
See also Reserves.
Orthopedic mechanics, 165, 242, 286
Orthopedic technicians, 492
Osteopaths, 156
Oversea duty, extra compensation for, 462
Oversea service, as criteria for release, 488
Oversea strength:
in major commands, 398–404
regional, 382–397
variation in, 380
Oversea theaters:
authorization for direct commissioning in, 215
distribution of Medical Department personnel in, 339–404
by corps and groups, 371–382
Medical Department installations in:
civilian employees for, 253–266
enlisted men in, 239–242
enlisted women for, 245–246
local labor utilized in, 255–266
non-Medical Department personnel for, 419–420
prisoners of war utilized in, 325–329
morale problems, 330–337
officer candidate schools in, 219, 220
sources of replacement personnel:
casuals from Zone of Interior, 303–305
personnel made available by administrative actions, 301–303
personnel released from hospitals, 298–300
temporary personnel, 306–307
table-of-organization strength of attached medical personnel and divisional medical battalions, 385
Oversea units, factors in requirement of:
additional table-of-organization units, 104
losses, 102–103
non-table-of-organization allotments, 103–104
reorganized table-of-organization units, 104
shortages, 105–109
Owen Stanley Mountains, 256
Pacific islands, 254
Pacific Ocean Areas, 382
general hospitals shipped to, 317
Pacific theaters, 284, 487
PADEN, Col. PAUL A., 41, 83, 111, 162
Panama Canal Department, 266, 384
Parasitologists, 212
Paris, 52

PATTERSON, ROBERT P., Under Secretary of War, 140
Pay, 451–485
adjustments in, 1
during emergency period, 451–453
of nurses, 453
of officers, 451–453
in early war years, 454–464
of dietitians, 464
of nurses, 462–463
of officers, 454–456
of physical therapists, 464
increase in, 462, 463
later war years, 464–470
of officers, 464–467
morale factor of, 451
resignation for insufficiency of, 451
Pay Readjustment Act of 1942—463
Peacetime selective service act. *See* Selective Training and Service Act.
Pearl Harbor, 2, 16, 47, 67, 73, 126, 130, 139, 146, 160, 167, 168, 199, 208, 210, 221, 254, 270, 290, 339, 380, 384, 452, 453, 476, 500
Percy Jones General Hospital, Mich., 101
Permanent losses, 420–449
influences affecting rate of, 420–432
types of, 432–449
Persian Gulf Command, 383
ratio of civilian hospital workers to military medical personnel in, 259
Personal hygiene, measures for, as function of Medical Department, 2
Personnel Control Branch, Personnel Service, Office of The Surgeon General, 37
Personnel Division:
Office of the Air Surgeon, 38, 223
Office of the Chief Surgeon, European theater, 52
Office of The Surgeon General, 84, 111, 149, 500, 506
Surgeons' Office, Southwest Pacific Area, 52
Personal Service, Office of The Surgeon General, 86, 171
chief(s) of, 27, 30, 75, 501
organization of, 27
Personnel Control Branch of, 37
See also Office of The Surgeon General.
Personnel Subsection, Medical Division, Office of the Chief of Air Corps, 26
Pharmacists, 17, 242, 286
appointment of, in Medical Administrative Corps, 7
Pharmacy Corps, 1, 7, 17–18, 53, 78, 213–214
abolishment of, 508
creation of, 3, 213–214
discharge rate in, 438
establishment of, 18
strength of, 214
overseas, 371–373
Pharmacy technicians, 165
Philippine Department, 384
Philippine employees, in general and station hospitals overseas, 257
Philippines, 245, 254, 257
Physical disability:
discharge for, 438
for return to civilian life, 437
Physical Standards Division, Office of The Surgeon General, 167
See also Office of The Surgeon General.
Physical therapists, 1, 55, 84, 88–90, 271, 304
civilian status of, 29, 42
creation of component of, 3
for affiliated units, 207
grade distribution for, 462
in World War I, 16
military status, 154
officer status for, 9–17
pay of, 464
procurement for, 231–232
objective, 232
Officer Procurement Service in, 231
rank of, 17
ratio of, to hospital beds, 88
requirements for, 90
separation of:
age for, 489
point score for, 489
strength of, 90, 232
overseas, 371, 373
superintendent of, 16, 88
training programs for, 232
Women's Army Corps members commissioned as, 232
Physicians, 497
alien, requirements of, for commission in Army of the United States, 152
in British Army, ratio of, to troop strength, 68
naturalized, requirements of, for commission in Army of the United States, 152
Physiotherapy aides, 165, 252, 254

Planning:
for personnel administration, 31–37
on demobilization, 487
postwar, 505–510
PM, New York newspaper, 154
Podiatrists, 156
Policy for personnel, changes in, 1
Position categories, in classification of Medical Corps officers, 268
Postwar developments, in Medical Department, 1
Postwar planning, 505–510
integration program, 505–510
POWELL, Lt. Col. BOLLING R., Jr., 494
Preventive Medicine Division, Office of The Surgeon General, 28
See also Office of The Surgeon General.
