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**W**elcome to Issue #44 of *The AMEDD Historian*! Recruiting is a vital mission that is often mentioned as the Army’s numbers are carefully considered. In the last century the growth of the U.S. Army was largely shaped by world events, and recruiting was a smaller component in building the huge armies of World War I and II.

The first article “Mobilization and the AMEDD” is an overview of how the Army gained soldiers and put medical professionals in uniform during times of great change. A follow-on article “Getting New Hospitals in WWII” relays the challenges (and numbers) involved in building a significant hospital system during the war.

Widely used by the end of World War II, penicillin’s introduction was a “game changer” in fighting infections and disease. Read about its initial use and distribution. Also, view a contemporary poster of interest. Be sure to see new document and book additions to the archives.

The experiences of joining the Army and serving during wartime are explored in “I’m in the Army Now-Stories of Mobilization”. Covering different medical specialties and spanning from World War I through Vietnam, the article provides firsthand viewpoints:

*“I am a company aid man attached to the 3rd platoon of Company K of the 71st Infantry [regiment] of the 44th Division. ... [continued on last page]*

**Mobilization and the AMEDD**

America’s armed forces have never been the size needed for major conflicts, requiring some kind of mobilization. It should not be a surprise that the kind of mobilization has changed as the Army has learned and tried to avoid problems. Meanwhile, Congress and the American public also had differing ideas about how to handle mobilization.

The World Wars

1917 saw America’s first modern mobilization. The Army had to go from around 120,000 (and 180,000 in the National Guard) to much bigger, and part of the problem was that how much bigger was unknown. How many mobilization camps would be needed? How many uniforms and weapons? How would personnel standards have to change to increase the recruiting pool? The demand was urgent as the Allies were gradually losing the war, and would likely lose if the U.S. did not deploy substantial forces.

Most National Guard units were well below full strength and were at moderate readiness for constabulary operations, let alone high-intensity warfare. There was an Enlisted Reserve Corps, but Congress had only authorized it in 1916; it had less than 100 personnel. The Medical Reserve Corps had approximately 1,500 doctors, and its start in 1908 was the first reserve corps in the whole Army. The AMEDD also had some “affiliated hospitals;” these were organized in conjunction with the Red Cross,

and were around 100 clinicians from various civilian institutions who promised to volunteer in time of war but had no military training.

With so few available troops, Congress authorized a draft. Between volunteering, the draft, and those who volunteered to avoid the draft (they could pick their branch of service), the U.S. mobilized around 5,000,000 personnel in around 20 months. To reach these numbers, the military widened eligibility standards, creating qualitative challenges for the AMEDD on top of the quantity of recruit medical examinations.

The Army had to build mobilization camps, decide what units it needed, how many units it needed, how to train, who should be where, and myriad personnel details. There were also equipment problems, both in quantity and quality. For personnel, the Army kept the Regular Army and National Guard, but created the National Army for the wartime personnel. Expecting a return to peacetime, it was possible to have a NA rank that was several grades higher than the RA (or NG) rank, so the peacetime force would not be top-heavy in rank. Various reserve corps were created, then abolished in favor of the Officer Reserve Corps, with some components. Thus a Medical Reserve Corps officer (by law limited to First Lieutenant) could have had a National Army rank during the war, then be commissioned into the Medical Officer Reserve Corps at another rank entirely. Unsurprisingly, it led to confusion and frustration.

After WWI, the Army worked with Congress to lay better plans. Industrial mobilization had been chaotic and ineffective. The U.S. was a leading producer of both steel and automobiles, but during WWI no American-produced tanks saw action. To smooth industrial mobilization an Assistant Secretary of War was created (previously there had only been the Secretary himself) specifically to oversee industrial mobilization, policy and plans. The Army Industrial College was established, later the Industrial College of the Armed Forces, and now the Eisenhower School for National Security and Resource Strategy. Plans were drawn up, both an Industrial Mobilization Plan and a Protective Mobilization Plan that integrated warplans with industry – it was foolish to plan for aircraft production in an area that no troops would be defending. New units, up to divisions, were created in the Organized Reserve, although most of them had few to no personnel. The National Guard was also reorganized. The Army also began professional military education for ORC and NG officers.

