# With the Suddenness of War

## 1940–1943

*"But only through the agency of competent medical administrators will these medical practitioners be able to work to proper advantage in the new conditions created by war."*[1]

The President declared a state of limited national emergency on September 8, 1939, less than four months before General Metcalfe succeeded General De Witt as Post Commander.[2] The international situation steadily became more alarming, and on September 19, 1940, the American Army began calling reserve officers and nurses to active duty and increasing the troop strength. On October 1, the Out-Patient Service[3] at Walter Reed opened a *Physical Examining Section* to examine retired, reserve and National Guard officers prior to assignment or reassignment to active duty.

It was not only impractical but impossible that some old customs and strict procedures be maintained. As a result of the Act of November 29, 1940 (P.L. 884, 76th Congress), the Secretary of War was authorized to dispense with any part of the examination for promotion of Regular Army Medical, Dental and Veterinary officers *except* the physical examination.

Thereafter, with rapidity which was often confusing to interested bystanders, junior officers became field officers and hospital commanders, although the majority were without the prior leavening of experience which had formerly marked the transition in the Regular Army Medical Corps from ward doctor, section chief, chief of a service

and, in time and if the position was desired, hospital commander. Their staffs were, by and large, Reserve Officers on extended active duty or Army of United States personnel, men who may have practiced their profession in civilian institutions but who had rarely been attached permanently to an organization complete with regulations and insigne and where military rank rather than ingenuity governed their income. There would be adjustment problems for some, with the personal struggle of the individual reluctant to meet the organizational code reminiscent of the axiomatic proverb concerning immovable objects and irresistible forces. As a consequence, perhaps, a whole new era of military medicine was in the making.

Any appreciable increase in manpower affected the hospital system, which at best provided only a fifteen per cent emergency expansion in fixed beds. As the number of dependents likewise increased, at a time when the professional personnel situation was critical, the Secretary of War found it necessary to limit the medical care of dependents during the national emergency.[4] By May 27, 1941, the President had declared a state of unlimited national emergency, and personnel and training became ever-present problems to all types of Regular Army commanders, most of whom appeared to realize that war was almost inevitable. At the Army Medical Center, during 1940, the number of fixed


*Radio Station, 1940*

beds increased from 1,250 to 1,440. The area behind the old gymnasium, still used as a plant propagation field for the greenhouse, was selected as the site for new barracks and bachelor officers' quarters for additional reserve officers and Medical Department Professional Service School students.[5]

Within the hospital organization, the latent and usually unacknowledged morale problem of military service versus civilian personnel emerged clearly at the ward level. The difference in cash or take-home pay and hours of work for military and civilian personnel caused more than the usual dissatisfaction in the former group. Whereas an enlisted ward attendant received a cash salary of $360 annually for twelve-hour duty, and all of the amenities such as food and clothing, shelter, medical care, including indefinite absence from duty, the civilian employee received $780 annually, none of the amenities and a restricted fifteen-day sick leave. Some of the basic dissatisfactions would in time be reconciled somewhat through Congressionally authorized increases in military pay, but the psychology of group identification, i.e., the man in uniform versus the civilian, was deeper than the dollar value placed on service.

Judging from the early recommendations for meeting personnel shortages, General Metcalfe was in complete sympathy with the expressed sentiments of national policy groups, including medical, that all able-bodied men must train for combat. In fact, he went one step farther and openly advocated replacing all enlisted personnel with civilian employees. A year later, however, under the pressure of the expansion, he realized that a fluid civilian staff presented even more complications than a fluid military staff. Wages, hours, availability and preference for hospital employment affected the civilian group significantly. As both industry and the Army were competing for skilled as well as adaptable trainee personnel, hospitals, civilian and military, were compelled to be less selective in their employment practice than was desirable in the interest of economic management.

By 1941, a soldier-assistant appeared even more preferable than usual to the hospital commander, who noted in the Annual Report that "the enlisted men in surgical clinics and wards, to a great extent, have been replaced by civilian personnel, which on the whole has been a poor substitute, and valuable training for enlisted technicians has been lost."[6] Training, the ever-present responsibility of the military hospital commander, was not incidental to the care of the sick but inseparable from that care.