Preventive program, of Medical Department, 1–2
Prisoner of War General Hospital No. 2, Camp Forrest, Tenn., 324
Prisoners of war, 2, 48, 261, 420
category of, 324
detail of, to Medical Department, 1
employed in Medical Department activities, 499
German, 326–329
Italian, 326
utilization of:
in oversea theaters, 260, 325–329
in Zone of Interior, 324–325
saving of military personnel effected by, 255
Problems, of Medical Department, 1
Procurement, 3
act of 3 April 1939 in, 122–124
at beginning of mobilization, 124–126
change from voluntary to involuntary service, 124–125
congressional action in, 133
contributions of organized medicine and nursing to, 156–164
deferment of professional students in, 198–206
during emergency period, 111–166
emergency measures, 124
early Reserve measures for, 112–124
effect of selective service legislation on, 131–134
establishment of rosters for Reserve officers in, 129
extension of reservists' tour of duty in, 129–130
for affiliated units, 206–210
Procurement—Continued
for Army Nurse Corps, 134–135, 221–222
for Dental Corps, 195–196
for dietitians, 231–232
for Medical Administrative Corps, 126, 214–220
for Medical Corps, 168–195
for Pharmacy Corps, 213–214
for physical therapists, 231–232
for Reserve units, 141–148
for Sanitary Corps, 126, 211–213
for Veterinary Corps, 196–198
in 1941–45—167–210, 211–246
legislation for, 167
limiting factor in, 1
objective of, in 1939—55
for sections of Officers' Reserve Corps, 55
of civilian personnel, 247–266
in Zone of Interior, 247–253
of enlisted men, 164–166, 233–246
preemergency procedures for, 111–112
restrictions on, 4
students in professional schools in, 136–140
War Department action in, 133–134
Procurement and Assignment Service, 73–74, 152, 168, 173, 174, 175, 178, 179, 180, 181, 182, 183, 184, 185, 186, 190, 211, 228, 229, 230, 273, 447
civilian dentists declared available by, 195
Committee on Allocation of Medical Personnel of, 73
creation of, 134
criteria for recruitment of professional personnel established by, 173
Directing Board of, 69, 150, 227
establishment of, 73, 74, 169
functions of, 162, 170–173
Negro doctors declared available by, 324
nurses declared available by, 228
Nursing Division of, 226–227
on medical branches of the Armed Forces, 297
organization of, 169–170
origin of, 161–163
ratio of dentists to civilians determined by, 76
ratio of physicians to civilian population recommended by, 74
reaction of, to Medical Officer Recruiting Boards, 176–177
relocation of civilian doctors by, 74

Procurement and Assignment Service—Con.
role of, in procurement, for—
Army Nurse Corps, 225–231
Medical Corps, 169–173
Subcommittee on Negro Health of, 324
Procurement of female technicians for medical installations, program of Women's Army Corps, 242–243
Professional civilian personnel, Medical Department, in oversea theaters, 253–254
Professional quality, of Medical Department personnel, oversea, 416–419
Professional retraining, 500–505
Professional schools, students in, 136–140
Professional Service Division, Office of The Surgeon General, 23
See also Office of The Surgeon General.
Professional students, deferment of, 198–206
early methods, 198–201
Professional Training Committee, 504
Professional Training Program, 509
Proficiency rating, of Medical Corps officers, 274
Proficiency symbol, in category classification, 268, 269
Promotion, 451–485
Army's system of, 292
as reward for exceptional service, 337
authority for recommendation for, 454
decentralization of, 483
during emergency period, 451–453
of nurses, 453
of officers, 451–453
for orthopedic mechanics, 492
in Army of the United States, 454
in early war years, 454–464
of nurses, 462
of officers, 454–456
inequalities in system of, 464
later war years, 464–470
of nurses, 467–468
of officers, 464–467
morale factor of, 451
overseas, 471–485
enlisted personnel, 483–485
officers, 471–483
temporary, 476–477
through vacancies, 477
"Protected" personnel, category of prisoner of war, 324, 325
See also Prisoners of war.
Protective-Mobilization Plan, 56, 57, 62, 141–142, 143
Provost Marshal, 152
Provost Marshal General's Department, 154
Psychiatric social workers, 101
Public Health Committee, Directing Board, Procurement and Assignment Service, 170
Public Law 828, December 1942, authority for field grades in Army Nurse Corps, 462
Public opinion, on concessions to officers in lower ranks, 125
Publicity campaigns, for recruitment of—
doctors, 191
nurses, 135, 191, 223
Puerto Rican Department, 384
Qualifications, for appointment to—
Army Nurse Corps, 8–9
medical service of Regular Army, 111
Sanitary Corps Reserve, 7
Quality, professional, of—
Dental Corps, 418
enlisted personnel, 418
Medical Corps, 416–417
Quartermaster Corps, 234
Questionnaires:
for classification of officers, 268, 273, 275, 281
See also "Classification Questionnaire of Medical Department Officers."
