MEDICAL CARE of VETERANS

APRIL 17, 1967

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1967

Washington, D.C. 20402 - Price $1.25 (paper covers)
Under the direction of Robinson E. Adkins, this publication describes the origin of veterans benefits and reviews the activities and evaluation of the Veterans Administration. Primary emphasis is on the Department of Medicine and Surgery. Major topics covered are: (1) Revolutionary War; (2) Civil War; (3) National Home for Disabled Volunteer Soldiers; (4) Spanish-American War; (5) Philippine Insurrection; (6) Boxer Rebellion; (7) World War I; (8) the Veterans Bureau; (9) the Veterans Administration; (10) World War II; (11) the postwar period; and (12) modern medicine. There is no index nor bibliography included.
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FOREWORD

The Committee on Veterans' Affairs welcomes this publication, the latest in a number of histories and studies depicting the origin of veterans' benefits and a review of the activities and growth of the Veterans' Administration with primary emphasis to the Department of Medicine and Surgery.

This work was prepared under the direction of Robinson E. Adkins, affectionately known as "Bob" throughout the Veterans' Administration. It is a simple statement of fact that Bob Adkins is the most beloved man ever to serve in the Department of Medicine and Surgery.

In compiling this history Mr. Adkins was assisted by several individuals who had experience in this overall field, but particularly by Guy H. Birdsall, the distinguished former General Counsel of the Veterans' Administration, and prior to assuming that office Chief of the Legislative Service of the Veterans' Administration. Mr. Birdsall's knowledge of Veterans' Administration laws and regulations can best be described as "encyclopedic." Because of the unique contribution of these two individuals the present study is more than usually welcome.

The Committee on Veterans' Affairs in recent years has worked in close cooperation with the Veterans' Administration, and it is my hope that we will continue to do so. Some of the laws which this committee has taken the leadership in developing were not initially supported by the Veterans' Administration. It is encouraging to report that after the laws have been in operation they are without exception fully supported by the agency, and in some instances, we believe, viewed with pride. To name but a few of the programs in which Congressional leadership has been paramount:

- The Korean GI bill of rights with the emphasis on the responsibility of the individual veteran;
- The pre-hospital-care program;
- The furnishing of a statement of the case to the veteran claimant as a part of the adjudication procedure;
- The requirement of findings of fact and conclusions of law in the decisions of the Board of Veterans' Appeals;
- The War Orphans Educational Assistance Act;
- The Dependency and indemnity compensation program;
- Group life insurance program for members of the Armed Services;
- The 125,000-bed ceiling in VA hospitals;
- Greater utilization of independent medical reviews;
- The 12-year construction program for new hospitals;
- The concept of non-service-connected pension embodied in Public Law 86-211;

The nursing home care program authorized by Public Law 88-450 providing 4,000 nursing home beds in the Veterans' Administration medical system, utilization of the same type of care in community nursing homes and implementation of the State home system for this care, and aid in the building of new facilities for this purpose;
PREFACE

From the very inception of Government-sponsored programs to meet the needs of the defenders of our Nation, efforts have been made to provide medical care and treatment, first to veterans with service-connected injuries and then, under certain conditions, to those veterans whose medical needs are not directly related to their military service. In the beginning, these services were provided by many different agencies of the Federal Government and by some State agencies. It was not until 1930, with the establishment of the Veterans' Administration, that these services were centralized into one agency of the Government, with a Medical Service designated to be responsible for all activities associated with medical care and treatment. Finally, by the act of January 3, 1946, Public Law 293, 79th Congress, the Medical Service of the Veterans' Administration was reorganized as the Department of Medicine and Surgery, which is now responsible for the largest medical and hospital system in the world designed solely for the care and treatment of veterans. This system has served well the dominant health needs of eligible veterans.

The Veterans' Administration medical program, as we now know it, has evolved over the years from many divergent sources. It has gone through, and will continue to go through, a process of expansion, development, and refinement of procedures and concepts of medical care and treatment, as the need for change is demonstrated.

Unfortunately, up until now, no comprehensive history of this program and its evolution has ever been recorded. Much of the material necessary for such a history is not readily available, since some of it is not centrally located, and some is retained only in the minds of individuals who were closely associated with the program down through the years, many of whom have left the Government service. A study and compilation of such a history could, therefore, be accomplished only by an individual who is keenly interested in his subject matter, and has had many years of experience with the Veterans' Administration medical program. Mr. Robinson E. Adkins, who is responsible for this compilation, is such an individual. He was associated with the Department of Medicine and Surgery from its inception. He has to a great extent been one of the guiding forces in the growth and development of the Department as we now recognize it. (See attached biographical sketch.)

This compilation has resulted from a painstaking assembly of a mass of material from many sources, some documented and some based upon actual experiences and recollections. It would not have been possible without the indefatigable labors of Mr. Adkins and those who assisted him in this endeavor. Mr. Adkins has expressed his appreciation for the assistance given him by Mrs. Grace M. Nesbitt, Mr. Guy Birdsall, Mr. John E. Dineen, Mr. Charles H. Cooke, Mr. Henry H. Meyer, and Mr. Francis A. Hunt, as well as the staff of the Medical and General Reference Library, the members
of the creative arts and audiovisual services, and by many other persons who contributed their time and special knowledge.

Mr. Robinson E. Adkins

Born in Oswego, N.Y., on July 12, 1894, Mr. Adkins was graduated from the State University of New York College in that city, and also attended Columbia University. He served 22 months with the American Expeditionary Forces in France during World War I.

He entered Government service in September 1919 as a training assistant for the Federal Board for Vocational Education (a predecessor agency to the Veterans’ Administration).

In 1926, he was appointed business manager of the Sunmount (N.Y.) Veterans' Hospital, and from 1929 to 1938, he served in the same capacity at the Rutland Heights (Mass.) VA Hospital.

In January 1938, he was transferred to the VA central office in Washington where he served until his retirement in February 1963.

In the Washington headquarters he progressed to increasingly responsible posts in a wide range of VA activities, and served for a time as an executive assistant to the Administrator of Veterans Affairs.

From May 1946 until his retirement, Mr. Adkins was executive officer in the Department of Medicine and Surgery. In this position he acted as the principal administrative adviser and top assistant to VA Chief Medical Directors Hawley, Magnuson, Boone, and Middleton.

He received VA’s highest honor—the Exceptional Service Award—in 1960, and holds an honorary fellowship in the American College of Hospital Administrators.
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(vii)
Reunion of the army of the Cumberland at the Old Soldiers' home in Milwaukee.

... to care for him who shall have borne the battle ... and for his widow and his orphan ... —A. LINCOLN
INTRODUCTION

During one of the more difficult periods in the functioning of the medical care program of the Veterans' Administration, there was appointed a special subcommittee of the Senate Committee on Labor and Public Welfare to investigate Veterans' Administration policies with respect to hospital administration. This was in 1951 and the membership of the subcommittee consisted of Hubert H. Humphrey, chairman, Lister Hill, Paul H. Douglas, Wayne Morse, and Richard M. Nixon.

In their report dated August 2, 1951, there was a significant passage on the opening page:

The medical care program of the Veterans' Administration is one of the largest in the world ***. Obviously, a program of this magnitude is one of considerable and continuing interest to the Congress and the people of the United States ***.

That interest *** is considerably heightened by the fact that during the last few years the quality of the medical care available to the beneficiaries of the Veterans' Administration has been raised to a point where it unquestionably represents the best medical care available anywhere in the world at any time in the world's history.

When one realizes that this program also represents an attempt on the part of Congress to partially discharge our obligation to the men and women who have offered their lives in defense of our country, it is obvious that anything materially affecting that program should be of immediate concern to the Congress.¹

In that passage, the subcommittee was echoing a sentiment that has existed throughout the world as far back as history is recorded. To trace the development of the medical programs in various countries is a purpose of this book. This theme was most eloquently set forth in the famous speech by Abraham Lincoln.

When on March 4, 1864, Abraham Lincoln took the oath of office for the second time, our country was in the throes of a grueling war. In the moving conclusion of his second inaugural address, Lincoln expressed the philosophy that has guided the Veterans' Administration, its functional and organizational forerunners and, indeed, the entire U.S. Government, in dealing with veterans, especially those disabled. He said:

With malice toward none; with charity for all; with firmness in the right, as God gives us to see the right, let us strive on to finish the work we are in; to bind up the Nation's wounds; to care for him who shall have borne the battle and for his widow, and his orphan—to do all which may achieve and cherish a just and a lasting peace, among ourselves, and with all nations.

There was widespread comment on this famous speech, concerning which Carl Sandburg wrote, in his biography of Lincoln: "Seldom had a President been so short-spoken about the issues of so grave an hour."²

Moving back again, in time, to a point three centuries before Lincoln's day, we find the theme of this history well expressed in an early statute which implanted in the minds of the English colonists who came to America a strong sense of public responsibility to those who became disabled through war service.

The English Parliament, in its 1592-93 session, passed "An Act for the Relief of Souliours," to provide for those soldiers and sailors who had served since 1588, the year of the British defeat of the Spanish Armada. This statute is what is called, in legal terminology, a "foundation document". It is, in fact, the cornerstone of the entire structure of the American compensation and pension system, and Federal care for disabled veterans, that came into being centuries later. It reads, in part: (the old-style spelling will be dropped for clarity's sake)

For as much as it is agreeable with Christian Charity, Policy, and the Honor of our Nation that such as have, since the 24th day of March, 1688, adventure their lives, and lost their limbs, or disabled their bodies—or shall hereafter adventure their lives, lose their limbs, or disable their bodies in defense and service of Her Majesty and the State—they should, at their return, be relieved and rewarded to the end that they may reap the fruit of their good deservings, and that others may be encouraged to perform the like endeavors; be it enacted * * *

One provision of this historic statute is worthy of note here. It established that payments to disabled veterans—not to exceed 10 pounds a year to a private soldier and 20 pounds to a lieutenant—were to be made on the basis of the degree of disability, the maximum to be set by law. This is the same basis on which payments are made to veterans in the United States today, with two important differences—namely, that officers and enlisted men receive equal payments (unless retired for disability) and that, while in 16th century England the "maximum degree" was set by "Justices in Quarter Sessions," in 20th century America it is determined and established by a board, one of whose most important functions is medical appraisal.

THE TOLL OF WAR

Since the Declaration of Independence was signed 190 years ago, the United States has spent a little over 33 years, when added together, fighting in seven major wars, the Korean conflict, and the military action in Vietnam. Also, in the century from 1790 to 1890 there were numerous small wars consisting of encounters with Indian tribes; although these Indian "wars" were spread out over such a long period, the number of men participating in each was small.

Figures on the number of personnel participating, killed, and wounded in U.S. wars from the Revolution to the Korean conflict vary from one history book to another, because the careful keeping of military and naval personnel records was not common in the 19th century. But the most conservative estimates in recent years—with the Department of Defense, the Veterans' Administration, and the Library of Congress conferring—show that, in all U.S. wars from the Revolution through the Korean conflict, 31,453,000 participated, 972,000 were killed, and 1,281,000 were wounded. There were

25,013,000 living U.S. veterans at the end of 1966. (Figures on Confederate participants killed and wounded in the Civil War are not included in any official U.S. Government statistics.)

During each war, those on active duty, as well as their people at home, hopefully looked forward to peace and the return of those men who would, on release from the service, become veterans.

Many, as the above grand total statistics show, did not return, having given their lives for their country; but from out earliest days, provision has been made for their surviving families.

THE STORY OF MEDICAL CARE

Many more came back maimed, suffering from wounds or disease. This book, following selected background material designed to make clear its historical frame of reference, tells the story of the medical care of this class of U.S. veteran. This care, which has long been one of the most important self-decreed obligations of our Government, is supplied today by 165 Veterans' Administration hospitals, 18 domiciliaries (including 2 restoration centers), and 211 outpatient clinics. They all operate under the "VA Pledge of Service" which often appears beneath the Veterans' Administration seal:

The VA is dedicated to administer veterans' laws efficiently, expeditiously, and with sympathetic understanding, and to exercise constructive leadership in veterans' affairs.

Millions of veterans, or their dependents, receive compensation, pension, or insurance checks regularly through the mail from the VA. There are also some 6 million people who, on matters of medical care or other than medical benefits, annually get in touch with the VA by correspondence, phone calls, or visits to its regional offices, clinics, and hospitals.

Veterans' benefits have evolved so elaborately down the years that the Administration, although not a Cabinet department, has more employees than any Cabinet department except two—Defense and Post Office—and larger expenditures than any Cabinet department except for Defense; Health, Education, and Welfare; Agriculture; and Treasury Department.

The Veterans' Administration—
Operates the third largest insurance company in the world;
Administers a loan guarantee program that has been responsible, since the end of World War II, for the building of about one out of every five homes in America;
Employs about 4 percent of all the Nation's doctors; and
Provides opportunities for part of the training of almost one-half of the approximately 7,500 doctors graduating each year from U.S. medical schools.

Additionally, in the field of medicine, the VA is the Nation's largest single employer of nurses, clinical and counseling psychologists, dietitians, medical and psychiatric social workers, physical and occupational therapists.

On sheer magnitude alone, therefore, it would seem well justified to compile and publish an account of the VA's Department of Medicine and Surgery, and how it grew. (The Department of Medicine and
Surgery is one of the VA's three major departments, the others being Veterans' Benefits and Data Management.

A PRINCIPLE IN ACTION

History shows that the American people, acting through their Congress, have supported the principle that a man who devotes part of his life—usually his young manhood—to defend his country, should be offered advantages over those who do not. Up until World War I pension was the only benefit bestowed upon the veteran except, following the Civil War, when the National Home for Disabled Volunteer Soldiers came into existence. Domiciliary care in which medical treatment was incidental was provided for the eligible veteran.

With the onset of World War I, and before that war was over, a new philosophy was developed in this country for the care of the veteran. This included voluntary insurance; allotment and allowance to take care of his family during his service; reeducation of those disabled who could not return to their former occupations or suffered loss of earning power due to such disablement; and disability compensation and medical and hospital care for those suffering from wounds or disease incurred in service.

During the early days of World War II this philosophy was expanded to provide all veterans with an opportunity to reroot themselves educationally and economically back into the life of peace from which they had been snatched by war. Additional provisions included educational opportunities, regardless of disability; loan guarantees for the purchase of homes or establishment of business or farm enterprises; and a readjustment allowance to tide the veteran over financially until employment was secured, for a maximum of 52 weeks.

TARDY PENSIONS

Since World War I, Congress has been swifter to act in behalf of veterans than it had been prior to that war. No really effective legislation in behalf of veterans of the Revolution was passed until 1833, 52 years after the war was over. Service pensions for veterans of the War of 1812 were granted 59 years later, in 1871; and for veterans of the Mexican War, which ended in 1848, 39 years later in 1887. The first pensions for veterans of the Civil War were paid 25 years after the conflict ended, and the Spanish-American War was over for 18 years before its eligible veterans received their pension benefits. Pensions for certain World War I veterans were provided for in 1930, 12 years after the Armistice; and this same benefit is applicable to veterans of subsequent conflicts. Since then the tendency of modern Congresses has been to increasingly help the veteran reach that level in life which he probably would have achieved had military service not diverted him from his normal life.

SOME DEFINITIONS

VA benefits and services are generally available to all eligible veterans who have been discharged from the Armed Forces under circumstances other than dishonorable. The eligibility of a particular veteran for a particular benefit or service is spelled out in detail in Title 38—Veterans Benefits, of the United States Code.
In the past, the terms “compensation” and “pension” as veterans' benefits in the United States have often been used loosely and indiscriminately, even in some public laws. But since the codification in 1958 of all veterans' benefits under Title 38, the terms have had definite meanings. For practical purposes, these meanings might be re-expressed in the following nonlegal language.

“Compensation” is a monthly payment for a disability incurred in, or aggravated by, military service. “Pension” is a monthly payment for a permanent and total disability not traceable to military service, subject to income limitations.

At present, the lowest compensation is $21 a month, for what is technically rated as a 10-percent disability. Compensation for the loss of certain vital organs or functions of the body may go as high as $600 a month in extreme cases, or even $850 if the veteran has dependents.

There are also medical conditions under which a service-disabled veteran of World War II or the Korean conflict may be given $1,600 toward the purchase of an automobile or other conveyance. There are conditions under which part of the cost of specially adapted housing, with ramps instead of stairs—and other appurtenances—will be met by the Government for veterans who suffer service-incurred disabilities which prevent them from walking normally.

As for veterans receiving pension, rather than compensation, benefits, there are two categories: those who were on the pension rolls on June 30, 1960; and those who came on after that date. Veterans in the first category have the right to be transferred to the second, but once they so choose they may not change back to the first.

In the first category of pensions, payment is granted when a veteran's income does not exceed $1,400 a year if he is unmarried, or $2,700 a year if he is married or has a minor child. The payment is $66.15 a month, or $78.75 if he is over 65 or has been permanently and totally disabled for over 10 years. If he is in need of aid and attendance, he receives $135.45 a month.

In the second category of pensions, the veteran receives $100 a month if his income is under $600; $75 if it is between $600 and $1,200; and $43 if it is between $1,200 and $1,800. For aid and attendance, if necessary, he receives $100 over and above his basic monthly rate.

For the wives, dependent children, and dependent parents of veterans receiving compensation payments, and the wives and dependent children (but not dependent parents) of those receiving pension payments, there are provisions which are specified in detail in Title 38, both while the veteran is living and after his death. Even in this field of a veteran's dependents, the principle of extending ampler benefits and services for disabilities connected with service, than for those not so connected, is basic throughout veterans' legislation and Veterans' Administration practice.

“Service pensions,” paid with no relation to the size of a veteran's income, are a special category of pension paid monthly to the fast dwindling number of veterans of the Spanish-American War. There are two rates: one for those who served 70 to 90 days; a somewhat larger one for those who served 90 days or more.

(In all references to veterans' benefits, the term “Spanish-American War” includes the Spanish-American War itself, the Philippine Insurrection, the Boxer Rebellion, and the hostilities which lasted until 1908 in the Moro Province of the Philippine Islands.)
The GI legislation of World War II—much of which was passed before that war was over and later amended to include veterans of the Korean conflict—and finally all who served at least 181 days since January 31, 1955—contained far-reaching provisions for loans, education, and insurance. The following tabulation will give some idea of the range of modern activities of the Veterans' Administration.

(1) The agency has administered, as of January 1966, a GI loan program of 71,000 farm loans, 238,200 business loans, and 6,100,000 home loans. These have totaled over $62 billion, of which $30 billion are outstanding. Veterans' monthly repayments or repayments in full have been outstandingly dependable. Defaults on home loans, for example, have been only 2.1 percent of the total of loans granted. The veteran becomes a homeowner with strong roots in his community.

(2) One reason why so many veterans have proved to be such excellent debt-paying citizens, with better than average incomes, is that almost 11 million of them improved their education and training under programs famous not only for helping veterans in particular but also for what they did for American education in general. This GI education was made available to all veterans, and veterans began to distinguish themselves on the Nation's campuses.

Special vocational rehabilitation training has been given to some 700,435 service-disabled veterans of World War II, the Korean conflict, and the post-Korean period. Of those so rehabilitated, 95 percent are now gainfully employed. The precedent for providing vocational rehabilitation for service-disabled veterans was set in World War I. A veteran prevented by service-incurred disability from resuming his former occupation is given all the medical attention, the vocational training and counseling, and, when necessary, the prosthetic appliances which will enable him either to resume that occupation with a new technique, or to undertake an entirely new one. The amputee, the blinded, the paralyzed veteran began to take positions on factory assembly lines, on teaching faculties, as accountants, etc.

(3) The Orphans' Educational Assistance Act, administered by the Veterans' Administration, provides educational benefits for the orphans of those veterans whose death was a result of wartime or peacetime service, as well as children of certain seriously disabled living veterans.

(4) Today, veterans hold almost 6 million insurance policies, valued at nearly $40 billion and making the VA the third largest standard life insurance business in the United States. An interesting item here: the lower than anticipated mortality rate of veterans permits declaration of generous dividend payments. From January 1961 through January 1966, a total of well over $1 billion in special and regular insurance dividends was declared. Since the vast majority of veteran recipients of these dividends use the funds for otherwive postponed or canceled expenditures, the beneficial effect upon the national economy has been substantial.

Most legislation for veterans is intended to help them live their adult lives efficiently and happily as respected and productive citizens. Even at the time of death, the Nation pays its respects to veterans.
The VA pays $250 toward funeral expenses, provides the flag that decorates a deceased veteran's casket, and also renders assistance in arranging with the Department of Defense for his burial in a national cemetery, if desired.

Compensation, pension, loan, vocational rehabilitation, and insurance operations are the responsibility of the Department of Veterans' Benefits of the Veterans' Administration.

The Department of Medicine and Surgery is responsible for all medical and related benefits:

1. VA outpatient clinics provide, generally, only for those veterans suffering from service-connected disabilities. In certain cases, pre-hospital and posthospital care is available at VA clinics to veterans suffering from non-service-connected disabilities.

2. Outpatient care is not as "glamorized" in the public imagination as is hospital care, but for the VA it has the practical advantage of keeping beds available for other patients who need them. And for the outpatient veteran, it has the psychological advantage of enabling him to live at home and be gainfully employed, at least part time.

3. VA hospitals provide care for three classes of veterans:
   a. Those suffering from a service-connected disability.
   b. Those who have a service-connected disability, but now need care for some other disablement—providing a bed is available in a VA or other Federal hospital.
   c. Those suffering from a non-service-connected disability and financially unable to defray the cost of hospitalization. Veterans in this third group are hospitalized by the VA if all three of the following conditions are met:
      - Hospitalization is deemed necessary;
      - They state under oath that they are financially unable to defray the cost of hospitalization; and
      - Beds are available.

   By law, VA beds must first be made available to veterans suffering from service-connected disabilities.

4. VA domiciliaries date back to March 1866 when Congress established a corporate body known as the National Asylum for Disabled Volunteer Soldiers. In 1873, the word "home" replaced "asylum" and when, in 1930, the Veterans' Administration absorbed the home's various branches, the word "domiciliary" was substituted for "home." Domiciliary is not spelled out in Title 38, but for practical purposes it has been defined as "an institution which provides a home—bed, board, and incidental medical care—for veterans who are so disabled that they cannot support themselves."

Admissions are confined to veterans suffering from a disability, disease, or defect, essentially chronic in type, which is producing disablement of such degree as to incapacitate them from earning a living for a certain prospective period. The historical background of this particular veterans' benefit, and its present status, will be developed subsequently.

