The AMEDD Historian

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Welcome to the latest issue of the *AMEDD Historian*! In this issue we are focusing on one of The Surgeon General's responsibilities, recruiting. We will look at different facets, and how it has changed over time.

Since we are experiencing historic events I would ask that you also take a moment to consider the preservation of your COVID-19 experiences or those of your unit. In order to preserve the institutional memory of the AMEDD and to share the history of Army Medicine, the AMEDD Center of History and Heritage (ACHH) relies on the contributions of historical materials from its community of Soldiers, veterans, and civilians. We (ACHH) are collecting internal documents, public information, and some interviews and photographs, but we cannot be everywhere.

If you are considering donating material please contact us through these web addresses: usarmy.jbsa.medcom.mbx.hq-medcom-office-of-medical-history@mail.mil or usarmy.jbsa.medcom.mbx.amedd-museum@mail.mil. Please use "COVID History" in the subject line. Unit POCs can contact the ACHH History Office to document and arrange the transfer of files to secure storage. Gathering historical materials transcends the COVID-19 emergency. If you have questions about whether something is historically significant or worth preserving please contact us. We are seeking labeled images (date, unit, location) of the deployment that show patient care/unit deployment areas. Be sure any images you wish to donate do not have PII or HIPAA information visible! (continued on page 5)

AMEDD Recruiting: the 19th Century

Grant Harward, PhD, ACHH

During the 19th Century, Surgeons General confronted an intractable problem. In 1818, Congress created the Medical Department, but it strictly limited the number of medical personnel the Surgeon General. While Congress expanded the Medical Department over the following decades, it remained undersized and Surgeons General never had enough medical personnel for the Army's needs. Post commanders often had to hire civilian contractors to provide medical services. Consequently, every Surgeon General focused on recruiting quality candidates to compensate for the Medical Department's lack of quantity. The Surgeon General had the responsibility of recruiting medical officers from the beginning, but only later expanded its authority to include recruiting medical NCOs and enlisted men.

Surgeon General Joseph Lovell. Courtesy National Library of Medicine

The first Surgeon General, Joseph Lovell, wanted experienced physicians, but he had difficulty attracting anyone other than inexperienced medical graduates. The Army was scattered across the country and the Medical Department did not have sufficient medical personnel to assign even one physician per post. This meant the loss of even one experienced surgeon was a significant blow to the 70-man Medical Department. In 1826, the Surgeon General reminded the Secretary of War that when an officer position became vacant in the line or other staff departments it was filled by someone of equal experience, "but the Medical Graduate, who succeeds the experienced Surgeon must at once assume all his duties and responsibilities, and have the sole care of the health and lives of the corps or Garrison to which he may be attached."

Furthermore, the unique status of medical officers contributed to a high rate of turnover. There were only two grades, surgeon and assistant surgeon. Neither held rank, and both were paid less than captains or lieutenants respectively. Therefore, while a lieutenant might expect to become a major or even a colonel during his career, an assistant surgeon could only become a surgeon. The low pay, lack of promotion, and challenging conditions of Army life made it almost impossible for The Surgeon General to attract experienced physicians away from profitable private practices, so he focused on recruiting fresh graduates from medical schools. The regulations only required assistant surgeons to have a diploma from a "respectable medical school, college, or society." Additionally, the Secretary of War was supposed to appoint candidates from each state according to the number of representatives it sent to Congress. The Surgeon General recruited enough medical school graduates each year to fill the few vacancies, but he argued funds for recruiting, transporting, and preparing new assistant surgeons would be better spent on increasing medical officers' pay so fewer surgeons would resign from the Medical Department. The Surgeon General emphasized, "The Surgeons are not only confined to their original pay whatever may be the necessary increase of the expenses as they advance in life but they are more constantly on duty than any other officer in service." Post commanders detailed surgeon's mates from the enlisted men to assist the post surgeon. In places where there was no post surgeon, the post commander hired local physicians. In 1829, citing the expense of contract surgeons, The Surgeon General wanted Congress to expand the number of medical officers and increase their pay. Moreover, he believed a Navy reform act the year before that included a requirement for assistant surgeons to be examined by a Navy Medical Board before appointment "would be equally beneficial to the Army."

The Surgeon General's lobbying eventually paid off. In 1832, Congress passed a law increasing the number of medical officers and requiring candidates for appointment to pass an examination by a Board. From then on medical graduates submitted applications, The Surgeon General invited promising candidates for the examination, the Medical Board examined those candidates who showed up and extend invitations to those who passed, The Surgeon General would submit the candidates who accepted to the Secretary of War, and the Secretary of War would submit the list to the Senate to confirm appointment as assistant surgeons. The Medical Board also administered an examination to assistant surgeons who had served five years to be placed on the list for promotion to surgeon. The three-person Medical Board usually met in New York City once a year to administer the three-day examination. In 1834, Congress also passed a law matching the salary of medical officers to that of line officers. The Surgeon General enthusiastically reported, "The recent law graduates the pay of Surgeons and Assistant Surgeons according to length of service, and requires an examination by a Medical Board previous to appointment, is believed to have been of essential advantage to the Army, by securing to it the talent and professional knowledge which absolutely is necessary." Nonetheless, the new Surgeon General, Brevet Brigadier General Thomas Lawson, became concerned the Medical Department was still not attracting the best candidates. Many of those invited to take the examination board did not show up and some of those who passed the exam declined the offer because the pay was too low. When a surgeon could not find an enlisted man capable of serving as a hospital steward (as surgeon's mates were now called), he often convinced the post commander to hire a civilian to fill this role. A law in 1838 made this practice official, and increased pay for stewards, but in 1842 Congress reversed this decision. The Mexican-American War was over so quickly that it hardly im-

Dr. William H. Arthur drew this cartoon of a worried candidate at an Examining Board. Arthur graduated medical school in 1877, got some experience and passed the examination in 1880. He retired in 1918 as a brigadier general.

pacted the Medical Department except that medical officers received rank in 1847. The Surgeon General had no control over the quality of surgeons who were appointed to volunteer regiments during the fighting. In 1856, Congress again allowed stewards to be appointed enlisted men or hired civilians, and increased the wages of cooks and nurses. The Medical Department had just over 110 medical officers when sectional conflict between the North and the South tore the country apart in 1861.

During the Civil War, the Medical Department expanded exponentially, but The Surgeon General's high expectations for surgeons caused conflict with the Secretary of War. Congress declared volunteer regiments should have four medical officers, even though Surgeon General Brigadier General Clement Finley believed half that was enough. Initially, State authorities organizing volunteer regiments often ignored the requirement medical officers passing an examination, or even holding a medical degree. Each brigade was supposed to have a trained and examined surgeon, however. In 1862, Surgeon General Brigadier General William A. Hammond received Congressional authority to require volunteer surgeons to pass a Board examination, but so many candidates failed that he was forced to relax his standards: the Secretary of War threatened to eliminate the examination altogether if more candidates did not pass. The Medical Department still relied heavily on contract surgeons, some of them physicians of national renown, to make up for its personnel shortages. The senior medical officer at every hospital, post, or command recommended enlisted men to be appointed as hospital stewards by the local commander. Hospital stewards were supposed to serve in that position for the rest of their enlistment. Civilians who wanted to become hospital stewards could apply by writing The Surgeon General and providing testimonials of their good character and medical competency. Depending on needs in the field, commanders could temporarily detail soldiers without any evaluation to medical duty as acting hospital stewards. Hospital stewards were supposed to know enough of pharmacy to run a dispensary and have sufficient practice in surgery to apply bandages or dressings, extract teeth, and apply cups or leeches. They also needed to know how to cook. By the end of the war in 1865, 6,000 regular and volunteer surgeons and 6,000 contract surgeons had served in the Medical Department at one point or another.

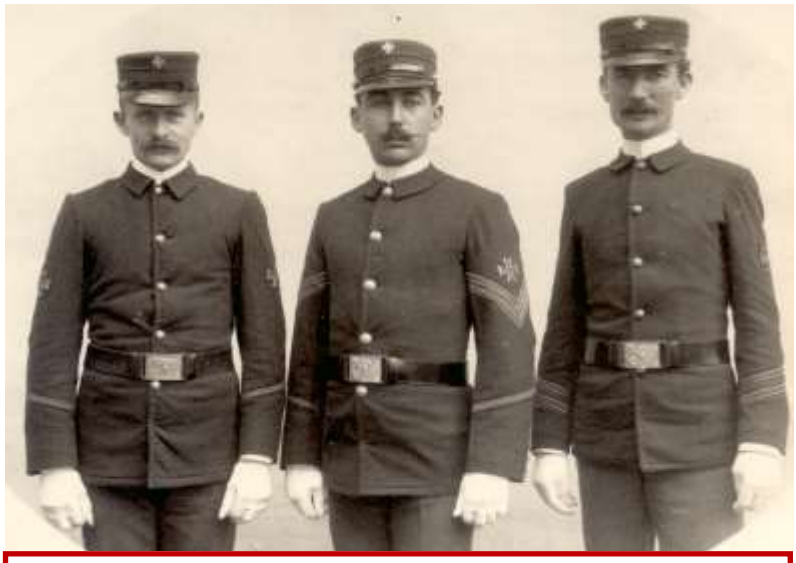
Dr. Josiah Curtis was a volunteer surgeon. With a background in sanitation and public health, he presumably had little trouble with the Army examination.
Courtesy Library of Congresss

After the Civil War, Congress moved quickly to return to the pre-war status quo. During demobilization the Surgeon General prioritized recruiting veteran surgeons, even waiving the age limit of 28 by subtracting the number of years a surgeon had served during the war from his age, with some success. By 1866, the Medical Department had less than 220 medical officers even though the number of posts had grown to nearly 300. Therefore, Surgeon General Brigadier General Joseph Barnes again lacked enough medical personnel to assign even one surgeon per post. The Medical Department again relied on contract surgeons. Congress thought the Medical Department was still too big, so in 1869 it suspended all new appointments of assistant surgeons. Almost immediately vacancies appeared because resignations were common as pay was too low and promotion unlikely. When Congress reorganized the Army's staff in 1876, it finally allowed the Surgeon General to again recruit new assistant surgeons, however, it also cut major and lieutenant colonel slots from the Medical Department, delaying promotions for years. The Medical Board (which operated primarily in New York City but sometimes in Chicago or even San Francisco) again began examining candidates. Meanwhile, post surgeons continued to select hospital stewards with the post commander's approval. This system provided a bare minimum of trained medical personnel for the Army during the Indian Wars on the frontier.