This planning helped for WWII, as did the gradual mobilization from 1939 to 1941. Overall, the industrial mobilization was effective, although there was much friction as government interventions had unintended consequences that needed new interventions, and as needs changed. The draft was revived (actually in peacetime, for modest numbers of personnel) and again volunteers, draftees, and draft-motivated volunteers filled the ranks. Units were nominally Regular, Reserve, or National Guard, but since all were below strength the designations soon made little difference. Instead of the National Army, the Army of the United States was created, so again personnel could have two ranks.

### The AMEDD's Role

In both World Wars the AMEDD had many roles in mobilization. These started with drawing up physical standards, to then implementing them in screening the recruits, then treating patients at training camps. To do this the AMEDD had to get facilities, equipment, and personnel. Given the range of skills and specialized equipment and facilities, that was no small task. That is also, obviously, only the supporting role: medical units themselves have to be organized, and get field equipment, and be readied for deployment. The AMEDD often worked with far more civilian organizations – such as the American Medical Association and Red Cross – than most branches did.

### The Cold War

The boom/bust mobilizations would not work if the enemy had a large force constantly ready, and the Army changed to meet the different threat. The active component was large, the reserves similarly large and more ready than before. The active component was fed by the draft, and draftees then became reservists. The draft was continued, although mainly it encouraged volunteering. Large forces necessitated large material stocks, a substantial defense industrial base, and many bases. Medically, the needs were more predictable. The draft

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provided personnel (including providers) except female nurses since Congress would not draft females. Medical facilities were built at bases, although large construction programs in the 1950s would mean a wave of obsolescent facilities decades later – but there was no way around that. Supplies and equipment were procured, including for civil defense efforts, and largely stored away. The patient population was overwhelmingly young males, 18-24, who were serving only a few years and without dependents, although as decades passed there were more retirees to see.

In 1973 the draft ended. Numbers fell, and the U.S. increasingly emphasized quality over quantity, but was unsure how that would actually work against the enormous Warsaw Pact forces. Abrams tanks were good, but far fewer than T72s. Soldiers would be better trained than before, but how much would quality compensate for quantity? Medical equipment and personnel were increasingly expensive, and there was trouble recruiting and retaining personnel, and fielding ready units. The Army increasingly emphasized fitness for active personnel (for instance the body composition program, or discouraging smoking) but had far less control on reserve component personnel. Into the 80s senior Army leadership still expected a wartime draft. Thus the AMEDD would have to first get the existing military deployed, including deploying many AMEDD units. Then it would have to find more personnel and equipment to handle the draftees and another wave of medical units.

From the 1990s, mobilization has come to mean only mobilizing existing units and personnel, not mobilizing the nation. That has substantially reduced the personnel and facilities required for mobilization, with the tradeoff being far less ability to mobilize a large force.

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— 27 July 1775 —



Maine National Guard unit with new recruits, 1917. Courtesy Maine National Guard.

## Getting New Hospitals in WWII

In 1939, the Army had around 12,000 hospital beds, enough for the peacetime force of about 120,000 troops but hardly a large war. Compounding the problem, much of that capacity was low-acuity beds. The AMEDD needed more facilities in total, and far more high-acuity care. The problem had been foreseen: the Army's Mobilization Regulations laid out priorities on how to expand the hospital system:

- Expand existing facilities;
- Use other Federal hospitals;
- Use civilian hospitals;
- Use empty military bases after mobilized units deploy;
- Use schools, hotels, or other civilian facilities;
- Build new facilities.

That was the plan on the shelf, but the Army did not follow it exactly. Veterans Administration and Public Health Service hospitals were not used, apparently because there was not such a crisis that those patients should not receive care. Civilian hospitals were not used, presumably to avoid severely reducing civilian healthcare. And while some barracks were used, there were two problems: there was often another unit forming at a base, and construction quality was not the same as for healthcare facilities. The AMEDD ended up moving down the list and leased some civilian facilities, but largely built new hospitals.



Rhoades General Hospital opened on 25 Aug. 1943 in a field near Utica, NY. It had 2000 beds and treated medical, general surgery and orthopedic surgery patients. After the war it was transferred to the State of New York. Modern hospitals are seldom built from wood, and the amount of parking is another major difference. But the staff and patients did have baseball diamonds and built their own small golf course.