5. Nursing home care, a new type of veterans' benefit, was enacted in 1964. Like domiciliary care, it will be developed further. In general, it provides for the accommodation of convalescents or other persons, not acutely ill and not in need of hospital care, who do require skilled nursing care and related medical services. It is offered either in some VA hospitals where appropriate beds are available or in nursing homes duly licensed and approved.
VA restoration centers are in operation in Chicago, Ill., and East Orange, N.J. In these, veterans no longer in need of hospital treatment but requiring adjustment to life outside the hospital are assisted by a team of doctors, nurses, psychologists, rehabilitation experts, and social workers. This team works with the community to provide restored veterans with opportunities for suitable employment.

Another Veterans' Administration use of the word center refers to an organizational element consisting of a combination of two or more of the following VA field stations under jurisdiction of one manager: insurance center, regional office, hospital, or domiciliary.

**DEPARTMENT OF DATA MANAGEMENT**

On February 1, 1963, the Department of Data Management was created. The vast numbers of veterans who sought various VA benefits accentuated a real need for the rapid and accurate processing of an enormous amount of pertinent benefit claim and claim-related information. To do this, VA undertook an expansion of its data processing capabilities by the acquisition of increasingly powerful equipment and training its own people in automated procedures.

Prior to the late 1950's, the extent of VA's automation was its electrical accounting machines. Between 1957 and 1959 major feasibility studies were conducted to see if it was technically and economically sound to convert the processing of compensation and pension payments and crediting of VA insurance premium payments to a modern data processing operation. In each instance the feasibility study indicated it would be efficient and economical to convert to computer processing.

So, in January 1960, the conversion to the computer processing of compensation and pension benefit payments was begun. This conversion process involved the gradual incorporation of compensation and pension accounts which had been serviced by electronic accounting machines at 66 geographically dispersed locations prior to 1960. By August 1962, the conversion process was completed and approximately 4,600,000 monthly benefit payments, resulting in a total monthly disbursement of $300 million were being uniformly processed by a computer system located at the VA Data Processing Center, Hines, Ill. The estimated annual savings resulting from this single conversion is $1,500,000. In addition, additional one-time savings accrue from time to time when system changes are required following the passage of legislation that alters either entitlement or benefit rates.

At about the same time, the conversion of VA insurance system transactions was undertaken. This particular conversion process called for the gradual incorporation of a variety of Government life insurance accounts into a computer system set up in the VA Data Processing Center at Philadelphia, Pa. By the end of 1963 approximately 5,900,000 insurance accounts had been assimilated into a single system at one principal operation location. The estimated annual savings is in excess of $3 million. The VA has since been able to realize a number of substantial one-time savings resulting from the
processing of accelerated insurance dividends, and from handling changes brought on by system changes as a result of new legislation. Encouraged by the successful conversion of these operations to computer processing, the VA then undertook a series of feasibility studies to uncover further uses for the equipment. A computer-based agencywide automated management information system and a computer-based agencywide integrated automated personnel statistics and payroll system were among the possibilities that were explored.

By early 1963 it was clear that the structure of the Veterans' Administration needed some reorganization. Each of the then existing organizational elements of the VA: the Department of Veterans' Benefits, the Department of Insurance, and the Department of Medicine and Surgery, supervised their own automatic data processing activities. In addition to this an agency staff element called the Office of the Assistant Administrator for Management Services was responsible for coordinating all automatic data processing activities and helping out with technical advice.

However, by February 1, 1963, the Veterans' Administration felt it would be more efficient to merge the former Department of Insurance into the Department of Veterans' Benefits and establish a separate Department of Data Management. Thus, all of the agency's ADP activities were integrated into one department. The newly created Department of Data Management was charged with the responsibility for—

1. Identifying areas of potential automatic data processing applications within the VA and conducted systems studies.
2. Designing, developing, and installing new automatic data processing systems to improve the quality of service to veterans and furnish timely information for management and research.
3. Conducting a continuing review of the VA automatic data processing systems and equipment to realize further improvements and economies.
4. Furnishing technical staff advice and assistance to all organizational elements of VA.
5. Providing staff assistance agencywide on communications.

Since its inception in early 1963, the Department of Data Management has extended, or is in the process of extending, the application of automatic data processing to a broad range of agency activities. This now includes (1) the compensation and pension program, (2) the insurance program, (3) the loan guarantee programs, (4) most administrative management and program support functions, and (5) the increasingly wide medical program areas in which potential benefits are indicated. In this latter respect the establishment of the VA "pilot" automated hospital information system (pilot AHIS) is an outstanding example. Further, the Veterans' Administration is presently using a computer to analyze electrocardiogram data remotely transmitted from certain VA hospitals.

These and other uses of the computer in the field of medicine will accelerate as a result of VA experimentation in these areas. The indicated results at this time are extremely promising, and suggest that a new era in medicine is about to unfold.
NOW THE HISTORY OF MEDICAL CARE

We reverted back nearly four centuries in this introductory section to bring into focus the theme of this document. The chapters which follow look still further back and then move forward with the story—sometimes smooth, oftentimes tumultuous and bitterly controversial—of the Veterans’ Administration’s expanding, ever-improving program of medical care of the American veteran.
ANCIENT TIMES—LEGENDARY AND OTHERWISE

Historians have largely ignored medical care for the disabled soldier of dawn-of-history times, partly, perhaps, because of the primitive character of the medicine and surgery of those days and the custom of killing the enemy wounded after a battle had been won.\(^1\)

Benefits, though not medical benefits, can be traced back to the Egypt of the Pharaohs, when entire armies were settled in conquered colonies, and plots of land were awarded to soldiers based on the extent and character of their service.

Soldiers of the great empires of the Tigris-Euphrates Valley—Babylonia, for example, were compelled to serve, but they were maintained by plunder and the tribute exacted from captured cities.\(^2\)

However, in ancient Greece two significantly related historical lines gradually converged in the areas of (1) medicine, and (2) benefits for both veterans and disabled veterans.

"Mycenaean" Greece flourished from 1600 to 1400 B.C., and a Mycenaean skeleton unearthed in modern times revealed "a fractured skull which had been neatly trepanned"—the earliest extant record of a surgical operation.\(^3\)

Later, of course, Greek medicine soared to its greatest heights with the career of Hippocrates, who not only authored the famous Hippocratic oath but also wrote a little-known monograph entitled "Wounds in the Head."\(^4\) During the same era, the historian, Thucydides, wrote a classically accurate description of bubonic plague.\(^5\)

Sanctuaries of healing, called asklepieia, flourished all over Greece, and "by experimentation with animals * * * the Greeks [became] able to deal with fractures and dislocations * * * and with wounds—especially head wounds—received in war."\(^6\)

For centuries, defensive and offensive wars were fought by the Greek city-states; Greek kings traditionally were "essentially military commanders"; and in Sparta and Periclean Athens "the army [was] identical with the state [because] every citizen had to serve."\(^7\) Yet it is surprising how meager are the records of Greek benefits for her war veterans. Thucydides wrote that "after 8 years of the Peloponnesian War," 2,000 Helots, or Spartan serfs, who had "most distinguished themselves against the enemy" were given their freedom.\(^8\)

As for disabled veterans, it is in Greece that the first discernible record of public support for them emerges. They were fed at public


\(^5\) Bowra, op. cit., p. 16.

expense; and many concessions, including pensions, were granted to those who could prove permanent injury. Public funds supported the children of Greek soldiers who had died in battle.  

In the Roman Empire, soldiers were a powerful and therefore a privileged class, especially the Praetorian Guard, whose duty was to protect the Emperor's person, and whose leader, the Praetorian Prefect—after the Emperor himself—was often the most powerful official in the Empire.

The principal benefit then bestowed upon veterans was land, usually allotted to them in whatever region of the Empire they came from, whether the Italian peninsula itself, or Spain, Gaul, Britain, Syria, or some other imperial province.

The Roman custom of giving land as a veteran benefit found expression in a stanza from "Horatius at the Bridge," a poem in Thomas Babington Macaulay's "Lays of Ancient Rome":

They gave him of the corn-land,  
That was of public right,  
As much as two strong oxen  
Could plough from morn till night * * *

Horatius was given this gift as a reward for his legendary lone stand against the entire Etruscan army at the Sublician Bridge over the River Tiber in 496 B.C.

**Bounty Lands**

Breaking chronological sequence for the moment, note should be taken here of the fact that during the 19th century land grants figured as important benefits to U.S. veterans.

Our lusty young nation then possessed millions upon millions of acres of undeveloped frontier land. The benefits consisted of warrants of land in the public domain, given to soldiers and sailors and their dependents as reward for service during the Revolution, the War of 1812, the Mexican War (1846-48), and some of the earlier Indian wars.

The purpose of these bounties was threefold: to induce enlistments in our Army and Navy; to reward service; and to develop frontier lands in the Nation's boundary States. During the life of the program (the last act authorizing warrants was passed on March 3, 1855, and the last such warrant was issued on July 1, 1917), 598,701 bounty-land grants were issued for 68,793,870 acres.  

Among those receiving 160 acres each were Abraham Lincoln (for service in the Black Hawk Indian War), Jefferson Davis, Robert E. Lee, Ulysses S. Grant, Philip H. Sheridan, William T. Sherman, David G. Farragut, and Winfield Scott.

**Back to Ancient Rome**

Another Roman benefit, granted to specially favored veterans and their descendants, was municipal office. This appealed to their wives and daughters because, within the class system of the Empire, it conferred a sort of upper middle class social status, which placed

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1 McMurtrie, op. cit.
them above ordinary city dwellers and the peasants of the countryside.

Under Augustus, who established the Empire and ruled it from 27 B.C. to A.D. 14, pension rights of disabled legionnaires were recognized, and they were also granted land plots. In the division of spoils, legionnaires wounded in action received larger shares. The early Roman custom was to send sick soldiers back to Rome for treatment. However, as the Empire expanded, this became increasingly difficult and finally impossible.

Take note of what then happened. Military hospitals were established at strategic centers. The sites of several of these have been excavated, the earliest dating from the first century A.D. These indicated, interestingly, that the general scheme of early Roman hospitals was not matched in efficiency of design until modern times.

In the center of these hospitals was a long refectory, or dining hall, surrounded on three sides by a corridor into which the sick rooms opened, with an outer system of corridor and sickrooms surrounding the inner. There were, typically, 60 rooms in these hospitals, each apparently heated by braziers and capable of accommodating eight patients.

History records no surgeons in the armies of early Rome, the wounded apparently either binding each other up or being cared for by slaves. With the growth of the medical profession in the Empire, surgeons, classed as noncombatants and called "immunes," began to appear in the ranks of the legions.

These reports of early Greek and Roman care of disabled veterans are too fragmentary to be connected in any significant way to the lineage of such care as practiced in America today. However, a major effort has been attempted to trace back, as far as available sources permit, the two major tributary sources which can be definitely identified as having been forerunners of modern veteran care.

THE FRENCH BACKGROUND

Chronologically, the earliest identifiable source point lies in 12th century France.

Although the exact year is not known today, eight centuries later, it is known that, during the crusades, Philip II, King of France from 1180 to 1223, founded a "hospice" for veterans. (Webster's defines hospice as "a home for the poor and sick.") It can also be established that the King's action received papal approbation, and that the hospice for veterans was endowed with certain churchly privileges. (The identity of the approving Pope is, however, unclear, there having been eight Popes, from Alexander III to Honorius III, during the reign of Philip II.)

Later, Louis IX, the greatest of the French medieval kings, returning from the crusades with a shattered host, established an "asylum"

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for 300 of his soldiers whose eyesight had been destroyed or impaired by the hot sun of the Middle East.

But this royal and papal largess turned out to be personal kindnesses. They were not emulated by other rulers. Nor were their acts taken collectively by nations as established social policy. Medieval nations, with the structure of the Roman Empire no longer binding them together administratively, were not as we know them today—great aggregations of power and wealth. They were merely loose confederations of lords with kings who were weak, though they later became much stronger.

By the 15th century, the feudal system in Europe had begun to crumble. Standing armies came into being. The professional soldiers, who frequently became the disabled soldier, started to be recognized as a special type, to which society began to feel an obligation. These developments, however, were indeed very gradual, and the war veteran in Europe during the early post-Middle Ages fared poorly, indeed pitifully. So did his dependents and survivors.

Soldiering was a business enterprise where young men pledged their allegiance to the army which paid best. No provision was made—nor was it expected—for the care of the wounded or of the dependents of those who had lost their lives. These classes of unfortunates were forced to seek help from private families or charitable organizations. Many of the disabled were cared for in the hundreds of monasteries that dotted the countryside. Eventually, with the decay of the feudal system and the decline in the number of monasteries, even this form of assistance broke down. The wounded, the war orphan, and the war widow had practically nowhere to turn.

The typical disabled soldier, his legs and health permitting, left the monastery, where the atmosphere was kindly but far from spirited, and turned to a life of vagabondage, hooligans, and begging. Society deplored his conduct, but half excused and half forgave him, as if he were on its conscience.

One way society salved its conscience for neglecting the veteran was by allowing him license to beg. Thus, armed and clothed in rags he would expose his wounds or mutilations, in an effort to arouse public admiration for his past valor as well as sympathy for his present misfortune. Some pitied him and gave him alms; others laughed and ridiculed him. This makeshift system tended to make him dangerous. When denied alms, he would rob, even kill, and by the end of the 16th century he and his companions had developed into an angry, explosive force. They banded together. As a small army of crippled and broken soldiers, they demanded from Henry IV redress of their grievances, and "the means to live at ease the rest of our lives." Henry IV was known as "Henry of Navarre," and ruled France from 1589 to 1610.

Touched by their plight, he took two compassionate steps. He took over an orphan asylum and renamed it Maison Royale de la Charité Chrétienne. This he dedicated to the use of veterans, and decreed that it be supported by all excess revenues that could be found in the budgets of French charitable institutions, especially monasteries. To gain admittance, a disabled soldier had to present a certificate from an officer stating how long he had served, citing the "combats, perils, and hazards to which he had been exposed" and the actions in which he
had been wounded. Widows and orphans of soldiers killed in battle were also eligible for admission.¹

Henry further established a sort of “veterans’ bureau” for receiving veterans and authorizing wounded soldiers for public care. These soldiers were permitted to wear a white satin cross on their coats, bearing the legend “For Having Faithfully Served.”

But the bureau collapsed from lack of funds. When Henry died in 1610, his “Maison Royale” was closed, for the naive plan for supporting it from the surpluses of other institutions had failed.

Louis XIII, Henry’s son, then decreed that disabled soldiers be given small pensions from funds collected from monasteries. The problems of collecting and distributing this money proved insoluble, and the project ended.

The Hotel des Invalides, Paris, France, established by King Louis XIV in 1670 and opened in 1675, for the care of aged and disabled veterans of the French armies. The “Hotel” today houses the Army Museum, the Church of St. Louis, the Tomb of Emperor Napoleon, and the Museum of Historical Relics. (1964 photo.)

Soon the countryside was terrorized by bands of thieving, throat-cutting veterans, augmented by adventurers pretending to be veterans.

Then Louis XIII developed another idea which saw reality under Louis XIV. This idea profoundly influenced American developments later.

Impressed by his father’s institutional idea of a Maison Royale Louis XIII founded a Maison himself—the Maison des Invalides. His Maison, the scaffolding for which was dedicated with great pomp
in 1635, was intended for the use of disabled veterans but, for reasons not clear today, it was never used as such during his reign. It did serve as a poorhouse, a madhouse, and finally a prison.

Louis XIV enjoyed a spectacularly long reign (1643 to 1715). He came to be known as "The Sun King". He attempted a new pension system for disabled soldiers. Officers would receive 10 times as much as enlisted men. The less severely disabled enlisted men were required to perform garrison duty. The men were not permitted to beg, and the penalties imposed for begging ranged up to and included hanging. Understandably, enlisted men violently protested this treatment. When the situation became critical, Louis XIV admitted the failure of his plan and revived the institutional approach of his grandfather, Henry IV.

In April of 1670, Louis XIV issued an edict establishing the Hotel des Invalides for the care, on a grand scale, of aged and disabled veterans of the French armies. Five years later its doors opened for the housing of 4,000 pensioners.

And now, we will leave Louis XIV's Hotel, to trace briefly the chronology and course of the other major development, this time by the English, that influenced in later years the care of the American veteran. The English approach, like the French, introduced the two principles—institutionalism and pensions—which were ultimately adopted by all Western nations in their philosophies of veteran care.

### THE ENGLISH BACKGROUND

In feudal times, the magnitude of the problem of supplying relief to war veterans in England matched that of France. Disabled soldiers were cared for, on both sides of the channel, in the same haphazard way. Disabled and impoverished veterans received no different, and no more effective, relief than did other needy citizens in England. To a large degree, there was a tendency to dump the wreckage of war into the lap of the gods.

By the 15th century, poverty in general was on the increase in England. It found its beginning in 1066, when William the Conquerer invaded England, bringing with him the Norman feudal system.

By the 16th century, circumstances in England had become chaotic. Large numbers of soldiers returning from war spearheaded waves of rioting and crime, filled the cities with beggars, and overtaxed the few existing private charitable agencies.

Provision for the relief of the hordes of poor, including disabled veterans, first took the form of licenses for begging.

On page 17 is reproduced an interesting document of the period: the "Begging License" of "William Browne of London, Gunner [who] lately served in her Majesties service against the Spaniards in the Barke of Fevertham, and in that service was shot through his bodie, and grievously wounded in sundry places, and by meanes of the same maimed for ever." This "License," issued on August 17, 1590, by Lord Howard of Effingham ("Lord High Admirall of England"), states that the Admiral further "thought [it] good to grant him these presents" because "I understand that he is greatly indebted to his Surgeons in the curing of his wounds and otherwise brought to extreme povertie [in the] defence of this our Countrye." Yet, note that the "Licence," for all its obvious compassionate interest, was only "to indure for the space of twelve months from the date thereof."
Harles Lord Howard, Baron of Effingham Knight of the Noble order of the Garter, Lord high Admiral of England, Ireland, and Wales, and the dominions and isles of the same, of the town of Calais and marches thereof, of Houndby, Scopyn, and Supenes, and Captain General of her Majeeties Seas and Haup Royal. To all and singular bearers of Warrant, justices of peace, High Sheriffs, Sub Sheriffs, Constables, Collectors, Comptrollers, Commanders, Barons, Viscars, Curats, Churchwardens, Collectors for the pence, and all other her Majeeties Officers, Ministers, and loving SUBs, as well within the City of London, as the dominions of her Majeeties Realm of England, and to every of them greeting. Whereas this bearer William Browne, of London gentry, lately served in her Majeeties Service against the Spaniard, in the Banks of Fiume, and in that Service was shot through his hode, and gravously wounded in sundry places, and by meanes of the same maimed for ever: In consideration whereof and so that I understand he is greatly indebted to his Surgeons, in the curing of his wounds and other wise brought to extreme poverty thereby. I have thought good to grant him these presents, and by authority hereof, in her Majeeties name do require and earnestly entreat you and every of you, throughout the said City of London and the dominions of her Majeeties Realm of England, to have a Christian and full regard of the said William Browne, and his extreme want and misery, gotten in the Service of our gracious Prince, and defence of this our Country, and to help and relieve him with your charitable benevolence and almes towards the supplying of their great want, and to permit, suffer, and assist them, to gather and make the same in all Churches and Chapels, and of all well disposed people within the said City of London, and her Majeeties said dominions, without any let, trouble, molestation, or interruption whatsoever, wherein you shall do a deed very acceptable in the sight of God, and greatly comfortable to him, his said wife and children in this extremity, wherein we require you not to fail. This presents to endure for the space of two and one months, from the date hereof. Given at London in her Majeeties high Court of Th'aduitalty, under the great seal thereof, the fourteenth of August, 1590. And in the two and thirtieth yeare of our Sovereigne Lady Elizabeth by the grace of God Quene of England, France and Ireland, defender of the faith, &c.

C. Howard.

God save the Queene.


By courtesy of the Trustees.
Also in 1590, Lord Howard, with Sir John Hawkyns and Sir Francis Drake, founded the "Chatham Chest," a benevolent fund, independent of the state, for seamen disabled in the royal service and suffering poverty. Every English seaman contributed sixpence to the fund each time his ship docked in a British port.

There was no full-time Royal Navy in England until the time of James II, toward the end of the 17th century. Before that, men like Drake who owned private ships—hence the term "privateers"—would serve voluntarily in the royal service in time of war, lending their ships, their crews, and their personal leadership. At other times, they engaged in commerce—or in piracy.

The fund set up by Drake and his associates was named after Chatham, a dockyard area on the Kent side of the Thames, near London, and the money, under the control of a board of governors, was literally in an iron-banded wooden chest, which is now in the National Maritime Museum in Greenwich.
No seaman who legitimately called upon the governors for assistance was left unaided. But the governors themselves, many of them members of reputable families, frequently borrowed or stole from the fund, and by the end of the 17th century most of the money was gone.

All merchant seamen (but not fishermen) were compelled to contribute to the Chatham Chest. They were subject to being called into war service and, if disabled in war service, became eligible for contributions from the Chatham Chest. But if they were disabled in purely merchant service, they were not eligible.13

Ultimately these feeble measures were abandoned, and the principle was established that relief of the English poor would henceforth be administered in each locality for local residents, with the overseer of the poor as the responsible official and the almshouse as the place of residence for the indigent. These principles were incorporated into what is known as the “Elizab than poor law.” This became the concept governing the administration of relief for civilians and for veterans in England.14

In 1593, long before the beginning of English colonization in America, the problem of relief of the poor and the disabled—the discharged soldiers as well as the destitute peasant—received national recognition and action in England. Parliament passed the “Acte for the Relief of Souldiours,” which is described in some detail in the introductory chapter of this book.

Even a quick reading of the provisions of this act reveals that, despite its high-flown language about “Reliefe and Reward,” the footing on which it placed the “Souldiour” so relieved and so rewarded was not of a nature to raise him in his own esteem or in the esteem of the populace generally. He was treated as a pauper, not as a man who had served his King and had shed his blood in defense of a homeland which now doled out alms unwillingly, to keep him from starving.

Unsatisfactory though it was, it was still the first Act of any Parliament, or equivalent body, to give to the disabled soldier a legal claim to assistance from his country.

Later acts continued and amplified the famous 1593 statute, and by 1599 the new system was in fairly smooth operation. In Elizabeth’s last Parliament, 1601, a new statute was enacted, owing to the increasing number of applicants, and the new law continued during the reigns of James I and Charles I—that is, until 1649.