As the practice of civilian medicine became more professionalized, the Medical Department focused its efforts on increasing the professionalism of medical NCOs and enlisted men. The Adjutant General controlled recruitment of enlisted men, but in 1885 the new Surgeon General, Brigadier General Robert Murray, requested Congress to establish a Hospital Corps for medical NCOs and enlisted men because the current system of detailing soldiers resulted in too much turnover and insufficient medical training. Murray hoped permanently assigning enlisted men as medical personnel (and offering them better pay as hospital stewards) would

produce more professional medical NCOs. The Adjutant General's General Recruiting Service and regimental recruiting detachments could also entice recruits with the chance to join the Hospital Corps. The next year, Congress approved a bill establishing the Hospital Corps with 150 hospital stewards and 600 privates, but did not incorporate the pay scale Murray wanted and thus made it less likely that medical NCOs and enlisted men would re-enlist. In 1887, the Hospital Corps was established, but Murray took another year to fully organize it because of a shortage of enlisted men qualified to become hospital stewards. There were two ways to join the Hospital Corps. First, enlisted men were transferred from the line and those who showed promise were promoted to hospital steward after training and examination. Second, civilians applied to take an examination and enlist as a hospital steward. Murray reported that nearly all civilians who passed the exam declined to enlist: they faced difficult conditions and terrible pay. Instead Murray appointed a few female matrons, who helped with cooking and cleaning.

The Surgeon General continued to attract a trickle of recent medical graduates to join the Medical Corps (as the body of medical officers was now informally known). In 1893, Congress authorized creating the Army Medical School in Washington, D.C., and the Medical Board began usually convening there to administer appointment and promotion examinations. The same year, as the Army contracted following the end of the Indian Wars, Congress cut funds for contract surgeons and reduced the Medical Corps to less than 120 officers, and within three years shrank the Hospital Corps to 100 hospital stewards and 530 privates.



Private Ernest Vollmeyer, Acting Hospital Steward Palmer A. Eliot, and Private John Hodgins, the Hospital Corps men who nursed President McKinley after he was shot.

The Spanish-American War in 1898 caught the Medical Department unprepared. Once more state militias' did not require surgeons to pass any kind of examination and did not train hospital stewards to the same level as the Hospital Corps. Congress authorized the Medical Corps to add eight (five regular and three volunteer) corps surgeons and 100 (36 regular and 74 volunteer) division and brigade surgeons. This left only 59 regular medical officers, so most regimental surgeons were volunteers or contract surgeons. Regular regiments had one surgeon and whatever hospital stewards were on hand, but volunteer regiments had three surgeons and three hospital stewards. Congress allowed The Surgeon General to appoint as many contract surgeons as needed, eventually 650, relying on references. Initially there were no plans to expand the Hospital Corps, but eventually 25 enlisted men from each regiment were transferred to the Hospital Corps, and some commanders made informal agreements with qualified civilians guaranteeing if they enlisted they would only serve as hospital stewards. Still, most volunteer hospital stewards had little training and were chosen at random. The Hospital Corps grew to over 300 hospital stewards and 2,900 privates (mostly transfers from regular regiments) overnight, and doubled by the end of the year. The Surgeon General hired 1,700 (male and female) contract nurses too. The Medical Department immediately started shrinking after the end of the war, but the outbreak of the Philippine War in 1899 meant it did not return to peacetime levels. Nonetheless, 500 surgeons, 250 hospital stewards, several thousand privates, plus 170 (female) nurses, had to support 125 posts in the United States, 567 garrisons in the Philippines, five general hospitals, troop transports, and other medical installations. In 1901, Congress formed the Nurse Corps (Female), and added dental surgeons to the AMEDD. After hostilities ended in 1902, Surgeon General Brigadier General Robert O'Reilly sought reforms to prepare the Medical Department for future wars, including a reserve, instead of allowing it to be caught unprepared again.

Over 84 years, The Surgeon General increased his influence over recruitment for the Medical Department. Surgeons General focused on attracting qualified physicians because they were the hardest to recruit and retain. The Medical Department managed to recruit enough surgeons in peacetime, but this was mostly because Congress placed strict limits on the size of the Medical Corps. Later, Surgeons General concentrated on

improving the quality of hospital stewards and medical privates and successfully lobbied to create the Hospital Corps. The Medical Department eventually even added the Nurse Corps (Female) that provided professional female nurses. The biggest challenge facing the Surgeon General at the turn of the century was how to not repeat the mad race to recruit surgeons and hospital stewards in wartime that yielded mixed results at best.

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(continued from page 1)

Additionally, the AMEDD Museum has received several important donations of items related to the Army response to COVID-19. Currently we have two respirators and a large collection of homemade masks used by Army personnel in New York. If you feel you have an important item to donate, please contact the AMEDD Museum Director: usarmy.jbsa.medcom.mbx.amedd-museum@mail.mil. The museum is seeking items used in patient care that were either field developed, or field modified, as well as field-made posters or signs used in Army-staffed locations. These should relate to the unit, mission, or COVID directly.

Please let us know your thoughts. We would like to hear your comments and are always seeking new articles for publication.

In addition to this publication, please visit our websites with attached social media feeds:

History: http://history.amedd.army.mil/

The AMEDD Regiment: http://ameddregiment.amedd.army.mil/

The AMEDD Museum: http://ameddmuseum.amedd.army.mil/index.html

These websites serve as great resources for the history of Army Medicine. Peruse our documents online, exploring valorous awards and medical advances as well as interesting biographical information.

Nolan A. (Andy) Watson
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Recruiting for Large Wars: The AMEDD from WWI through the Cold War

Sanders Marble, PhD, ACHH

Early in the 20th Century, several Surgeons General struggled to get the AMEDD ready for a potential war. The 1898 war with Spain had showed severe mobilization problems, and the Army had begun to address those, including establishing a General Staff charged with preparing contingency plans in peacetime. The AMEDD stockpiled some supplies and equipment, but the key element identified was ready personnel. Winning arguments in the Army and with Congress took ten years, but in 1908 the Medical Reserve Corps was established, the first reserve component the Army had. (The National Guard was older, but it was not necessarily part of the Army; legislation was still unclear.) Doctors were the critical point because enlisted men could be trained quickly, but doctors could not; other AMEDD personnel either would not be in field units or were an afterthought.

Thus by WWI there was a small force of Regular Army doctors, around 400, who were apparently recruited by word-of-mouth, including perhaps by retired Army doctors who had become faculty at medical schools. To join the Army they had to pass an examination, then they went through the Army Medical School for several months. (For more, see Lewis Barger's articles on the Medical Field Service School and its predecessors.) Alongside the RA doctors were the doctors in the National Guards of the various states, groups that were increasingly but not wholly tied into the Army. And the Medical Reserve Corps was a pool of physicians who had volunteered to be ready in wartime. (That was their sole liability; they had no annual training requirement.)

Just before WWI there was one other kind of AMEDD reserve formed, affiliated hospitals. These were based on major hospitals and medical schools such as Johns Hopkins and Harvard, and the civilian institution recruited enough doctors and nurses to be the professional core of a rear-area hospital, and raised money to buy their equipment, while the Army would provide the leadership cadre and enlisted men. The Army would also only mobilize the units if there was a war, and there were some understandings that – if a war lasted – the universities would be able to rotate some staff home to continue teaching.

WWI

When the U.S. joined WWI, a draft was quickly instituted, which included physicians. (While physician volunteers would be commissioned directly as officers, draftees entered the Army as privates, and could apply for a commission, so doctors had an incentive to volunteer but they did not have to.) Thus, the AMEDD had no trouble getting enough doctors, ending up with 30,591 – 95% of whom entered the Army during the war. With the wave of patriotism, there were also volunteers, and the AMEDD accepted physicians older than the usual limit for personnel. Surgeon General William Gorgas was a former president of the American Medical Association, and used the AMA and the state medical associations to take information to doctors and encourage them to volunteer. They would not accept female physicians (although 55 served as Contract Surgeons, a legal status that allowed them to give orders), and they finally allowed some African-Americans to serve in the Medical Corps, although as few as possible. Balancing specialists was somewhat of a problem, since there was only one specialty board as an outside quality check. A physician could claim to be a specialist at anything and the Army would have to find a way to determine his real bona-fides, then assign him appropriately. In the end, the Army appointed consultants from the eminent civilian physicians temporarily in uniform and had them sort out who was qualified. Because there was no way to know when the war would end, a Medical Enlisted Reserve Corps was established so medical students could be protected from the draft. It turned out that this provided few doctors to the Army (primarily those who finished their internship during the war) but it was an insurance policy against a prolonged war.

William C. Gorgas, Surgeon General 1914-1918, managed the expansion of the AMEDD to cope with WWI.

After WWI, the 1920 National Defense Act changed the Army's structure. The National Guard was clearly part of the Army, the reserves were reorganized (with units added instead of just a pool of individuals), and the AMEDD initially kept affiliated reserve units. None of that would help recruit Active Duty physicians, and the AMEDD began offering paid internships. Internships were becoming a standard part of medical education but were generally unpaid, so the Army was able to attract young doctors, assess them, and offered many of them permanent commissions. There was also a large pool of doctors who had served in WWI and retained their reserve commission into the 1920s. However, by the later 20s the Army had (for good reasons) instituted promotion and retention criteria for reserve officers – previously officers could be in the reserves as long as they renewed their oath of office every five years. Now they would have to spend time on staying in the reserves, and numbers dropped. The economic hardships of the Great Depression meant there was no shortage of applicants for the Regular Army. There was also Medical ROTC, although it was unpaid.