Quinacrine hydrochloride, 500
Quota, for civilian nurses' aides, 251
Rank, 451–485
adjustments in, 1
during emergency period, 451–453
of nurses, 453
of officers, 451–453
in early war years, 454–464
of dietitians, 564
of nurses, 462–463
of officers, 454–456
of physical therapists, 464
later war years, 464–470
of nurses, 467–468
of officers, 464–467
morale factor of, 451
of Medical Department officers overseas, 470–471
of reservists, 452
of The Surgeon General, 4
Ratings, for female medical technicians, 244
Ratio, of medical troops, to total oversea troop strength, 339, 341–345
Ration, of labor, in Great Britain, 261
Readjustment regulations, War Department, 490
Reassignments, in effective utilization of personnel, 331, 332

Recall to active duty, legislation provided for, 167
Reception centers, 285, 293
enlisted men assigned to Medical Department from, 295
enlisted personnel classified at, 166
recruits classified at, 286, 287
Reconditioning program, 239
Records, of officers, for uniformity of classification, 278
Recreation, in effective utilization of personnel, 331
Recruiting:
for Army Nurse Corps, 221
for female technicians for medical installations, 242–243
in procurement for Medical Corps, 190–191
of medical reservists for active duty, 122
Recruiting campaigns, for nurses, 228
Recruits, classification of, at reception centers, 166
Red Cross, 5, 19, 55, 69, 102, 112, 122, 135, 163, 164, 223, 224, 227, 228
civilian nurses' aides trained by, 251
First Reserve of, 222, 223
in procurement for Army Nurse Corps, 222, 224
Nursing Service of, 134
publicity campaign of, for recruitment of nurses, 135
Registry of Medical Technologists of, 165
staff workers of, in Army hospitals, 252
technicians registered with, 233
Red Cross Reserve, 207
Red Cross workers:
for the Medical Department, 19
in Army hospitals, 419–420
Redeployment, 4, 487–510
during period of partial demobilization, 487–491
factor of, in personnel planning, 36
problems of, 490–491
Redistribution, of Medical Department officers, 315–316
Reduction:
in Medical Corps strength, protests against, 72, 73
of criteria for demobilization, of officers, 493–495
REED, Senator CLYDE M., 493–494
Regimental Combat Team, 442d—153
Regional hospitals, in Zone of Interior, 312
Registration of nurses, for military service, 230
Registry of Medical Technologists, 165
Regular Army, 5, 9, 17, 111
authorization for nurses of, 54
authorization of Medical Department officers of, 53
commissioned status of women in, 154
integration of Medical Department corps, 505–508
Medical Department officer corps in, 5
professional retraining for Medical Corps officers of, 502–505
qualifications for appointment to Medical Department corps of, 111
quota of personnel for, 53
strength of, 72
increase in, 58, 61, 505, 506
statutory, 54
worldwide and overseas, 404
Regular Army Medical Corps, appointment of women doctors in, 1
Regulations, Army:
on classification system, 270
pertaining to candidates for Medical Corps Reserve, 148
See also specific Army Regulations.
Release of officers, criteria for, during partial demobilization, 487–489
Relocation of civilian doctors, by Procurement and Assignment Service, 174
Reorganization, of—
Office of The Surgeon General, 27, 30
War Department, 40–43
Replacement system:
in utilization of personnel, 297–317
organizational changes in, 306–307
procedural changes in, 306–307
temporary personnel in, 306–307
Replacement training center(s), medical, 165, 217, 235, 292, 320, 454
Replacements:
factors in, in oversea units, 102–103
sources of, in oversea theaters, 298–305
Report, subcommittee of Senate Committee on Education and Labor, on procurement of doctors for armed services, 194
Requirements:
additional oversea units, 102
Army Nurse Corps, 84–87
civilians, 66, 100–102
Dental Corps, 75–76
dietitians, 88–90
enlisted men, 91–98
enlisted personnel, 60–65
enlisted women, 99

Requirements—Continued
factors affecting determination of, 58–66
in 1939–41—53–66
in 1941–45—67–109
Medical Administrative Corps, 78–84
Medical Corps, 67–74
Medical Department officer shortages in, 58–59
Pharmacy Corps, 78
physical therapists, 88–90
Reserve shortages in, 59–60
Sanitary Corps, 77
Veterinary Corps, 76–77
Requisitions, processing of, 305
Research, as function of Medical Department, 2
Reserve Corps, Medical. *See* Medical Corps Reserve.