Now, as in the case of Louis XIV’s Hotel des Invalides, we will briefly touch upon here, and later return to, the early British institutional approach to veteran care—in this case, its development in 17th century England.

During the Puritan Commonwealth of Oliver Cromwell, Charles II lived in France under the patronage of Louis XIV and came to admire “The Sun King.” When, in 1660, he was invited to return to England for the restoration of the monarchy, he brought with him a knowledge of, and a taste for, certain French practices. Some of these were frivolous, but his serious concern for the welfare of soldiers and sailors loyal to the Stuart cause was an echo of Louis XIV’s recognition of the claims of veterans.

Charles II, King from 1660 to 1685, adopted measures looking toward bettering the plight of veterans as far as the country’s means

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would allow. However, in spite of his good intentions, the nation—town and country alike—swarmed with beggars, most of whom represented themselves as ex-soldiers.15

Now a sprightly young woman enters our story: She is Eleanor Gwyn, an actress, who, using the stage name of Nell Gwynne, became the mistress of three English noblemen in succession, then the celebrated mistress of Charles II, with whom she lived until his death.

Alert and proud, a Chelsea Pensioner, wearing the uniform of red coat and black cap, recalls old battles and past campaigns at London's Royal Hospital. Over 400 retired British soldiers live in the Hospital, which was founded as Chelsea Hospital in 1692 by Charles II, and designed by Sir Christopher Wren. (British Travel Association photo.)

She is significant in this history because she was influential in causing Charles II to establish the Chelsea Hospital. The word "hospital" is used here in its original sense of "a place of shelter and rest."

Nell, who lived in a cottage on land in Chelsea given to her by the King, was accosted by a beggar one day as she rode about town in her coach. The beggar was an English soldier who had been wounded in the civil war in defense of the royal cause. She hurried back to the King, and, knowing of his desire to help needy English veterans, appealed to him to take action.

The King responded warmly, sent for the paymaster of the armed forces and, undoubtedly influenced by the example of Louis XIV in establishing the Hotel des Invalides in France, proposed that funds be raised for building and endowing a shelter.15

When the question of location arose, it was quickly settled by Nell, who offered the land on which her cottage stood. It was accepted; she moved into a new home in Pall Mall; and in 1681 Charles decreed the establishment of a "royal hospital" at Chelsea. But not until 1692—7 years after the death of Charles II, in the third year of the joint reign of William and Mary, and 22 years after the opening of the Hotel des Invalides—did the Chelsea Hospital (designed by Sir Christopher Wren, the distinguished architect) open its doors.

William and Mary shortly afterward founded the Greenwich Hospital for invalided English seamen. It, too, was designed by Sir Christopher Wren. It opened in 1702, the year of William III's death.16

The influence of both these "hospitals" on the development of medical care for veterans in the United States was extensive.

THE AMERICAN COLONIAL BACKGROUND

The English "Acte for the Reliefe of Souldiours" was the cornerstone of all the later American compensation and pension systems, and medical care programs for war veterans. Implanting in the minds of the English colonizers of America a sense of public responsibility to veterans disabled by war, it was the forerunner of all American colonial pension legislation.

Among the early settlers of the New World—English, Dutch, French, Spanish, and Swedish—only the English brought with them the benign and constructive influence of a 16th century "Acte" which was compassionate toward war veterans; also practical, because of the favorable effect the statute would exert on the attractiveness of military service as a career.

The two components of the old act are clearly indicated in its wording: compassion ("** ** that such as have adventured and lost their limbs or disabled their bodies ** ** should, at their return, be relieved, and ** ** reap the fruit of their just deservings") and practicality ("** ** that others may be encouraged to perform like endeavors").

Interestingly, the first American veterans' benefit law on record, enacted in 1636 by the Pilgrims who had settled Plymouth Colony, reversed the sequence of the components of the English "foundation document" by putting practicality first and compassion second:

That in case necessity require to send forces abroade, and there be not volunteers sufficient offered for the service, then be it lawfull for the Governor and [his] assistants to press [men into service] in his Majesties name ** ** provided that if any that shall goe returne named & hurt, he shall be maytayned competently, by the colony during his life.

"Abroade" meant "out of the colony" and "to press" meant "to draft," and the assumption of this authority by the young colony was an act of great common sense. Plymouth had been founded only 16 years earlier, in 1620, and in 1636 was engaged in a war with the

Pequot Indians, "a short, sharp, and decisive conflict * * * which saved the [area] from savage conflict for nigh 40 years." 18

The practicality of this law was further indicated by the fact that, 7 years later, the four colonies of Plymouth, Massachusetts Bay, Connecticut, and New Haven banded together to form the New England Confederation for defense against the Indians and the Dutch.

By the time the United States was welded together into a single nation in 1776, the concept and policy of benefits for veterans, and very specifically for those disabled, were well established.

Actually, Virginia had acted before Plymouth, her general assembly having passed in 1624 a law whose 32d article promised "* * * those hurte upon service to be cured at the publiche charge; and, in case any be lamed, to be maintained by the country according to his person and quality."

"Service," in this document, meant, according to an explanation elsewhere in it, "service at the beginning of July next (1625) [when] the inhabitants of every corporation in the colony shall fall upon their adjoyning Savages, as we did last year."

But this law could not be ratified before the Virginia Company had to surrender its charter to the King, becoming a Royal Colony.

Therefore, not until 1644 was equivalent legislation passed by Virginia. It ordered that "Whereas, in the last expeditions against the Indians, diverse men were hurt and mayned and disabled * * * be it therefore enacted by the authority of this Grand Assembly that [they] be relieved and provided for."

In 1661, the General Assembly of Maryland passed an act providing that "every person that shall adventure as a soldier in any warre in the defence of the Country, and therein happen to be mayned or received hurt, shall, according to his place and quality, receive maintenence from the Country." This act was confirmed in Lord Baltimore's name in 1662.

The roster of Colonies passing similar legislation prior to 1776 reads as follows: New York, 1691; North Carolina, 1715; New Hampshire, 1718; Rhode Island, 1718; South Carolina, 1747; Georgia, 1755; and Delaware 1756. New Jersey and Pennsylvania did not pass theirs until 1777. All these laws, enacted in Colonial America in the 17th and 18th centuries, were clearly influenced by Mother England's position on this ultraimportant matter, as indicated by the "Acte" she had passed in the late 16th century.

It is of especial importance in the history of the medical care of the American veteran to note that, among the colonial laws authorizing pensions to disabled veterans, New Hampshire alone specifically indicated authorization for payment of medical care. "An act for the payment of cure of soldiers that are wounded" is the name of the New Hampshire statute of 1718, and its significant passage—practical and compassionate, in that order—reads:

For the better encouragement of soldiers to adventure their persons against any enemy: Be it Enacted and Ordained by his Excellency the Governor, Council, and Representatives, convened in General Assembly, and by the Authority of the Same: And it is hereby Enacted, That in case any person within this province being actually in arms by the command of his officer, or as a voluntier, shall be

wounded by the French or Indian enemy, the charge of the cure shall be paid out of the publick treasury.

**MEDICINE IN THE COLONIES**

The first all-purpose colonial hospital, Pennsylvania Hospital, was founded in Philadelphia in 1752, with Benjamin Franklin serving as one of its principal promoters and also as its first “clerk” or secretary. A specialized hospital, mainly for sick sailors, had been founded somewhat earlier, in 1749, in Charlestown, S.C.

The hospital in Philadelphia was such a novelty for its time that on Sundays the curious citizens of the town flocked to it and wandered through its corridors and wards. They so disturbed the patients that finally, in 1760, the managers ordered that “persons who come out of curiosity to visit the house should pay a sum of money, a groat at least, for admittance.” (A groat was worth 4 18th century pennies.)

The first colonial medical school was also founded in Philadelphia in 1765. Known then as the College of Philadelphia, it later became the University of Pennsylvania. It was affiliated from the beginning with Pennsylvania Hospital.  

King’s College of New York City (later Columbia University) founded a medical school in 1768. After the colonies became a nation, Harvard and Dartmouth followed with medical schools in 1783 and 1798, respectively.

Before the founding of the Medical Department of the College of Philadelphia, young colonials who wished to become “doctors of physic,” or surgeons, either studied privately, as apprentices with established medical men, or went to such European medical centers as London, Edinburgh, Paris, or Bologna. The medicine they studied cannot fairly be judged by the standards of the 20th century. Knowledge of infections was limited. So was knowledge of drugs. There was strong confidence in powdered herbs, in the juices of herbs, and in the juices of fruits, especially lemons. Blood-letting (permitted to barbers as well as to physicians) was common; sometimes it succeeded, sometimes it failed, but it was believed in almost religiously. So was induced sweating, as a means of causing “unhealthy humors” to vaporize from the body.

Surgery was conducted without the mercy of anesthetics, of which the first effective type—ether—was not introduced until the 1840’s. Stiff doses of whisky or rum were administered to surgical patients, or strong men held them down while, screaming, they were cut open. In cases of amputation, the flesh was cauterized with hot irons.

The cutting open, however, was often remarkably precise, because knowledge of anatomy was well ahead of other branches of medicine. The superb anatomical drawings of Leonardo da Vinci (1452-1519) and Vesalius (1514-64) are admired, even in our own century, not only for their artistry but also for their accuracy. And the “scientific surgery” of John Hunter, a Scot (1728-93), was enlightened in its approach. There existed also, from the researches of William Harvey (1578-1657), a good knowledge of the circulation of the blood.

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19 Dr. John Morgan was the founder of the Pennsylvania Medical School. Dr. William S. Middleton, Chief Medical Director of the Veterans Administration, 1954-63, has published a valuable study of Morgan’s service to education, entitled “John Morgan, Father of Medical Education in North America,” *Annals of Medical History*, 9: 127.
The ships on which colonists emigrated to the New World—and also the new cities of Boston, New York, Philadelphia, Williamsburg, and Charlestown—were frequently swept by death-dealing plagues, pestilences, and epidemics, especially yellow fever and smallpox. During these afflictions, the medical men of the time so distinguished themselves by devotion to their patients that, as a class, they came to enjoy higher respect here than their fellow medical men then did in England. They were regarded as solid, substantial members of their communities, and laid the foundations for the prestige which the profession of medicine has achieved in the United States.

By no means, however, were all 18th-century medical affairs conducted in an atmosphere of "sweetness and light." In Philadelphia, for example, during an epidemic of the yellow fever, the physicians of the city became divided into two hostile groups. One group favored the method of treatment developed by Dr. Benjamin Rush, and the other that of Dr. William Currie.

Rush believed in copious bleeding; Currie held that bleeding weakened a patient. Each group attacked the other in newspaper articles. Dr. John Rush, son of Dr. Benjamin, publicly caned a Dr. Roos, one of Currie's followers. Whereupon, Dr. Ross challenged young Dr. Rush to a duel, which he declined. One result of the controversy was the founding of the Philadelphia Academy of Medicine, a Rush group, of which Dr. Philip Syng Physick, one of the most eminent of early American medical men, became the first president.20

Dr. Rush, senior, was one of the five doctors who signed the Declaration of Independence, the others being Drs. Joshua Bartlett and Matthew Thornton, of New Hampshire, Dr. Oliver Wolcott, of Connecticut, and Dr. Lyman Hall, of Georgia.21

Dr. Physick, of the amazingly appropriate name for an 18th-century doctor, has been called the father of American surgery.22

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21 Packard, op. cit., p. 816.
The American Soldier, 1781. Artilleryman, New York or New Jersey Infantry Officer, New England and Middle Atlantic States Infantry Lines.
Chapter II
From the Revolutionary War to the Civil War

The Revolutionary War

1775-83:
U.S. participants: 290,000.
U.S. deaths in service: 4,000.
U.S. wounded: 6,000.
Last veteran died April 5, 1869 (age 109)

June 20 and July 4 in the year 1776 are important dates in history. On June 20, the Second Continental Congress—which included such luminaries as Washington, Jefferson, Franklin, John Hancock, John Jay, John Adams, Samuel Adams, and Patrick Henry—was deeply involved in the tremendous acceleration of events which led to the adoption, on July 4, 1776, of the Declaration of Independence. The excitement of those spirited days was well expressed by John Adams when, on June 20, he told the Congress: "By every post and every day, independence rolls in on us like a torrent."1

Concord, Lexington, and Bunker Hill were a year in the past. Patriotic feeling ran high.

In this medically oriented treatise, it is apropos to mention that it was a doctor—Dr. Joseph Warren, a Harvard graduate—who dispatched Paul Revere to arouse the Minute Men. Furthermore, Dr. Warren, after his appointment as a major general of the Massachusetts Colony's troops, "shouldered a musket and was in the thick of it at Lexington." He was killed at Bunker Hill.2

Although the colonists had no system of organized medical care, any more than they had an organized army, voluntary medical and surgical aid was supplied to the wounded and sick.3

Nine physicians tended the wounded at Lexington and Concord, and our wounded at Bunker Hill were removed to the northern and western slopes, and there treated by the surgeons accompanying the troops.4

After the battle of Bunker Hill, our wounded were taken to houses converted into hospitals in Charlestown, Watertown, Roxbury, and Cambridge.5

Later, on the 27th of June 1775, the Provincial Congress of Massachusetts ordered a hospital to be established in the camp about Boston for the treatment of soldiers stricken with smallpox.

Three weeks after that, on the 17th of July, the Second Continental Congress took the first step toward organizing a medical department for the Continental Army. A committee was appointed to develop a plan for "a general hospital service." Ten days later, the Congress

3 Ibid., p. 627.
4 Ibid., p. 529.
5 Ibid., p. 531.

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passed a resolution calling for the establishment of "a Hospital for an Army of 20,000 men," the staff to consist of:

A Director-General and Chief Physician, his pay four dollars a day; four Surgeons, each daily one and a third dollars; one Apothecary, one and a third dollars; twenty Mates and one Clerk, two-thirds of a dollar; one Nurse to every ten Sick, at one-fifteenth of a dollar per day; and labourers occasionally.  

"This legislation," wrote Col. P. M. Ashburn, in his "History of the Medical Department of the United States Army," published in 1929, "although loosely drawn and quite inadequate in its provisions, was an improvement upon the previously existing state of affairs."  

Planning for the future of the war which was already in progress was a complex challenge. And the Second Continental Congress, numbering only 56 members at its meeting on June 20—this little provisional government of the 13 Colony-States and their population of 2,600,000—had staggering responsibilities. These included the drafting of the Declaration of Independence and the Articles of Confederation, the expansion of the Army, the creation of a Navy, the borrowing and issuance of money, and a host of other complicated tasks, all requiring creative, highly practical planning. Therefore the Second Continental Congress was, and indeed had to be, not only patriotsically minded, but financially minded.

Here are some of the smaller financial resolutions that were moved and seconded on June 20, as culled from the Congressional Journal of that day:

Resolved: To [pay] to Captain William Richards, for the detention of his shallop [a small open boat with oars and sails] for 20 days on the public service the sum of £15 *** to Robert Irwin, wagggon master, the sum of £17.55.0, for wagggonage *** to Abrahann Mills, for nursing and boarding six soldiers in the small pox, the sum of £12.14.8. ***  

The final piece of business transacted in the statehouse in Philadelphia on that Thursday in June was also financial—and it was big—so colossally big, in the long run, that the delegates, longvisioned though they were, could not possibly have foreseen its later magnitude.

This is how the record of the important concluding congressional action on June 20, 1776, was listed in the Journal:

"Resolved, That a committee of five be appointed to consider what provision ought to be made for such as are wounded or disabled in the land or sea service, and report a plan for that purpose: The members chosen, Mr. Paine, Mr. F. Lee, Mr. Hall, Mr. Ellery, and Mr. Lewis."  

The session then "Adjourned to 9 o'Clock to Morrow."  

A month and a week later, on August 26, having received the "report of the committee on disabled soldiers and seamen," the Congress "agreed" to it, ordered it "published," and it was duly printed in the September 4, 1776, issue of the Pennsylvania Gazette. Thus an early step was taken toward the establishment of a system of invalid pensions to apply throughout the colonies. This step proved that concern for those who had been, or might become maimed in the Revolutionary conflict was uppermost in the minds of the Founding Fathers even before the Declaration of Independence was declared.
But it was not a law at that early date: it was only an agreed-to committee report.

The report fills four pages in the Congressional Journal. Here are some observations on it and highlights from it:

It demonstrated that the committee members were familiar with (1) the veterans' benefits laws that had been enacted by the various colonies during the preceding 140 years, and with (2) the ancestor of all colonial legislation, the "Acte for the Relief of Souliours," passed by the English Parliament in 1593. That "acte" promised, to disabled war veterans, "the Fruit of their Good Deservings." The report of the 5-man committee was logical development from these earlier enactments.

It promised half-pay for life, or during disability, to every officer, soldier, or sailor losing a limb in battle, or being so disabled in the military or naval service as to be rendered incapable of earning a livelihood.

Those partially disabled were to be given proportionate relief.

One feature of the plan followed the English precedent of recommending an invalid corps of disabled soldiers for guard or garrison duty or for shipboard and other duties that navy pensioners could perform.

The wording of the report proved that when the Declaration of Independence stated that "these United Colonies are, and of a right ought to be, Free and Independent States," the drafters meant exactly that. The pre-Declaration of Independence report referred to "the United States of America" in several places, and recommended that both the administration and the financing of the proposed pension plan be left not to "the Colonies" but to "the several States."

The last-named provision caused the entire project, admirable though it was in purpose, to encounter serious obstacles. In many instances, the administration and financing of the plan by the States were performed with such laxity as to render it pitifully ineffective.

In 1778 and 1782, the Congress had to deal again with invalid pensions. First, they were made retroactive to those injured since the beginning of the war, rather than merely since the submission and approval of the committee's plan. Further provision was made for the sick and wounded who were unfit for garrison or field duty. They could apply for discharge, instead of being included in the corps of invalids. If their request was granted, they were authorized to receive $5 per month in lieu of all other pay and emoluments.

When peace had been established by the Treaty of Paris in 1783, Congress again gave its attention to pensions. Resolutions passed in 1785 recommended to the States a new and uniform pension scale, as follows:

Commissioned officers, wholly incapacitated, were to be allowed half pay. For noncommissioned officers and privates, total disability rated $5 per month, with proportionate amounts for partial incapacitation.

The administration was again left to the States, which were to appoint officers to examine and act upon claims, and, when approved, make the pension payments. The money so expended was to be

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10 Ibid., pp. 700-705.
The First Act by the Congress providing for the payment of Invalid Pensions, September 29, 1789.

Deducted from the States' share of support of the Federal Government.

Lists of all pensioners were to be forwarded to the Secretary of War annually. These lists are still preserved in the Archives of the United States in Washington, D.C.

On March 4, 1789, the Congress of the Confederation, after arranging for the first Presidential and congressional elections under the new Constitution, "quietly expired." But, on June 11, 1788, less than a year before its demise, it took its final action in invalid pensions. No person should receive such a pension unless application for it was made within 6 months after that date. This action reduced the number of eligibles.

As of 1792, there were some 1,500 invalid pensioners on the U.S. rolls, costing approximately $100,000 per year.

Because the administration of these benefits by the States had been so unsatisfactory, the Federal Government took over the payment of pensions. This was authorized (1 Stat. 1–95) on September 9, 1789, the day before the adjournment of the First Congress of the United States.

For many years afterward, the Congress retained direct control over the final awarding of all claims.

Congress had now become, for the first time, the guardian of the disabled veteran, his widow, and his orphan—a right which it has jealously guarded ever since.

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Ibid., p. 23.
SERVICE PENSIONS

Only brief mention will be made of the service pensions. Revolutionary Army officers had advocated half pay for life for all officers who served for the duration of the war. (It had long been the British custom to place military officers on half pay when they retired.)

George Washington was at first opposed. In November 1777 he wrote "**but will not half pay be attended with enormous expence [and] add a debt of such magnitude as to sink the colonies under the load of it?"

Later he reversed his view, discussing, in a letter from Valley Forge to the President of the Congress, "the necessity of some better provision for binding the officers by the tie of interest to the service, as no day, nor scarce an hour, passes without the offer of a resigned commission ** otherwise I much doubt the practicability of holding the Army together much longer."

In 1778, he again wrote to Congress on the subject: "I do most religiously believe that the salvation of the cause depends upon it, and [that] without it your officers will moulder to nothing." Later (in a letter to Governor Morris): "Our Army as it now stands is little more than a skeleton." Still later (to John Armstrong): "I have never yet seen the time in which our affairs were at so low an ebb."

There was endless congressional discussion of half pay for officers for life; then of half pay for "7 years after the conclusion of the war." Then, on August 24, 1780, the first national pension law for widows and orphans was passed. This provided for 7 years of half pay for widows or orphaned children of officers who died in service. Then, on March 22, 1783, the so-called Commutation Act was passed, providing 5 years' full pay to officers in lieu of half pay for life. Resentment of "pension officers" by States and communities reached dangerous levels. In New England, the animosity was particularly noticeable.

Congress officially disbanded the Revolutionary Army on November 3, 1783, and the following is a summary of the Pension Bureau's final tabulation of costs of all Revolutionary War pensions, invalid (disability) and service:

Service pensions (to the death of the last survivor in 1879): $46,177,845.
Invalid pensions: estimated as between $3 million and $4 million.
Widows' and other dependents' claims allowed (to the death of the last widow in 1906 and of the last daughter in 1911): $20 million "or slightly more."
Grand total of all Revolutionary War pension disbursements: approximately $70 million.14

MARINE HOSPITALS

In July 1798 the Senate passed, and President John Adams signed, an act for the relief of sick and disabled seamen. The act provided that the master or owner of any American ship coming from a foreign port should pay 20 cents a month for each seaman employed on the

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vessel, the money to be deducted from the seaman's wages and turned over to the collector of the port of entry.

The resulting fund, which in time had to be aided by outright grants from Congress, led to the formation of the marine hospital system. These hospitals were for the care of our merchant seamen, not U.S. Marine Corps veterans as some erroneously believe. At its very outset, the young American Republic did not plan for a large Defense Establishment. It did anticipate a large merchant marine. For example, in 1798, the year the act for the relief of seamen was passed, there were afloat 898 documented American merchant vessels. Of these, 603 were engaged in foreign trade.

In time, the marine hospitals developed into the U.S. Public Health Service, and in 1922 57 Public Health Service hospitals (some of which had been erected as training camp barracks during World War I) were turned over to the Veterans' Bureau. These became the nucleus of the present Veterans' Administration's hospital system.