WWII

The U.S. mobilized gradually for WWII. In mid-1940 the Guard and Reserves were activated, and in the autumn of 1940 a peacetime draft was begun. (At that point, Reserve activation became mandatory instead of voluntary as it had been under previous law.) Activating the National Guard and Reserves brought in some medical officers, although most units were below strength, so even though strength had grown, requirements had grown faster. The affiliated units had been revived, and would bring in many personnel when the U.S. joined the war. But the civilian partner organizations had been promised the affiliated units would only be activated for a war so until then those personnel were unavailable. Then, since the units would only be mobilized as units (not as individuals) they might be mobilized long after other reserve units and individuals, which sparked questions of fairness.

In November 1941 a Procurement and Assignment Service was organized, one of the many temporary agencies created for the wartime emergency. Its job was balancing civilian and military need for physicians; doctors above the minimum civilian need were "available" for military service, but did not have to join. The PAS worked with the AMA and state medical societies, the military, and other government agencies. Doctors could not be drafted as doctors, but they could be drafted to serve the same as anyone else (and then seek a commission, or not) but draft boards were very reluctant to draft doctors. Instead, local medical societies were a main focus: they essentially controlled admitting and attending privileges at hospitals, and since much care (especially lucrative care) was inpatient, blocking doctors from the hospitals would ruin their practice and thus "encourage" them to join the military.

Wartime recruiting was slow at first. In June 1942 the Chairman of the War Manpower Commission, Paul V. McNutt, spoke at the AMA annual meeting: "We are not getting enough [doctor] volunteers. … The voluntary plan must work and work promptly – or some other more vigorous plan will have to be produced." In 1942 recruiting did increase almost 24,000, but that was weighted to the latter part of the year. Through 1942 and 1943 the military felt there were too few doctors volunteering, and both Army and Navy asked for a special call of doctors. This was not granted, and the military instead tried intensive recruiting efforts among recent medical graduates and also stronger persuasion of those the PAS had deemed "available." Army physician recruitment in 1943 and 1944 was only about 500/month. The Army compensated by making doctors work harder (which at least reassured doctors still in civilian practice that the Army was not wasting doctors), revising hospital organization to economize on physicians, and assigning fewer doctors to battalions but substituting Medical Administrative Corps officers as assistant battalion surgeon. (The MAC was a precursor to the Medical Service Corps.)

The Army tapped one pool of physicians it had ignored in WWI, female doctors. In April 1943 the law was changed and women could serve in the Medical Corps, but only 76 did (1% of the roughly 7500 female physicians), hardly more than the 55 contract surgeons in WWI. (Some female physicians worked as Contract Surgeons in WWII as well, although some of them were later commissioned.) The AMEDD again largely ignored African-American physicians, commissioning under 350 doctors in total. They were unit surgeons for the segregated 92d and 93d Divisions, and, in a change from WWI, two small hospitals had African-American staff.

There were programs to protect medical students from the draft. At first, they were put in the MAC Reserve. Later the Army and Navy started programs to defer some college students, who were enlisted, took

compressed courses, and were focused on subjects that would help the war effort – if the war lasted to 1946 or later. The Army program was the ASTP, Army Specialized Training Program, and it had just over 20,000 medical students, of whom 13,000 graduated, but not all served because they had to complete an internship and some went on to a short residency.

Through all this, The Surgeon General had very limited control of enlistment and the Army engagement was often decentralized to speed processing of paperwork. For instance, when teams went around the country to work with PAS and Selective Service, there was not time to consult with Washington. During WWII, The Surgeon General did not have immediate access to the Chief of Staff, and his influence over recruiting was severely limited.

The Cold War

After WWII, the AMEDD had almost a repeat of events after WWI. The Medical Corps shrank rapidly (even a little faster than after WWI, since a number of Regulars had not retired during WWII and retired in 1945 or 1946), while the Reserves were filled with recently-demobilized men who had not resigned their commissions. The draft law lapsed, and when the AMEDD tried to revive affiliated hospitals they found little support. The ASTP service obligation was cut, and a number were transferred to the Navy, Army Air Forces, or the Veterans Administration. However, once the ASTPers were discharged, the military was deeply understrength, with only 1,200 Regular Army physicians, 40% of the requirements.

American medicine was also changing, with more specialization and residencies becoming much more common. To raise the clinical qualifications of Regular Army physicians, the AMEDD established residency programs at five large hospitals. In the short term these would draw doctors from units to the hospitals, but the hope was that in the long term doctors would join the Army to receive a paid residency. (There were only limited service obligations that went with paid training.) In 1949, the military asked ASTP doctors who had not served, or served less than their original three-year obligation to join or re-join. Only 425 ASTP medical graduates did from approximately 9000, despite personal letters to each of them signed by the Secretary of Defense. Meanwhile, the American Medical Association (and state associations) would not pressure anyone to join, instead saying that physicians were very patriotic and would volunteer if there was a crisis. Meanwhile, the Army changed regulations to reduce the need for physicians (for instance, reducing the number of physical examinations required, and putting Army patients in VA hospitals) to prove it was not wasting doctors. Some other remedies were tried, including incentive pay and higher priority for quarters.

When the Korean War broke out, the Army was unready, and the AMEDD had a large percentage of its doctors in residency training, without field experience or even equipment. Doctors did not volunteer from civilian life, and in the autumn of 1950 Congress passed a 'doctor draft' law that specifically targeted doctors. (A potential loophole was preemptively closed: drafted doctors who refused to take a commission in the Medical Corps would have to serve as enlisted doctors.) Since many doctors had already served in WWII, and thus were exempt from the draft, the burden fell heavily on the youngest doctors, which meant those with the least training. Still, thanks to the residency-trained regulars and experienced reservists who were recalled, the services were able to provide excellent medical care in the Korean War. It also funneled doctors to the Public Health Service, which was an option for drafted doctors.

After the Korean War, when it was clear there could be a crisis at any time, the doctor draft was continued but with a wrinkle: under the "Berry Plan" (named after Dr. Frank Berry, Assistant Secretary of Defense for Health and Medical Affairs) doctors could time their service. They could go into the military after their internship (and serve as a general medical officer, probably as a battalion surgeon or equivalent position), after part of their residency (and probably serve in a hospital), or after their residency was complete. This brought the military specialty-trained doctors and it let doctors have some choice about their military service. The draft also encouraged medical students and young doctors to join the reserves and National Guard, so it provided manpower to all three components. Finally, the services had a predictable supply of fully-trained manpower, and the Reserve Components were also full. Meanwhile, the Army had residency programs for the Regular Army doctors, but with a modest and stable number of those, the residency program could also be modest. And draft boards took a dim view of doctors who chose not to sign up for the Berry Plan, and they were likely to serve a privates.

The Army did not rely solely on draftees, although they were a substantial majority of the Medical

Corps through the draft era. From 1957 there was incentive pay for doctors, and from 1968 there was continuation pay to encourage Regular Army doctors to stay until they were close enough to retirement that they would stay to retirement. Congress also raised the entry grade for doctors from First Lieutenant to Captain, recognition of the educational requirements. The Army also had some scholarship/recruitment programs for those medical students who were interested in the Army. There was a Senior Medical Student Program that provided full pay and allowances, and there were internships (again, with full pay and allowances) that would bring a young doctor to the edge of a residency – and they could stay in the Army for a paid residency, and then their service obligation would take them fairly close to retirement pay, so with promotions and interesting assignments many stayed. There were also programs to allow interested West Point and ROTC cadets to defer service until after medical school, and Regular Army officers could apply to go to medical school (with pay and allowances). All of these programs had some active duty service obligation, although it seems to have changed over time.

Dr. Frank Berry, had served as a colonel in WWII, and was Assistant Secretary of Defense for Health and Medical Affairs from 1954-61. In that role, he instituted the Berry Plan.

This system was reasonably stable, although with residency deferrals popular (typically a majority of 'Berry Planners' deferred) the military had to predict needs several years ahead. Regular Army doctors could take the command and staff positions that suited their career progression, while the draftee doctors could provide the bulk of the patient care and did not compete for spaces at professional military education courses. TDA medical positions could be fully manned, and line units could also have their medical personnel; only TOE medical units would not have their full number of medical staff. There were efforts to have some medical units at higher readiness, with their clinical staff coming from the post where the unit was based instead of being scrambled from various places.

When draft calls were increased to support operations in Vietnam the doctor draft readily provided more doctors. The pool of eligible personnel increased in 1966 when osteopaths became eligible to practice in the military, but otherwise there were more of the same. Battalion surgeons were often draftee doctors, while Regular Army doctors had the leadership positions in the deployed hospitals, in charge of the 'Berry Planners' who had (some or all of) their residency training. Even though the Army Medical Corps expanded about 1600 above the pre-war strength during the Vietnam War, there was no trouble getting enough doctors to serve and quality was not a problem either.

The move to an all-volunteer Army necessitated the termination of the Berry Plan. As the draft ended, though, doctors that had deferred their service when the draft was still in effect continued to enter the Army as draftees until 1980.By then, military recruiting of physicians had changed substantially.

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AMEDD Recruiting after the Draft
Sanders Marble, PhD

In 1973, as the draft was ending, the Surgeon General reported "In the future, reliance will be placed on procurement education programs, particularly the scholarship program, to fill the Army's need for physicians." Those words have been true since. With no compulsion to serve, the military had to spend substantial amounts to recruit doctors, and since recruitment cost so much, retention became a concern because it was substantially cheaper to retain a doctor than hope to find a replacement and train them from scratch.

Recruitment centered on three main routes:

In 1972 Congress passed the Health Professions Scholarship Program (HPSP), granting scholarships for tuition and fees, plus a living-expenses stipend, to students who would undertake military service on a 1:1 repayment basis, one year of military service for each year of scholarship. At first 5000 scholarships were offered, with 1850 for the Army, and several years before any graduate was ready to practice. The HPSP has, indeed, become the most common route for recruitment of physicians.

A second new program was a military medical school, the Uniformed Services University of the Health Sciences, USUHS or USU. Proposals had been tabled starting in 1967, so it was not a result of the end of the draft, but approval in 1972 came at the right time. Over time, USU graduates proved more likely to stay for a 20-year career, while HPSP doctors often left earlier. USU opened in 1976, and graduated its first physicians in 1980, but they would not be ready to practice for another year, and not through residency for several more years.