U.S. Army photo, via National Archives

In 1939-40 they indeed started with expanding existing hospitals. The Army was expanding, but money and construction resources were needed on so many projects that hospitals were not a top priority. Some barracks on posts were converted to wards, or porches were enclosed and became extra ward space. In

1940 plans started for more hospitals, spread around the continental U.S. because that would reduce travel time for ill and injured troops sent to hospitals, and to avoid concentrations of hospitals if there were enemy attacks on the homeland. The AMEDD also was more rigorous in patient regulating: low-acuity patients were not sent to high-acuity hospitals even if it was nearby.

Getting civilian facilities was underway, but while many properties were offered for lease, only about 3% were suitable. Some were priced too high. Others were too small to be useful, or lacked elevators, or had corridors too narrow for litters, or other practical bars. Ultimately, 23 hospitals of various types were in leased buildings.

But the bulk of wartime hospitals were wartime construction. In 1935 the AMEDD had drawn blueprints for 44 types of hospital buildings that could be combined into hospitals from 25 to 2000 beds. The designs were optimized to be inexpensive, quick to build, and need little skilled labor. As a result, they were mainly wood, were one-story, and because of the fire risk they were spread out and thus needed more acreage. By 1940 some of the designs were viewed as cramped (e.g. for dental clinics or X-ray facilities) and some had to be re-drawn. But over 30 hospitals were built during the war (and others converted from barracks late in the war.

Without the hastily built (or converted) hospitals, the AMEDD would not have had the capacity to treat the hundreds of thousands of wounded (or the myriad sick and injured) during WWII. And without the prewar planning, they would have been slower to mobilize that capacity.

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— 27 July 1775 —

**New ACHH Archival Donations:**

Photo album, diary, and leather souvenir belonging to Marisha McMahan, an Army nurse who served with the 52d Evacuation Hospital in New Caledonia during World War II.

**Found in Collections:**

Set of six handwritten operative notes by Captain Lester J. Wallman, M.D. Wallman served with the 1st Auxiliary Surgical Group during World War II.

**New to the Research Library:**

Dempsey, Jack. *His Sword a Scalpel: General Charles Stuart Tripler MD, USA*. Traverse City: Mission Point Press, 2023.



Upper right, Marisha McMahan in New Caledonia, 1942.  
Lower right, her diary.  
Left, one of CPT Wallman's surgical notes.



# Penicillin

THE NEW LIFE-SAVING DRUG

## Saves Soldiers' Lives!



Men who might have died  
will live...if YOU

*Give this job Everything You've got!*

Alexander Fleming, a British scientist, discovered penicillin in 1928. However, production and purification were enormous problems and it was 1939 before much effort was put into solving them. By then the British war economy was stretched fighting a global war. In the summer of 1941 two British scientists brought penicillin to the U.S., hoping to gain interest and stimulate production. President Roosevelt had organized the Office of Scientific Research and Development in June 1941; it had a Committee on Medical Research. The OSRD largely organized college and university researchers for national defense topics. The CMR became involved, not least in pointing out how important penicillin could be. In the 1930s sulfa drugs had seemed to revolutionize wound care, but their limits were being seen: they paused some bacterial growth, but did not kill bacteria. The British also met with the U.S. Department of Agriculture's Northern Region Research Laboratory, which brought expertise in growing cultures more quickly and efficiently.

With some production problems moving in the right direction, the War Production Board got several pharmaceutical companies to work collaboratively on purification and packaging. Commercial rivals did work together under the 'win the war' pressure.

By mid-1943 production was improving, but still very limited, and the AMEDD conducted early clinical trials, tightly controlling distribution. At first the focus was infected wounds, but as available quantities gradually increased more trials were started. By the spring of 1944 production had expanded enormously, and penicillin could be used in almost every wound and tested on many diseases. The Army distributed it in every theater of war.

In summary, in WWII the U.S. mobilized not just a 'whole of government' effort, but pulled in industry and academia to take penicillin from an unusual laboratory incident to a widely-available drug.

Image from Office of War Information, via National Archives.