Reserve nurses:
authorized for assignment to active duty, 134
call to active duty of, 55
Reserve Officers Training Corps, 5, 57, 122, 124, 136, 137, 200–201
Reserve shortages, 59–60
Reserve Subdivision, Military Personnel Division, Office of The Surgeon General, 22, 27
Reserves, 5, 9, 290
call to active duty of physicians in, 168
classification of officers of, 1940—268–270
assistance of civilian agencies in, 268–270
compulsory service for, 123
Medical Administrative Corps section of, 7
Medical Department officer corps in, 5
of Medical Department, 2
officers and nurses of, for medical service of active forces, 112
Sanitary Corps section of, 7
strength of, worldwide and overseas, 404
Reservists:
adequacy of, 112
allotment of, to Medical Department, 55
compulsory active duty for, 129
deferment of service for, 127–129
extension of tour of duty of, 129–130
extension by interpretation, 129–130
Service Extension Act, 1941—130
geographic restriction on use of, 125
legislation pertaining to, 122, 124, 129
of Medical Department, 5
rosters of, 128–129
Residencies, 192
Residents, 139
effect of selective service on military status of, 137
military obligations of, 137
Resources Analysis Division, Office of The Surgeon General, 35, 36, 37
See also Office of The Surgeon General.
Responsibilities, of Medical Department, 1
Restrictions:
geographic, on use of—
National Guard, 54, 125
reservists, 125
in legislation pertaining to reservists, 124–125
Retention, of trained noncommissioned officers, in Medical Department, 166
Retirement, 443
age for, 445
Retraining, 487–491
during period of partial demobilization, 487–491
professional, 500–505
Return, to civilian life, 437
Reynolds, Maj. Gen. Charles R., 57, 60, 141, 142
See also Surgeon General, The.
Reynolds, Brig. Gen. Edward, 455
Reynolds plan, in procurement for Medical Corps, 184–185
Roberts Field, Liberia, 259
Rome, 254
Roosevelt, Franklin Delano, 18, 54, 61, 67, 69, 112, 124, 161, 187, 193, 229, 230
approves establishment of Procurement and Assignment Agency, 162
authorized to—
commission officers in the Army of the United States, 130
defer draftees by age group, 167
extend tours of active duty for Reserve officers, 130
empowered to call Medical Department Reserve officers to active duty, 122
personal physician of, 205
questions ratio of doctors to military strength, 68
state of the Union message of 6 Jan. 1945—229
Rotation:
drawbacks of, 335
in utilization of personnel, 332–336
influence of, 336
system of, 290

Royal Army Medical Corps, 154
Sanitary companies, 320–321, 396
  purpose for, 411
Sanitary Corps 1, 5, 7, 56, 59, 77, 79, 124, 166, 462
  abolishment of, 508
  classification of officers of, 280–281
  commissions in:
    direct, 212
    directive pertaining to, 212
    discontinued, 77
  discharge rate in, 438
  misassignment of officers to, 213
  Negro personnel in, 318
  procurement for, 126, 211–213
  promotion in, 469
  reservists of, as substitutes for Medical Corps reservists, 60
  strength of, 213
    overseas, 371, 373
Sanitary Engineering Committee, Directing Board, Procurement and Assignment Service, 170
Sanitary engineers, 169, 211, 212, 381
  improper classification as, 280–281
Sanitary technician, 286
Sanitation of messes, as function of Medical Department, 2
Schools, medical, unapproved American, graduates of, 150–152
Scott, Dr. Norman M., 210
Sea duty, extra compensation for, 462
Secretary of Defense, 1
Secretary of the Navy, 187, 188
Secretary of War, 3, 17, 21, 53, 102, 111, 122, 128, 129, 130, 153, 154, 155, 175, 180, 183, 184, 187, 188, 189, 194, 199, 205, 214, 224, 237, 322, 324, 452, 453, 469, 490, 493–494, 507
  Assistant Civilian Aide to, 323
  civilian consultants to, 250
  favors draft of nurses, 229
Secretary of War's Personnel Board, 179, 180, 181, 506
Seeley, Col. Sam F., 162
Seine Base Section, European theater, 255 261
Selective Service Act. *See* Selective Training and Service Act.
Selective service boards, authority of, for selection of professional men, 131
Selective Service System, 134, 170, 178, 186, 187, 188, 201, 317
Selective Training and Service Act, 125, 132, 138, 184, 187, 339, 462
  amended, 167
  effect of, on procurement during emergency period, 131–134
  passage of, 5, 54, 124, 131
  third- and fourth-year students in Reserve Officers Training Corps deferred by, 137
Senate Committee on Labor and Education, 68
Senate Military Affairs Committee, 230
Separation:
  criteria for Medical Department officers, 487–489
  for transfer to Enlisted Reserve Corps, 205
  problems of, 490–491
Separation centers, medical officers needed for, 493
Serologists, 212
Service command commanders, 179
Service command surgeons, 275, 492
  restoration of position in responsibility to service command commanders, 45
Service commands:
  Medical Department qualified personnel transferred by, 294
  method of assignment of medical personnel in, 45
Service Extension Act of August 1941—130
Services of Supply, Army Service Forces, 154, 173, 217, 293
  allotments to, 72
  commanding general of, 320
  creation of, 289
  Military Personnel Division of, 173, 224
  Officer Procurement Service of, 179, 181–185
  See also Army Service Forces.