A third path was direct commissioning of fully-qualified doctors who want to serve in the military. These have been the smallest of the three main elements, and numbers have fluctuated the most. At times, the Active Duty Service Obligation (ADSO) has been lowered to make volunteering more attractive. Offering loan repayments to doctors who had taken loans and completed medical school has been a tool to attract direct-commission doctors. Accession bonuses are often available, but are legally limited in amount (and thus have lost value due to inflation) and are set across DoD, which can hinder a particular service.

Rep. F. Edward Hébert had been proposing a military medical school since 1967, but it was approved shortly after he became chairman of the House Armed Service Committee in 1971. Collection of the U.S. House of Representatives

A fourth element, never a large program and now mainly rolled into USU, was allowing serving officers and high-scoring ROTC and USMA cadets to go to medical school. After the late 70s this was reduced to almost nothing.

In the 1970s, doctors deferred under the Berry Plan were still coming eligible for military service, and the military still called them up. The draft ended in 1973, but the last draftees came on active duty in FY1980, finishing their service two years later. The Berry Plan tapered out faster than HPSP and USU graduates became available, and the AMEDD was severely short of doctors in the 1970s, below half of authorizations for several years. In the 1970s factors were identified that are still true for recruiting medical students and physicians. They want competitive pay, and in 1974 Congress passed the Variable Incentive Pay Act to help the military be competitive. Over the years various special pays have been used to make Army pay and allowances roughly comparable with civilian income; these have had political support from Pentagon leaders and Congress, so money has been available, but the high cost has required repeated justifications. They want career fulfilment and stable duty tours, and the Army has tried various ways to meet those desires within general military requirements. They also want adequate facilities and assistance to efficiently and effectively practice medicine, and the military has struggled with the budgets to do that.

Graduate medical education (GME) was also early identified as a recruiting and retention tool. Medical students could get a scholarship for medical school, then be offered specialty training conducted in an Army

medical facility where they would treat Army patients, all while incurring a substantial ADSO. In the late 1970s, a majority of volunteers identified GME as the main reason they joined, whether through HPSP or as a direct accession. At times, GME has been expanded to improve recruiting, such as offering GME in any civilian program rather than only for critically-short specialties. However this has led to gaps in needed wartime capabilities.

Alongside the post-draft drop in Active Duty strength were drops in Reserve and National Guard medical personnel. The draft had motivated many volunteers for those components, and when it went away, many unwilling volunteers left. The aging of the WWII generation also played a role, as men in their teens and twenties at the end of WWII had served, then gotten medical education and joined the Reserves or Guard. With severe problems filling the Active Duty ranks, the AMEDD seems to have put little effort into recruiting for Guard and Reserve units in the 1970s and 80s. There have been efforts to get doctors leaving Active Duty to join the Guard or Reserves; available information does not show results.

In the 1980s, physician strength stabilized. HPSP and USU pipelines were producing substantial numbers of doctors. Including their GME, HPSP volunteers would be under ADSO for up to a decade, and also including GME USUHS graduates incurred sufficient ADSO to make it more likely they would serve through retirement eligibility. As inflation eroded fixed-rate special pays in the early 1980s, variable specialty pay was instituted. The 1990s saw a military drawdown while volunteer doctors, recruited to support a Cold War-size force, were still in training or had ADSOs. (Given the lengthy pipeline, it has proven slow to change decisions about physician force-structure taken years before.) Thus, lower recruitment could be accepted, and by the late 1990s Medical Corps strength had stabilized although the high overall average disguised specialty shortages.

Operations in Afghanistan and Iraq challenged recruiting, and retention. However, the timelines for physician recruiting run up to a decade, and thus stretch into the future. Just what will develop is not yet history, and is beyond the scope of historians. However, recruitment has been an enduring challenge for Surgeons General, and without compulsory service, the AMEDD will have to continually assess and adjust the range of incentives to recruit enough physicians.

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Two organizations created to recruit AMEDD personnel were the Medical Reserve Corps (left) and Army School of Nursing (right).
The MRC enrolled thousands of doctors before WWI, and became the Medical Section of the Officer Reserve Corps afterwards. The ASN trained nurses at Army hospitals from 1919-1932, but only about 10% joined the Army Nurse Corps before the ASN was closed . It was judged a poor return on investment.

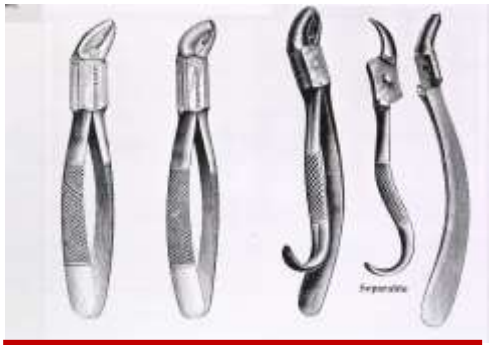
On-Boarding: Qualifications for Early Dental Corps Members
By Nolan A. (Andy) Watson, ACHH

There have always been challenges providing a technically proficient force to care for the military. Ensuring that care providers are capable and clinically knowledgeable is understandably of great importance. There are policies and procedures in place today to determine these attributes through certifications and boards of review, but how did it work roughly 100 years ago, when there was need to validate the practitioners of a new specialty? In this instance the Dental Corps had to define standards to fill their new branch and then later expand.

The first formal step for the inclusion of dentists into the Army occurred on 2 February 1901, when Congress passed legislation directing the Army Surgeon General to employ thirty civilian contract dentists. The resolution provided an early opportunity for some, but ability, skill, and dental knowledge needed to be determined. Candidates for the positions had to be graduates of a medical or dental school, be between the ages of between 24 and 40, be of good character (complete with testimonials), pass an officer candidate physical, and pass an exhaustive examination of theoretical and practical dentistry under the scrutiny of a board of review. Dental school graduates who were already in the Army Hospital Corps were excused from the exam portion.

There had been considerable political pressure in the previous years to establish a Dental Corps within the Army, led by the National Dental Association. (The NDA had been the American Dental Association until 1897 and resumed that name in 1922.) There were no national standards for dentistry that the Army could adopt, and the NDA could help draft those standards, while also using those new standards to press states to adopt them for dentists. The Army's specific needs were addressed through the physical examination, which was intended to ensure resilience, especially since the contract dentists could be assigned to duty in the Philippines or other arduous and hazardous duty assignments.

The Surgeon General, George H. Torney, named the first three contract dental surgeons to serve on the dental examining board and as supervisory dental surgeons. The examination began in Washington, D.C. in late February 1901. To ensure their academic knowledge the candidates were examined on: anatomy, physiology, histology, physics, chemistry, metallurgy, bacteriology, orthodontics, oral surgery, as well as many other aspects of dentistry. One wonders of the depth of these subjects in 1901.



The sort of extraction forceps Dental Corps candidates would have used in the practical examination.

According to Surgeon General reports, an average score of 75% was required in each subject for the theoretical portion and 85% for the practical portion. The usual time allotted for the complete examination was 10 to 12 days, but the tests normally ran 2 weeks in length. Candidates were not authorized quarters or travel allowances during their examinations. The candidates were given 2 hours for each subject to provide written examinations, with the total written examinations lasting about a week. Practical exercises in demonstrating dental skills and techniques were facilitated by onsite dental tools and equipment.

By December 1901 the examinations were complete and 71 dentists had been examined, with 28 selected to fill the 30 positions. There was criticism on the difficulty and thoroughness of the examination and board process. However, critics were reminded that the selectees were representing the dental profession nationally and would need to be the best examples available for Army service.

Dentistry became an official part of the Army on 3 March 1911, with the passing of H.R. 31237, which provided for a Dental Corps. The resolution provided 60 positions in the new Dental Corps. The standards for the Army Dental Corps were similar to the previous ones for contract dentists, but there were some changes to reflect the new commissioned status. The appointees must be citizens of the United States, be be-

tween the ages of 21 and 27, and they were required to pass the physical examination required for appointment in the Medical Corps. These requirements were in addition to the previous dental educational and practical skills that were to be determined by examination. The results were again supervised by three board members, with the Secretary of War authorized to select the board members. Each examining board was to consist of two commissioned dental surgeons and one Army physician.

Where would they receive the two commissioned dental surgeons for the board? Another part of the resolution allowed for "contract dental surgeons attached to the Medical Department at the time of the passage of the Act may be eligible for appointment…" The examination requirement for the former contract dentists could also be waived, provided that their service had been satisfactory. By August 1911 all 30 contract dentists at the time had been commissioned. Of note, John Sayre Marshall, often referred to as the "father of the Army Dental Corps" was mandatorily retired after receiving his commission at the age of 64. Marshall, a continuous advocate for dentistry in the Army, served during in the cavalry during the Civil War. Later he would receive an M.D. from the University of Syracuse and focus on oral and dental surgery. Also, of the 30 newly commissioned dentists, 16 were part of the original contract dentist group from 1901, and 6 of the selectees later served as Chiefs of the Dental Corps.

One of John S. Marshall's contributions to the Dental Corps was being chairman of the first examination board for contract dentists.

The examination and board system was in place to fill future vacancies, and now there were cadre in the Army to oversee and advise on possible changes. It took time to fill the new corps. By April 1914 the Dental Corps had 67 members. Three years later when America entered World War I in April of 1917, there were 86 Regular Army Dental Corps officers. Wartime expansion would increase the Dental Corps to a peak of 4,620 at the close of the war. Reserve and National Guard dentists greatly increased these numbers, but so did the dental board of review system which had been adapted and multiplied for the war effort. The challenging examinations had developed into a system that shaped and increased the Dental Corps from 30 former contract dentists in 1901 to 4,620 Army dentists at the close of 1918.

The Army had worked with a still-forming profession to establish the clinical and military standards needed. As the Army's practitioners gained experience, it could modify its requirements, although not diverging greatly from the civilian clinical standard. Meanwhile, Army standards to be an officer were 'above and beyond' what were needed to be a civilian practitioner, and those would be under Army control over the coming years.

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Army Nurse Corps Recruiting during The Vietnam War
Paula Ussery, AMEDD Museum

On 17 April 1956 three Army Nurse Corps officers arrived in Saigon, Vietnam, assigned to the U.S. Military Assistance Advisory Group, the first Army nurses assigned in that country. By 1965 the escalating war there brought an expanded need for Army nurses at a time when there was a critical shortage of nurses in the United States.