## Preparing for Mobilization

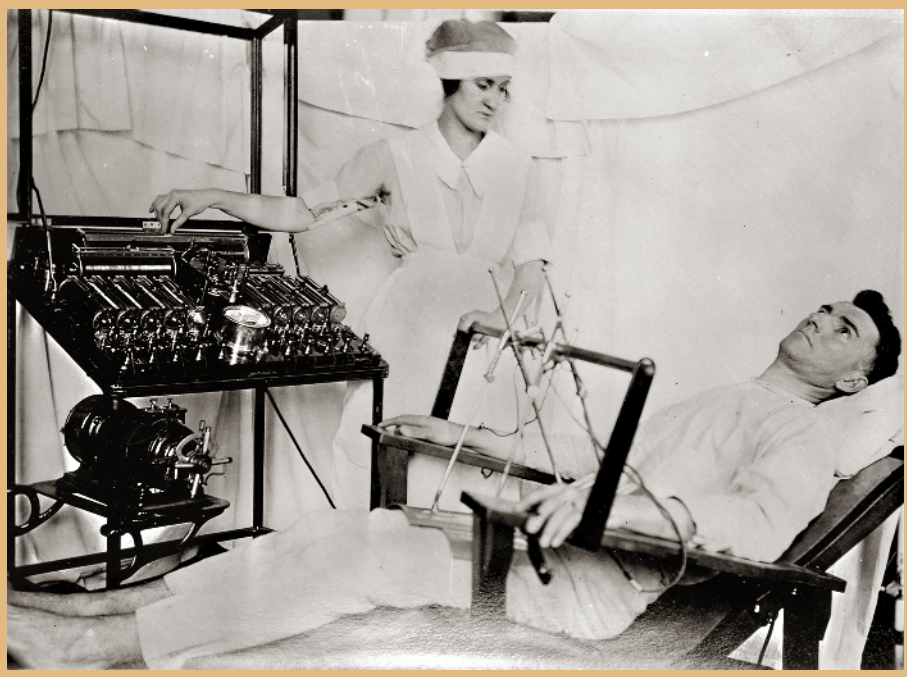
Recruits newly arrived at the Army Medical Center were assigned to the *Recruit Training Section* of the Headquarters and Service Detachment for three to four weeks of basic training. Following such training the more adaptable men were detailed to the Medical Department Professional Service Schools and to form a pool of qualified technicians, cooks, etc., for other Post activities and for stations in the field. Whereas the hospital and the School had long provided an indirect but steady flow of training technicians for other Army medical installations, the training program now had a three-fold objective: (1) maintaining the usual hospital activities; (2) maintaining the usual School

activities; (3) providing men trained in administration and general service (Headquarters and Service Section) for ultimate reassignment to holding or inactive units in the Troop Basis.[7] The third requirement created an especially difficult problem, for the current lack of Post housing and food service facilities did not then permit the training of a large number of men, while the overall demand for such personnel was mounting.[8]

All of the non-commissioned officers in the Walter Reed Detachment, men assigned to the hospital, were qualified to operate iron lungs and oxygen tents, and all wardmasters were trained in the latter technique. By and large, however, the general spread of Medical Department activities was so broad that it was necessary to have the men specialize in some aspect of the professional program. By November 11, 1940, a special training course was initiated which would prepare corpsmen for duty as assistants to surgeons in small hospitals. On December 1, fifteen corpsmen began a course in instruction in the duties of wardmaster and ward attendant.[9]

The Medical Service then controlled 807 beds and five cribs and conducted the usual specialty clinics. The number of consultations was increasing rapidly, for the military population of the District of Columbia had increased 400 per cent in 1940 and 1941. This placed an extremely heavy burden on the staff of the Out-Patient Service, which in 1941 attended 3,449 military personnel and 38,099 dependents.[10]

With one exception, the chiefs of the medical sections were still Regular Army



*1940, Bergonie Chair*

doctors, but Reserve officers were beginning to replace the ward doctors. Although they were well trained and conscientious "as would be expected, a certain amount of time (was) necessary for training them in the peculiarities of military medicine and government hospital administration."[11] By 1941, an attempt was made to correct such drawbacks by accepting fifty officers for one to three months of professional and administrative training at Walter Reed, prior to reassignment as directed by the Surgeon General's Office.