Seventh U.S. Army, 216, 217
Sheep, Brig. Gen. William L., 23
Shipments, of Medical Department personnel to oversea theaters, 303–304
Signal Corps, 107, 234
Skilled civilian workers, in Medical Department, 253, 254
Snyder, Maj. Gen. Howard McC., 85
Solomons, 383
Somervell, Gen. Brehon B., 86, 87, 155, 179, 204
  See also Commanding General, Army Service Forces.
South Atlantic, 266, 383, 386

South Pacific Area, 257, 382, 383
affiliated units in, 208
classification system in, 284
Southwest Pacific Area, 104, 220, 232, 245, 298, 305, 306, 317, 382, 383, 397
chief surgeon of, 284
civilians employed in, 256
classification system in, 284
organization for personnel administration in, 52
shortages of Medical Department officers in, 107
Special Assistant, to the Secretary of War, 229
Special draft of doctors, proposed, 186–193
Specialists:
assignment of, 290
enlisted critically needed, 492
directive pertaining to, 237, 238
in Regular Army Medical Corps, 267–268
promotion of, 467
Specialization, in medical profession, 267
Specialties, occupational, Medical Department. *See* Occupational specialties, Medical Department.
Specialty boards, American. *See* American specialty boards.
Specialty centers, use of, 312
Staff functions of Medical Corps Officers, 2
Standard Oil of New Jersey, 30
State committees, of Procurement and Assignment Service, 170
State Governors, 111
assistance of, in recruiting for enlisted women for Medical Department, 244
Station and Job Assignment Recruiting Plan, 243
Station Hospital, Fort Huachuca, Ariz., 319
Station hospital(s):
closure of, in Zone of Interior, 312
corps area surgeons authorized to employ civilians for, 248–249
Protective Mobilization Plans for number of, 62
reorganization of, under T/O 8–560, 28 Oct. 1944—301
See also Hospitals, station.
Statistical clerks, 165
Statistics, on strength of Medical Department, 9
Statutory strength, of Regular Army, 54
STILWELL, Gen. JOSEPH W., 259
Strategic and Logistics Planning Unit, Office of The Surgeon General, 87
Strength:
active-duty, of Medical Department groups, by Army components, 112
Army Nurse Corps, 227, 228, 229, 230
civilian nurses' aides, 251
Dietitians, 232
Medical Administrative Corps, 218, 219
of Corps Area Assignment Group, 30 June 1939—26
of Medical Department, 53–54, 339–449
in 1944—1
on 7 Dec. 1941—9
statistics, 9
Pharmacy Corps, 214
Physical Therapists, 232
Sanitary Corps, 213
"Strength of the Army," 33
STROHM, Col. J. G., 144
Student-apprentice program, for dietitians, 232
Students:
in professional schools:
commissions for, in Medical Administrative Corps Reserve, 139–140
deferment of, 138–139, 198–206
of medicine, supply of, 3
Subcommittee on Medical Education, Health and Medical Committee, Council of National Defense, 161
Subcommittee on Negro Health, Procurement and Assignment Service, 324
Subcommittee on Nursing, Medical and Health Committee, Office of Defense Health and Welfare Services, 163–164, 223, 226
Substandard American medical schools, graduates of, 150–152
Superintendent(s), of—
Army Nurse Corps, 84, 222, 225, 228, 230, 453, 463
Hospital Dietitians, 16
Physical Therapists, 16
Supply and Distribution Committee, National Nursing Council for War Service, 223
Supply Service, Office of The Surgeon General:
chief of, 455
See also Office of The Surgeon General.