The nursing shortage was due to increased demand for several reasons: the rise of group insurance plans; the post WWII baby boom; and women left the profession to marry and have a family. The 1960s and 1970s also saw a rising wave of feminism that encouraged women to seek professions other than the traditional ones of teacher, secretary, or nurse. The ANC shortage was acute: in 1965 5,000 nurses were authorized, but it had only 2,981 nurses. To meet the expanding demands of the Army, the Nurse Corps, a predominantly female organization, had to step up recruiting. By 1969 thirty-three Nurse Corps officers were assigned to recruiting duty. Nurse Corps Chief Mildred Clark encouraged the use of all forms of media, and recruiters appeared on local TV and radio shows, made recruiting trips to colleges and universities, and the ANC placed ads in a variety of magazines and professional journals.

The ad campaigns, in a decade of social change, took several angles. Some campaigns encouraged women to join the Army Nurse Corps for professional growth. One such campaign used the slogan "Do More. Be More. As an Army Nurse." Another used the slogan "Let the Army Bring Out the Specialist In You," and a third emphasized that an Army nurse could be a professional and still maintain her femininity, "The Most Beautiful Girl in the World is a U.S. Army Nurse." The nurse pictured is in fatigues, but her hair is neatly combed. She is wearing a maroon ascot and eyeshadow, mascara and eyeliner. Another campaign encouraged joining from a sense of duty, "Ask an Army Nurse About Patriotism. And She Will Tell You About Nursing."

The Nurse Corps also recruited nurses during the Vietnam years via educational assistance. The first program, launched in April 1956, was the Army Student Nurse Program. Formulated by LTC Mildred Cark, the Army Nurse Corps procurement officer, it provided tuition assistance, and pay and allowances of a private, first class (E-3), to nursing students (both men and women) from the end of their second year in either a three-or four-year program, and from the end of their third year in a five-year program. The schools of nursing were approved by the Department of the Army and accredited by the National League for Nursing. Upon successful completion of the degree and state licensure, the participant was commissioned a second lieutenant in the U.S. Army Reserve and obligated to serve on active duty for two or three years, depending on the length of time in the nursing program.

In December 1960 the ASNP was revised to authorize the participant, enrolled in the last two years of a four-year degree, to be commissioned six months before graduation and to receive full pay and allowances. The 1960 revision also permitted payment of tuition, books, and incidental fees. In November 1961, the ASNP was opened to graduates of a hospital school of nursing (diploma) program to complete their baccalaureate degree if they could graduate within twenty-four months. This program was immensely successful; in 1960 54% of nurses entering the ANC were graduates of this program. Throughout the Vietnam years, this program was the major resource for recruiting nurses and continued until 1975.

Another educational incentive was the Walter Reed Army Institute of Nursing, WRAIN. The idea for WRAIN was created by a committee of COL Margaret Harper, Jeanne Treacy, and Major Eva Snow. Surgeon General Leonard Heaton approved, and agreed that WRAIN would be a four-year baccalaureate degree program, rather than a three-year diploma program. The Army selected the University of Maryland as its partner and negoiations began. Although initially opposed by both the National League of Nursing and the American Nursing Association, COL Margaret Clark was able to respond to their concerns and WRAIN opened in the fall of 1965. As with the ASNP, WRAIN graduates were obligated to serve as members of the Army Nurse Corps after graduation.

Due to a national advertising campaign, more than 1,000 applications flooded in. As the Army wanted 100 graduates initially, 135 candidates were accepted. The first two years the candidates attended a National League of Nursing accredited school. The Army paid tuition, some academic fees and paid the student as an E -3 enlisted soldier. The last two years, the candidate attended classes and practiced clinical skills at the Walter Reed Army Medical Center. Upon graduation and successful completion of state licensure, WRAIN graduates were commissioned at Second Lieutenants in the ANC.

The attrition rate for the first class was higher than expected at 52%. Due to this the admission committee shifted its focus from looking at SAT scores to more carefully reviewing letters of recommendation and seeking those who had some form of prior hospital experience. This proved successful and the attrition rate declined until it reached the teen percentiles during the last years of the school.

Barbara Tassone a member of the first class of WRAIN, and thought the education and opportunities were outstanding. “Professionally it was a fantastic opportunity. Our professors were the best of the military-intelligent, enthusiastic and experts in their field. We were exposed to a multitude of experiences that were unparalleled.”

Recruiting and attrition of minority candidates was especially worrisome. WRAIN, as an Army school, had never excluded minority candidates. However in the spring of 1972, there were no minority candidates on campus. An outside activist group demanded that the fall class have at least that 10 African-American students or face “serious reprisals.” In response the administration at WRAIN called upon two African American Army nurses, Major Clare L. Adams, a WRAIN faculty member, and Army Nurse (retired) COL Margaret E. Bailey, to assist with minority recruitment. They traveled around the country seeking candidates and personally interviewed those who expressed an interest. They were successful in their quest (and continued their efforts for at least one more year) as the incoming class of 1974 had 10 African American, two Asian and one Hispanic student candidate.

The power of educational assistance in recruiting is borne out by the 1969 statistics. In 1969 1,521 nurses joined the ANC and the Corps had a total strength of 4,817. The largest number of these 1,071, were produced due to the ASNP. The second largest number, seventy-eight, came from the WRAIN, which had graduated two classes. After January 1969 President Richard Nixon began the slow withdrawal of U.S. forces and thus the Army needed fewer nurses.

WRAIN existed for 14 years and graduated 1,222 Army nurses, the last class graduating in the spring of 1978. Cost was the major reason cited for discontinuing the school: the annual cost per WRAIN candidate was $36,000, expensive but still less than the cost of an undergraduate degree from the United States Military Academy. Contributing factors to the Army’s decision included the military drawdown after Vietnam, and the easing of the overall nursing shortage in the United States.

Individual insignia (left) and Distinctive Unit Insignia (right) of the Walter Reed Army Institute of Nursing. The individual students were known as WRAIN-drops.

Recruiting in a Shortage: Army Nurses in the 1980s
Robert L. Ampula, AMEDD Regiment

In the 1980s there was a nationwide shortage of nurses, and even a drop in nursing students. The Army had to recruit in this challenging environment, with understandably poor results. In 1986 the Army recruited 26% of mission, in 1987 38% and in 1988 21%. Civilian hospitals were offering flexible work hours, increased benefits, signing bonuses, child care, transportation, and other incentives. Army pay was also lower, and half of the nurses who applied to be commissioned quit before their paperwork was completed.

Nurse Corps leadership worked for several years to address the shortages, but were hampered by laws and policies that had to be changed. By the late 80s more ROTC scholarships were made available for nurses, and Active Duty nurses were used as recruiters in nursing schools. By the early 90s signing bonuses were available, non-ROTC stipends were available for some nursing students in their last two years, and student loan repayment was available. However that was in the early 90s, and in 1989 conditions had changed so that the ANC met its recruiting mission.

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I was a nurse recruiter in the late 1980s in northern Florida and south Georgia. I talked with recruiters from across the country, and the recruiting experience was markedly different depending on where you recruited and when. We faced many obstacles that the civilian sector did not, such as physical disqualifications, height and weight restrictions, age limitations, law violations, single parent issues and more. So it was a highly competitive environment among military recruiters as we were all working this very reduced group.

I always felt it was my duty to help the applicant and to make the Army better at the same time. As such, I never tried to over-sell. In my mostly rural areas, one disgruntled Army nurse would ruin Army nurse recruiting in the area for many years. Each nurse had unique needs and goals and I felt it was my duty to attempt to meet as many of those needs and goals as possible as well as meet the Army's mission. One size most definitely didn't fit all. For instance, something such as the chance to travel was an incentive for some, but it could be an obstacle for others because of the fact that they would need to leave family and friends.

At times well-intended policy got in the way. The Nurse Corps and Recruiting Command could often be their own worst enemy at times. During a Q&A session with the Nurse Corps Chief, I offered that according to the current recruiting rules neither she nor her staff qualified to be an Army Nurse. Stunned, she asked why. I told her that the rules state the applicant must have done 6 months hands-on patient care in the last year in order to qualify, and I believed she and her staff hadn't done that in the last 5 years let alone 6 months out of the last 12. There was relevance in my statement. One of my applicants who was the president of the state nursing society, was denied entry into the USAR because he was doing administrative work and not hands-on nursing. He could have provided the name of every nurse in the state, and possibly the school they attended.

That brings me to another major issue at that time, the National League for Nursing (NLN) requirement: nurses must have graduated from an NLN accredited school. This became one of the first questions we asked an applicant, what school did you graduate from? That would send us to a book that listed all of the NLN-accredited schools. Surprisingly, there were many that were not, and this immediately disqualified them. Try to explain that to a motivated, patriotic nurse. Who cares what school they graduated from? State licensure determines if they are an RN. With all the limitations about height and weight and citizenship we were already behind the power curve and this was another obstacle.

At the time, the nurse recruiting mission was by specialty, such as operating room nurse, nurse anesthetist, or ER nurse. (Yes, this was a mission as opposed to a quota, and one knows what happens to one's career if you fail at a mission). It seemed the recruiting region divided the mission total by the number of recruiters. While that seems fair, this was an inefficient way to do business. For instance, I had no schools that produced nurse anesthetists in my area. At that time, established nurse anesthetists were making matchless wages in the civilian sector. Even patriotic nurses who considered a career in the Army balked at what we could offer, even with advanced rank to reflect their experience. Recruiters with schools that produced them had a much better chance at recruiting them with the loan repayment program.

Many of the nurses I recruited would come to see me when they came home for leave. One nurse related a rather humorous anecdote. She mentioned that while attending Officer Basic at Fort Sam Houston, they were housed at a local hotel. One of the first evenings there, the leaders had them gather in the classroom area
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for a briefing. When the commander came in, as is normal, ATTENTION was called. She said all of the nurses remained seated. Again the command came, ATTENTION. She said one of the nurses said, 'you already have our attention.' You have to love the limitations of direct commissioning.