The Neuropsychiatric Section, perhaps even more than some other medical sections, was pressed for space and expanded to eight wards and 311 beds. Further, through a temporary arrangement with St. Elizabeth's Hospital, military patients could be transferred to that institution but remain under the administrative authority of Walter Reed. In order to expedite the professional care, two doctors, ten civilian nurses and three stenographers were assigned to St. Elizabeth's for temporary duty. The ten patients present on January 21, 1941, increased to 144 by July 31, but thereafter the number declined steadily until the program was terminated on December 31, 1941.[12] There were more than 400 fewer inpatients at Walter Reed in 1941 than in 1940; still, the administrative operations increased. The United States Government had already sent military observers' groups to many strategic areas, but the later large overseas hospitalization program had not developed, and so 413 patients were transferred from Panama, Puerto Rico, Bermuda, Trinidad, Greenland, Iceland and Newfoundland to Walter Reed during this year. The work of the *Disposition and of the Line of Duty Board* in this and other Army hospitals increased so rapidly that, as a further effort to economize on time and personnel, War Department Circular No. 217, October 15, 1941, permitted the former board to perform both functions.

Some other organizational changes were incidental to the mobilization program. For instance, in the spring of 1941, a sub-section of maxillo-facial surgery was established at the hospital, under the direction of the chief of the EENT Section. In August a joint course of instruction was inaugurated for medical and dental officers, with Colonel Roy Stout, Dental Corps, representing the latter service. A one-to-three month course in Orthopedic and Traumatic Surgery was given forty Reserve Officers with prior experience in this field, the course including ward administration and military routine. Further, five enlisted men were given a four-to-six month course in shop training, thereby becoming qualified brace-makers and fitters of prosthetic appliances. Although blood substitutes were still not in general use, both the liquid and dried type were provided by the Army Medical School, for use in the operating room at the hospital. Such substitutes, the professional staff decreed, not only had no ill effects on the patient, but they were more readily available for transfusions than the former system of individual typing or cross-matching with donor. As a further concession to time-saving factors, the hospital staff began using commercially prepared intravenous fluids, purchased through medical supply channels rather than made entirely at the laboratories of the School, with their depleted personnel.

Of the 22,355 patients examined in the various surgical clinics of the Walter Reed General Hospital during the year, 1,175 were gynecological. The increasing size of the Army was not confined to uniformed manpower, for 3,015 female patients attended the pre-natal clinic in contrast to the 1,182 of 1940, and 302 infants were delivered, in contrast to the 175 of the year before. It was necessary, therefore, not only to establish an appointment system for the pre-natal clinic, but as a matter of War Department policy, Army hospitals were allowed to admit female dependents on the Surgical Service for emergency work only.[13]

The demands for additional personnel and services were not confined to doctors, nurses and corpsmen, but included dieticians and physiotherapy and occupational sides. In an effort to cooperate with the Army training program, the *American Medical Association Council on Medical Education and Hospitals* reduced the usual one-year physiotherapy aide-training to six months, provided the half-year in theory and practice was supplemented by a six-month supervised practice period in an Army hospital.[14]

*Colonel Roy Stout, Dental Corps, Oral and Maxillo-facial Surgeon*

Civil defense preparations brought a large-scale redraping of many of the hospital windows with blackout curtains, including six rooms in the Obstetrical Section. An air conditioner was provided for the delivery room. Further, as there was always a possibility that the power system would fail during a bombardment, a new Army field X-ray machine, with film processing and drying units, was acquired for accessory and reserve (emergency hospital) functions. Corpsmen and civilian personnel were instructed in air raid precautions and fire fighting, and all wards and services were issued flashlights and other paraphernalia needed during such an occurrence.

## Increasing the Tempo

Brigadier General Shelley U. Marietta succeeded Brigadier General Raymond F. Metcalfe on February 1, 1941, and the Army Medical Center had for the third time in its history a former staff member and chief of a professional service as Post Commander.[15] As noted elsewhere, General Marietta's professional reputation required no enhancing.