## “I’m in the Army Now” - Stories of Mobilization

### Paula Ussery and Chuck Franson, AMEDD Museum

Mobilization of the Army Medical Department for World War I actually started before Congress passed a declaration of war. American civilian medical personnel volunteered to help with both Red Cross and civilian hospitals in Europe between 1914 and 1917. Prominent names in American medicine such as George Crile and Harvey Cushing traveled to Europe as volunteers. Crile took a contingent of nurses, surgeons, and technicians from Cleveland’s Lakeside Hospital in 1915 and served at the *Ambulance Americaine* in Paris for three months. Having seen the conflict firsthand, American medical professionals returned concerned that America was not prepared medically for a potential involvement.

One result of these volunteer trips was the tasking of the American Red Cross with the recruitment, outfitting and organizing of reserve “base hospitals”. These reserve hospitals were organized around large facilities utilizing volunteers who already worked together daily. Base Hospitals were organized from the Harvard Medical School, from the Lakeside Hospital in Cleveland, from The University of Pennsylvania Hospital in Philadelphia, and from Washington University/Barnes Hospital in Saint Louis, Missouri to name just a few.

Thirty-three base hospitals were already organized by the time of America’s entry into WWI in April 1917. In fact, the first U.S. Army unit that sailed for France was Base Hospital No. 4, MAJ George Crile’s unit. Although initially it was believed that base hospitals would be far behind the front lines. This was not always the case due to the ebb and flow of battle. Sadly, the first four American casualties in WWI were from the AMEDD. 1LT William Fitzsimons, Medical Corps Reserve, and three enlisted men of Base Hospital No. 5 died when their facility was hit by seven bombs dropped by a German air raid on 4 September 1917. Two of the KIA were regular Army soldiers and the other two volunteers.

The first six base hospitals (2, 4, 5, 10, 12, 21) sent overseas replaced British hospital units in established facilities, and they treated predominantly soldiers from Australia, Great Britain, New Zealand, Canada, and other British Empire countries.

The AMEDD not only provided base hospitals for British forces, but also provided evacuation units for the French and Italian armies. After the declaration of war, a French military commission met with the War Department to discuss assistance. One French request was medical evacuation help, and on 23 June 1917 via General Order No. 75 the United States Army Ambulance Service was created. The USAAS attracted the adventurous by offering the promise of quick and certain service in Europe. Training was held at Camp Crane in Allentown, PA. Volunteers came from Army recruiting stations and by the end of June 1917 over 3300 were in training there. In all, 20,310 volunteers (2,085 officers and 18,225 enlisted) trained at Camp Crane between 1 June 1917 and 10 April 1919.

Volunteers came from Army recruiting stations, various pre-existing volunteer ambulance units, and a variety of institutions and industrial organizations. Sponsors of USAAS sections included over forty universities and colleges including Harvard, Yale, Dartmouth, Stanford, and the Universities of Michigan, Wisconsin, Virginia, and Nebraska. Operationally the men and equipment were a component of the allied forces although their pay and equipment came from the U.S.

An Army Ambulance veteran wrote of his service, “It is difficult for one who has not led the life to appreciate just what his car means to the *ambulancier*. For periods of weeks, mayhap, it is his only home. Its interior serves as a bedroom. Its engine furnishes him with hot shaving water. He works over, under and upon it. He paints it and oils it and knows its every bolt and nut, its every whim and fancy...”



1LT William Fitzsimons, first U.S. Army casualty in WWI. Fitzsimons had volunteered for thirteen months in Europe before the U.S. joined the war.



Frieda Damn was a nurse with Base Hospital #21, which took over operation of British General Hospital #12. She received this Scottish ‘Glengarry’ cap from an unknown patient.

Ambulance driver Bernard Bulawa, a student at the University of Chicago was one of 177 students who enlisted on 3 July 1917. Trained at Camp Crane, Bulawa was assigned to Parc "F" upon arrival in France. Parc "F" was assigned to the First French Army. It was bombed and lost all of its equipment while located at Breteuil and was awarded a unit citation from the French government for its service. Bulawa was wounded twice during his service. He was gassed in July 1918 and wounded in August 1918 by shrapnel.

The insignia for the U.S. Army Ambulance Service was a French cock or rooster. This example is from Bernard Bulawa. His Victory Medal (far right) has seven battle clasps: Montdidier-Noyon; Somme Defensive; Somme Offensive; Aisne-Marne; Aisne; Defensive Sector; Oise-Aisne.