On another occasion, another nurse visited me and she said that she never really grasped the meaning of my comments about being an Army officer as well as an Army nurse until she was going to work one day at Fort Campbell. She said that as she walked up to the hospital she passed a bus stop. She was stunned when soldiers on crutches and casts came to attention and saluted her. She said that was when she realized her dual roles.

SP4 Ernesto Echavarria Serrano, Second Known Vietnam Triple Silver Star Recipient

Robert L. Ampula, AMEDD Regiment

In the autumn 2019 issue of the AMEDD Historian, Number 27, I wrote an article on Vietnam medic SFC William Koutrouba, who earned the Silver Star an incredible three times. Although this is rare, I would be negligent if I didn't follow that article with a second brave Vietnam War medic who also earned the Silver Star three times during the first of his two tours in Vietnam. That soldier was SP4 Ernesto (AKA Ernest) Echavarria Serrano. He also received the Bronze Star, Air Medal, and four awards of the Purple Heart.

Ernesto Serrano entered the Army on June 18, 1968 from Los Angeles, California and underwent basic training at Fort Ord, CA. He started his medical training as a 91A at the U.S. Army Medical Training Center at Fort Sam Houston, TX on 26 August 1968. By November 2, he was enroute to United States Army Pacific and was subsequently assigned to the 9th Infantry Division on 9 December as a 91B10. On January 1st 1969 he was assigned to the 47th Infantry Regiment, 9th Infantry Division and listed as a 91B20.

On March 1st 1969 Ernesto was serving as a medic with the Headquarters and Headquarters Company of the 2d Battalion, 47th Infantry Regiment (Mechanized), 3d Brigade, 9th Infantry Division in the Republic of Vietnam. That day he and his platoon were on a reconnaissance operation in a booby trapped area near Binh Phoc when they suddenly came under intense enemy fire. SP4 Serrano was wounded in the initial engagement, but he ignored his own wounds to move toward others in his platoon who were also wounded. As he began moving toward one of those casualties he was struck again by enemy fire, but never wavered in his mission to reach the wounded soldier. Once at the soldier's side, he performed lifesaving emergency aid and prepared him for evacuation. When others in his platoon attempted to have him evacuated for his own wounds, he refused and moved to the next casualty. This continued until he had treated and evacuated all of the other casualties. Only then would he allow himself to be evacuated. His heroic actions would earn him a Silver Star.

Less than two months later, SP4 Serrano was part of a quick reaction force that was alerted to re-supply and assist one of the brigade's other companies that was engaged in an intense firefight with a large enemy force. When Ernesto arrived at the battle he observed that all of the company's medics had been wounded and were in need of evacuation. In addition, there were several other casualties that were pinned down by heavy hostile fire. Without thought for his own personal safety, SP4 Serrano immediately maneuvered across the open terrain and progressed from man to man administering emergency aid. He continued treating and evacuating casualties continuously for over two hours while under heavy enemy fire. For these actions he would earn another Silver Star.

On 12 May 1969, SP4 Serrano and elements of his battalion made contact with a well-entrenched, numerically superior enemy force using small arms and automatic weapons. In the initial fusillade, one of the battalion's soldiers was seriously injured and lay approximately fifty meters from SP4 Serrano. Without considering his own welfare, he traversed the open terrain under heavy fire to reach the wounded man and administered medical aid. He subsequently moved the injured man to an evacuation point. He volunteered to accompany the lead elements during two ensuing attacks on the enemy positions in order to provide immediate care to the injured. Over and over he exposed himself to the heavy fire to provide aid to the wounded. He treated a total of thirty-seven soldiers over the course of the six hour engagement. He was cited for his skillful and speedy medical care that limited the number of soldiers evacuated to only fourteen. His courage and devotion earned him another well-deserved Silver Star.

When his first tour ended, he stayed for another year in Vietnam and was first assigned to the 3d Field Hospital and then the 51st Field Hospital. He was promoted to SP5 and served until February 8, 1971 when he

rotated back to the United States pending his discharge from active duty on February 10, 1971. He served in the United States Army Reserves until he was discharged on 1 June 1974.

Upon returning home, he married his wife, Josephine in 1972. He initially worked doing private home nursing care. He then worked for 8 years in agriculture. After that he went to work as a welder and pipe-fitter.

My initial intent before writing this article was to locate Ernesto in hopes of interviewing him. It turns out I was a few months late as, unfortunately, all of my searches led me to his obituary. Ernesto passed away June 26th, 2019 in Guadalupe, CA. I conducted rudimentary searches for his family members in hopes of uncovering additional information about him, but I have thus far come up empty. Although I haven't given up hope of reaching them, I didn't want to delay sharing what I know of SP4 Ernesto Serrano's Army service.

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Training the AMEDD – World War I
Lewis L. Barger III, ACHH

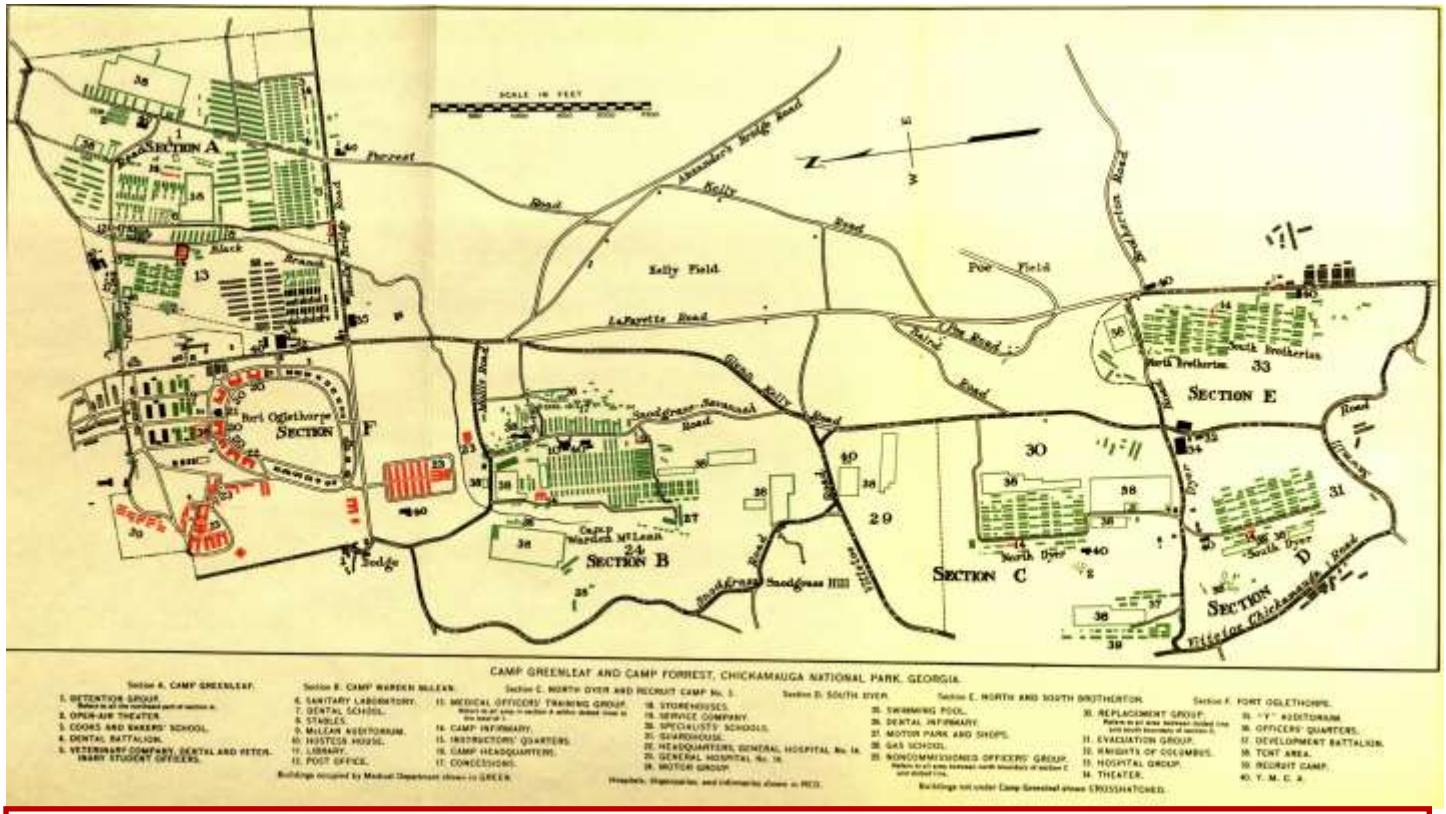
The First World War had been underway for two and one-half years before the United States declared war on Germany. Before that, the United States had maintained an official policy of neutrality and President Woodrow Wilson had run for re-election with slogans including "He Kept Us Out of War" and "America First." That sentiment changed, though, when it was revealed that Germany was seeking an alliance with Mexico as insurance against American entrance into the war at the same time that German submarines were resuming unrestricted submarine warfare in the Atlantic.

Despite America's pre-war neutrality, some steps were taken to prepare for war. The 1916 National Defense Act had authorized an increase in the Regular Army from a little over 100,000 to 175,000 and in the National Guard from a little over 130,000 to 435,800. Recruiting had done little to turn those authorizations into trained soldiers, and those numbers would represent only a fraction of the nearly 2.5 million men that would be wearing an Army uniform two years later.

Congress declared war on April 6, 1917 at a point when all of the major combatants were nearly exhausted. The French and English were desperate for fresh manpower to pour into the trenches and immense pressure was placed on General John J. Pershing, the commander of the American Expeditionary Force (AEF), to turn over men or units as quickly as they could be brought over. Pershing refused, intending to fight an American army alongside his allies, but to accomplish this he needed time to turn newly inducted civilians into combat formations. The Army struggled in the U.S. with basic training, specialist training, and unit training; the numbers and types of units needed changed, and shipping availability and priorities changed as well. Army-wide, training ended up far below what pre-war regulars thought was adequate. Officers, NCOs, and enlisted soldiers received some training in the United States, designed to teach military skills and the rudiments of their job in their particular organization. Pershing's staff in France also made plans to conduct additional training in Europe, both for units and individuals.