Surgeon, Army Ground Forces, 456
Surgeon, Fifth U.S. Army, 382
Surgeon General, The, 17, 25, 26, 33, 34, 38, 40, 41, 58, 60, 61, 67, 68, 69, 72, 73, 77, 78, 79, 80, 81, 86, 90, 99, 111, 124, 127,

Surgeon General, The—Continued
128, 129, 133, 134, 135, 137, 138, 142, 143, 144, 146, 147, 148, 149, 150, 151, 152, 153, 154, 159, 161, 162, 167, 170, 171, 175, 176, 177, 178, 179–180, 182, 183, 184, 185, 188, 191, 192, 193, 194, 195, 196, 199, 200, 203, 204, 207, 208, 210, 212, 213, 215, 216, 217, 222, 225, 228, 229, 231, 232, 233, 235–236, 237, 242, 243, 244, 248, 250, 251, 267, 269, 274, 275, 277, 278, 279, 292, 296, 312, 313, 316, 317, 318, 319, 320, 438, 451, 453, 454, 455, 456, 469, 483, 492, 493–494, 500, 501, 506
affiliated units allocated by, 142
announces conditions for commissioning graduates of unapproved medical schools, 150–151
appointment of, 4
appoints liaison officer to Procurement and Assignment Service, 162
argument of, against ceiling figure for Army Nurse Corps, 84
assignment authority of, 46, 289
authority of, over—
civilian personnel, 43
recruiting boards, 175
awards certificate of appreciation to unaffiliated unit, 210
comments of, on rejection of special draft of doctors, 190
disagreement with General Staff on Protective Mobilization Plan, 62
essentiality of Medical Department officers determined by, 453
estimate of, for—
dentists, 76
nurse personnel, 87
estimates ratio of doctors to military strength, 67
in recruitment of medical reservists for active duty, 122
institutes "reconsideration program," 183
instructed to prepare plan for recruiting boards, 173
instructions of:
on classification of officers, 275, 276
to recruiting boards, 174
jurisdiction of, over affiliated units, 142
lack of authority of, to reassign medical personnel, 291
medical personnel requirements estimated by, 56
on promotion of medical officers, 465, 466, 467
Surgeon General, The—Continued
on redeployment of medical personnel, 487–488
orders closing of recruiting boards, 179
plan of:
for Medical Department, 510
for medical service of a fully expanded army, 69
for utilization of Negro personnel, 318
to conduct survey of medical profession, 156, 159–161
position categories established by, 268, 270–271
position of, on ratio of physicians for civilian medical service, 74
promotions recommended by, 452, 453
proposed ratio of Medical Department enlisted personnel to total Army strength, 62
proposed revival of affiliated units, 141–142
rank of, as provided by Federal statute, 4
recommendation of, for—
allotting technicians, 293
appointments in the Reserves, 132
calculation of nurse requirements, 55
removal of restrictions in selecting Reserve officers, 123
use of "branch immaterial" officers, 60
recommends—
commissions for students in professional schools in Medical Administrative Corps Reserve, 139, 140
establishment of officer candidate school for Medical Administrative Corps, 126
special draft of doctors, 184, 186–190
requests—
cooperation of American Medical Association in recruitment, 156
discontinuance of procurement, 194–195
increase of Medical Department's enlisted personnel quota, 60
training-center facilities, 165
responsibility of, for administration of personnel affairs, 21
restrictions imposed upon, 42
shift of command authority from, 42
stand of, on reduction of Medical Corps officers, 68
testimony of, on women doctors, 154–155
Surgeon General's Office. *See* Office of The Surgeon General.

Surgeon General of the Navy, 74, 161, 162, 189, 206
Surgeon General of U.S. Public Health Service, 127, 161, 162
Surgeon's Office, Southwest Pacific Area, 52
Surgeons, contract. *See* Contract surgeons.
Surgery, consultant in, in—
European theater, 282
Office of The Surgeon General, 272
Surgical hospitals, 59
See also Field medical units.
Surgical technicians, 243, 244, 286, 306
Surplus, of medical officers, 301
Suspension of appointments, in Dental Corps Reserve, 57
Table-of-allotment units, promotion authorized in, 455
Table-of-organization units, 303, 396
changes in, 381
overstrengths in, 301
promotion authorized in, 455, 456
reduction of enlisted complements in, 255
technicians authorized by, 293
vacancies in, 305
Tables of organization, 90
for oversea units, 95, 96, 97
for Women's Army Corps hospital company, 244
for Zone of Interior hospitals, 91
promotion provided by, 455
revision of, for personnel allowances, 313–314
used as manning guides for Zone of Interior station hospitals, 64–66
Tactical medical units and detachments:
enlisted personnel for, 61
increase in number of, 61
See also Field medical units.
TAFT, Senator ROBERT A., 231
Teams, for recruiting medical personnel, 190–191
TEASLEY, Lt. Col. GERALD H., 270, 283
Technical Information Branch, Army Nurse Corps, 228
Technical manuals, War Department, on—
enlisted personnel classification, 285
officer classification, 270, 277
See also specific War Department Technical Manual.
Technicians, procurement of, for Medical Department, 242, 243
Technologists recruitment of, for medical installations, 242–243
Temporary duty, as alternative to rotation, in utilization of personnel, 336
THATCHER, Maj. HAROLD W., 320
Theater chief surgeons, personnel functions of, 49
organization, 49–52
Theaters of operations:
classification system in:
development of, 281–283
uniformity of, 283–284
distribution of Army strength in, 385
fixed hospitals, ratio of—
dietitians and physical therapists to beds in, 89
nurses to beds in, 86
personnel functions of theater commander in, 47–49
temporary personnel as replacements in, 306–307
types of Medical Department units in, 396
undermanning units in training in, 307–311
See also specific theater.