The next massive mobilization was due to WWII. With fighting in both Europe and the Pacific, Congress passed a resolution on 27 August 1940 calling up the National Guard, many of the Reserves, and some retired Army personnel. This was followed by the Selective Service and Training Act on 16 September 1940 that required all males between the ages of 21 and 45 to register for the draft. This act dramatically increased the size of the Army and with the attack on Pearl Harbor on 7 December 1941, the size of the Army increased once again as America became a combatant nation.

One of the National Guard units called up in 1940 was the 135th Medical Regiment. A unit of the Wisconsin National Guard, the 135th was inducted into federal service on 15 October 1940 at Madison WI. It was assigned initially to the 3d Army and began its training at Camp Shelby MS. Sailing on 4 March 1942 it arrived in Brisbane, Australia 37 days later on 6 April. Among the AMEDD personnel was CPT William Metzler.

A graduate of Marquette Dental School, he served with the unit in scattered locations across Australia, where he occasionally practiced "al fresco" dentistry (setting up the patient chair in the sun to work) then embarked for New Guinea. In July 1944 the unit was reorganized as the 135th Medical Group and placed in charge of all evacuation whether by land, sea or air during the Leyte and Luzon Campaigns. For the anticipated invasion of Japan, the 135th was assigned to support the Marine Corps. Metzler continued to serve with the unit until his return stateside.



CPT William Metzler working on a patient in Australia in 1942.

6th Army Patch from MAJ William Metzler's service in the Pacific.

Statistically the most numerous AMEDD specialty was medical aidman – combat medic in today's parlance. In WWII a battalion of 900 infantry soldiers had 30 combat medics attached to it. Among the combat medics who served during World War II was Richard Lee Sanner, from Anamosa IA. He was drafted in the spring of 1943.

He went to Camp Grant for medical training. He recalled, "However medical basic training did go on and was interesting, boring, invigorating, tiring, painful, happy, sad, and frustrating. We did learn a lot



about all kinds of medical emergency treatments, hygiene, survival, and general health information, all geared... to making us good combat medics. We saw lots of training films ... Some of the medical training films, especially those that dealt with VD, were quite graphic and... somewhat sobering and revolting.” After medic training, Sanner was assigned to the 119th Medical Battalion of the 44th Infantry Division.

He embarked on 5 September 1944 heading for the European Theater. After additional training in France (including lessons in French) the 44th began combat operations in Marianviller, France. Sanner described his first battlefield experience, “I was assigned to the relative safety and comfort of the company aid station, where I kept records, prepared medicines and helped process the sick and injured who were brought in ... for medical assistance or treatment.” In November 1944 he was assigned to a four-man litter squad. The medics were identified as non-combatants. “On our helmets large, red crosses with white backgrounds were painted; new white arm bands, with their large red crosses printed on them were issued to us. We litter bearers were soon quite involved in helping them off the front lines after they had been treated by the medical aidmen there.” In January 1945 Sanner was transferred within the division to the 71st Infantry Regiment. On 31 March 1945 he wrote a letter home and described his duties:

“I am a company aid man attached to the 3rd platoon of Company K of the 71st Infantry [regiment] of the 44th Division. As an aid man ... I am the medical aid person for the men on the front line. We treat all casualties, illness, injuries, sickness and also act as a chaplain. I say this latter, not because we really are, but because the men come to us with many troubles... I have been on line for a long time and many times; I have sweated out artillery shellings, sniper fire, and mortar shellings; I have treated casualties; had blood-soaked hand that didn't get washed for over a week until the blood finally rubbed off; I have done nothing sensational or outstanding ...”

He was slightly wounded by fragments from a grenade on 2 May 1945, only six days before Nazi Germany surrendered. He treated his wounds and continued working. He was honorably discharged in 1946.

The geopolitical map at the conclusion of World War II quickly became one divided between democratic and communist nations. As Winston Churchill said in his famous speech in Fulton MO in March 1946: “A shadow has fallen upon the scenes so lately lighted by the Allied victory. Nobody knows what Soviet Russia and its Communist international organization intends to do in the immediate future, or what are the limits, if any, to their expansive and proselytizing tendencies.” America resumed its draft to meet this new Cold War challenge.