How the VA hospital system is linked with a deep-rooted past can be further amplified by pointing out that "hospital money" for the support of England's Greenwich Hospital was collected from seamen of the American colonies beginning in 1730. The influence of Greenwich led South Carolina to open a seamen's hospital in Charleston in 1749.

In its "whereas" section, the South Carolina legislation describes, in elegant 18th century language, the very inelegant conditions under which sick sailors putting in at Charlestown had previously been cared for. It told of seamen being lodged in "punch houses" (waterfront inns or taverns frequented by seamen) which emit "noisome smells" and threaten to spread disease among the inhabitants of the town. Virginia passed an act for the relief of seamen in 1780, and North Carolina passed a similar act in 1789. Then, Virginia opened a seamen's hospital in Norfolk in 1788.

The first hospital to be operated by the marine hospital system was the one in Norfolk, Va. This was an existing structure the Federal Government bought in 1801 but used for only a short time. The first of the system's buildings specifically designed and erected as a hospital was opened at Charlestown, Mass., in 1804. Through a series of changes of location in the Boston area, this became the Boston Marine Hospital and the real parent of all future marine hospitals. The Norfolk purchase was but a temporary expedient. Boston was the true beginning.

The first two medical directors of the Boston Marine Hospital were Dr. Thomas Welsh (1799–1804) and Dr. Charles Jarvis (1804–7). The third, Dr. Benjamin Waterhouse, whose term ran from 1807 to 1809, turned out to be one of the most colorful and controversial personalities in American medical history. It was he who persuaded President Thomas Jefferson to adopt vaccination as a national policy. Also, it was he who introduced the first affiliation of a Federal hospital with a medical school. He was able to accomplish this feat because

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of his advantage of being a professor of medicine at Harvard and as well the director of Boston Marine Hospital.

Waterhouse's idea of affiliation did not become a policy of the Boston Marine Hospital or of the marine hospital system after he was compelled, for political reasons, to retire from his Federal position. But interestingly enough, a similar idea, though not inspired by the Waterhouse memory, was adopted by the Veterans' Administration in 1946 and has been in practice ever since.

Throughout the 19th century, as the United States developed its resources and expanded its boundaries, marine hospitals came into being at inland ports as well as at coastal ports. In 1902 the name of the service was changed to Public Health and Marine Hospital Service. In 1912 the name was changed again, this time to the U.S. Public Health Service. The number of population groups, along with merchant seamen, now designated as beneficiaries of the Service includes officers and enlisted men of the Coast Guard, officers and crew members of the Coast and Geodetic Survey, and Federal employees injured on duty. The term "marine hospital" is no longer used officially, but in many cities some of the older hospitals of the Public Health Service are still popularly called by their old name—"Marine Hospital."

The War of 1812

1812-1815:
- U.S. participants: 287,000.
- U.S. deaths in service: 2,000.
- U.S. wounded: 5,000.
- Last veteran died May 13, 1895 (age 105).
- Last dependent died 1946 (age not available).

On the 18th of June 1812, the United States, hardly recovered from its war for independence, declared war on the United Kingdom.

The War of 1812, undertaken in part to capture Canada, expand the western frontier of the United States, and annex Florida, has been described by the noted historians, Professors Morison and Commager, as "a futile and unnecessary war," which was "unsuccessful—and generally unpopular in the United States until it was over." According to the professors further made note of the mistaken early belief, in this country, that the war would be "short * * * a mere frontiersman's frolic into Canada."

"The British," according to Morison and Commager, "absorbed in their struggle with Napoleon, paid little attention to America * * * and not until Napoleon was disposed of [he abdicated in April 1813] did they make any effort to win this outlying conflict." On the other hand, the United States "did not discover Andrew Jackson until the close of the war."

Although the Treaty of Ghent, signed in December 1814 and ratified by the Senate in February 1815, achieved nothing but "the conclusion of hostilities and [a return to] prewar boundaries," the war did little to settle this country's continuing grievances against England. The British had burned the White House as well as other public

18 U.S. Public Health Service, 1798-1893," by Ralph Chester Williams, M.D., Commissioned Officers Association of the U.S. Public Health Service, Washington, D.C., 1931. Chapter I of this is devoted to the foundation of the marine hospitals. Trask, op. cit., pp. 1-11, is more brief on the same subject, but helpful to the general reader, and he quotes the entire act, interestingly worded, which led to the foundation of the seamen's hospital in Charlestown, R.I., in 1749.
20 Ibid., p. 417.
21 Ibid., p. 431.
The American Soldier, 1812. Medical Corps Officer, Light Artillery Sergeant, Light Artillery on the March, Northern Frontier.
buildings. The War of 1812 came to be described later, with incredible inaccuracy, as "The Second War of Independence."

Modern readers, used to today's instantaneous communications systems, find it interesting that Andrew Jackson's decisive victory in the Battle of New Orleans in January 1815 came after the signing of the Treaty of Ghent. This strange historical event occurred because news of the conclusion of hostilities traveled so slowly.

The legislation raising troops for the War of 1812 promised the enlistees the same invalid pensions as had been granted Regular Army ** * * ** that is, $5 a month for enlisted men and up to half-pay for officers, as well as pensions for widows and the dependents of those dying in service, of whom there were approximately 2,000.

As in the case of the veterans of the Revolutionary War, there are no records pertaining to the medical care of the wounded and disabled of the War of 1812. It should be assumed that the 1812 veterans did receive such medical care as was available at the time either at their own expense or as beneficiaries of some echelon of local government.

After the war was over, its veterans, like their predecessors of the Revolution, started a campaign for a service pension. This campaign proved to be a long uphill battle with much of the same violent opposition as the boys of '76 experienced.

Not until February 14, 1871—59 years after the beginning of hostilities—was a service pension authorized for the veterans of the War of 1812. By this time, the number of surviving eligible veterans was so small that the cost was no longer prohibitive, and the opposition died down. The law granted $8 a month for life, regardless of the recipient's income.

Those who had not been loyal to the Union during the Civil War forfeited their rights to this pension. However, this provision was repealed in 1878. Widows married to a veteran prior to the Treaty of Ghent (1815) were also eligible, unless they had remarried. Later, the limitation as to marriage date was removed and the rate to widows was liberalized.

THE INDIAN WARS

From 1817, at intervals, through 1898:

- U.S. participants: 106,000.
- U.S. deaths in service: 1,000.
- U.S. wounded: figure not available.

Throughout the latter part of the 18th century and most of the 19th, the United States fought various hostile Indian tribes.

No statistics that would make a basis for even the roughest of estimates are available from the Indian conflicts of the 18th century. However, beginning with the "Seminole Indian wars" of 1817–18, a number of these conflicts were of sufficient importance to be called, without exaggeration, minor wars.

The uniform custom of Congress has been to extend the benefits of existent pension laws to soldiers disabled in these campaigns, also to their widows and orphans. In general, the Indian war pensions granted were similar to those provided for veterans and dependents of the War of 1812.24

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However, service pensions for veterans of the Indian wars were not voted until 1892. The first service pensions, under the provisions of the act of July 27, 1892, went to those who had fought in certain specified Indian wars between 1832 and 1842. It should be noted that more than one-half a century passed before these service pensions were provided.

The wars then covered were the “Blackfeet Indian wars” (1823), the “LeFevre Indian war” (1827), the “Sac and Fox war” (1831), the “Black Hawk war” (in which Abraham Lincoln commanded a company of Illinois Militia), the “Cherokee and Pawnee disturbances” (1833–39), the resumed “Seminole Indian wars” (1825–42), and various conflicts with the Cayuse, Navaho, Comanche, Kickapoo, Snake, and Sioux Tribes from 1848 (not ceasing during the Civil War) to 1898. Unmarried widows of deceased veterans of these wars were awarded pensions under the 1892 act.

In the early years of the 20th century, the range of years covered by Indian war pensions was extended to include 1817–58, and finally from 1817 to 1898. A 1927 law granted Indian war pensions on the basis of mental or physical disability, and age.

THE MEXICAN WAR

1846–1848:
U.S. participants: 79,000
U.S. deaths in service: 13,250 (1,700 killed in battle and died of wounds; 11,550 died of disease)
U.S. wounded: 3,393
Last veteran died September 3, 1929 (age 98)
Last dependent died June 20, 1963 (age 89)

Today, the little-remembered Mexican War is mainly of interest to historians.

Yet more U.S. combatants died in that war than in our Revolutionary War, War of 1812, and Indian Wars combined. Furthermore, the U.S. death rate of the Mexican War, 13,250 out of 79,000 participants, was approximated in our history only by the Civil War’s casualties, 364,000 out of 2,213,000.

“Manifest destiny” was a popular political catchword toward the middle of the 19th century. It implied “divine sanction for the territorial expansion of the young Nation.” Advocates of “manifest destiny” were very vocal prior to the Mexican War, which, incidentally turned out to be far more advantageous to United States than the abortive War of 1812. The latter war added California, New Mexico, and Texas to our possessions and substantially rounding out the Nation’s continental area, with the exception of Alaska. Only the present southwestern boundary remained. This was accomplished by the 1853 “Gadsden Purchase” from Mexico.

The Mexican War is also of unusual interest to students of military medicine. The deaths in battle, 1,700, as estimated by Morison, were overwhelmingly outnumbered by those from “other causes.” Disease claimed a shocking 11,550. Morison’s casualty figures are

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The American Soldier, 1847. Dragoon, Infantry Officer, Campaign Dress, Infantry Column, Campaign Dress.
approximately those of Ashburn, who gives the total killed and dead from wounds as 1,549. Deaths from sickness were stated as 10,986, for a total death toll of 12,535.28

Ashburn includes in his figures an additional 3,393 “wounded but not mortally.” 28

The U.S. Navy performed outstandingly in this war. On March 9, 1847, using 65 “surf boats,” it landed at Veracruz, Mexico, the entire force brought there by General in Chief of the Army Winfield Scott for the purpose of invading Mexico City. This force consisted of 12,000 men, together with their horses, vehicles, artillery, and supplies.29

The Army, on the other hand, was woefully unprepared, particularly its medical department. “Hospital equipment was practically nil.” 30

Concerning the first general hospital established at Veracruz for Gen. Winfield Scott’s expedition, Surgeon John B. Porter wrote:

There was not a single steward except invalids and incompetent ones: an invalid ward master; no well men left for cooks and nurses *. There was not a single kitchen table, bench, bunk, privy, chamber utensil; in a word, there was nothing but the miserable sick.30

At the beginning of the war, the Army Medical Corps consisted of a Surgeon General, 20 surgeons and 50 “assistant surgeons”—a roster later expanded by the addition of two surgeons and 12 “assistant surgeons.” There were also 48 “volunteer medical officers.” 28

Malaria, dysentery, and yellow fever were the scourges of this war. General Scott, for the march on Mexico City, ordered “one wagon to be assigned to the medical director of each division, for extra medicines and hospital stores.” 31 But the desperate health situation of our Army was indicated in a letter General Scott wrote shortly before he captured Mexico City on September 14: “We have (left behind) about 1,000 sick at Vera Cruz, 1,000 at Jalapa, 200 at Perote, and 1,017 here at Puebla. We have but 5,820 effective enlisted men.”

According to Ashburn, military medicine had, by the mid-19th century, “advanced somewhat beyond that of the Revolution and the War of 1812.” But there were questionings of the value of antiphlogistic treatment to counteract inflammation, amputation on the battlefield, and the debridement (cutting away of dead or contaminated flesh) of wounds. Ether, as an anesthetic, had just come into use, but was not fully accepted. In fact, it was blamed by some military doctors, notably Surgeon John B. Porter, for the high death rates in this war. Surgeon Porter went on record that he had discontinued its use.32

When the Mexican War broke out, Congress passed an act calling for 50,000 volunteers, to be furnished by the States in regiments, each of which was to have one surgeon and one “assistant surgeon.” 33 The same law promised to provide the volunteers the same disability benefits then available to members of the Regular Army.

Between 1848 and 1850, several laws were passed granting benefits to widows and orphans of soldiers who had lost their lives in this war.
Service pensions for Mexican War veterans were authorized in 1887, at the rate of $8 a month for veterans and for surviving widows who were (1) 62 years of age or over, or (2) were disabled or dependent. These pensions were liberalized, and the amounts increased, in later years.

**VETERANS’ “HOMES”**

As recounted earlier, Louis XIV’s enormous *Hotel des Invalides*—which developed out of short-lived “homes” for veterans established by earlier kings of France—was opened in 1675 for the housing of 4,000 pensioners and “dedicated to the care, on a grand scale, of aged and disabled veterans of the French armies.” We have also previously mentioned the story of the founding of the Chelsea Hospital for veterans of the English army. Conceived by Charles II, but not opened until 1692, \(^{34}\) 7 years after his death, the Chelsea Hospital was modeled after the *Hotel des Invalides*.

Brief mention was also made of the opening of the Greenwich Hospital for English seamen in 1702, the last year of the reign of William and Mary.

Although all three of these early institutions were established for the care of aged and disabled veterans and their dependents, rather than solely as domiciliaries, they are considered to be the ancestors of the many soldiers’ and sailors’ “homes” and domiciliaries that later came into being throughout most of the civilized world, including the U.S. Naval Home in Philadelphia and the U.S. Soldiers’ Home in Washington, D.C.

Although neither of these two Federal “homes” for veterans is operated by the Veterans’ Administration, brief descriptions of them will be included, following additional thumbnail material on their European “ancestors.”

Today the *Hotel des Invalides* is little more than a huge war museum containing the tomb of Napoleon. There is still, however, a domiciliary on the grounds, in which a few old soldiers and their wives still live. And there are branches still operative in Louvain, Avignon, Arris, and Nice—each going by the name of *Institution Nationale des Invalides*.

During the 17th, 18th, and 19th centuries, the *Hotel* was crowded with the maimed, the blind, and the mentally ill, all under the care of the Sisters of Charity. Military discipline was the rule at the famous old *Hotel*, which functioned like a garrison. But the morale of the pensioners was good—and so was the bill of fare, which included, of course, wine. Amusements were limited, consisting mainly of cards and skittles (ninepins), but all were permitted to work in their rooms, tend little gardens outside the building, and visit their relatives, if they had any.

The Chelsea Hospital was also organized along military lines, following the structure of an English regiment. Its designed capacity was for 500 “in-pensioners,” but soon this population was greatly outnumbered by the “out-pensioners,” who by 1789 numbered over 20,000. \(^{35}\) In World War II, Chelsea Hospital was bombed and there has been, since then, a continuing trend in England away from centralization of disabled veterans in one institution. As a result,

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\(^{34}\) Op. cit., Glasson, p. 11.

\(^{35}\) Ibid., p. 12.
such veterans have been increasingly scattered among a variety of locations—at Kytes, Derbyshire, and the Duchess of Gloucester House.

The Greenwich Hospital, sponsored by William and Mary—see chapter I, page 21—was established for the care of invalided English seamen. Eligible for admission were those who had served in the Royal Navy or in privateers engaged in the royal service. The population of the Greenwich Hospital rose from an initial 42 in 1702, the year of its founding, to 1,000 in 1738, 2,700 in 1813. In the latter year, there were 12,000 “out-pensioners.” In addition, nurses who were widows of seamen were admitted and the institution was simultaneously used to educate the sons of sailors in seamanship. Greenwich Hospital was cleared of occupants in 1869 and opened as a naval college in 1873, in which capacity it is still in use.35

U.S. NAVAL HOME

In May 1826, the Navy purchased, for $16,250, a 24-acre tract of land near Philadelphia on the banks of the Schuylkill.

On this site, a year later, the cornerstone was laid for the U.S. Naval Asylum—a handsome structure of gray stone with Ionic columns and a large porch on each side. At the ceremony, Com-

mander William Bainbridge, Chairman of the Board of Commissioners of Navy Hospitals, said:

* * * A home will be established here for the faithful tar who has been either worn out or maimed in fighting the battles of his country. A comfortable harbor will be secured where he may safely moor and ride out the ebb of life, free from cares and storms * * *

Its doors opened in 1833.

Thus was established the "permanent asylum for disabled and decrepit navy officers, seamen, and marines" which had been authorized by an 1811 act. The financing of such an "asylum" had been authorized even earlier—in 1799—to consist of deductions of 20 cents a month from persons in the naval service, paralleling the identical deductions from the pay of merchant seamen authorized in 1798. (Since 1935, no deductions have been made from seamen’s pay for support of this home.)

The navy moneys were augmented by the amount of all fines imposed upon naval personnel.

Qualifications for entering were, and still are: the pensioner must be so injured and/or infirm as to be unable to contribute materially to his own support. Also eligible are persons who have served for 20 years, are incapable of further service, but have distinguished themselves by gallantry in action or some other highly meritorious conduct in the naval service.

In 1890, the institution’s name was changed to U.S. Naval Home.

At the present time, much remains unchanged at the home—the physical plant, the regulations, administration, eligibility for admission, and so on. When opened, the site was "near Philadelphia" but the city has grown up and around it, heightening the impression of tranquility a visitor receives on entering the park-like grounds.

Down the decades, all concerned with the home have made great efforts to make it truly a home. Its library, well stocked with newspapers and magazines, is in constant use. Cards, chess, checkers, and backgammon are popular games, and much light work of a hobby nature is done in the workshops—the making of mats, hammocks, etc. Beer is sold in the canteen.

The beneficiaries furnish their own rooms from pocket money or other personal sources. The privacy provided by these small rooms is much prized, as the sense of independence and dignity it produces throughout home fosters a warm atmosphere of comfortable, honorable retirement.

There is a minimum of restriction: the beneficiaries are free to come and go as they please. Passes are allowed for up to 72 hours and extended leaves are granted, in some cases for up to a year. Many of the beneficiaries seldom leave the home, and some are paid a modest wage for work as inside housemen, gate keepers, mail carriers, and so on.

Although officers have always been eligible for admission, its population consists almost entirely of retired or discharged enlisted men of the Navy, Marines, and Coast Guard (while the latter, in wartime, was part of the Navy). The home’s capacity is 350, and, on January 1, 1966, 245 were living there. Of these, but four received some form of retirement pay, pension, compensation, or social security benefits, and the average income was $160 a month. Those without income are given $10 a month for pocket money.
In case of minor illness, beneficiaries are sent to the four-bed infirmary. In case of serious illness, or the need for extended medical treatment, they are sent to the U.S. Naval Hospital in South Philadelphia, 2 miles away.

The U.S. Naval Home provides a warm, congenial atmosphere for the declining years of "old salts"—truly a "snug harbor" for the "sailor home from the sea."

**U.S. SOLDIERS' HOME**

Not until 1828 was a bill for the establishment of an army "home" placed before Congress. It was introduced by Congressman William Ramsey, of Pennsylvania, and called for an "Army Asylum."

It did not pass.

In 1841, the House Committee on Military Affairs, reporting favorably on a similar bill, stated:

"* * * it is not to be disguised that the profession of arms in this country, unlike all other professions and occupations, cuts off the hope of provision for old age. And this, together with the temptations offered by the high price of labor, accounts for the great frequency of desertion, which * * * renders it impossible to fill the ranks of the Army."

It did not pass either.

In 1844, Gen. Winfield Scott lent his strong influence to the cause, having long favored the establishment of a soldiers' home in the United States along the lines of the Hotel des Invalides in Paris.

Public support joined official support, as indicated by the following excerpts from a powerful article appearing in the New Orleans Daily Delta on March 12, 1848—a month after the Mexican War, in which General Scott figured so prominently, was ended by the Treaty of Guadalupe Hidalgo.

The article revealed a terrible situation:

Ever since the Mexican War began, our city has been the depot of all the sick and disabled soldiers who have been discharged from the service * * * melancholy and discouraging spectacles of want * * *.

Every ship and steamer from Mexico lands on our wharves whole companies of unfortunate men who have been cut down in the service of their country by disease or wounds, and who are thrown out of employment in a state of destitution, abandoned by the country which they have served at such severe sacrifice * * *.

The poor rank and file, who have borne the brunt of the fight, drag home their shattered frames, only to lie down and die of poverty, or barely to support existence upon the charity of passers-by. This is * * * revolting to the sensibilities of every republican—of every man. To remove these painful scenes—these disgraceful stains upon the character of our Government—is an object worthy of the highest effort of every philanthropic legislator and patriot * * *.

The establishment of institutions similar to those of Chelsea, in England, and Les Invalides, in France, would go far to effect this object and would remove some of the strongest objections to enlistment in our Army. If men knew that they would be taken care of, in case of disability in the service, there would be a much greater alacrity in joining our Army than exists at present. The present usage is to discharge all men who are unable to perform duty to the cold and uncertain charities of the world.

The impassioned article concluded by pleading that "these great defects in our Military Establishment might be easily removed, and incentives to enlistments created * * * by the establishment of a retreat for disabled soldiers of good character [and] such an establishment could be handsomely supported without drawing upon the Treasury for any addition to the Army expenditures."

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The next development in the long battle for a soldiers' home was more effective than all preceding efforts combined.

On November 3, 1849, General Scott wrote to the Secretary of War, in part as follows:

I enclose herewith a draft for $100,000 [which] I hope you will allow to go to the credit of an Army asylum * * *. The sum is, in small part, the price of American blood so gallantly shed [in the Mexican War]; and, considering that the Army receives no prize money, I repeat the hope that its proposed destination may be approved and carried into effect.

This substantial sum was the residue of some $220,000 which General Scott had gathered, in his progress through Mexico, through levies on captured communities and the expropriation and sale of tobacco owned by the Mexican Government. Parts of this money had been distributed among U.S. soldiers, and parts given to the wounded at hospitals.

Two more years elapsed before, in 1851, an act was passed to utilize the money offered by General Scott, together with the un-
The expended balance of $500,000 which had been appropriated in 1847 to return wounded and disabled veterans of the Mexican War to their homes.

Only the Washington, D.C., installation will be described in this history, but mention should be made of the fact that three "branch homes," established at about the same time were soon closed for various reasons. One at New Orleans opened in 1851 was closed in 1852. One at East Pascagoula, Miss., remained open from 1851 to 1855. The final one at Harrodsburg, Ky., lasted 5 years after its opening in 1853.

The enabling act of March 3, 1851 (9 Stat. 595-7), authorized the establishment of a "Military Asylum for former soldiers of the Army." The act of March 3, 1859 (11 Stat. 434) changed the institution's name to "Soldiers' Home." Solely through usage, it has come to be known as the U.S. Soldiers' Home.

It is much larger than the U.S. Naval Home, its several buildings standing on approximately 300 acres of ground (as compared to the Navy's 24) and its capacity rated as close to 3,000 (as compared to the Navy's 350).