Pershing's problem was the Medical Department's problem. They initially calculated that they would have to support an Army of 1,000,000, requiring 7,000 medical officers and an additional 1,000 to meet "wastage," a term borrowed from the British to describe those disabled and killed when no infantry attacks were under way. To meet this need, they had 500 trained medical officers in the Regular Army and 1,000 or so in the Guard and Reserves who were partially trained. The remainder would be starting from scratch. Similarly, they expected that 90,000 of 100,000 enlisted medical soldiers would be inducted with no previous military training. The same day the U.S. declared war on Germany, Colonel Edward L. Munson recommended to Surgeon General William C. Gorgas establishing an instruction program for officers covering five broad areas: sanitary organization and tactics; military hygiene and sanitation; clerical functions; general professional methods as modified by the environment of war; and military information relative to

the government of medical officers and men as part of the Army. Seven years earlier, Munson had developed the curriculum for what later would be named the Army Field Service School for Medical Officers at Fort Leavenworth (see Newsletter #29, Spring 2020, "Training The AMEDD – The Early Years"). Munson planned to establish medical training sites and man them with experienced cadre who would teach his updated curriculum. The cadre would be drawn from graduates of the Army Medical Field School and officers who had deployed to the Mexican border in 1916-1917, thus providing both formal instruction and practical experience in field operations. Surgeon General Gorgas approved Munson's plan, made Munson the Chief of a new training division in the Surgeon General's Office responsible for all AMEDD pre-deployment training, and forwarded his requests for support to the Adjutant General. On 11 May the War Department approved the plan, including the establishment of training sites at Fort Oglethorpe, GA, Fort Riley, KS, Fort Benjamin Harrison, IN, and Leon Springs, TX. The last would never open, the camp at Fort Benjamin Harrison would be short-lived, and a camp at Fort Des Moines would operate briefly to train the 114 African-American officers the AMEDD commissioned. The majority of AMEDD personnel received their initial training at either Fort Riley or Fort Oglethorpe.



The Medical Officers Training Camp at Camp Greenleaf, Chickamauga, GA, was a large installation that could train individuals and units. Map from Bispham *Medical Department of the United States Army in the World War. Volume VII* , 1927.

The first priority was to train officers for duty in combat divisions. Camps were set up to accommodate 1,000 student officers at a time as well as training four field hospital companies and four ambulance companies. Munson's original plan of instruction was fleshed out and became a three-month basic course for division-level medical officers. By adjusting courses, the basic course was shortened by a month and used to train officers slated to serve in the hospitals stationed behind the divisions. As the war progressed, additional professional education courses were added to Camp Greenleaf, which became the main camp of instruction for Medical Corps officers. Various types of units also trained there. Schools were established to teach military surgery, internal medicine, radiology, laboratory methods, neurosurgery, otolaryngology, ophthalmology, preventive medicine, and epidemiology.

Despite all the best laid plans of Munson and the Division of Medical Department Training, few officers or enlisted soldiers received a full course of training at the camps. As the rest of the Army sped up inductions and training, the demand to fill units outweighed the AMEDD's desire to keep its soldiers through a full course of

training. Amid these pressures, there was no way to train officers for a replacement pool.

Because Pershing did not wish to turn his force over to the Allies as individual replacements or feed divisions into the fight piecemeal, it meant that there would be opportunity to train units in France while the AEF expanded. On 27 August 1917, the Training Section in AEF Headquarters published a plan to organize a school system that would train individual replacements and organizational leaders. The schools were built into the AEF organizational plan, which consisted of (initially) one field army, a growing number of corps, and six divisions for each corps. Four of those divisions were combat divisions and the remaining two divisions would train replacements. One division, the depot division, was located near a port of debarkation and would train individual soldiers as they came off the ships, ensuring they had a basic level of individual training and any training resulting from new experience. The last division in the corps, the replacement division, was located behind the four combat divisions and was charged with training commanders and staff officers at all levels for the combat divisions, along with continuing the training of individual replacements. The replacement division was to have schools for: infantry, artillery, engineer, cavalry, signals, gas, aeronauts (both heavier and lighter than air), and field grade officers. And there was a corps sanitary school.

The Army Sanitary School at Langres, France. (Left) Exterior view of the building (from Bispham, *Training*, 1927). (Right) Instruction in a classroom (courtesy National Library of Health and Medicine).

The sanitary schools had a common curriculum, which bore a striking resemblance to the courses that had been taught at Fort Leavenworth before the war. However, it took advantage of having actual combat casualties that physicians could treat while learning about war surgery and military medicine. The remainder of the curriculum covered military hygiene, military medical administration, and sanitary tactics and also benefited from being able to observe and treat outpatients from the combat divisions.

The AEF training schools plan proved over-ambitious, at least for the Medical Department. The I Corps schools, including a field service school for medical officers, opened at Gondrecourt, France on 15 October 1917. Three weeks into the five week course, the director was reassigned and shortly after that a scarlet fever outbreak preemptively ended the course. A second attempt to run a full course began in January 1918, but only a few officers were able to attend and the school itself had inadequate equipment and facilities. There was no third attempt. The II Corps sanitary school opened at Chatillon sur Seine in February, 1918, benefitting from better facilities but ran only one, four-week class. These experiences showed there were too few medical officers to spare in a corps. Instead, it was determined that the Army Sanitary School at Langres had sufficient capacity to conduct the training, and classes could be filled from across the AEF.

The Army Sanitary School was established in the same order as the corps schools. The commandant, Lieutenant Colonel (later Colonel) Bailey K. Ashford, was an accomplished public health doctor and was more experienced than most officers with the curriculum of the school. He was a graduate of the Army Medical School and had studied the Correspondence Course for Medical Corps Officers run out of Fort Leavenworth. He had served in the Spanish-American War as a junior medical officer in Puerto Rico and had been the 1st Division's surgeon until he was directed to establish the I Corps Sanitary School, and then the Army Sanitary School, clearly indicating command confidence in his abilities.

When he reported for duty in Langres on the 1st of November, Ashford expected classes would be about

100 field grade officers. For the curriculum, he expected to provide professional training in the latest techniques (as developed by the British and French) for practicing medicine and surgery, as well as providing instruction in the tactical skills necessary to perform a medical officer's duties in corps and division units. By the time the school opened a month later, though, changes were clearly needed. Ashford rapidly adapted the curriculum to create a course based on demonstration and practical exercise. He did not want to replicate other training programs; officers were still receiving training prior to deployment and the corps sanitary schools were still planned. Instead, Ashford selected a new target audience: "medical officers in a position to spread information which could not be attained by the reading of books or papers, or from the divisional or corps schools." The Army Sanitary School's mission would be training those officers who could best pass on practical experience to officers who would never have an opportunity to attend training because their duties tied them to their station. Ashford anticipated a minimum of didactic lecture and rote memorization, instead emphasizing discussion, demonstration, and most importantly, time spent where medicine was being practiced, from the front lines to the base hospital.

Ashford was not interested in differentiating between front-line and rear area service. Since students at the Army Sanitary School were supposed to be able to take what they learned back to their organizations, regardless of whether they were front-line or rear area units, and share that knowledge with the other medical officers, Ashford wanted to ensure students were familiar with the entirety of the medical framework in France, from front-line dressing station to the base hospitals in the rear. In the United States, only officers assigned to forward units were given training in front-line medicine. Officers assigned in the rear received an abbreviated and limited training course, that omitted (among other things) trauma treatment. Ashford reasoned that doctors who had experienced conditions in the front would be better prepared for the types of wounded soldiers they would receive and better able to provide them care. They would also gain an empathy for the doctors working at the front, and, should the need arise, be prepared to serve there.

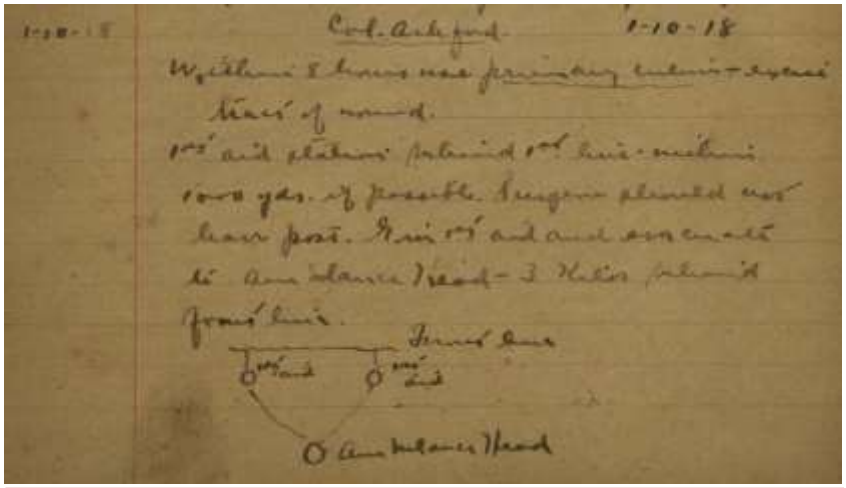
COL Bailey K. Ashford, MC, commandant of the Army Sanitary School.
Courtesy National Library of Medicine

The first class reported to Langres on December 2, 1917 and departed for Paris the following day. What followed was a whirlwind tour of medical sites. One day they spent 13 hours at a fracture hospital and the next the morning learning the Carrel-Dakin method of wound treatment followed by an afternoon of clinical lecture and case presentation. Students visited the medical museum at the Val-de-Grace, attended demonstrations of the French medical service, and observed operations. They spent two weeks at the Royal Army Medical Corps school of instruction behind the British 1st Army where they attended lectures, observed demonstrations, and participated in practical exercises covering all types of injury and illness which the British had experienced on the front lines. They received a lecture on treatment of the euphemistically named "N.Y.D.N," or Not Yet Diagnosed Nervous, British code for shell-shock. They visited a Red Cross Depot. They observed ambulances evacuating casualties. Each day at 16:30, they paused half an hour for tea.