Although WWII had ended, there were men who had been deferred during the war in order to complete their degrees. These men were called to active duty as those who had fought in WWII were discharged. Among the AMEDD officers who found themselves on active duty was Dr. Robert Bernstein of Yonkers NY. He had graduated from Vanderbilt University in Nashville TN in 1942. He then entered the University of Louisville School of Medicine, training to be a medical doctor under the Army Specialized Training Program. Upon graduation in 1946, Bernstein was commissioned as a First Lieutenant, Medical Corps, in the Army Reserve (inactive) and began his medical career as an intern at Grassland Hospital in Valhalla NY.

The Army called him to active duty in July 1947 and after attending Medical Field Service School at Fort Sam Houston in San Antonio, he was ordered to Japan. Volunteering for the airborne upon arrival in Japan, he attended the 11th Airborne Division's Jump School. He had assignments with the 11th Airborne Division in Korea and Kentucky. When the Korean War broke out in June 1950, CPT Bernstein, now assigned to the 187th Regimental Combat Team, arrived in Korea in September 1950.

Serving as the Battalion Surgeon of the 2d Battalion, 187th Airborne Regimental Combat Team, he participated in both combat jumps the unit conducted, and was wounded. According to Bernstein, “We were in North Korea, going after guerillas in the mountains, and our battalion had sent a reinforced company to hunt them down. We probably shouldn't have even been out on that operation. But the battalion



Combat medic Richard Sanner's "Ike" Jacket. It has the patch for the 44th Infantry Division on the left shoulder and his Combat Medic Badge and ribbons.

commander had me with him, along with a little group of his staff. We were out about 20 minutes ahead of the company. We were moving up a narrow valley, with rice paddies in the valley floor between mountains on either side. Our little group was going along, singing Christmas carols, when suddenly the North Koreans on the hillside opened up on us with small arms and automatic weapons fire. We quickly scrambled over the nearest rice paddy berm and took cover as best we could, but, not before I had taken a bullet, right in the butt. The company of paratroopers came up and drove off our attackers. The medics put me on a litter, however, I got off and walked out, or rather limped out, to keep from getting stiff. I was operated on in a Mobile Army Surgical Hospital (M.A.S.H.). The surgeons tried unsuccessfully to take the bullet out..." Major Bernstein returned to the 187th and remained in Korea nearly two years.



Silk flag from the People's Democratic Republic of Korea (North Korea) from MG Robert Bernstein.

All women who have served in the United States Army in the 20th Century were volunteers. The Army Nurse Corps faced a serious shortfall of nurses in the 1950s and 1960. Between 1950-1955, ANC personnel losses exceeded gains by 55%. Thus the ANC began an aggressive recruiting drive, Operation Nightengale. Two successful incentives were education-based. Both the Army Student Nurse Program and the Walter Reed Army Institute of Nursing provided pay and allowances in the grade of E-3 while a student. Upon graduation from either, the nurse was commissioned and owed the United States Army 3 or 4 years of service.

One of the nursing students who joined the ANC through the Army Student Nurse Program was Gayle O'Rear. An "Army brat" (her father was an Army dentist), O'Rear recalled "I first joined the Army when I went into the Army Student Nursing Program as a junior in the St. Louis University School of Nursing in St. Louis MO. I was sworn in as a Pvt. E-3 while in school. On December 1, 1968, which was 6 months before I graduated, I was sworn in as a 2LT."

Her first assignment was at Ft. Benning GA (now Ft. Moore), then she was assigned to the 67th Evacuation Hospital in Qui Nhon, Vietnam. Vietnam was one of her most challenging assignments during her career: "I had never been in a warzone, nor in a place that was so different. The Vietnamese people lived in mud and stick huts and farmed with oxen pulling plows." O'Rear was required to serve in the ANC for three years, but she decided "I enjoyed being in the military because I was able to [do] a greater variety of things that my civilian counterparts couldn't do such as travel, work on projects outside of nursing, but which affected nursing such as logistics, and equipment design." She retired with the rank of colonel on 31 July 1994. Undoubtedly her approach to her career was a factor in her success as an Army nurse: "My philosophy throughout ... was that I really didn't care where I worked or what I did, but I didn't want to be bored. I had to have a purpose and a challenge which the Army Nurse Corps certainly succeeded in giving me."



In 1974 the All-Volunteer Force was implemented. Although there is currently no draft, the critical need for medical personnel is recognized in the "Health Care Personnel Delivery System," a standby plan produced in 1986 by Selective Service at the request of Congress. This plan if enacted would create a medical draft in the event of a national emergency. Interestingly enough, it would require a mass registration of both male and female health care personnel.