Following the declaration of war with Japan, December 8, 1941, the tempo of hospital activities increased rapidly. Single rooms became two-bed rooms. Double rooms became three-bed rooms, and cubicles and wards were crowded to capacity as stand-by beds were set up. The 8,025 admissions for 1941 increased to 10, 818 during 1942, and providing satisfactory hospital service for such a number presented many difficulties. The patients

were restless, apprehensive over the mobilization objective, duration of emergency service and their families, in many instances still residing in the home communities. Hospital activities were influenced by an atmosphere of tension which had not characterized the World War I expansion period. In the former emergency, of short duration, evacuation of the wounded was not only a longer process, but the war was practically over before the peak load of evacuees began arriving in the United States, and few if any were returned to active combat. By the spring of 1942, however, when the convoys began arriving from North Africa, a global war had become almost a front-yard affair. Later, some patients followed the order of battle so closely that on occasion, as they underwent anesthesia, their last comprehensible mumblings were pleas for information on siege of Bizerte.[16]

Regular Army service or maintenance personnel was not only in short supply, but the demands of the civilian labor market, supported by increasingly tempting salaries, created such a grave civilian personnel situation that by September 1942, General Marietta was compelled to replace some civilian ward mess attendants with enlisted personnel in order to maintain the necessary services to the sick. There were no major changes in the hospital organization during the year. On the other hand, the changing type of cases admitted, such as an increasing number of burns, maxillo-facial injuries, orthopedic, paraplegic, infectious hepatitis and neuropsychiatric cases, required more medical and nursing care than usual. The principal interruption of professional activities arose from the requirements for training a large proportion of reserve officers, the majority of whom apparently had no prior service, while maintaining the usual high quality of medical care afforded the sick. Such an arrangement, while necessary to the war effort, placed a heavy burden on the staff and probably prolonged the hospitalization of some patients. Many patients objected to the rapid change in staff members as this interrupted the doctor-patient relationship so important in maintaining confidence and a sense of professional security, the lack of which retard physical and mental recovery in some types of cases. The Medical Service, with an authorized allowance of forty-three duty officers, had only thirty-three regularly assigned, who must also supervise 152 trainees and six internes on rotating assignments.


*Major General Shelley U. Marietta, February 1, 1941–February 9, 1946*

*New Addition to Red Cross, WRAH*

The enrollment of physiotherapy students not only increased, but four doctors from the Medical Department Replacement Pool[17] were given brief courses in this department during 1942. A Dieticians' Pool was organized in June 1942, to train in Army methods and procedures, and with a view to future foreign service assignments, dieticians admitted from civilian hospitals. The regular student training course was, like the course for aides, shortened from one year to six months. Regularly scheduled courses were conducted for mess officers, sanitary officers, enlisted cooks and mess stewards. Large numbers of officers from the Adjutant General's Departmental (nutrition) School made "field trips" to the hospital kitchens, messes and ward kitchens during the year. Further, the director of the Dietetic Department lectured monthly to the Medical Department Replacement Pool officers then being trained for unit assignment, and to newly assigned duty officers at the hospital.[18]

As a result of some defective commercially prepared yellow fever vaccine, the Army experienced an outbreak of toxic hepatitis in late 1942, with 116 cases admitted to Walter Reed from the United States and overseas stations. This unfortunate circumstance encouraged intensive study of this condition both at the Army Medical School and in other military medical installations. As was to be expected during a period when personnel faced

*The New Fire Station, located near the site of the old Lay Mansion, 1946*

increased exposure to the elements, there was an unusually large number of admissions for atypical pneumonia. Further, the doctors at Walter Reed noted that "a new drug, Penicillin, was tried for the subacute bacterial endocarditis."

The Surgical Service met many of the expansion problems which characterized the World War I period. Orthopedic surgery increased, and all of the attendant functions, such as plaster, X-ray and dressing rooms were concentrated on Ward 11, in the Main Building. Moreover, the brace shop began training additional brace-makers for overseas stations. An Orthopedic Branch of the occupational therapy program began functioning in February 1942 with diversional work carried on with bed patients. In December the entire Occupational Therapy Department was placed under the supervision of the Orthopedic Section. The Surgical Service likewise experimented with Penicillin, finding it especially helpful in treating osteomyelitis.