Third U.S. Army, 327
organization for personnel administration in, 52
T/O 8–117, November 1940, sanitary companies established under, 320
T/O 8–550, 3 July 1944, on reorganization of general hospitals, 301
T/O 8–560, 28 Oct. 1944, on reorganization of station hospitals, 301
revision of, 104
TOE 8–117, for establishment of Italian service units, 326
TOE 8–500, 23 Apr. 1944—253
Training:
Army Medical Residence Program, 502
Army Specialized Training Program, 212, 276
civilian nurses' aides, 251
enlisted men, 165, 293–295
for civilian physicians in military methods, 168
in dietetics and physical therapy, 232
of medical specialists, 193
of Wacs, for Medical Department work, 243
Training officer, Medical Administrative Corps officer serving as, 7
Transfer(s):
loss to Medical Department through, 448–449

Transfer(s)—Continued
of qualified personnel from Medical Department, 294
Transportation Corps, 99
Triangular organization, of combat divisions, 313
Tripler General Hospital, 258
TUCKER, KATHERINE, 227
Twelfth Air Force, 305, 330–331, 335
Unaffiliated units:
as source of officer personnel, 210
certificate of appreciation awarded to, 210
Under Secretary of War, 140
Uniforms, of Army Nurse Corps, 221
United Kingdom, 104, 302
United States, entry of, into World War II, 125
See also Zone of Interior.
Units, of Medical Department, operating strength in oversea areas, 385, 387
University of Minnesota, 73
University of Pennsylvania, 227
University of Rome Medical School, 254
Unskilled workers, civilian, in Medical Department, 253, 254
U.S. Army components, 5, 111
See also Army of the United States; National Guard; Regular Army; Reserves.
U.S. Army Forces, Far East, 397
U.S. Army Forces in the Middle East, 245
U.S. Army Medical Department. *See* Medical Department.
U.S. Department of State, 152
U.S. Navy, 2, 77, 190
U.S. Public Health Service, 127, 157, 172, 190, 211, 456
Utilization, 3, 289–338
assignment, 289–297
morale factors in, 329–337
of limited-service personnel, 235–236
of native labor troops, 324–329
of Negro personnel, 317–324
of prisoners of war, 324–329
replacement system in, 297–317
Vatican City, 254
V–E Day, 34, 82, 108, 196, 241, 260, 302, 304, 330, 339, 380, 397, 417, 487, 490, 504
V–J Day, 245, 325, 493, 494
V–12, Navy College Training Program, 201, 203
Venereal disease, control measures for, as function of Medical Department, 2
Veterans' Administration, 127, 128, 162, 248
Medical Department officers assigned to, 339
Reserve officers employed as civilians in, 128
transfer of medical officers to, 73
Veterinarians, 76, 77, 169
Army regulations governing, 77
inducted as enlisted men, 133
Veterinary company, 61
Veterinary Corps, 1, 56, 59, 76–77, 112, 203, 292
creation of, 7
deficits in, 58
field grades in, 456
general officers in, 456
Negro personnel, 318
of Regular Army, integration gains, 508
procurement for, 196–198
objectives of, 77
sources of, 197
promotions in, 455
separation from:
age for, 489
point score for, 489
strength of, 197, 204
authorized, in 1939—53
overseas, 371, 373
Veterinary Corps Reserve, 200
Veterinary Division, Office of The Surgeon General, 23, 28, 197
chief of, 197, 200
See also Office of The Surgeon General.
Veterinary Medicine Committee, Directing Board, Procurement and Assignment Service, 170
Veterinary officers, duties of, 7
Veterinary phase, of Army Specialized Training Program, termination of, 204
Veterinary Service, function of, 77
Veterinary students:
commissioned in Medical Administrative Corps, 199–200
deferment of, for occupational reasons, 139
in Army Specialized Training Program:
commissioning of, upon graduation, 202–203
school costs for, 202
with Reserve commissions, transferred to Medical Administrative Corps Reserve, 137
Veterinary surgical technician, 286
Victory Program. *See* War Munitions Program.

VOGEL, Maj. EMMA E., 16, 88
See also Physical therapists.
Voluntary enlistment, 164
Volunteer Directing Board. *See* Directing Board, Procurement and Assignment Service.
WAAC. *See* Women's Army Corps.
WAC. *See* Women's Army Corps.
Walter Reed General Hospital, 167, 454, 502
War, Secretary of. *See* Secretary of War.