Perhaps most importantly, medical officers went to casualty clearing stations where they treated British patients under supervision, getting acquainted with the horrific injuries of industrialized warfare. They saw living conditions near the front, and experienced artillery barrages; the experiences Ashford had noted "could not be attained by the reading of books or papers." The students returned to Langres on Christmas Day. They received some training on gas instruction, closure of war wounds, and the effects of high explosives. The majority of their remaining time was spent documenting the entirety of their training, based on their notes , which would provide the material they needed to pass on what they had learned once they returned to their units and

also serve to document for the school the training they had conducted

A second class reported to the school on January 9, 1918. Like the first class, they attended lectures, demonstrations, and practical exercises in Paris before heading to the front lines, but this group studied at the French Fifth Army medical school. All instruction was conducted in French, and then repeated in English each night by three officers who were fluent in French. During what time remained, officers participated in operations on wounded men. The course was not identical to that attended by the first class, but the essential elements were there, presented from the French perspective. When they returned to the Army Sanitary School a more mature syllabus awaited, and from February 4th to 21st the class received 5-6 hours of training each day, excepting Sundays. They also spent an additional 3 hours each day writing up their notes from their visit with the French Army as the first class had done.



On 19 January 1918 MAJ George E. Hilgard, MC, took these notes on how to establish front-line medical support from COL Ashford's lecture at the Army Sanitary School. MAJ Hilgard was regimental surgeon of the 9th Infantry, and the Sanitary School was intended for this train-the-trainer work. Courtesy COL Mark Burnett, MC.

By the third class the program of instruction was fairly well set. That would change during the fourth class. As mentioned earlier, corps level schools failed due to an inability to release sufficient numbers of medical officers to make the classes worthwhile. A letter from General Headquarters, AEF sent to the Commandant of Army Schools on the 4th of March directed that all school instruction for medical officers would be consolidated at the Army Sanitary School. Classes would be shortened to a month, but the top half of the class would still have the opportunity to spend two weeks near the front learning from one of the allied medical corps. Instruction at the Army Sanitary School was finalized based on the three preceding classes and consisted of sections on administration, sanitation, surgery, medicine, tactics, and general instruction in related military topics like the organization of the expeditionary forces, construction of trenches and their associated structures, weapons effects, and gas defense.

The school continued to operate through the end of combat, with the ninth class in session when the armistice went into effect. A tenth class was conducted, and then the school closed. By the eighth session, school instruction was augmented by a complete set of handouts, produced on a mimeograph machine, and prepared to complement the course of instruction. These mimeographs, prepared over the preceding ten months, also served as a means to export the course beyond the walls of the school house. Although the full set of course materials were not available before October, there were undoubtedly individual classes prepared and mimeographed earlier which then would have been taken back with the officer who attended the course and passed around among the other medical officers in his unit or headquarters. In this manner, the school truly did extend its influence throughout the Medical Department of the AEF. The mimeographs served both as instructional materials, and also as a means for standardizing best practices, even for officers who never had the opportunity to attend classes. When new information was developed, new mimeographs could be prepared and printed rapidly for dissemination to the force.

Overall, though, the Army Sanitary School was only a qualified success. Initial assumptions that many medical officers would be able to leave their units for six weeks at a time proved overly optimistic. The Medical Department and the Army's understanding of how peacetime training affected wartime preparedness would shift as a result of their experience mobilizing from 175,000 regulars to 2.5 million in about 19 months, and the significant challenge of developing a training program, constructing camps, and creating instructors to turn an enormous mass of men into soldiers. One of the successes of the Medical Department was its focus on training for its regular officers during peacetime. The officers that developed training plans and served as training camp commandants were either former instructors or students of the Field Service

School for Medical Corps Officers at Fort Leavenworth. This lesson was not lost on the AMEDD.

When an Army-wide General Order was published in 1919 authorizing all the technical services their own schools, that order specified that the Medical Department's school would be the Army Medical School. Although the Army Medical School did teach some courses useful for preparing doctors for field service, its training was focused on medicine and surgery peculiar to Army service. The Surgeon General argued successfully for the creation of a second school for the Army Medical Department. The Army Medical School would ensure that Medical Corps officers were good Army doctors. The Medical Field Service School would give them the skills they would need to be good soldiers.

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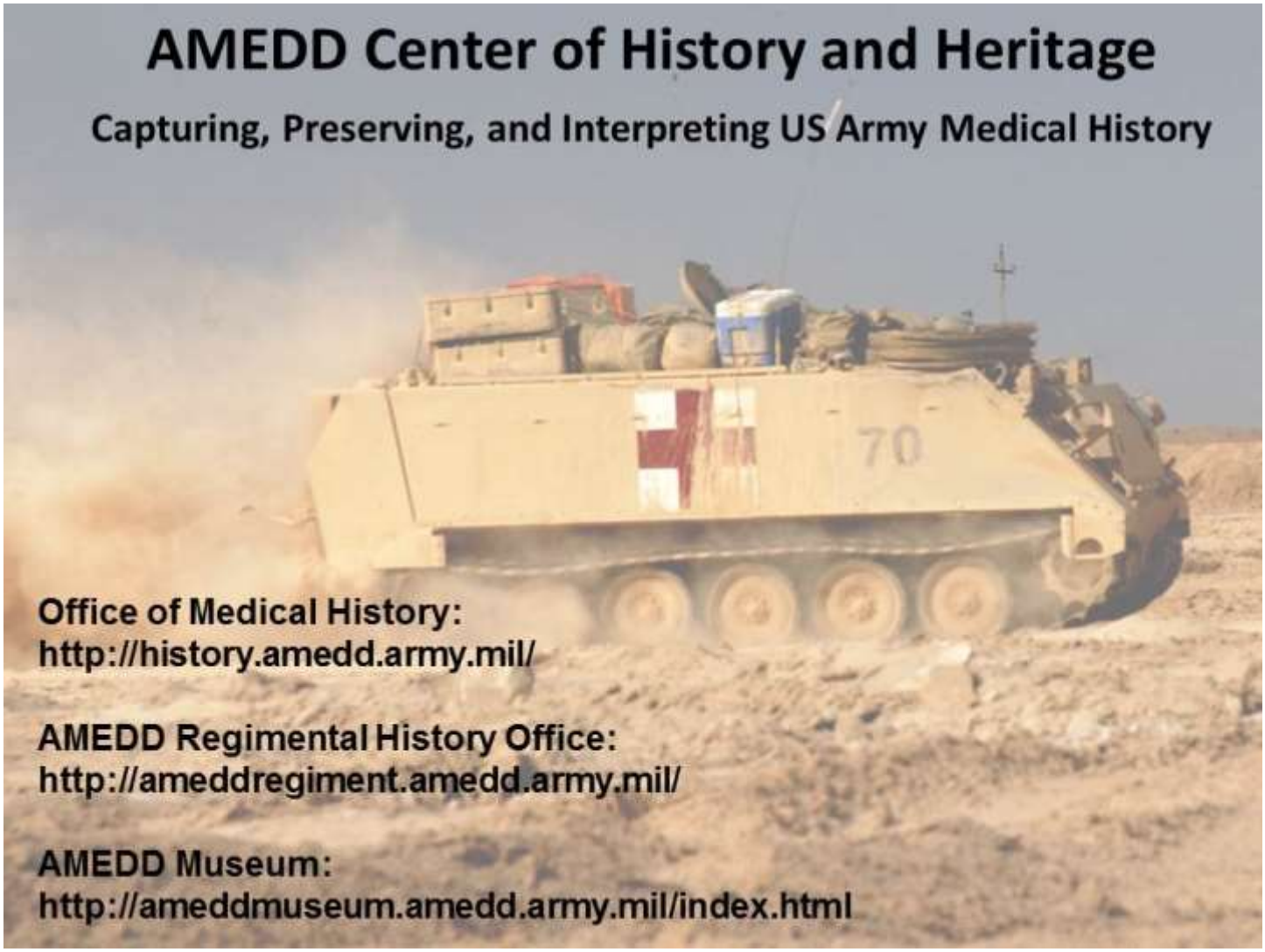

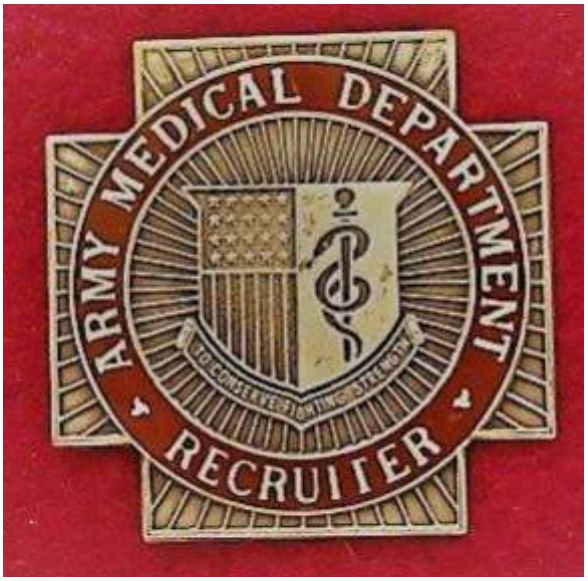

From the early 1980s until 30 September 1995 the Officer Procurement Division of the AMEDD Personnel Support Agency (and later the U.S. Army Health Professional Support Agency) were responsible for recruiting all officer health care professionals (less nurses who were recruited by USAREC). The small recruiting force of AMEDD officers were known as Personnel Counselors and assigned to a field office in a region.

This badge was devised for wear by these officers while in a duty status. It was approved 24 January 1991 and issued to Personnel Counselors, Regional Directors, and Program managers, beginning in May 1991. It was no longer authorized for wear after 30 September 1995; USAREC assumed the mission for all AMEDD recruiting the following day. A limited number of badges were produced and those personnel authorized to wear the badge were relatively few in number.

Courtesy AMEDD Museum

Writing for *The AMEDD Historian*

We are seeking contributions! We believe variety is the way to attract a variety of audiences, so we can use:

- Photos of historical interest, with an explanatory caption
- Photos of artifacts, with an explanation
- Documents (either scanned or transcribed), with an explanation to provide context
- Articles of varying length (500 word minimum), with sources listed if not footnotes/endnotes
- Book reviews and news of books about AMEDD history

Material can be submitted to **usarmy.jbsa.medcom.mbx.hq-medcom-office-of-medical-history@mail.mil**
Please contact us about technical specifications.

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