Situated on a sweeping rise of ground at a juncture between Washington Northwest and Washington Northeast, it is in a neighborhood frequented by tourists visiting the nearby national shrine attached to Catholic University. Visitors are welcome to the grounds of the home. In spring and summer they attend concerts given by the home's own musicians in the bandstand near the Upshur Street entrance.

Also near this entrance is the Anderson Cottage, where the few women members of the home reside. Originally, when purchased in 1851, this was called the Riggs Mansion. Here, in the humid Washington summers, President Abraham Lincoln would often stay overnight for the cooler air.

The Veteran's Administration's new 710-bed hospital, opened in April 1965, stands on 34 acres which were formerly part of the land where the U.S. Soldier's Home is located.

The home's eligibility rules and administration are very similar to those of the Navy Home, except that the members of the Army Home are subject to the Articles of War.

The home is open to men and women of the Regular Army and Air Force who have completed 20 years of service; those who have been discharged for disability in line of service; and veterans of all wars who are unable to earn a livelihood due to non-service-connected disability.

The appropriated sums for support of the Washington home, described above, are supplemented by all stoppages and fines adjudged against soldiers, all forfeitures on account of desertions, funds left unclaimed by relatives of deceased soldiers, and post funds of military installations. The home's monetary support is further augmented by a levy, once 25 cents a month but now $1.20, on the pay of all Army enlisted men and warrant officers.

The home's aggregate fund, down through the decades, has grown to over $98 million as of January 1, 1966. Practically all of the members have an income from various sources, such as retirement pay,

38 Ibid., p. 135.
social security, etc. Those without income of any sort are given $10 per month from the home funds. Quite a few men own automobiles, which they keep on the home premises.

As at the Navy Home, the Army provides many recreational facilities—a library, hobby workshops, rooms for chess and checkers, frequent fishing and bowling trips.

Beer is sold in the canteen between 8 a.m. and 10 p.m., except on Sunday, when the hours are shortened to 1 to 10 p.m. The home's administration believes, as does the Navy, that making beer easily available at the home considerably lessens any tendency to go outside for a drink.

The home's members, in addition to monthly checkups, are afforded excellent care at the home's recently constructed 457-bed hospital. If surgery is required they are sent to Walter Reed Hospital; if mentally ill, a transfer is arranged to St. Elizabeths Hospital.

The home, as this brief description indicates, is not a charitable institution, but rather a haven for veterans of the Regular Army or Air Force. For well over a hundred years now, the U.S. Soldiers' Home has given its members, in their declining years, comfort, good living, and a feeling of freedom and independence—all at no cost to the taxpayer.

ST. ELIZABETHS HOSPITAL AND DOROTHEA LINDE DIX

Military psychiatry was introduced to this country at St. Elizabeths Hospital, Washington, D.C. Founded in 1855, it is today one of the world's largest and best known institutions for the care and treatment of the mentally ill. Although never a unit of the Veterans' Bureau or the Veterans' Administration, St. Elizabeths does, however, accommodate among its 6,700 beds 350 set aside for former members of the Armed Forces who are mentally ill. The VA reimburses the hospital for the care of these patients.

From the beginning, St. Elizabeths has been a leader in its field. It has trained thousands of psychiatrists, psychologists, and psychiatric nurses, as well as social workers, chaplains, and occupational therapists. It was the first hospital in the Americas to use the malaria treatment for paresis and is believed to have been the first American hospital to use the psychoanalytic technique in the treatment of schizopirenia.

In World War II, hundreds of medical officers, nurses, corpsmen, and Red Cross workers received their orientation in psychiatry there. More recently, the hospital has pioneered in the use of the arts, including psychodrama, music, and the dance, as therapeutic disciplines.

Originally named "The Government Hospital for the Insane," it was intended for the mentally ill of the Army, the Navy, and the District of Columbia. In 1916 its name was officially changed to St. Elizabeths, the old name of the tract of land on which it is located, across the Anacostia River in the District of Columbia. It was under the Department of the Interior from 1855 to 1940, and the Federal Security Agency from 1940 to 1952.

40 Material abstracted from various documents in the portfolio "Centennial Activities at St. Elizabeths Hospital, 1855-1955." This portfolio is unpublished, but is available to researchers upon request. It is noteworthy that three documents were prepared not only by members of St. Elizabeths medical and administrative staff, but also by patients of the hospital.
Since then, it has been under the Department of Health, Education, and Welfare.

This great institution is largely the creation of one great woman, Dorothea Linde Dix.

Miss Dix (1802-87) was born in Hampden, Mass. After completing her education, she became a schoolteacher, a lecturer, and an author of books for children. Suffering a physical collapse at age 34, she went to the estate of friends in England to recuperate. Eighteen months later, when her grandmother died, she returned to the United States. The grandmother's will provided her with an annual lifetime income of $3,000, a comfortable amount in those times, and never afterward would she accept compensation for any of her many services to mankind.

In 1841, she volunteered to teach a Sunday school class in the East Cambridge, Mass., jail. Among the inmates was a group of the insane. These, Miss Dix was shocked to discover, were treated less considerately than beasts of burden. Determined to discover how similar unfortunate were treated elsewhere, she visited jails, almshouses, asylums, and hospitals in Massachusetts, then in several other States and eventually in several countries of Europe.

Everywhere she went, she besought the authorities to show more consideration and to make better provision for the mentally afflicted than was generally common in the 19th century. She was not always unsuccessful in her one-woman crusade.

Capable of being gracious and persuasive with the people she sought to influence, she once talked so kindly to a man hospitalized for being violently and incurably insane that 2 months later, no longer in chains, he was performing useful chores around the building because he became convinced by Miss Dix that he possessed value as a human being.

Unfortunately, as Superintendent of Nurses of the Union Army during the Civil War, she was prejudiced against nurses who were under 30, or who were pretty, or who wore the garb of the Sisters of Charity or the Sisters of Mercy. Nor was she always an effective and practical administrator. Therefore, at the urgent requests of physicians and officers in the field, the Army Surgeon General would often override her and appoint as nurses any women, young or not young, pretty or plain, in religious garb or civilian garb, who showed ability and willingness to minister to wounded and suffering soldiers.

In 1852, Miss Dix persuaded Congress to appropriate $100,000 for the insane of the Army and Navy. Of this amount, $25,000 was earmarked for a land purchase. The owner of the selected property, called "St. Elizabeth's," asked $30,000 for it. Once again Miss Dix put her persuasive powers to work and the seller brought his price down to $25,000.

In her lifetime, Miss Dix did not seek personal publicity, and politely declined to permit buildings or institutions to be named in her honor. However, the recently built (1936) admissions building at St. Elizabeths is fittingly called the Dorothea Linde Dix Pavilion.

And the eminent historian, Samuel Eliot Morison, on page 517 of his new "Oxford History of the American People," devotes a long paragraph of tribute to her. Although rarely mentioned, if at all, in similar books written in the past, she is now getting the recognition she did not seek. But what she did seek—recognition of the human importance of the mentally ill—is steadily increasing.

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The American Soldier, 1863. Engineer Officer, Infantry Sergeant. Western Theater, Artillery and Infantry Advancing.
CHAPTER III

THE CIVIL WAR, 1861–65

Union forces: 1

Participants ........................................................................... 2,325,000
Deaths in service ................................................................. 359,528
Deaths in battle ................................................................. 110,238
Deaths from other causes ................................................... 249,290
Wounded .............................................................................. 280,040

Confederate forces (estimate):

Participants ........................................................................... 781,200
Deaths in service ................................................................. 153,300
Deaths in battle ................................................................. 94,000
Deaths from other causes ................................................... 59,300
Wounded .............................................................................. 100,000


INDUCTION "EXAMINATIONS"

Today, it is difficult to conceive of medical induction "examinations" that consisted of "opening and shutting [recruits'] hands, bending the elbows and knees, and rotating the shoulder joint, with a casual glance at the teeth and eyes and a question as to age and previous general health." 1

Or "passing recruits at the rate of 90 an hour" after merely "looking at [their] legs and groins." 1

Or a mass "examination" consisting of an entire regiment marching in the rain past an Army medical officer who, observing them only visually, "passed" all of them, except for "seven or eight bad cases" that he saw. 1

Yet this was the perfunctory, ridiculous way in which northern recruits were "examined" in the early days of the Civil War, under the strains and confusions caused by the urgent need for men, the pleas of recruits eager to serve, and the pressures of unscrupulous recruiting agents.

Actually, Army regulations applicable at the time called for far more thorough examinations, although they were sketchy by modern standards:

In passing the recruit, the medical officer is to examine him stripped; to see that he has the free use of all his limbs; that his chest is ample; that his hearing, vision, and speech are perfect; that he has no tumors; no ulcerated legs; no rupture or chronic cutaneous affection; that he has not received any contusion or wound of the head that may impair his faculties; that he is not subject to convulsions; and that he has no infectious disorder that may unfit him for military service. 1

But even these basic and elementary requirements were ignored in those frantic early days after Sumter. It is small wonder, therefore, that—

Some 400 women successfully enrolled in the Union Army as men;

Sec footnotes on p. 80.

(49)
Of the 90-day volunteers responding to Lincoln's first call 15 to 20 percent were reported to be incapacitated by disabilities incurred before entering service;

Chronic cases were soon clogging hospital beds that were needed for battle casualties;

These chronic cases included men between 60 and 70, some of whom suffered from hernia, epilepsy, and syphilis; and

Disabled men began pouring out of the Union forces in 1861 as though out of a sieve. To cite one instance, the Medical Director of the Army of the Potomac reported that, out of 3,929 men discharged during October, November, and December of 1861, 2,881 were released due to preenlistment defects or diseases.¹

Gen. George B. McClellan, commander of the Army of the Potomac and later general in chief of all the armies of the Republic, took steps to halt these disgraceful induction procedures. The first was War Department General Order 51, August 3, 1861, requiring regimental surgeons to examine their men. This order by its sheer novelty, startled its recipients. Lack of compliance with this order led to General Order 104, December 3, 1861, calling attention to the Union's alarming losses through disability discharges and providing punishment for delinquent surgeons.²

**UNION ARMY**

At the beginning of 1861, the U.S. Regular Army strength stood at 16,367: (15,259 enlisted men and 1,108 officers), organized in 19 regiments (10 infantry, two dragoons, four artillery, two cavalry, and one mounted riflemen). It is noted in the official "History of Military Mobilization in the U.S. Army" that "Even after the firing on Fort Sumter, it was impossible to concentrate all the Regular Army without stripping the frontier of its defenses against the Indians." (After Sumter, 313 officers, but "few if any enlisted men," resigned or joined the Confederacy.)³

This tiny army was untrained for large-scale operations and its higher echelons were commanded by elderly officers, due largely to the lack of provisions for retirement for either age or disability. But before the war's end, it enrolled a total of 2,325,000. However, its total on-duty strength never, at any one time, reached half that number, owing to four factors:

1. Short terms of enlistment and service;
2. Over 200,000 discharges for disability, many, as previously stated, caused by careless, or nonexistent, medical examinations at induction;
3. Heavy casualties—killed in battle or dead from "other causes"; and
4. Heavy desertion rate—16,365 deserted from the Regular Army and 182,680 from volunteer units.⁴

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⁴ Ibid., p. 97.
MEDICAL CORPS

In the early days of the war, the medical corps situation in the Union forces presented, by and large, a picture as dismal as that of the recruits.

On January 1, 1861, the medical staff of the Army consisted of the Surgeon General, 30 surgeons, and 83 assistant surgeons. Of these, three surgeons and 21 assistant surgeons of southern origin resigned to serve with their home States. Five surgeons and eight assistants, even though hailing from States which had seceded, remained with the Union Army. Three assistant surgeons were dismissed for disloyalty. Thus the Union’s medical corps began its Civil War service with less than 100 officers.

The Surgeon General, Col. Thomas Lawson, a veteran of the War of 1812, was over 80 years old. Seniority had elevated him to the top spot and, in the absence of a retirement system, he had stayed on and on.

His principal efforts, according to military historians, lay in holding down expenses and he is reported to have considered the purchase of medical books an extravagance in the corps which he commanded. It is also reported that he became angered when he learned that one Army post owned two sets of surgical instruments.

The colonel was also concerned about the military status of the medical corps, having in 1847 secured the passage of an act conferring military rank on Army doctors.

It is not surprising that the onset of the Civil War found the Army Medical Department unprepared for the gigantic job that lay ahead.

However, the political and moral climate of the period was favorable for rapid improvement in both the military and civilian care of Civil War wounded and disabled. The country was becoming increasingly conscious of the need for improving the lot of the underprivileged and impoverished. It was typical of the temper of the times that, as the war moved on into its ever more terrible reality, the care of the wounded and the sick became a matter of ever deeper concern.

In April 1861, the headquarters of the Army’s Medical Department in Washington was staffed by the Surgeon General, two surgeons, two assistant surgeons, and three clerks.

Regiments of the first 75,000 Union volunteers furnished their own surgeons, without reference to their professional qualifications. As additional regiments were called, each was required to have an assistant surgeon who had been commissioned by the Governor of the State concerned—after an examination.

It is an understatement to say that these appointments were haphazard. Some Governors issued commissions without examinations. Some States assigned the power of appointment to colonels, again requiring no examination. Men without medical degrees were frequently recommended—and appointed.

One notorious case was the recommendation for appointment as surgeon of an individual whose sole medical qualifications consisted...
of a term of service as a hospital steward and a year of "reading" in a doctor's office.

PENSIONS AND BOUNTIES

In an extraordinary session convened on July 14, 1861, Congress authorized the President to accept the services of up to 500,000 volunteers. Pension benefits were authorized on the same basis as for personnel of the Regular Army. Widows or legal heirs of those killed in service were promised $100, in addition to any back pay or allowances due.

For a year, these benefits applied only to the half-million volunteers authorized, but in July of 1862 this gap was closed with passage of the "general law" pension system. Now those disabled in line of duty were pensioned as well as the widows, children, and dependent relatives of those dying while performing military duty. This law, although amended and broadened in later years, remained in effect until the Spanish-American War, for both peacetime and war veterans.

Bounties had been used by the United States in previous wars, as an aid in recruitment under the volunteer system. But, because the Civil War was fought on a scale larger than any heretofore known, bounty payments came to staggering totals for that day. They were paid by the county and/or State, and varied accordingly.

There was much local competition in bounty payments and they became progressively higher as communities vied with each other to get recruits.

Of all the men "raised" by the North during the Civil War, only 6 percent can be ascribed to the highly unpopular draft process. The principal importance of the Enrollment Act of 1863 lay not in its effect on manpower procurement but in the fact that it "established firmly the principle that every citizen owes the Nation the obligation to defend it and that the Federal Government can impose that obligation directly on the citizen without mediation of the States. Of almost equal importance were the lessons learned from the Civil War draft which served as the basis for the well-planned selective service laws of World Wars I and II."

THE U.S. SANITARY COMMISSION

Well-known to the American public were the horrors of the Crimean War (1854-56) during which the British Army's mortality rate was appalling. England sent Florence Nightingale to help reduce this rate. In one of the earliest formal attempts by civilians to improve the lot of wounded soldiers, she placed in effect a radical program of hospital reform, sanitation, and preventive measures which operated under a civil commission composed of three British sanitarians. Its name: the British Sanitary Commission.7

According to Dr. William Quentin Maxwell, author of "Lincoln's Fifth Wheel," the British Sanitary Commission "produced astonishing results." The death rate in the Crimea, according to Dr. Maxwell, dropped from 293 out of every 1,000 in September 1854 to "only 25 out of every 1,000" in January 1856.8

Immediately after the outbreak of the Civil War, many civic-minded groups throughout the North sprang into being, dedicated to insuring that this country would not neglect its responsibilities to its wartime sick and wounded.

The first such group appeared in Bridgeport, Conn., on April 15, 1861, the day after the surrender at Fort Sumter. Within the week, sister groups—committed to the unselfish, patriotic task of cheering the recruits and supplying them with necessities and comforts—formed at Lowell and Charlestown, Mass.; Newport, R.I.; Cleveland, Ohio; and New York City. All these groups took action against the increasingly ominous future by collecting articles likely to be of use in the care of casualties—such as bandages, splints, medicines, quilts, blankets, pillows for wounded limbs, socks, etc.—and by enrolling in nursing courses at leading hospitals.

Several of the groups, supported by schools and churches, joined forces under the name of the Women's Central Association of Relief. A list of questions asking how they could be of service was prepared and sent to the Surgeon General of the Army in Washington. This questionnaire was, to put it mildly, poorly received. The Federal medical authorities made it clear that they regarded the new, eager association as a nuisance, its list of questions impertinent. The association was informed that the Medical Department was "fully roused and fully competent," the Surgeon General pointing with pride to the Department's work in the Mexican War as an example.  

Undaunted, a delegation was sent to Washington to learn at first hand what needed to be done. Arriving on May 16, the delegation found that new regiments were being kept standing in the streets, unfed for 12 to 18 hours, because their officers did not know how to requisition food and shelter. The regiments' volunteer surgeons "did not know how to procure medicines and every bureau of the War Department seemed to be in wild disorder."  

The upshot was that the delegation boldly requested the Secretary of War to establish a commission to help correct these and many other irregularities and inadequacies, including the outrageously superficial "examinations" of recruits.

Although proponents of the plan asked for neither legal powers nor money, the proposal did not strike a responsive chord in Washington. Even President Lincoln saw no point in such an organization, fearing it would be "a fifth wheel to the coach."

(The President's phrase became famous. As mentioned earlier, Dr. William Quentin Maxwell wrote a book entitled "Lincoln's Fifth Wheel." Prof. Allan Nevins, in his preface to Maxwell's book, succinctly explains the expression: "The Army's wagon has always required four wheels: the quartermaster's services, the commissary, the transportation services, and the medical and surgical care." However, as will be seen, the Commission proved to be the opposite of an unnecessary "fifth wheel," functioning, instead, throughout the course of the war, as an enormously valuable adjunct to the often overwhelmed, and sometimes bungling, Medical Corps.)

The delegation to Washington, despite the official coolness it encountered, continued its pressure, and, in surprisingly short order—
considering the usual sluggish tempo of bureaucracy, even in times of emergency—the document establishing the commission was forwarded to the Secretary of War. He signed it on June 9, 1861. The President, apparently thinking better of his earlier doubt, approved it on June 13th, two days less than two months after the surrender at Fort Sumter.

The original name given in the document of authorization was: "A Commission of Inquiry and Advice in Respect to the Sanitary Interest of the United States Forces." This clumsy name soon, and thereafter, was shortened by popular usage to "U.S. Sanitary Commission"—a title which was obviously derived from the brilliantly successful British Sanitary Commission.

Thus, to the vast Civil War burst of makeshift methods, erratic and spasmodic organization; a new force in American life was added, idealistic, orderly, and skilled. The Commission's name was unglamorous but its members were superbly dedicated to service.

Prominent in its distinguished leadership were its president, the Reverend Dr. Henry Whitney Bellows, minister of the All Souls Unitarian Church of New York; its corresponding secretary, Dr. Elisha Harris, a leading New York physician; and its executive secretary, Frederick Law Olmsted, noted architect and designer and superintendent of New York City's Central Park. Drs. Bellows and Harris were the joint originators of the idea for this splendidly humanitarian project.

The Commission received the broad powers to investigate and advise that it had asked for. Subject to the approval of the Secretary of War, it could write its own rules and regulations. Its main self-assigned responsibilities were:

- to examine the workings of the system by which recruits were enlisted;
- to keep itself informed as to the sanitary condition of the various regiments—their camp sites and the camps themselves, drainage capabilities, etc.;
- to suggest means of preserving and restoring the health of the troops and their comfort and efficiency;
- to suggest provisions for cooks, nurses, and hospitals; and
- to provide such supplementary aid, over and above that provided by the Government, as the generosity of private citizens might enable it to give.

Throughout the war and up to May 1866, when the Commission disbanded, it collected, in privately subscribed donations, approximately $5 million—or exactly $4,924,480.99, according to the amazingly precise figures compiled by Miss Katharine Prescott Wormeley. Miss Wormeley, who was passionately active in the work of the Commission, was the author of an eloquent book, "The Other Side of War," published in 1889. Worthy of note here is a comment in her book which showed her keen awareness of one of the most deplorable medical aspects of the Civil War: "Alas, it is not battle which is destroying so many lives as it is the terrible decimating diseases brought on by exposure and hardship and the climate of marshes and watercourses")

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Another $2 million was raised by the Commission’s 11 branch offices throughout the North.

According to Carl Sandburg, $15 million worth of bedding, clothing, vegetables, and other foods went to the troops through the instrumentality of the Commission.13

The great “Sanitary Fairs” sponsored by the Commission in various major cities raised $2,736,888.94.12

These figures constitute the components of the generally agreed-upon value of $25 million of— as defined by Professor Nevins— “the Commission’s public services: money, goods, and personal help.”14

THE USSC IN ACTION

Some of the outstanding achievements of the Commission were:

it sent inspectors and supplies to the scene of some 500 military encounters;

it organized 7,000 “aid societies” throughout the North, finally bringing virtually all the women in the North into effective contact with the war effort;

it set up lodges where exhausted or convalescent soldiers could find food and shelter (the impressive statistics: 2,300 men lodged, on the average, during every night of the war years; 1 million night’s lodgings provided; 4,500,000 meals served);

it kept the soldiers in touch with their families and friends through the use of an enormous directory it compiled;

it helped veterans secure their bounties, get their back pay, and apply for their pensions;

it distributed among the army surgeons some 5,000 monographs on recent advances in medicine;17 and

it outfitted and manned hospital ships to take wounded soldiers from port to port, in particular transporting those wounded in the Virginia Peninsular Campaign to hospitals in New York and New England.

On July 21, 1862, the Commission brought its powerful influence to bear on the atrocious recruiting “examinations” still practiced by the Army. On that date, the executive committee of the Commission wrote a letter to the President which stated:

The careless and superficial medical inspection of recruits made 25% of the volunteer army raised last year not only utterly useless but a positive encumbrance and embarrassment that now seriously retards the recruiting of the new levies we so urgently need.

Although there was no formal agreement between the Union and the Confederacy on the care and treatment of prisoners of war, aid was given by the Commission to Union personnel in Confederate prison camps “whenever the door has been opened.” The Commission also extended “to the Confederate prisoners in our keeping all the succor and human care [that] the claims of a common humanity have required, establishing the principle and usages of neutrality in respect to the treatment of such persons.”16

15 Ibid., p. 9.
CONFEDERATE MEDICAL CARE

The South was even worse off than the North, because the Federal blockade systematically prevented the importation from Europe of drugs and surgical supplies through Confederate ports.