War Department, 2, 21, 47, 53, 55, 58, 72, 84, 90, 95, 102, 103, 104, 108, 123, 125, 128, 130, 132, 135, 137, 138, 140, 142, 144, 146, 147, 152, 156, 159, 170, 175, 186, 187, 190, 194, 200, 203, 204, 205, 209, 212, 216, 217, 228, 239, 251, 275, 276, 283, 297, 304, 307, 312, 324, 336, 396, 445, 462, 487, 490, 505–506
action of, in procurement during emergency period, 133–134
ceases to press for legislation to draft nurses, 231
classification questionnaire for officers, 273, 275
curtails Army Specialized Training Program, 203–206
establishes ceiling on Medical Corps strength, 73
extends tour of Medical Department Officers, 123
Manpower Board of, 32
orders classification of Reserve Officers, 268–270
policy of, on—
assignment of Japanese-American officers, 153
promotion, 453
promotion regulations of, 464
Protective Mobilization Plan of, 56, 57
readjustment regulations of, 488, 490
relaxes physical requirements for duty, 167
reorganization of, 27, 40–43
responsibility of, for Medical Department personnel, 54–57
terminates activities of Medical Officer Recruiting Boards, 179
War Department Circular—
No. 58, on policy of rotation, 332
No. 99, on change in table of organization of general hospitals, 303
No. 209, guide for authorization of personnel, 314
War Departmentment Circular—Continued
No. 232, on proficiency qualifications of officers, 277
No. 33, governing commissions in Sanitary Corps, 212, 213
No. 460, on classification procedures for Medical Department officers, 283
War Department General Staff, 33, 40, 55, 56, 59, 61, 62, 63, 64, 65, 76, 77, 81, 87, 99, 100, 123, 124, 132, 140, 143, 146, 149, 157, 159, 160, 176, 194, 197, 207, 237, 268, 312, 314, 384, 438, 451–452, 465
affiliated units approved by, 142
assignment of Reserve nurses to active duty authorized by, 134
disapproval of, of estimated nurse requirements, 84
War Plans Division of, 67
War Department Manpower Board, estimate of nurse personnel requirements, 85
War Department Memorandum W615–44, pertaining to critically needed specialists, 237
War Department Reserve Pool, 127, 128, 140
War Department Technical Manual—
12–406, "Officer Classification, Commissioned and Warrant," 270, 277
12–426, on civilian occupational classification of enlisted personnel, 285
12–427, on military occupational classification of enlisted personnel, 285
War Manpower Commission, 84, 170
Bureau of Placement of, 169, 226
Chairman of, 68, 74, 169, 177, 178, 184, 186, 187, 226
Director of, 69, 187, 188
Nursing Supply and Distribution Service of, 226
War Munitions Program, 67
War Plans Division, War Department General Staff, 67
Warrant officers:
legislation increasing pay of, 462
Medical Badge authorized for, 337
Washington Post, newspaper, 229
Waste disposal, as function of Medical Department, 2
Water supplies, as function of Medical Department, 2
WD AGO Form No. 178–2, "Classification Questionnaire of Medical Department Officers," 273, 275
WELSH, Col. ARTHUR B., 35
WENTWORTH, Col E. T., 144

Western Europe, 54
Western Hemisphere, 125, 382
White House, 297
WOLMAN, ABEL, 211
Women doctors, appointment of, in Regular Army Medical Corps, 1
Women Physicians Committee, Directing Board, Procurement and Assignment Service, 170
Women's Army Corps, 9, 155, 217, 245, 296, 380, 420, 463, 467
  assignment of female doctors to, 154
  Director of, 244
  members of:
    as technicians, 99
    commissioner as dietitians or physical therapists, 232
    for hospitals, 99
    for medical installations, 212
    in Medical Department, 1
    physical therapy technician courses for, 232
  Negro hospital companies of, 322
  organization of hospital companies of, 244–245
  program of, for procurement of female technicians for medical installations, 242–243
World War I, 2, 5, 56, 141, 143, 144, 156, 168, 267, 268, 313
  civilian consultants used during, 250
  dietitians in, 16
  physical therapists in, 16
  Red Cross hospitals used in, 222
  service of female doctors on a contract basis during, 154
  strength of Medical Department during, 53
X-ray technicians, 165, 243, 286, 492
Yale-New Haven Hospital, 227
Yugoslav service troops, for Medical Department activities, 326
Zone of Interior, 1, 64, 65, 104, 214, 215, 275, 282, 283, 293, 295, 297, 301, 304, 305, 334, 451–470
  all-Negro hospital established in, 319
  changes in hospital system in, 312–313
  civilian personnel for Medical Department, 19, 247–253
    contract surgeons, 250
    dietitians and physiotherapy aides, 252
    nonprofessional personnel, 252
    nursing personnel, 250–251
    occupational therapists, 251–252
    overall employment, 247–250
    procurement of, 247–266
    Red Cross workers, 252
  commands in, 40
  decentralization of personnel administration in, 40–45
  distribution of Medical Department personnel in, 339–404
  enlisted men for Medical Department in, 233–239
    problem of illiterates, 233–234
  enlisted women for Medical Department in, 242–245
  hospitals in:
    allotment of Medical Administrative and Medical Corps officers to, 81
    closure of station, 312–313
    manning guides for, 91
    occupational therapists in, 251–252
    prisoners of war cared for in, 324–325
    ratio of dietitians and physical therapists to beds in, 88
    ratio of nurses to beds in, 86
  officer candidate schools in, 217–219
  organization for personnel administration in, 4
    Air Corps, 26–27
    Air Surgeon's Office, 38
    corps areas, 24–26
    Surgeon General's Office, 21–24
  personnel planning, 31–37
  utilization of prisoners of war in, 324–325

U.S. GOVERNMENT PRINTING OFFICE:1963