From May 16, 1942, until the end of December, 105 major neurosurgical operations were performed at Walter Reed, the work becoming so heavy that a separate section was established on December 26, under the direction of highly a trained civilian doctor, commissioned to and assigned to duty. The majority of the patients were directly or indirectly under treatment because of trauma, although the usual percentages of neo-

*Main Entrance, Forest Glen Section*

plasms, intractable painful maladies and congenital anomalies appeared. Of especial interest to the military service, thirty-nine patients were treated for intervertebral discs. As the war progressed and complaints of low back pain increased, distinction between discs, traumatic injuries of temporary nature and the fancied injuries of the neuropsychiatric casualty was a time-consuming process for doctors in the classified stations as well as those in the hospitals.[19]

The EENT and Maxillo-Facial subsection trained forty-one Medical Department Replacement Pool officers, in connection with a four-week course at the Army Medical School. In addition to the regular staff, a special detail of instructors was assigned which included Doctor John B. Davis of Baltimore and Doctors Robert H. Ivy and A.B. Batson of Philadelphia. Lectures, demonstrations, applications and visual aids were used in instructing the eighty-eight Dental and forty-seven Medical Officers so trained.

Pressed by bed shortages and too many patients, the Obstetrical Section, which had appeared busy when receiving thirty patients a month, was able to accommodate ninety by reducing the number of hospital days per patient. Thus, as a result of emergency economies, American women again adopted some post-partum habits of remote ancestors. The practice of early ambulation of the patient and early discharge from the hospital became so commonplace that by 1949 it was accepted therapy. In this, as in other sections of the hospital, able civilian doctors were in charge.

The Anesthesia Section (General Surgery) was especially busy, for in addition to the increased case load for surgery, the newly activated units required both doctor and nurse anesthetists. Some fifty-four one-hour lectures were given during the year. On October 1, 1942, six officers arrived for a three-month course in Anesthesia.[20] Replacement Pool officers assigned to temporary duty in this section were required to follow the established training program provided by the Surgeon General's Office. Twenty-one officers were so trained, all of whom received anesthesia assignments on departure from Washington.[21]

As the number of ward patients increased, the entire Red Cross welfare program expanded, and the Gray Ladies came into their own again. The Radiologic Section accepted Gray Ladies as chaperones for female patients, thus economizing on the services of nurses, for, like other sections of the hospital, the radiology work increased phenomenally. From 23,001 X-ray examinations in 1941, the number increased to 32,826 in 1942, with 720 consultations by mail. Further, an increasing number of diagnostic time-consuming procedures such as myelography, encephalography, venography and arteriography were performed in this department, directed by Colonel Aubrey Otis Hampton, a reserve officer on active duty, formerly Chief of Roentgenology, Massachusetts General Hospital, Boston.

In view of the steadily increasing number of carcinomas diagnosed at the Walter Reed General Hospital in the last ten-year period, formation of the *Tumor Board*, in 1942, is of special interest. This was encouraged by Major Milton Freidman, likewise a reserve officer on active duty. The board, composed of the chiefs of Medicine, Surgery, Radium Therapy, the pathologist and the senior roentgenologist, met weekly for discussion of all tumor cases with the ward doctors prior to adoption of specific therapy.

## Expanding the Army Medical Center

Neither time nor costs permitted construction of a significant number of permanent-type general hospitals during this period, and some military authorities believed it more practicable to convert existing structures to emergency use. The building program was not without complications and misunderstandings,[22] for in March 1942 the War Department formed a new overhead agency called the Services of Supply, a year later renamed Army Service Forces, for coordinating and streamlining emergency activities. The Army Ground Forces, Army Air Forces and the Army Services of Supply were established, and the geographically divided administrative areas of the Army, once known as *Departments*, then as *Corps Areas*, in 1943 became *Service Commands*. Further, and unfortunately from the Surgeon General's viewpoint, the general and station hospitals were transferred from the direct control of his office to the Service Commands, each of which, however, had a senior ranking medical officer in charge of Medical Department activities. Thereafter, in the case of the Army Medical Center, an "exempted" station, some administrative affairs were under the jurisdiction of the Third Service Command, Baltimore, Maryland, and some were under the Military District of Washington.

*Exterior View, Forest Glen*

During the summer of 1942, the Surgeon General's Office was directed by the *Services of Supply* organization to plan for emergency expansion by surveying hotels, hospitals and other buildings suitable for conversion to immediate use in the event of enemy action. In the meantime, a construction program was under way which would enable the Medical Department to provide increased hospitalization for troops in the Zone of Interior, the continental United States, and for long-term cases evacuated from overseas stations.