Certain individual Confederate physicians, particularly Dr. Simon Baruch of South Carolina, father of Bernard Baruch, performed wonders of medical competence with meager materials.17

But the overall medical picture in the South was inexpressibly miserable:

The South’s losses in human wealth were pathetic. It was forced to skip almost a generation of young men, dead of disease, killed in battle, or wounded into economic in competency * * *. The wounded came back generally with the loss of an arm or leg. In some communities, at least a third of the veterans lacked a limb. Mississippi spent in 1866 a fifth of her revenues on artificial arms and legs.18

According to H. H. Cunningham, author of "Doctors in Gray," criticism of Confederate medical officers was rife during the war. The most frequently heard charges were that they were "inexperienced, ignorant, inefficient, neglectful, cruel, and having a propensity for strong drink."

Some Richmond surgeons, according to Cunningham, "under fire for the first time suffered an attack of shell fever and did not stop running until they were 12 miles from their original position—a tribute perhaps," the author drily added, "to their physical condition."19

But Cunningham, a few pages later, acknowledged that such accusations, and rumors of accusations, were far overbalanced by praise from high quarters. "Humanity," "professional skill," "unselfish devotion," "untiring in their devotion to the wounded" were phrases descriptive of Confederate surgeons expressed by President Jefferson Davis, and Generals Lee, Beauregard, and Longstreet. After the battle of Chancellorsville, Dr. Lafayette Guild boasted of the medical officers of the Army of Northern Virginia that "as a body of professional gentlemen [they compared] favorably with any other similar organization upon this Continent. Their conduct on many bloody battlefields has secured to them an enviable reputation, and has elicited praise from all who witnessed their noble self-sacrifice during and after a battle."20

THE SANITARY FAIRS

Reference was made earlier to "the great Sanitary Fairs" which were held in various northern cities by the Sanitary Commission. They merit being called "great," for they were attended by what Carl Sandburg described as "immense crowds," and the public that swarmed to them competed patriotically to supply gifts to be auctioned off. Equal enthusiasm and generosity was shown as well in the bidding. As noted earlier, a total of nearly $2,737,000 was raised at these fairs for the benefit of the Union troops.

At a New York Sanitary Fair, the actress Fanny Kemble donated a book containing the signatures of all the U.S. Presidents, including Lincoln. Also auctioned off were a trotting mare named Lady

20 Ibid., pp. 260-261.
Woodruff and the jewels of a lady of Spanish descent who was a strong champion of the cause of the North. Lincoln himself donated his original handwritten draft of the Emancipation Proclamation and a pen-and-ink draft of the Gettysburg Address.

A vivid impression of these occasions emerges from a Lincoln anecdote told by Sandburg. Women, usually dressed in their best, were much in evidence at the sanitary fairs. When Lincoln was invited to attend a Chicago fair, he replied: "What do you suppose my wife would say to ten thousand ladies coming at me in that style?"

Another picture emerges from a reference in Leslie's Weekly to the wounded Union volunteer, aged 70, who was on view at one of the fairs. "Such sights," the magazine stated, "bring to us the reality of the great struggle and make us see the earnestness of purpose and necessity that underlies all the dazzle, beauty, and fashion of these great fairs." 21

EVALUATIONS OF THE USSC

Although the Commission encountered much obstruction at some military levels—particularly from Secretary of War Edward M. Stanton, who "continually impeded it * * * out of mere jealous prejudice"—the leading Union generals hailed its work as invaluable. According to Allan Nevins, "The generals in the field, quickly learning how unselfish and efficient [the Commission's] labors were, raised a unanimous chorus of praise." 22

Professor Nevins, in an overall evaluation of the Commission, called it "the great philanthropic organization which did so much to save lives and alleviate agony during the four years of the conflict."

He continued: "In a nation which had no medical association, no nursing schools, no apparatus for meeting a sudden strain on hospital facilities, the Commission mobilized the best talent available for the war emergency. One of the facts which appalls the student of the Civil War is the enormous amount of suffering that occurred on the field and in hospitals. The work of Pasteur and Lister lay, so far as any application to surgery went, well in the future. Almost every abdominal wound meant death. Any severe laceration meant amputation, with a good chance of mortal gangrene or erysipelas."

In truth, after-battle scenes of the Civil War were like those pictured in Dante's "Inferno." The air was filled with groans, screams, sobs, and curses. To lose consciousness could be a mercy. Then the rain would fall on the inert, broken, and bleeding bodies, and pneumonia would take over.

Nevins again: "Surgeons on both sides were men of sympathy and kindness, but they worked in soiled uniforms, used bloodstained bandages, whetted their knives on the nearest wooden fence and wiped them on the nearest dirty rag. So rudimentary was knowledge of hospital sanitation that surgeons marveled when tent hospitals, open to the clean winds and sunshine, proved healthier than wooden buildings with dirty walls and filth-soaked floors. Every house [in battle areas] was converted into a hospital, where the floors were covered with wretches, sometimes with arms or legs torn off, who, after the first bandages, got no medical care, no nursing, not even nourishment. The pain and anguish, the callous neglect, and needless loss of life,

would have been far greater but for the heroic labor of the Sanitary Commission [which] became an instrumentality in which Americans might well take the deepest pride. It was * * * the most powerful organization for lessening the horrors, and reducing the losses of war which mankind had thus far produced." 23

But it was from two people closely associated with the Commission that the most eloquent tributes to its performance were to come.

The Reverend Doctor Henry Whitney Bellows surely had in mind the great humane organization of which he was president when he said: "What chloroform is to surgery, humanity is to war. It does not stop the bloodshed, but it spares needless suffering."

The previously mentioned Miss Wormeley, author of "The Other Side of War," called the Commission "the great artery which bears the people's love to the people's army." 24 And when war-caused death, maiming, and agony were at their height, she made a fervent plea. "I hope the people will continue to sustain the Commission," she wrote. "Hundreds of lives are being saved by it. I have seen with my own eyes in one week fifty men who must have died without it. And I speak if lives saved only; the amount of suffering saved is incalculable." 25

**USCC LEGACIES**

One of the nurses who volunteered to help wounded soldiers was Clara Barton, later to introduce the Red Cross to the United States. And the famous Dorothea Linde Dix (see pages in ch. II) although not a member of the USCC, was granted a commission as "Superintendent of Nurses, U.S. Army." She was responsible for organizing and training the nursing staff which functioned during the war, and did much to screen and prepare the Commission's nursing volunteers.

The Commission furthermore gave early (1862) attention to "matters of great importance respecting the more permanent wants of the disabled classes." 26 (The resultant Perkins report and Ordonaux report, undertaken in August 1862, will be treated later.)

In its own words, the Commission was "much exercised with the subject of the future of the disabled soldiers of this war and [calculated] that if it continues a year longer, not less than 100,000 men of impaired vigor, maimed, or broken in body and spirit, will be thrown on the country. Add to this a tide of another 100,000 demoralized for civil life by military habits and it is easy to see what a * * * burden to [our] already strained resources is in store for us * * *. We want to economize our battered heroes, and take care of them in such a way as to maintain the military spirit and the national pride * * * and to keep in the eye of the Nation the price of its liberties." 27

From a later (1865) Commission report, the following is extracted: "Too much cannot by any possibility be done for the men who have become disabled in the war * * * to do all we may for their comfort, we shall never half repay them for the sacrifices they have made or half balance our debt of gratitude." 28

23 Ibid., pp. 1-111 (preface).
26 USCC Doc. No. 49, October 1862.*
27 USCC Doc. No. 4042, May 1865.*
* In connection with footnotes 28 and 29, the Perkins Proposals are also covered from pages 154 to 162, and the Ordonaux Proposals from pages 162 to 165 of "Public Policy Towards the Employment, Retirement, and Rehabilitation of the Old Soldier," a thesis presented to the faculty of the Graduate School of Cornell University for the degree of doctor of philosophy, by Thomas Henry Patton, Jr., June 1899, published by University Microfilms, Inc., Ann Arbor, Mich.
Finally, in its sponsorship of the "Perkins Proposals," the Commission helped lay the groundwork for the domiciliary and medical care of economically depressed or physically disabled veterans. How those proposals eventually affected the large veteran population of the post-Civil War period will be told in the next section of this chapter.

A few statistics will show how well justified this concern for the future was: from April 1861 to July 1865, 1,057,423 of Union wounded and sick had been treated in 204 Government hospitals which, at the end of the war, had a total capacity of 136,894 beds.

THE USSC LOOKS AHEAD

As early as August 1862, long before the Civil War was over, the Sanitary Commission, anticipating the postwar period, requested Stephen H. Perkins, a Boston philanthropist, to inquire into European systems of care for disabled veterans. Perkins accepted the mission and spent the winter of 1862–63 in France, Prussia, Austria, and Italy. He visited personally all the important establishments for veterans and was especially watchful for features which might be applicable to the United States as well as pitfalls which might be avoided.

As a result of his investigations, Perkins proposed that compensation should be paid to every permanently disabled veteran, with a maximum rate (for injuries equivalent to the loss of one limb) and a minimum rate (for minor injuries). He also urged that the Government should establish in every State, "industrial villages" for disabled veterans. This idea, in modified form, was gradually adopted by many of the States and can well be regarded as the beginning of State soldiers' homes.

The Commission also requested Dr. John Ordronaux, professor of medical jurisprudence at Columbia College, New York City, to prepare a study on the postwar care of disabled veterans.

Dr. Ordronaux suggested settling veterans on the public lands, employing them on the Pacific railroad projects, giving them civil service preference, establishing an employment service for them in the large cities, and modeled on the European idea, if their physical condition permitted, using them as garrison forces.

The Sanitary Commission did not accept all of the Perkins or Ordronaux proposals, nor were all of its own ideas eventually adopted by the Federal or State Governments. The Commission itself, for example, was strongly opposed to Federal care for veterans, favoring instead, family care supported by local community action. This was undoubtedly the result of its success with the many local organizations which supported its wartime work and its difficulties with the Washington bureaucracy.

What the Commission accomplished, however, was more important than any adoption, rejection, or modification of its specific proposals for the care of veterans. Its most creative accomplishment was the national interest it aroused in the necessity for such care when the war was over. That interest resulted in the founding by Congress of the National Home for Disabled Volunteer Soldiers, one of the forerunners of the Veterans' Administration's modern medical program.
Chapter IV

The National Home for Disabled Volunteer Soldiers

(The official name was "National Home" (singular), but for the convenience of the reader the term "National Homes" (plural) will be used in the text. When the "Home," a national organization with branches in 11 localities throughout the country, and therefore 11 homes, was absorbed in 1930 into the Veterans' Administration, the VA itself gave it the name of National Homes Service.)

Of special interest at the beginning of the story of the national homes is the fact that one of the principal advocates of the national, as opposed to the local approach to veterans' care, was Fred N. Knapp, superintendent of special relief of the Sanitary Commission. Differing with the locally oriented thinking of the Commission’s Rev. Dr. Bellows, Mr. Knapp supported the development of semimilitary institutions which would be a combination of home, workshop, and trade school. He urged the buildings not be constructed in a lavish style. They had to be made available quickly, otherwise the “sanitaria,” as he called them, would not be helpful to those discharged veterans who desperately needed immediate care.

On the whole, it was Knapp’s ideas, rather than those of the Rev. Dr. Bellows, which prevailed with Congress. It can therefore probably be claimed with justification that if the national homes were not a direct outgrowth of the Sanitary Commission, they derived, at least indirectly, and in no small measure, from an important official of that organization.

Ideas * * * actions * * * results: these were the Commission’s contributions to the life of this crucial period in American history. What precise degree of credit is due to Bellows, Perkins, Ordronaux, Knapp, and other private citizens is difficult if not impossible to determine. Private citizens deserve as much credit as legislators.

On February 28, 1865, Senator Henry Wilson, of Massachusetts (who later, from 1873 to 1875, served as Vice President under Ulysses S. Grant) introduced "An act to incorporate a national military and naval asylum for the relief of totally disabled officers and men of the Voluntary Forces of the United States." The act, after passing both Houses of Congress in the remarkable time of 2 days, was signed by President Lincoln on March 3, 1865, 6 weeks before his assassination. On March 5, Congress incorporated what was at first called the National Asylum for Disabled Volunteer Soldiers and Sailors. An act of January 23, 1873, changed the word "asylum" to the word "home."

The incorporation of 1865 called for a directorship of 100, but the distinguished members—including Andrew Johnson, Ulysses S. Grant, William T. Sherman, Carl Schurz, Horace Greeley, Oliver Wendell Holmes, and Henry Ward Beecher—could never assemble a quorum. The development of the National Homes was thereby held up for an

(61)
entire year until an amendment of March 2, 1866, provided that the business of the institution be administered by a board of managers with 12 members. These were to be the President of the United States, the Chief Justice, and the Secretary of War all three ex officio, together with nine other citizens, not Members of Congress, no two of whom should be residents of the same State, and none being eligible who had given aid to the Confederacy. Members of the board were not salaried, although they received expenses. Responsibility of the board was to Congress, not to the executive branch. During the 64 years of existence of the homes (1860–1930), the President who most frequently welcomed the board of managers to meet with him was Theodore Roosevelt.

At first, the homes were intended only for Union veterans who suffered economic distress from disabilities incurred during the Civil War. But after a series of acts passed during the 1880’s—principally Public Law 114, May 2, 1887—they were opened to veterans suffering economic distress from disabilities not incurred in military service.

Moreover, Public Laws 120 and 121, July 8, 1884, permitted admission of veterans of the War of 1812 and the Mexican War. And Public Law 217, May 26, 1900, permitted admission of veterans of "any war in which the country has been engaged." Thus the homes were opened to veterans of the Spanish-American War.

During the 19th century, access to a national home was considered to be admission to a place of residence, not a hospital. Medical care was incidental to residency at the outset; thus medical care was only on what might be described as an infirmary level. But by 1930, when the various national homes were absorbed by the Veterans' Administration, the infirmary level had risen to an accredited hospital level. Throughout the 1920's the Veterans' Bureau had been contributing to the homes, which helped improve the level of medical care. Down through the years, two generations of successive boards of managers had done their work well.¹

THE WORK OF THE BOARD OF MANAGERS ²

The board of managers of the national homes held its first meeting on May 16, 1866, in Washington, D.C.

The board's first President, Maj. Gen. Benjamin Franklin Butler, served ably for 14 years, the longest term of any of its presidents.

How quickly Butler and his associates worked is evident from the record. On October 6, 1866, the first of the homes, called the eastern branch, was opened at Togus Springs, near Augusta, Maine. The northwestern branch was opened at Milwaukee, Wis., in May 1867 and the central branch at Dayton, Ohio, in September of the same year.

The homes were run along military lines with the governor and deputy governor of each branch, as the resident directors were called, almost invariably retired generals or colonels. Residents of the branches were called "members," as are residents of Veterans' Administration domiciliaries today. Although they were treated with respect and kindness, they were expected to conform to the institutions' firm discipline. Failing to do so, they were expelled, and, to be

¹ Patten, Thomas Henry, "Public Policy Toward the Employment, Retirement, Rehabilitation of the 'Old Soldier.'" University Micolling, Inc., 1939, pp. 223-230 (cf. bibliographical note).
² Proceedings of Board of Managers, NHDVS, 1866-1930. Also individual files of historical memorabilia held by these Veterans' Administration hospitals and domiciliaries which were formerly national homes.
readmitted, had to appeal not to the governor or the deputy governor, but to the august board of managers itself.

Members of the board, except the ex officio members, visited all the homes at least twice a year. No detail was too microscopic to be worthy of their attention. Delegation of authority to the governors, high though their former military rank might have been, was almost incredibly limited.

The Board’s annual proceedings, printed at the central branch in Dayton, are filled with items which range from the sublime to the ridiculous with occasional unintended elements of humor on the one hand or pathos on the other. Only examples, in the Board’s own language, can adequately convey what must have been the atmosphere of its meetings. Here are some typical ones, selected from over a period of years:

Central branch, September 1876: Nathan M. Jackaway to be readmitted on condition that he do such work or duty as the governor shall direct, for the period of 3 months without pay—and in addition, pay his own transportation.

(Literally hundreds of readmission cases like this appeared in the printed proceedings of the Board, so that they were matters of public record. The fact, therefore, that the poor Jackaways had been runaways from the national homes was for all to know who cared to know.)

Washington, D.C., Board of Managers meeting, April 1882: In the second quarter of 1881 there is an error of $1 in the account of the northwestern branch.

(The matter of the missing dollar was taken up at a meeting of the Board at which there were present the President of the United States (Chester A. Arthur), the Chief Justice of the Supreme Court, and the Secretary of War. Present also were five generals, a colonel, and a major.)

Pacific branch, March 1930: For repairs and painting of bandstand, $75.

(During 1929, the Governor of the Pacific branch was responsible for a budget of $1,365,876, but the money for repairing and repainting a bandstand was somehow a matter on which the Board chose to render the decision.)

So it went: the gravest attention to the minutest detail. But there was no failure to see the woods from looking at the trees. Items of a more truly revealing character appeared in the proceedings:

Northwestern branch, March 1879: It appearing that Maurice J. Hanlon, late Company B, 26th Michigan Volunteers, by his last will and testament, made a legacy of $105.97 to the national home, having made the Deputy Governor, General Hinks, his executor, the Board of Managers, in recognition of the grateful remembrance of the deceased of the benefits of the home to himself and his disabled comrades, accept this token and direct the Deputy Governor to expend it in some proper manner, as he may see fit, rendering the hospital more cheerful and pleasant to those disabled inmates who may occupy it, and if found convenient to make some recognition which shall keep alive in the minds of his comrades the deceased donor.

Northwestern branch, September 1883: The application of Luther Griggs, to be permitted to undergo treatment outside the home, for the restoration of his sight at the expense of the home, is granted.

The gift of the grateful Maurice J. Hanlon, to be used in the hospital at the northwestern branch, and the case of the blind Luther Griggs point up the fact that although the national homes were primarily places of residence, they had medical programs from the beginning. Each home had a surgeon, as the resident physician was called, appointed not by the local Governor but by the national Board of
Managers. This surgeon was provided with a good medical library. If special outside medical care was judged necessary for a member at a nearby private hospital or in the office of a private physician, the home would pay the expenses.

Each home also had what was called a post fund, apart from the operating budget allotted to it by the Board of Managers from congressional appropriations. The fund consisted of money from gifts like Hanlon’s, from fines imposed upon members who broke the rules, and from profits made by little tobacco and gift shops established on home premises. Money from the fund was used for the decoration of hospital wards, recreation rooms, messhalls, and lobbies.

Whatever may be thought of the Board’s failure, if failure it was, to give the Governors more freedom of action, it cannot be questioned that its overall guidance was creative. The homes increased both in number and in size. In addition to the first branches at Togus, Milwaukee, and Dayton, the following were founded:

Southern branch, Kecoughtan, near Hampton, Va., 1870; western branch, Leavenworth, Kans., 1885; Pacific branch, Santa Monica, Calif., 1888; Marion branch, Marion, Ind., 1890; Danville branch, Danville, Ill., 1898; Mountain branch, Johnson City, Tenn., 1901; Battle Mountain Sanitarium, Hot Springs, S. Dak., 1902; Bath branch, Bath, N. Y., 1929. The Bath property had been a State Soldiers’ home.

The fact that no new branches were founded during the 15 years between Kecoughtan (1870) and Leavenworth (1885) emphasizes an additional observation that can here be made about Civil War medicine: exceptionally sturdy young men who managed to survive its inadequacies during the war itself began to pay the toll of physical decline during their forties and fifties. The need for Leavenworth and the other branches that followed became evident as these ailing Civil War veterans sought admission.

The general offices of the national homes were located in Hartford, Conn., until 1900; then in New York City until 1915; then for only 11 months in Kansas City, Mo.; and finally in Dayton, Ohio, from 1916 to 1930 when the homes merged with the Veterans’ Administration.

At times, when the Board of Managers met in Washington, D.C., it held its meetings in the Arlington Hotel, on the site of the present Veterans’ Administration building.

In 1871, a congressional investigating committee reported on certain significant facts about the early national homes:

Liberal expenditures have been made to provide chapels, libraries, reading rooms, amusement halls, and other facilities for recreation and for intellectual and moral culture, as well as to furnish good quarters, food, clothing, and hospital attendance. The constant and proper aim of the management is to provide * * * that the asylums were in no sense almshouses * * * but homes which the disabled soldiers have earned for themselves by their sufferings and sacrifices. *

Notable in the development of the homes was the fact that each branch gradually developed a character, a personality, of its own. There were uniform home rules and regulations intended for observance by all the branches without exception, with inspectors representing the Board of Managers to see that they were enforced. But there was no set style of architecture or landscaping, and no insistence that local customs and traditions be discouraged. The result was that

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* House of Representatives, No. 45, 1871, 41st Cong., third sess.
National Home for Disabled Volunteer Soldiers, Eastern Branch, Togus, Maine, 1866.

Veterans Administration Center, Togus, Maine, 1966.
each branch was as different from the others in atmosphere as Harvard is different from Yale. Under the Veterans' Administration, since it inherited the homes in 1930, these local differences prevail to this day.

A brief account of the first six homes, those founded up to 1888, will suggest how “local color” was as characteristic of them as was the military, or certainly semimilitary, discipline of their daily routine.

TOGUS

The first of the national homes—opening as the eastern branch on November 14, 1866—was formerly a hotel on a property of 1,100 acres, near Augusta, Maine, belonging to a wealthy man named Howard Beals. The land had been given the Indian name of “warronmontogus,” meaning “mineral water,” eventually was shortened to Togus. Beals, believing that the water had medicinal value, undertook to build a resort rivaling New York’s Saratoga Springs. The venture not proving successful, he sold the hotel and the acreage to the national homes for $50,000.

The first governor at Togus was Maj. Gen. Edward W. Hinks. The first member was James P. Nickerson, who had served during the Civil War with the 19th Massachusetts Volunteers from June 30, 1861, to June 30, 1865.

The first resident surgeon, and therefore the first physician in the history of the national homes, was Col. B. B. Breed. Nickerson, Colonel Breed’s first patient, although complaining of chronic rheumatism, was decidedly ambulatory. Objecting to performing chores around the home, he left it three times and was readmitted three times, but was permanently dropped from the rolls on May 10, 1871. He set a pattern which was followed by hundreds of home members for years afterward. They would enter a branch, leave it, be readmitted, again leave it, sample another branch, and eventually, at last old and tired, end their days in this branch or that. This type, constituting less than 1 percent of the veteran population, was not encouraged by the national homes. Although strict, the homes were tolerant of the foibles of veterans who, in their days as soldiers, were dosed with whisky rather than with medicine on many a Civil War battlefield.