1LT Gayle O'Rear in Vietnam.

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— 27 July 1775 —



19 January 1945. Medics push an assault boat loaded with medical supplies forward to the banks of a stream in Luxembourg. Wounded from the 4th Infantry Division were across the stream, needing support.

## All the Eggs (and Surgical Instruments) in One Basket: Army Medical Logistics Mobilization

Scott C. Woodard, ACHH

Critical medical-surgical product shortages experienced during the COVID-19 pandemic brought attention to overreliance on foreign medical product manufacturers and sole-source critical components. Along with surgical dressings, plasma, penicillin, and eyeglasses, the AMEDD of WWII labeled surgical instruments as “problem items” because of their importance, difficulty in getting them, and the quantities required. Shortages revealed during the coronavirus outbreak echoed the past where the AMEDD reflected on medical supply shortages during WWII in the official history writing “No problem in medical supplies had caused the prewar planners more concern than the procurement of surgical instruments.”



Samples of surgical instruments displayed in a “showroom” allowed manufacturers to copy the approved patterns of Army Medical Department tools.

Even before WWI, the US was dependent on Germany as the source of supply for surgical instruments. Domestic production in the US increased during the First World War, but by the 1920s, German manufacturers dominated the field once more, providing most of the 85 percent of instruments imported to the United States. Following the British blockade of Germany in September 1939, US domestic factories could not keep up with the internal demand from civilian and military hospitals, and foreign demands from France, England, and Latin America. The machine tools, forgings, and skilled labor to manufacture surgical instruments was not available. In the 1920s the Industrial Mobilization Plan envisioned silver and jewelry manufacturers converting to produce surgical instruments, but by 1940 they provided only limited relief. To get around quality problems as the new plants struggled, the Army Medical Purchasing Office in New York established a showroom displaying the exact instruments required; manufacturers could see what ‘right looked like’.

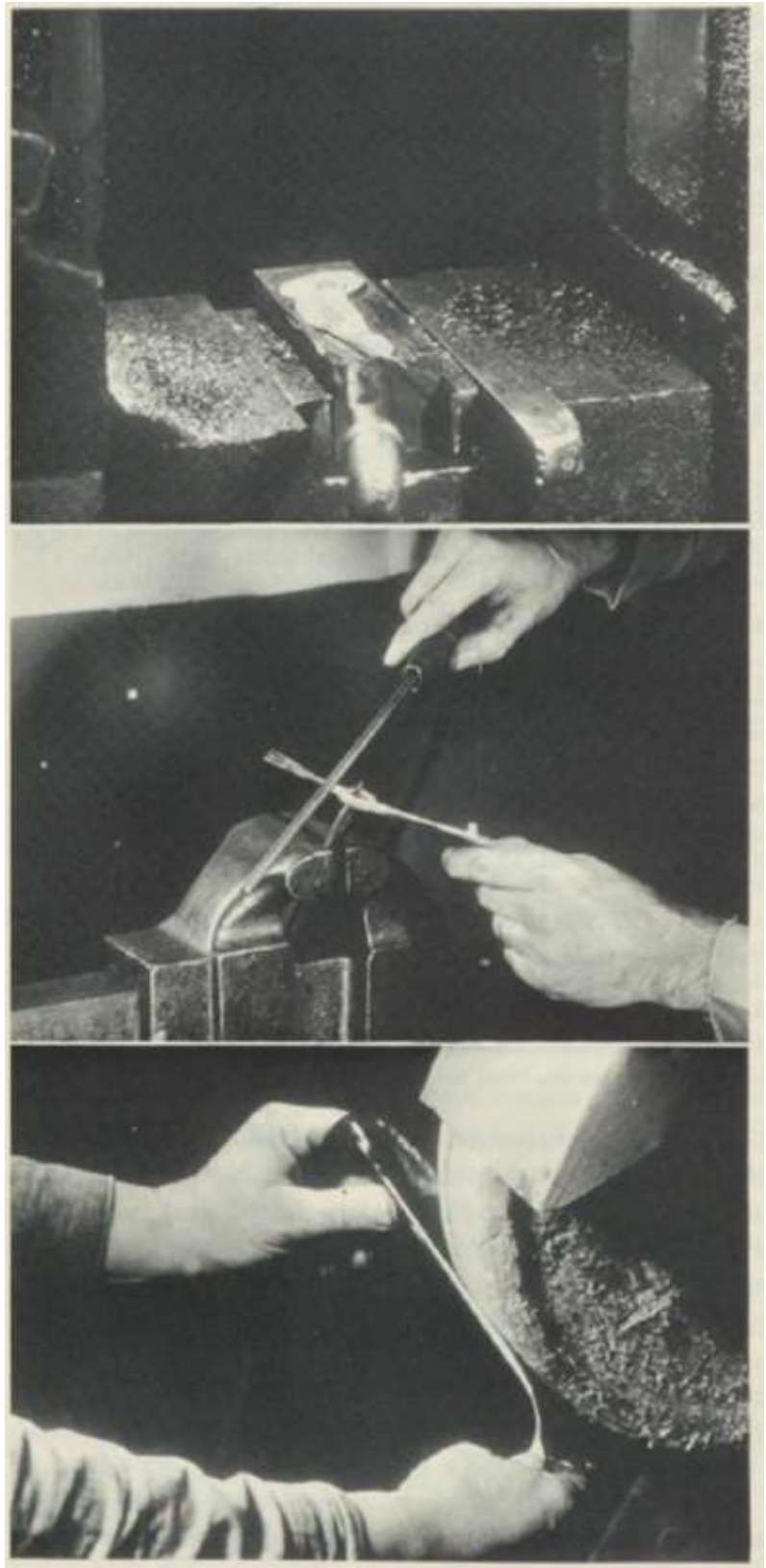
In 1940 the Army and Navy Munitions Board established a priority list for resources required by the War Department. Early on, Army medical supplies were given fourth priority (of eight) for producers to obtain the raw materials to produce end items. This only allowed for manufacturers to ask for permission to order those managed component resources, which might not actually be available. As the war continued priority ratings expanded. Initially, a major difficulty faced by the AMEDD was the lack of any group within the War Production Board (WPB, formerly the Office of Production Management and the Munitions Board), that was