*Exterior View, Forest Glen*

In Washington and at Walter Reed, hospital authorities surveyed the adjacent neighborhoods of Takoma Park and Shepherd Park, apparently with some idea of adapting one of the larger apartment houses in the vicinity to convalescent use or as officers' quarters. In this as in other communities where civilian housing was to be affected, the proposal was unpopular. The Army Medical Center expansion problem was met through purchase, on September 1, 1942, of the National Park Seminary, a girls' school at Forest

*Main Recreation Room, Forest Glen Section*

Glen, Maryland. The buildings were heterogeneous, old and in poor repair, but the 185-acre tract was only four miles from the Center, and valuable. On one side it adjoined property of the Baltimore and Ohio Railroad, which afforded a way station, and excellent paved roads connected the tract with Washington and Silver Spring, Maryland.

The restoration and adaptation of the school structure was both more extensive and more costly than at first contemplated. By December 31, 1942, when the first patients arrived, 1500 people could be fed there, regardless of the fact that the principal features of the plant were incomplete. Called *The New Section, Convalescent Section* and finally the *Forest Glen Section*, the addition was used for the extended care of convalescents. Occupational Therapy and

Physiotherapy rooms were provided, and the Post Exchange and Library maintained branch services. In fact, except for the professional care of bed cases, administration at the Forest Glen Section emulated the usual Post functions so familiar at the Army Medical Center.

## A Distaff Branch

The National Capital Parks donated two greenhouses to the Army Medical Center in 1943. One was located, rather conspicuously, on the Georgia Avenue side of the reservation rather than behind the formal garden area with other greenhouses. The structure was dismantled by the Post Engineer, who salvaged eighty per cent of the wood and forty-five per cent of the glass. Half of the building was redesigned as a moving picture theater, and all of the equipment, including the picture screen, was furnished by the Army Motion Picture Service. General Marietta had long considered more extensive recreation facilities a necessity for enlisted men of the Post, but because of nearby community facilities, the movie project was not authorized by the Military District of Washington. Movies were shown only on the wards and in the Red Cross house, for patients; therefore, the makeshift "greenhouse theater" was a welcome addition to the recreational facilities of the command. The remaining half of the building was converted into a recreation room for the enlisted men. One company of service troops was assigned to the Center during the year, quartered at Forest Glen, and provided with appropriate recreation facilities in that area.[23] The remaining greenhouse was erected adjacent to other greenhouses under the jurisdiction of the head gardener.

*The Greenhouse; Enlisted Men's Game Room (later occupied by a snack bar)*

Lumber from a dismantled chicken house was used to convert an old granary into a rabbetry, for the hard-pressed Army Medical School. About 200 shrubs were replaced, and at Forest Glen, some 1,000 pieces of mixed trees, shrubs and evergreens were added. The plant heating facilities of the Center were expanded; a second story was added to the Guard House, and in the Main Building the air conditioning apparatus, installed in 1934, was removed to the attic in order to provide additional space for hospital activities. A radiation therapy extension was completed in October 1943, and a 100,000-volt, a 200,000-volt and a 1,000,000-volt therapy room were installed. In July 1943, facilities were prepared for housing a forty-piece band at Forest Glen.[24] New tennis courts were constructed as the personnel increased, and schedules at the Rea swimming pool were modified to accommodate the increased members. Road maintenance and upkeep was constant throughout the Post, and the usual repair, utilities and enlargements were made as required in a rapidly expanding organization.

Lt. Colonel Gertrude L. Thompson, Principal Chief Nurse at Walter Reed following Miss Keener's retirement in the summer of 1943, faced a hard four-year period during which demands for nursing service increased rapidly. Supervision of the auxiliary training program for WAC's, nurses and corpsmen was a function of her office, as well as increased responsibilities which came at a time when she had fewer Regular Army nurses as assistants. Petite, agreeable and scholarly, Colonel Thompson had a quietly expressed preference for being addressed as "Miss," and she seldom invoked the "official" title of her office.

The Women's Army Auxiliary Corps was authorized on May 14, 1942 (Public Law 554, 77th Congress) without full military status or the corresponding military grades afforded the Regular Army, inequalities which were corrected in the reorganization of the Women's Army Corps a year later. The pre-authorization public relations material featured the Auxiliaries as numerical replacements for able-bodied enlisted men required by the combat forces, and this idea became firmly fixed in the minds of some military authorities, including key personnel in the Surgeon General's Office.

Organization of such a Corps had strong Congressional support from Congressman Edith Nourse Rogers, of Massachusetts, a Gray Lady at Walter Reed during World War I, and from influential military leaders such as the Chief of Staff, General George Catlett Marshall.