Alcoholism among the members was a problem at Togus and at times at all the national homes. When the men received their pension payments, many would make a beeline for the nearest saloons. On one occasion at Togus, when the main building caught fire, they knew where the medicinal liquor was stored. This they made a heroic and successful effort to save from the flames. As they stood outside in the night air, routed from their beds and watching the fire, they warmed themselves with the one prescription in which so many of them believed.

Beer was sold in the homes to keep the members from patronizing outside bars and drinking cheap whisky, but in 1907 Congress, influenced by the Prohibitionists, put an end to this practice. It was never resumed, either by the homes themselves, or their successor agency, the Veterans’ Administration. (However, beer is still sold in the U.S. Naval Home in Philadelphia and the U.S. Soldiers’ Home in Washington.)
Togus, despite its problems, flourished as a place of refuge and good care. Reading matter, band concerts, and training in useful trades and crafts were offered to the members. Bricks for new construction at the home were made by members at a kiln set up for training purposes.

In 1944, Togus, by then a part of the Veterans' Administration, ceased being a domiciliary. It is now a VA center, with a regional office and an 869-bed hospital, mainly for neuropsychiatric patients but with beds and facilities for general medical and surgical cases. With its three main buildings constructed in a uniform and attractive style of architecture and surrounded by numerous auxiliary buildings on a pleasantly wooded and neatly landscaped sweep of ground, it is a handsome, dignified institution.

MILWAUKEE

The northwestern branch, the second of the national homes to be founded, has an interesting background.

During the Civil War, Wisconsin had been a center of active, dynamic Union loyalty and enthusiasm. Its various groups of volunteer women workers had been among the most effective in support of the local and national activities of the U.S. Sanitary Commission.

These women deplored the fact that wounded and sick Wisconsin soldiers were being looked after, in the haphazard Civil War manner, in such distant places as Tennessee, Missouri, and Washington, D.C. They felt that the young men had a right to be cared for in their own splendid State, with its wonderful fresh air.

Chief among these women was Mrs. Cordelia P. Harvey, widow of a Governor of Wisconsin. Mrs. Harvey, lamenting the plight of Wisconsin troops exposed to what she regarded as “the contagion of Southern air,” went to Washington to see President Lincoln.

She called on him in his office three times. At first, the President was coolly courteous to her but frankly opposed to her idea that a soldiers’ hospital should be opened in Wisconsin. However, the dauntless Mrs. Harvey kept pressing, and won from the President a note to Secretary of War Stanton asking that he see her.

Stanton, however, would not commit himself. The Surgeon General of the Army, he said, was in the South, and nothing could be decided until he returned to Washington. Mrs. Harvey then returned to talk with the President and to complain about her reception by Stanton. The President listened, shifting in mood from irritation to resentment to depression, but then he astonished Mrs. Harvey by inviting her to come and see him again the next day.

The next day, her third visit to his office, he told her that an order had gone out the day before from the War Department for the opening in Wisconsin of the hospital she had come to Washington to urge.

Actually, Wisconsin was finally provided with three soldiers’ hospitals: one at Madison in 1863, and in 1864 one at Milwaukee and another at Prairie du Chien.

When the hospital at Milwaukee proved inadequate, a large group of Wisconsin citizens banded together and founded a Wisconsin Soldiers’ Home. This was operated from February 3, 1865, to May 1, 1867.
National Home for Disabled Volunteer Soldiers, Northwestern Branch, Milwaukee, Wis., 1867.

Veterans Administration Center, Wood, Wis., 1966.
Then, in 1866, when the national homes started, the same Wisconsin citizens urged the Board of Managers to establish a branch in Milwaukee. Typical of the well-organized, determined ladies of that State they offered $95,000 toward the purchase of a site for the northwestern branch of the national homes. The site, now known as Wood, in Milwaukee, was purchased for $79,700, and covers 382 acres. The branch was opened on May 1, 1867, and the Wisconsin Soldiers’ Home was closed.

Wood is now what is called a Veterans’ Administration center, a combination of hospital and domiciliary. The hospital, affiliated with Marquette University School of Medicine, is capable of caring for over 1,200 patients, while the domiciliary houses over 1,000 members. It is large, active, and ideally suited to the care of the veterans of our own century. And of historical significance, too: this facility is evidence of how modern-spirited were certain women of the 1860’s who found in the Sanitary Commission an outlet for their talents and energy.

DAYTON

In December 1929, the Board of Managers of the National Homes, reviewing fiscal year 1929, pointed to the central branch, in Dayton, Ohio, as the branch which was typical of all branches.

Like Milwaukee, Dayton had its beginnings in the good spirit and generosity of local citizens.

Camp Chase, near Columbus, Ohio, was developed from the Tripler Military Hospital, a Federal gift to the State. In turn, the State offered the camp, and $1,600 in unexpended appropriations, to the Board of Managers of the National Homes.

The Board accepted the offer of the camp as a temporary site for the central branch. Then, for $46,800 it purchased 400 acres of land 3 miles west of Dayton, $20,000 of this amount being donated by Dayton citizens.

The Dayton branch opened in September 1867 to accommodate 450 veterans transferred from Camp Chase. At first, the only buildings were a farmhouse, a barn, log cabins, and temporary wooden structures. The first permanent brick and stone building was begun in 1868 and dedicated as a hospital in 1870. By the standards of its time it was by no means a small hospital; it had 300 beds. It was designed to treat old wounds and to combat smallpox, rheumatism, and “consumption” (tuberculosis). These were the diseases prevalent among Civil War veterans who had been left lying for hours, half-dead, on swampy, malarial, and damp fields of battle.

Somehow, although Dayton was no different from other national homes in its one purpose of providing a domicile for disabled and indigent veterans, it took on a special characteristic of its own from the very beginning. This characteristic might well be described as cultural.

There are four evidences of this:

1) The grounds were laid out by Army Chaplain Thomas B. Van Horn on order of Secretary of War Stanton. The layout of the main buildings, and the wide winding roads and walks of today, follow closely the original plan of the chaplain. In the early days, member Frank Mundt took such an interest in landscaping the grounds that he turned them into a place of beauty. Down through the years,
other members have taken pains to preserve them as he had left them, and even to enhance them.

(2) Also at Dayton, from as early as 1870 to as late as 1933, a military band was kept intact. This, in the opinion of proud Daytonians, ranked next to the U.S. Marine Band as the best of its kind in the country.

National Home for Disabled Volunteer Soldiers, Central Branch, Dayton, Ohio, 1867.

Veterans Administration Center, Dayton, Ohio, 1966.

(3) Dayton had a large and select library, together with a hundred beautiful paintings, presented to it by Mrs. Mary Lowell Putnam, sister of the famous poet James Russell Lowell, and mother of a young Union officer who had been killed in the Civil War. Many of these paintings are still there.
(4) The home also had a memorial hall, built in 1878, that was destroyed by fire in 1880, then rebuilt and dedicated in 1881. A combination of theater, music hall, and general assembly room, this hall was used not only by home members but by the cultural societies of Dayton as a place where they could attend recitals, concerts, and lectures by national and world notables.

The Dayton establishment is now one of the Veterans' Administration centers and one of the largest field stations in the VA service. The present domiciliary has an authorized bed capacity of 1,600, this includes an 87-bed "cottage" for female beneficiaries. About 1,000 members are admitted annually.

In addition, the station operates 779 beds in two hospitals, which in VA statistics are shown as one institution. These are the Brown Hospital, a general medical and surgical hospital built in 1931 and operating 597 beds plus the Patrick Hospital with 182 intermediate beds. The latter was built in 1940 as a domiciliary but was converted to a hospital in 1948. The two hospitals are affiliated with the Ohio State University School of Medicine. They feature approved residency programs as well as training programs for paramedical personnel. Extensive research programs are conducted in the various fields of medicine.
The medical progress at Dayton is a tribute to the sound basic planning by the Board of Managers.

In 1929, the year before the homes became a part of the Veterans' Administration, the Board could point to a central branch hospital at Dayton, staffed by: a chief surgeon, 22 assistant surgeons, 10 attending specialists, 72 trained nurses, 109 ward attendants, 12 cooks, and scores of clerical, engineering, and other personnel.

All the homes were staffed to teach trades and crafts. Dayton, in particular, boasted a superior course in printing that won for it the printing of the annual proceedings of the Board of Managers.

**KECOUGHTAN**

A southern branch of the national homes was opened at Kecoughtan, near Hampton, Va., in 1870. Despite its name of "southern branch," it was for Union, not Confederate, veterans. A building was available which before the Civil War had been the Chesapeake Female Seminary. When the war came, it was converted into a hospital for soldiers wounded during the Virginia and North Carolina campaigns.

One of the purposes of Kecoughtan was the care of those negroes, as well as whites, who had served in the Union Army. Integration had not proved feasible at Togus, Milwaukee, or Dayton; but at Kecoughtan it worked.

In 1910, E. L. Cobb, a member of the home, wrote a lavishly illustrated book, "Optic Views and Impressions," on Kecoughtan's history and customs. His dedication of the volume is touching:

To my comrades who left home and loved ones, in the darkest hour of our Nation's history, to save it from dissolution, and preserve its motto "E Pluribus Unum" this book is fraternally dedicated.

With the hope that they may be cheered with the thought, after perusing these pages, that "The gates stand wide open" to welcome them in their old age, and
find a resting place while waiting the summons of our Supreme Commander to answer the new rollcall, and be mustered for their reward.

Kecoughtan is now a Veterans' Administration center. The hospital has 570 beds, the domiciliary accommodations for 1,203 members. The buildings of the Center face upon Hampton Roads, a body of water formed by the confluence of the southern end of Chesapeake Bay and the mouths of the James and Elizabeth Rivers. It is a region filled with history, and a fitting place for the care of veterans who have helped to make history.

WESTERN BRANCH—AND A HINT OF THE END

A western branch of the homes was opened at Leavenworth, Kans., in 1885. The branch developed, like the other branches, into a fine institution. It is of special historical interest because in 1928 it became the object of the first threat (as the Board of Managers viewed it) to the national homes as an independent service to veterans.

Gen. Frank T. Hines, Director of the Veterans' Bureau, had requested the Federal Board of Hospitalization to adopt the following resolution:

National Home for Disabled Volunteer Soldiers, Western Branch, Leavenworth, Kansas, 1885.
"That the hospital facilities of the National Military Home, Leavenworth, Kans., be transferred to the jurisdiction of the U.S. Veterans' Bureau, and that these facilities be enlarged to provide an additional 200 beds, in order that the veterans who are in that area and who can be served by this unit, may have ample facilities."

The Board of Managers of the Homes wrote to President Coolidge and stressed three objections to the resolution:

1. The Leavenworth hospital was needed for the Leavenworth domiciliary.
2. A division of responsibility at Leavenworth between the national homes and the Veterans' Bureau would be complicated, awkward, and expensive.
3. The Leavenworth property, legally, did not belong to the executive branch of the Government but to the Board of Managers, responsible to the legislative branch.

This last fine legal point, which the Board in its sense of responsibility and in its pride felt obliged to uphold, did not include recognition that what Congress had given, Congress could take away. President Coolidge held the view that only congressional legislation could settle the issue, and for a time the homes kept the Leavenworth hospital.

But the transfer of jurisdiction not only of the Leavenworth hospital, the home, and subsequently all the homes and their hospitals took place, as we shall see, less than 2 years later.

The former western branch of the national homes is now the Wadsworth, Kans., Veterans' Administration Center. It is named after two former officials of the national homes: Maj. James W. Wadsworth, Vice President, and Col. C. W. Wadsworth, General Treasurer. The hospital, affiliated with the Medical School of the University of Kansas, has 783 beds. The domiciliary accommodates 1,000 members.
PACIFIC BRANCH—DYNAMIC BEGINNING, DYNAMIC GROWTH

The present Veterans' Administration Center in Los Angeles, Calif., the agency's largest single unified operation in the country, situated in West Los Angeles on the road to Santa Monica, is divided into four extensive tracts of varying size by the intersection of the north-to-south San Diego Freeway and the east-to-west Wilshire Boulevard, with a tunnel under the boulevard linking the northern and southern tracts. On the northeastern side of the vast property is the second largest national cemetery, surpassed in size only by Arlington.

When the national homes opened a Pacific branch here in 1888, the property, along with $50,000, was granted by various members of a family named Jones from two of its ancestral ranches: the Rancho San Vicente y Santa Monica, and the Rancho San Jose de Buenos Aires. The family, interested in the development of the area, believed that a well conducted Federal institution in the vicinity would be an asset to the community and an aid to its growth. The Joneses indeed were farsighted.

At the time of the opening of the Pacific branch, the Sawtelle area of Los Angeles County was not even suburban. It was truly rural. Sheep and cattle grazed on the rolling, peaceful countryside, nestled between a range of mountains immediately to the east and the Pacific Ocean 3½ miles to the west.
If one of the largest metropolitan complexes in the United States now borders the VA Center, the Board of Managers of the National Homes must be given credit for two decisions. One was to preserve the privacy of the inner grounds of the Pacific branch for the veterans who lived in it.

The other was to cooperate whenever possible in the development of Los Angeles. In the course of time, therefore, the board sold land judiciously to the county of Los Angeles and the State of California for roads, a branch of the University of California, a transportation line, water pipes, sewer pipes, and other facilities helpful to the veterans as well as to the citizens of the developing neighborhood.

In 1888, 400 veterans living at the California State Soldiers’ Home at Yountville in Napa Valley applied for and were granted transfer to the new Federal institution at Sawtelle, 500 miles to the south. They told the Yountville commandant that they preferred marching to their new home to traveling by train or ship. The commandant attempted to dissuade them; their average age, he said, was 50; they were not in condition. Yet, they talked him into letting them do it.

Careful preparations were made for the expedition. An advanced party scouted campsites and watering places. Each man carried his own bedroll and personal gear. During the trip, innumerable rabbits and wild fowl, and two bears, were shot by the men and went into the communal mess-pot. Only a few of the marchers fell by the wayside from foot blisters or other infirmity. These were picked up and conveyed by oxcarts at the rear of the column.

Thus in an atmosphere of good discipline, self-imposed by the veterans themselves, did Sawtelle begin. Since 1888, both its domiciliary and its hospitals have cared for a total of more than 500,000 veterans.

In addition to the domiciliary, which can accommodate 2,550 members, the VA center today has two hospitals: Brentwood, with 1,981 beds, predominantly neuropsychiatric; and Wadsworth, with 1,430 beds, predominantly general medical and surgical. The latter hospital was named after the already mentioned Maj. James W. Wadsworth of the National Homes.

The center is affiliated with the University of California Center for the Health Sciences, the University of Southern California Medical School, the Loma Linda College of Medicine, and the California College of Medicine. The Jones family and the 400 marchers of 1888 have left their mark on Sawtelle.

STATE SOLDIERS’ HOMES

Along with the development of the National Homes for Disabled Volunteer Soldiers went the development of State soldiers’ homes, some of them founded under the stimulus of the “Perkins Proposals to the Sanitary Commission.” The National Homes, with congressional authority, paid part of the cost of caring for disabled veterans in State homes.

The first State home was founded informally in Massachusetts in 1862. In May of that year, a group of disabled soldiers landed on a wharf in Boston, whereupon a citizens’ committee was formed to meet their immediate needs. A merchant donated some rooms in a warehouse loft as well as supplies of food and clothing.
Meanwhile, a group of Bostonians formed an association to build a permanent soldiers' home along the lines of the Hotel des Invalides in Paris and the Chelsea Hospital in London. In 1867, the Massachusetts Legislature appropriated $10,000 for an institution which proved adequate until 1882. In that year, a new home was constructed in Chelsea, Mass., where it exists today, one of the oldest and best known of the State soldiers' homes.

In fiscal year 1965, a daily average of 9,146 VA beneficiaries were provided with the State home type of domiciliary care at 33 State soldiers' homes located in 28 States. The VA reimburses the States for such care with payments up to one-half of the cost of this care, but not exceeding $2.50 per member per day. Twenty of the State homes provide havens for veterans' wives, widows, or mothers. For this care the VA does not pay.4

CONFEDERATE VETERANS AFTER THE CIVIL WAR

In general, what happened—or rather what did not happen—in the fields of compensation benefits and medical care for Confederate veterans, is saddening evidence of what blockade, defeat, and post-war poverty can do to a people who, in the conflict itself, fought intrepidly. In many cases medical and historical records have been so destroyed or mislaid that any picture of their total effort in veteran care during and immediately after the Civil War is at best incomplete.

Confederate veterans could not organize themselves effectively to obtain the medical and economic assistance they needed. As late as 1878, the local Federal authorities in the South forbade them to do so. Some of the veterans, in weak, scattered organizations called Survivor Associations, would listen to grand oratory. They made and broke local political leaders, but they accomplished practically nothing in the veterans' behalf.5

It was not until 1889, in New Orleans, that the United Confederate Veterans was organized. Even this was largely a sentimental gesture, rather than a concerted practical action. The members, now well on into middle age, would listen to the customary oratory and cheer Mrs. Jefferson Davis on one of her frequent visits.6 But the action stopped there.

There are records of 14 small State homes for Confederate veterans founded shortly after the war in the following States: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, and Virginia.7 It will be noted that some of these States had not been members of the Confederacy.

In 1901, the Mountain Branch of the National Homes was opened at Johnson City, Tenn. This home was intended for the unique purpose of caring for the needy survivors from among those southerners (an estimated 300,000 of them) who had served on the Union

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4 Patten, pp. 172-229.
7 Patten, p. 206, says that it is "impossible to obtain comprehensive data on all these homes." An important Southern historian and the secretary of an important Southern historical association have told the compilers of the present volume that they have come across little material on Southern veterans. Patten, for information admittedly not comprehensive, quotes George E. Ijams and Phillip H. Mate, "History of the Medical and Domiciliary Care of Veterans," "The Military Surgeon," vol. 76, No. 3, March 1935, pp. 113-133.
side during the Civil War. Confederate veterans were barred from eligibility.\(^8\)

In 1916, 50 years after the Civil War and 15 years after the Mountain Branch of the National Homes was opened, the Senate Committee on Military Affairs held hearings on the possibility of admitting Confederate veterans (then with an average age of 74.4 years) to the National Homes. Southerners had fought loyally during the Spanish-American War. Likewise they were supporting, through Federal taxation, their own State homes and State pension systems and partially supporting the national pension system and the National Homes. Capt. Perry M. De Leon, a former Confederate naval officer and veteran of the Spanish-American War, as well as a former U.S. Consul General to Ecuador, presented the case for Confederate veterans eloquently. But no legislation was enacted.\(^9\)

It was not until Public Law 85-425, approved May 23, 1958, that the Federal Government provided pensions for persons who served in the Confederate forces, or their widows or children.

The last man who was popularly and sentimentally thought to be a veteran of the Confederacy died on August 11, 1959, at what he thought was the age of 116. Actually, he was 103 and had not fought in the Civil War at all.\(^10\)

Very probably the last bona fide Confederate veteran was Gen. John Salling, of Slant, Va., who died on March 16, 1959, at the age of 112.\(^11\)

At present, there are approximately 1,200 widows and orphans of Civil War veterans among the Veterans' Administration's beneficiaries.

**UNION VETERANS AFTER THE CIVIL WAR**

The Grand Army of the Republic was founded in 1866. Strangely, it was not chartered by Congress until 1924. It held its last encampment in 1949. Its last member, Albert H. Woolson, of Minnesota, died in 1956, and the organization ceased to exist.

To what extent was the GAR a tool of radical Republican politicians? Certain historians, with scholarly support, have claimed that it was.\(^12\) To what extent did it successfully promote special legislation in behalf of Union veterans?

Whatever the answers to these questions, it is a fact that the first specific legislation in behalf of Union veterans, their widows, and their orphans was the Service Pension Act of June 27, 1890, passed 25 years after the Civil War was over. Terms of the act were liberalized by later Congresses.

Because the Grand Army of the Republic was founded in 1866, the farsighted legislation which in 1865 and 1866 set up the national homes was not, and could not have been, the result of GAR influence.

In the 19th century, veterans who had pension problems would take them up not with the GAR but with private "pension agents." The largest of these agencies was that of George E. Lemon. In 1884 alone, the Lemon agency handled 125,000 pension claims, more than all the others combined. Lemon also, in 1877, founded the National

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\(^8\) Congressional Record, vol. 34, pt. 2, Jan. 21, 1900, pp. 1277-1278.

\(^9\) Hearings on Homes for Confederate Veterans, 64th Cong., first sess. (pursuant to S. 643), vol. 1, p. 3.

\(^10\) Congressional Record, Sept. 8, 1958, p. A7335.

\(^11\) Congressional Record, Mar. 16, 1959, pp. 3844-3845.

Review, a weekly newspaper. This publication's original object was to advertise for pension claims, and in 1882 it became the official pension paper for the GAR. Not until after World War I did it cease being the chief source of information for pensioners throughout the country.13

Interestingly, in connection with the Grand Army of the Republic, another group of public-spirited 19th-century women organized themselves in behalf of Union veterans: the Woman's Relief Corps, a ladies' auxiliary of the men's organization. Local groups which had been meeting independently in New England and in the Middle West were pulled together as a national organization in 1883 by Mrs. Kate B. Sherwood, of Toledo, Ohio, a journalist and poet. The women visited and performed acts of mercy in the national homes and the State soldiers' homes. To this day their modern successors are active in the similar work of the Veterans' Administration's volunteer service program.

The Woman's Relief Corps has also been the principal sponsor of Memorial Day and the Pledge of Allegiance to the Flag.14

SUMMING UP

Between the Civil War and the Spanish-American War, the largest single accomplishment in behalf of veterans was the development of the national homes.

In October 1866, the first resident surgeon of the national homes, at Togus, Maine, examined his first patient, and inaugurated what was later to become the world's largest medical system.

SUPPLEMENTARY NOTE TO CHAPTER IV

Just as there is a Federal tradition of care for veterans which has its roots in Europe, there is also a State-by-State tradition of such care which has its roots in the Nation. "State Veterans' Laws," House Committee Print No. 246, Government Printing Office, Washington, D.C., 1956, is a 369-page summary of what, up to the date of publication, the States have done in behalf of their veterans. A mere summary of them being of such length, the laws themselves, presumably, fill thousands of pages.