“familiar with the needs for health supplies.” This was corrected with the Health Supply Section standing up within the WPB. Now the manufacturer requesting brass allotments for the internal mechanism in sterilizers no longer received ignorant denials or were confused with ordering quantities of gun cartridges by the WPB.

The newly “mobilized” American surgical instrument manufacturing base eventually delivered products valued at approximately \$25 million in 1943 and \$15.5 million in 1944 (\$435 million and \$265 million in 2023 prices). The national mobilization and focused effort to meet this critical “problem item” succeeded after many errors. The newly developed domestic capacity for surgical instrument manufacturing, and their ultimate delivery to Army surgical teams across the globe in WWII, contributed to the AMEDD’s success and the Allied overall victory in 1945.

Source: Anderson, Robert S. Medical Department, United States Army: Medical Supply in World War II, Office of the Surgeon General, Department of the Army, Washington, DC, 1968

These pictures depict the skilled benchwork of polishing surgical instruments following forging and milling.



*I have treated casualties; had blood-soaked hand[s] that didn't get washed for over a week until the blood finally rubbed off..." -Richard Sanner, WWII*

The first part of our newsletter concerns forming the force and getting medical professionals into uniform. The middle concerns people, their care and experiences. Lastly, our bookend is medical logistics during World War II, and mobilizing the right medical equipment for healthcare during wartime .

Please let us know your thoughts. We would like to hear your comments and are always seeking new articles for publication. Please visit our website and follow us on social media.

### 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 [usarmy.jbsa.medical-coe.mbx.office-of-medical-history@army.mil](mailto:usarmy.jbsa.medical-coe.mbx.office-of-medical-history@army.mil) Please contact us about technical specifications.

**The opinions expressed in The AMEDD Historian are those of the authors, not the Department of Defense or its constituent elements. The bulletin's contents do not necessarily reflect official Army positions and do not supersede information in other official Army publications or Army regulations.**

### AMEDD Center of History and Heritage

*Chief, Mr. Nolan Watson*

*AMEDD Museum 210-221-6358*

*History Branch 210-221-6958*

*Research Collection 210-808-3296*

<https://achh.army.mil>