At the time of organization, the Surgeon General and the Superintendent of the Army Nurse Corps objected to using WAC's as hospital attendants. The Surgeon General believed such a policy would result in dismissal of faithful civilian employees, as well as creating a housing problem. The Superintendent of the Army Nurse Corps disapproved on the general principle that non-professional personnel, including nurses' aides, should not care for patients.[25] As personnel shortages became acute, circumstances forced a reevaluation of Medical Department policy. Because of an already critical housing situation for the Troop Command, as well as the inherent problems of administering two classes of enlisted personnel, both General Marietta and his executive officer, Colonel Thomas Hester, MAC, resisted the assignment of WACs as long as possible.[26] However, as Walter Reed was in the spotlight of national affairs, in proximity to WAC (policy) headquarters, it afforded an excellent background for public relations and recruiting media featuring the WAC. It was, therefore,

a foregone conclusion that Walter Reed, as the Army's best-known general hospital, would have a detachment of women.[27]

> *On June 1, 1943, a group of enlisted members of the WAC were assigned to duty in ward kitchens, replacing a like number of soldiers, and, with additional WACs arriving periodically, their total strength in the Dietetic Department (was) forty-six, thus relieving an equivalent number of men. Two WACs (were) Staff Sergeants serving as assistant stewards and two (were) corporals.*[28]

An old landmark lost part of its identity in December 1943 when Building No.7, the enlisted men's barracks, underwent modest transformation into barracks for female enlisted personnel. A beauty shop, laundry tubs and ironing boards were installed in the basement, with clothes lines in the basement and on the second floor porches. The former recreation and lounge rooms were expanded and equipped for women.

The early public relations media claiming that women could serve as numerical replacements for men created problems for the Director of the WAC as well as for some hospital commanders. The former, responsible for the morale and efficiency of the women only, and the latter, responsible for the morale and efficiency of an entire organization, thereafter including women, plus his primary mission – care of the sick – sometimes found their mutual problem difficult to solve. As a result, the Medical Department, including the Commanding General of the Army Medical Center, was criticized for showing a lack of understanding of the problems of women, poor utilization and the misuse of enlisted women beyond the limits of their physical endurance. In fact, in the opinion of some WAC officers,[29] the Medical Department was an organizational "Simon Legree" of the worst order.

For a time some Army nurses allegedly resented the assignment of WACs to ward duty, viewing them only as female orderlies or manpower replacements as promised by recruiting propaganda and not as equally fragile members of the reputedly weaker sex. Some enlisted men resented the arrival of the enlisted women; and many believed the women were favored in the matter of ratings. The situation was in some respects like the earlier objection of the hospital stewards and corpsmen to the Army's use of graduate nurses. Although the WACs had basic training, drill, were instructed in social hygiene, gas-mask drill and, after conversion to the WAC in August 1943, attended many of the same orientation lectures, they were for at least two years something of a public curiosity. Unavoidably, since progress is ever painful, some civilian and military staff members accepted them as such. Some of the early job-placement difficulties developed from the too literal interpretation of "the law," for insofar as heavy work was concerned, the women were not one-for-one replacements for men. By the end of 1943, it was obvious to administrative officers and Walter Reed that

> *In the progressive replacement of male by female technicians, a minimum of men is necessary for certain work, such as heavy lifting, unpleasant clean-up duties, morgue or veneral work.*[30]

The Laboratory Service, whose procedures increased in proportion to the 18,046 inpatient admissions for the year and which had voiced longstanding complaints over both the quality and inconstancy of technical personnel, apparently welcomed the WACs more enthusiastically than some of the other hospital sections. The first WACs were assigned to the Laboratory in July, and by the end of December, twelve were on duty in this section, the Laboratory officer noting that his problem was minimal, for

> *As a whole they were professional medical technicians before entry into military service and hence, they were rapidly assimilated.*

As was to be expected, the fact that both male and female personnel believed themselves appreciated and necessary to the war effort contributed to harmonious working conditions. In fact, the Laboratory officer wanted at least twenty-five to thirty-three per cent of the staff to be in this category. With the change from WAAC to WAC, only twenty per cent of the auxiliaries at the Army Medical Center requested release in comparison to twenty-five per cent at other stations.

During the first year of their assignment the days lost by women on furlough never exceeded ten per cent; no days were lost for *Absence Without Leave*, arrest or confine-

*Reviewing the Lady Soldiers.*

ment in the guardhouse. The average duty strength from July to December, 1943, was 141.15; the women had so proved their abilities that General Marietta noted cautiously in the Annual Report that "the arrival of WAC personnel entailed considerable office work at the outset; however, their efficiency as soldiers had greatly overshadowed the problems first encountered."

## Associate Activities

The 28th Portable Surgical Hospital was activated at Fort George C. Meade, Maryland, on June 14, 1943, and transferred to the Army Medical Center on September 6. The Commanding Officer and a cadre of six enlisted men were present for duty, and two surgeons and one internist joined later.

The transient unit personnel had almost doubled by September, and activities transferred to the Military District of Washington required the maintenance of new files and the initiation of new procedures. Essentially a responsibility and a function of the Medical Service of the Army Ground Forces, the portable surgical unit was developed to create a self-sustaining portable hospital capable of portage over terrain inaccessible to motor transportation. The training emphasis was placed on emergency nursing and surgical procedures and individual protective measures against the enemy. Although the unit had not actual maneuver experience, its activities formed the basis for preparing experimental work reports to the Surgeon General's Office. The unit headquarters, for organization and personnel, was established at the Army Medical Center, but the unit supply depot was at the Forest Glen Section. The men lived a life of simulated field activity, housed in pyramidal tents erected on the old playing field, on the north side of the reservation.

In preparing the final report of this experiment for the Surgeon General's Office, military medical authorities agreed that both officers and men should be general service personnel (rather than specialists), the former as graduates of the Medical Field Service Training Course at Carlisle Barracks, and that the unit should have maneuver experience, with all of the supplies and equipment functionally marked at supply depots prior to issue.[31]

The presence of this unit did not directly affect the hospital staff or the inpatient care, but its location and association with the organizational set-up of the Army Medical Center was reminiscent of the early post-Spanish-American War plans. At that time the Companies of Instruction formed the basis of determining the training and equipment required by the medical components of a field medical Army; and because of this a Field Hospital was assigned in conjunction with the Walter Reed General Hospital when it was opened for service in 1909.

## References

1. Editorial: *Military Surgeon*, Vol. XLI, 1917, pg 721.

2. From December 26, 1939 to January 31, 1941.

3. Called Service rather than Clinic in order to agree with later designations.

4. AG 702 (11-28-40) M-A-M (Ltr of Dec. 18, 1940).

5. Annual Report, WRGH, 1940.

6. *Ibid*, 1941.

7. The overall planning program for present and future military activities. The Troop Basis is ordinarily forecast a year or more in advance, but in periods of military activity it is under constant study and revision.

8. Annual Rpt. WRGH, 1940.

9. *Ibid*, In evaluating Medical Department training activities at the Army Medical Center, it should be recalled that the medical doctrine is prescribed by the Surgeon General's Office.

10. In terms of visits, or treatments.

11. Annual Rpt. WRGH, 1940.

12. *Ibid*, 1941.

13. AG Ltr. 18 Dec. 1940. As the war progressed all regulations governing the medical treatment of dependents were tightened, and dental care was eliminated for all cases except extractions and actual emergency work.

14. Annual Rpt. WRGH, 1941.

15. Percy M. Ashburn, CO from Sept. 19, 1915-October 5, 1916, was Chief of the Medical Service and Adjutant.

16. Personal knowledge of the writer.

17. Pools were established for all classes of personnel, in order to provide ready assignment or replacement.

18. Annual Rpt. WRGH, 1942.

19. *Ibid*.

20. One additional student joined later.

21. Annual Rpt., WRGH, 1942.

22. Blanchfield, *Organized Nursing and the Army*, *op cit*.

23. Annual Rpt. WRGH, 1943. In this case the service troops were Negro.

24. The hospital had a band for a short time during World War I, and during the early twenties, an orchestra.

25. Blanchfield, *op cit*.

26. Conversation, Col. Thomas Hester, MAC, 1943.

27. Interview, Miss Mattie Treadwell, WAC Historian, 1946-1950.

28. *Ibid*, and informal review of the official history of the WAC organization.

29 *Ibid*.

30. Annual Rpt. WRGH, 1943.

31. *Ibid*.