Many of these laws would seem to be merely sentimental, ceremonial gestures of good will toward veterans, rather than being practical in their effect. They do, however, give evidence of the traditional belief of American legislators that veterans, somehow, should be specially recognized.

One type of State veterans' legislation, of course, has been decidedly practical in its effect: the type which has set up the various State homes. These, although partially supported by Federal funds, undoubtedly lessen the domiciliary responsibility of the Veterans' Administration.

Committee Print No. 246 was the third staff report of the President's Commission (sometimes called the Bradley Commission) on Veterans' Pensions.

14 Material supplied by Mrs. Jessie H. Johnston, former president (1944-66), Woman's Relief Corps. Mrs. Johnston is now the society's representative on the National Advisory Committee of the Veterans' Administration Volunteer Service (VAVS) operation.
Spanish-American War (1898-99):
- U.S. participants: 280,564.
- U.S. deaths in battle: 369.
- U.S. deaths, other causes: 2,061.
- U.S. deaths, total: 2,430.
- U.S. wounded, total: 1,594.

Totals (including Philippine Insurrection and Boxer Rebellion):
- U.S. participants: 392,000.
- U.S. deaths in battle: 2,000.
- U.S. deaths, other causes: 9,000.
- U.S. deaths, total: 11,000.
- U.S. wounded, total: 6,000.

1 Of this number, 90 percent were volunteers.
2 Totals in this column are given for the Spanish-American War which, for statistical purposes, officially includes the Spanish-American War itself, the Philippine Insurrection (1899-1902), and the Boxer Rebellion (1900-01). For the latter two, individual statistics are not available. For the Spanish-American War itself, individual statistics are available and are given in the first column.

CHAPTER V
THE SPANISH-AMERICAN WAR, PHILIPPINE INSURRECTION,
AND BOXER REBELLION

In this chapter, the term “Spanish-American War veterans” includes, as it generally does in Veterans’ Administration terminology, U.S. veterans of two other conflicts: the Philippine Insurrection (an outgrowth of the Spanish-American War) and the Boxer Rebellion. Similarly, although the Spanish-American War officially ended on February 6, 1899, the term “Spanish-American War,” under existing laws administered by the Veterans’ Administration, means the period beginning on April 21, 1898, and ending on July 4, 1902.

There were comparatively few combat casualties in these conflicts. The largest percentage of disabilities arose from diseases contracted by men unprepared for tropical climates or for unsanitary living conditions in the field.

On April 22, 1898—the day after the beginning of the war between the United States and Spain—Congress gave to those in service in the war with Spain (and later to those serving in the Philippines and in China) the same benefits that applied to the Regular Army with respect to pay allowances, and disability benefits.

The United Spanish War Veterans, founded in 1898, at one time had 106,000 members. The Veterans of Foreign Wars, one of the largest national organizations, was founded in 1913 through a merger of the American Veterans of Foreign Service and the Army of the Philippines, both of which were founded in 1899.1 These organizations, as part of their programs, manifested deep interest in the welfare of veterans and their dependents.

In proposing service pension legislation, the United Spanish War Veterans, supported by the Veterans of Foreign Wars, stressed the difficulties veterans encountered in proving service connection of

their disabilities, because of the lack of complete records and the nature of their diseases, tropical and other. The first service pension law pertaining to this group was the act of July 16, 1918, and pertained solely to widows and children of these veterans. Widows received $12 a month. Widows with children under 16 received $2 additional for each child. In case of death or remarriage of the widow leaving a child or children under 16 years of age, such pension was payable to the child or children. Provision was made for payment of pension for a child beyond the age of 16 if mentally ill, or otherwise permanently helpless.

The act of June 5, 1920, provided service pension for the veterans, $12 to $30 a month for disability, and “age pensions” of $12 at 62, $15 at 68, $24 at 72, and $30 at age 75. These acts were subsequently liberalized both as to eligibility and rates. The Economy Act of March 20, 1933, curtailed these benefits, but the cuts were restored in 1935 and subsequently increased to keep pace with the rise in cost of living and advancing age of the veterans.

Until 1967, medical care and treatment, including outpatient treatment for honorably discharged veterans, was furnished by the National Homes for Disabled Volunteer Soldiers. Eligible veterans also were cared for in State Homes, with Federal contribution; and as well in the U.S. Soldiers’ Home, Washington, D.C., the U.S. Naval Home, Philadelphia, Pa., St. Elizabeth’s Hospital, Washington, D.C., and occasionally in Army and Navy hospitals.

On April 20, 1922, the War Risk Insurance Act was amended to provide that all hospital facilities under the control and jurisdiction of the U.S. Veterans’ Bureau would be available to veterans of the Spanish-American War, the Philippine Insurrection, and the Boxer Rebellion, who were suffering from psychiatric and tubercular ailments and diseases. In 1924, this provision was liberalized to include non-service-connected veterans of all wars, providing a bed was available and the veteran was unable to pay for such care.

“REMEMBER THE MAINE!”

The Spanish-American War is one of the curiosities of U.S. history.

It has been called, with some reason, the byproduct of another war—a very different kind of war—a newspaper war between two giants of American journalism, Joseph Pulitzer and William Randolph Hearst. In the 1890’s, the two New York newspapers controlled by these colorful men—Pulitzer’s “World” and Hearst’s “Journal”—waged a bitter circulation battle by reckless use of sensational headlines and lurid atrocity stories.2

Edwin Godkin, editor of the liberal weekly “Nation” and a prominent social critic, watched with growing alarm as a Cuban revolution against its Spanish rulers was heated up into a public demand for a war with Spain. When Godkin finally spoke out in anger, there was no doubt in anybody’s mind that he was referring to William Randolph Hearst in his denunciation of “a blackguard boy with several millions of dollars at his disposal (who) has more influence on the use a great nation may make of its credit, of its army and navy, of its name and its traditions, than all the statesmen and philosophers and professors in the country.”

Indeed, to this day the Spanish-American War is sometimes referred to as "Hearst's War."

However, the revolution on an island so close to our mainland sincerely engaged America's freedom-loving sympathies, quite apart from artificial inflation of these sympathies by the public press. Washington made diplomatic representations to Madrid, urging a moderation of Spain's severe treatment of the rebels. The Spanish Government attempted to pacify American public opinion, but this opinion, in its inflamed state, grew strong enough to put pressure on President Cleveland to send military aid to the rebels. Cleveland resisted the clamor, and so, at first, did his successor, President McKinley.

But the fire was the event, on February 15, 1898, in Havana Harbor, two explosions caused the U.S.S. Maine to sink with the loss of two officers and 255 enlisted men. An outcry arose in the United States that either Spain had plotted the destruction of the ship, which was never proved, or that it had been negligent in protecting it.

Other countries intervened in an attempt to prevent war, but on April 21 Spain severed diplomatic relations with the United States. On April 25, Congress declared that a state of war, retroactive to April 21, existed between the two countries. Four months later, on August 12, an armistice was signed by the United States and Spain. A peace treaty, signed in Paris after another 4 months (December 10), was ratified by the Senate on February 6, 1899.

That was 9 days short of a year after the sinking of the Maine—and, during that brief period, an even briefer period of only 10 weeks actual combat took place. "Ten weeks of fighting, and the United States had wrested an empire from Spain," stated historians Morison and Commager in "The Growth of the American Republic."

Historians agree that this war was as popular in the United States as the War of 1812 was unpopular.

It was fought on two fronts, on opposite sides of the globe, and its major engagements—two by sea and one by land—were quick victories.

On May 1, an American fleet commanded by Commodore George Dewey destroyed a Spanish fleet in Manila Bay.

On July 3, an American fleet commanded by Adm. W. T. Sampson destroyed the Spanish Atlantic Fleet as it attempted to escape from Santiago Harbor in Cuba.

From actions begun on July 1 at El Caney and San Juan Hill in Cuba, an American landing force under Gen. W. R. Shafter forced the Spanish garrison at Santiago to surrender on July 16. At San Juan, Theodore Roosevelt, who had resigned as Assistant Secretary of the Navy in order to enter active service, led his regiment of "Rough Riders."

An American landing in Puerto Rico on July 25 was virtually unopposed, and the remaining scattered hostilities in this hemisphere ceased on the 12th of August.

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1 The mast of the U.S.S. Maine dominates section 24 of Arlington National Cemetery, and around it are buried 83 men of its crew whose names are known and 167 whose names are unknown. The Veterans' Administration, too, "remembers the Maine." On its compensation and pension rolls, as of Jan. 1, 1966, are 17,000 Spanish-American War veterans and also 65,000 dependents of veterans of that transitional period in our history—our emergence onto the world scene as a major nation.

2 Oo. cit., Morison and Commager, p. 333.

The U.S. troops under Gen. Wesley Merritt were sent to Manila to secure the victory won by Dewey. On August 13, General Merritt led 11,500 troops in an assault on Manila. The city surrendered and General Merritt assumed the governorship of Manila on August 23, 1898.

As a result of the war, the United States obtained the Philippines, Puerto Rico, and Cuba, with the understanding that it would set them free.

This happened early in the case of Cuba: the Cuban Republic was established on May 20, 1902. In 1917, Puerto Ricans became U.S. citizens under the provisions of the Jones Act, and on July 25, 1952, the Commonwealth of Puerto Rico was established. On the 4th of July, 1946, the Republic of the Philippines came into existence.

THE PHILIPPINE INSURRECTION

In February of 1899, 6 months after General Merritt became Governor of Manila, the Filipinos, under Emilio Aguinaldo, revolted against the occupying Americans. This turn of events had its ironical side, because Aguinaldo had been respected by the United States as a leader. He had been encouraged by Dewey to return from exile after the Battle of Manila Bay.

Aguinaldo was captured in March 1902, and the Philippine Insurrection was declared ended by proclamation on the 4th of July 1902.

It was followed by U.S. military assistance to the local government of Moro Province, where an uprising had occurred. This action terminated—as far as U.S. military assistance was concerned—on July 15, 1903, when the Moro provincial government informed the United States that it was prepared to control the situation.

THE BOXER REBELLION

In 1900, antiforeign sentiment broke out actively in Peking and other cities of imperial China.

The name of the Chinese secret society which fomented this sentiment meant, roughly translated, “righteous fists”—therefore Boxer Rebellion was the name given by English-speaking people to this movement.

With American and other embassies and consulates in China being burned and looted by the fanatics, the United States joined Great Britain, Russia, Germany, France, and Japan in putting the movement down, our troops who participated (from June 1900 to May 1901) being known as members of what was called the “China Relief Expedition.”

Germany insisted that the Chinese Empire, by way of punishment, be broken up, its provinces becoming separate, independent nations. But the United States argued that the proposed punishment would be out of proportion to the crime, and that the Chinese would only connive and agitate to remerge themselves anyhow.

The American view prevailed, and the Western Powers and Japan settled for (1) the presence of their own nationals as guards for their embassies and consulates, and (2) a free, unimpeded access route between Peking and the sea.
During the closing years of the 19th century, medicine began one of the several great "new births" in its history. Pasteur and Lister were "teaching and doing things which were to revolutionize medicine and surgery, establish the new sciences of bacteriology and hygiene, and . . . unlock one treasury of knowledge after another." The roentgen ray and diphtheria antitoxin had begun to come into use. The former was the "greatest aid to surgery after anesthesia and antisepsis," the latter the "first fruits of the modern study of immunology and the first product of the new science of serology." 

Nevertheless, to the surprise and dismay of the country and the medical profession, typhoid fever developed in every regiment during the Spanish-American War, reaching epidemic proportions in every camp. Some 13,770 recognized cases occurred in the eastern camps of the Army and in the Cuban and Puerto Rican camps. This plague ran its terrible course largely because of lack of knowledge in that day of the epidemiology of typhoid. It was the universal feeling, though, that typhoid was transmitted only by contaminated water. Uncontaminated water had been provided by the Army Medical Department at all camps and that "was supposed to insure against [typhoid]."

It was equally unknown to military medicine, and to the entire medical world, that malaria and yellow fever were mosquito-borne. There was very little knowledge of the causes and epidemiology of the dysenteries. All of these diseases therefore added their toll to that of typhoid.

Furthermore, the Medical Department of the Army was handicapped by the fact that Congress had reduced the Medical Corps by 15 assistant surgeons in 1894. On May 1, 1898, the Hospital Corps consisted of "99 hospital stewards, 100 acting stewards, and 592 privates." A month later, the acting stewards were increased to 200. There were "no women nurses nor any authorized."

On August 4, 1898, the health situation in the Cuban expedition became so serious that its commander, General Shafter (supported by nine general officers, Col. Theodore Roosevelt, four division surgeons, and the chief surgeon of the expedition) notified the War Department that it was "absolutely and immediately necessary that the Army be withdrawn from Cuba." The statement read: "This Army must be moved at once or it will perish * * * [it] is now in a very critical condition."

Fortunately, the Spanish having surrendered at Santiago on July 16 and an armistice signed with Spain on August 12, it was possible "to begin the evacuation of the Army from Cuba at once." Thus the merciful brevity of the Spanish-American War saved our military forces from a health catastrophe of unimaginable proportions. This appalling brink-of-disaster fact is not generally known today.

The Puerto Rican and Philippine campaigns of this war "did not so nearly approach disaster from disease" as did the Cuban expedition.
CHAPTER VI

WORLD WAR I: AUGUST 4, 1914, TO NOVEMBER 11, 1918

U.S. participation: April 6, 1917 to November 11, 1918 (U.S. veterans who served in the Siberian campaign in Russia up to April 1, 1920, are considered to be veterans of World War I): 1

U.S. participants: 4,744,000.
U.S. deaths in battle: 53,000.
U.S. deaths, other causes: 63,000.
U.S. deaths, total: 116,000.
U.S. wounded, not mortally: 204,000.

Note.—From House Committee Print No. 60, 67th Cong., 1st sess., 1921.

In early August of 1914 the entire structure of veterans’ affairs in the United States was resting on peace. It was a flimsy, fading peace that was on the brink of being shattered by a succession of gigantic devastating events.

At the beginning of that fateful August, there were alive in this country 785,000 veterans of all our wars except the Revolution and the War of 1812. Nearly 400,000 of these veterans had seen service in the Spanish-American War, which had ended more than a decade earlier.

The chief benefits being received by our veterans and their families in 1914 were pensions. Over $174 million was being paid out annually by the Pension Bureau of the Department of the Interior. No one dreamed to what vast extent these expenditures would expand in the next half century.

Applications for bounty lands were still trickling into the Pension Bureau. The last original land warrant was not issued until July 1917.

Nearly 17,000 U.S. veterans were now living in the 10 National Homes for Disabled Volunteer Soldiers. The Government was spending $3,600,000 annually to maintain these homes.

The Naval Home in Philadelphia and the Soldiers’ Home in Washington, D.C., were running at capacity in the summer of 1914.

EUROPE GOES TO WAR

That summer, Europe was a vast powder keg. On June 28, a Serbian assassin lit the fuse that would detonate it. In Sarajevo, the Province of Bosnia, the Archduke Franz Ferdinand, heir to the Austrian throne, and his wife were shot and killed. “That day,” wrote historians Morison and Connemar in “The Growth of the American Republic,” “closed an era of progress, liberalism, and democracy—and inaugurated the age of warfare, destruction, revolu-

2 House Committee Print No. 60, 67th Cong., 1st sess., 1921.
tionary upheavals, and dictatorships, of which we have not yet seen the end."³

July 28, 1914: Germany declared war on Serbia.
August 1, 1914: Germany declared war on Russia.
August 3, 1914: Germany declared war on France.
August 4, 1914: Great Britain declared war on Germany.

President Wilson declared U.S. neutrality, expressing the sentiment of the country as a whole.

The conflict in Europe spread rapidly. The Allies looked to the United States for war materials and food. Our merchants and manufacturers stepped up production to meet these needs. A period of prosperity not previously known in this country followed.

Germany, intent on stopping delivery of these war materials, waged ruthless submarine warfare that cost the loss of many U.S. ships.

BUREAU OF WAR RISK INSURANCE

The sudden declaration of war in Europe brought about in the United States the establishment of a far-reaching marine insurance program—designed to fill the immediate and urgent need for America to assume the high risks taken at sea by its vessels and cargoes.

The War Risk Insurance Act—more formally known as Public Law 193, 63d Congress: "An Act to authorize the establishment of a Bureau of War Risk Insurance in the Treasury Department"—was passed on September 2, 1914. The establishment of this Bureau was necessitated by the fact that the rates for insuring vessels and cargoes had, owing to the ever-increasing submarine warfare, soared to undreamed-of-heights. Without ample insurance, commerce on the seas had become an unthinkable gamble, a threat of ruin to every shipowner or shipper whose property was destroyed. And the lives of all ships' personnel were now in heavy jeopardy.

Great Britain had already underwritten risks of the vessels flying the British flag and was pressed to the limit to protect its own commerce. This left the neutrals to look after themselves.

The Bureau of War Risk Insurance, with William C. DeLanoy, an insurance executive from New York City, as Director, on the first day of its existence began to write insurance in the name of the Government against hulls and cargoes of American vessels. In June 1917, this coverage was extended to insure the lives of officers and crews of American merchant vessels according to their scale of pay. The coverage ranged from $1,500 to $5,000.

From September 21, 1914, when the Bureau of War Risk Insurance was established, until January 4, 1919, when rates were withdrawn, the operation of the Bureau resulted in a balance sheet that was heavily on the plus side. This was one of the few times that a Federal benefit program resulted in a profit to the United States. It was all the more interesting because the rates for this Federal marine insurance were considerably lower than those of private companies.

Actually, the profit in insurance of "cargoes, freights, and bottoms" under this program amounted to $16,569,815.86 during the

William Cooper DeLanoy

William Cooper DeLanoy was born in New York City in 1861, the son of John A. and Emma (Peshine) DeLanoy. His father was secretary of the Bowery Insurance Co., which, undoubtedly, influenced William and his brother to form an independent insurance firm in 1882. He was appointed Director of the Bureau of War Risk Insurance in 1914. The Bureau then provided marine insurance only. But, with the act amended in October 1917, the Bureau provided insurance for the military personnel. Mr. DeLanoy played a large part in shaping the procedures and policies in connection with the operation of this program. He resigned as Director on October 5, 1918, to become manager of the Marine Insurance Section of the Railroad Administration.
period described above; in the "seamen’s section" it ran to $475,076.89. The total net income over expenses was $17,044,892.75. This, added to the $50 million sinking fund voted by Congress to carry on the work, brought to $67 million, the total that was returned to the Treasury.

THE UNITED STATES ENTERS

The Lusitania had been sunk without warning off the coast of Ireland by a German submarine on May 7, 1915. In all, 1,198 lives were lost. The number of Americans drowned was 114.

The German submarines, after a lull in 1916 stepped up their campaign in early 1917. In February of that year, they sank over 200 ships. Within 15 days after President Wilson’s second inaugural on March 3, the U.S. steamships Memphis, Illinois, and Vigilancia were sunk. The latter was sunk without warning. In April, the loss rate rose to almost 100 ships a week. During that one month, 800,000 tons of shipping were destroyed with grim loss of life to neutrals as well as to belligerents.

The history of the U.S. entry into World War I is too complex for summarizing here, except to state that the precipitating factor was the German attacks on our shipping.

The Bureau of War Risk Insurance, of course, paid the indemnity on the hulls and cargoes in the event of disaster. During World War I, 61 merchant vessels were sunk. It was not until 1957 that the Administrator realized that he, as well as his predecessors, were “ admirals” of a "sunk fleet”.

Inasmuch as the owners of 61 insured vessels had been reimbursed for their losses, the entire 61 boats were technically the property of the Veterans’ Bureau, and later, the Veterans’ Administration.

During the years following the war, salvage experts reclaimed almost $30 million worth of material for the Government. In 1957, however, an inquiry was received as to the sale of one of these ships, the SS Lewis Luckenbach, which had been sunk off the coast of France. Proposals were issued for the sale, and it was sold to the highest bidder for $60,000.

Realizing that technically the ships were the property of the VA because of the War Risk Insurance Act, Mr. Higley felt that this matter was quite apart from the purpose of the VA in serving the ex-soldier. Therefore, he turned over the 60 remaining ships to the Maritime Commission of the Department of Commerce. Before this was done, there were numerous letters received by the VA, written by apparently prosperous American citizens, who asked how they could purchase a ship from the VA. By turning over the ownership to another governmental department, Mr. Higley happily ceased to be the “admiral” of a “sunk fleet.”

Suffice it to say that on April 2, 1917, President Wilson, addressing an extraordinary joint session of the new Congress on the first day of its convening, asked for a declaration that a state of war with Germany existed. Using a phrase that was to become famous—“The world must be made safe for democracy”—he said, among other things:

American ships have been sunk, American lives taken, in ways it has stirred us very deeply to learn of, but the ships of other neutral and friendly nations have been sunk and overwhelmed in the waters in the same way. There has been

4Treasury Department press release, July 20, 1919, p. 3.
no discrimination; the challenge is to all mankind. * * * With a profound sense of the solemn and even tragic nature of the step I am taking, and of the grave responsibility which it involves, but in an unhesitating obedience to what I deem my constitutional duty, I advise that the Congress declare the recent course of the Imperial German Government to be, in fact, nothing less than war against the Government and people of the United States; that it formally accept the status of belligerent which has been thrust upon it; and that it take immediate steps not only to put the country in a more thorough state of defense, but also to exert all its power, and employ all its resources, to bring the Government of the German Empire to terms and end the war. * * * There is one choice we cannot make, we are incapable of making. We will not choose the path of submission.

After the President finished, the Chamber rang with cheers. He departed for the White House with his private secretary, Joseph P. Tumulty, where, as recounted in Tumulty's book, "Woodrow Wilson As I Know Him":

For a while he sat silent and pale in the Cabinet Room. Then he said: "Think what it was they were applauding. My message today was a message of death for our young men. How strange it seems to applaud that." Then, laying his head on the Cabinet table, he sobbed as if he were a child.

On April 6, Congress passed the resolution he had asked for. The count was 82 for and six against in the Senate, 373 for and 50 against in the House.

Miss Jeannette Rankin of Montana, the first woman ever to be elected to Congress, was one of the 50 Representatives to vote against the resolution. During the final vote, the Clerk of the House had to call her name four times before she responded. She faintly said "No," and added, "I want to stand for my country, but I cannot vote for war." Later, she told reporters: "In urging suffrage, we women had declared that war was stupid and futile and destroyed the best of the race. I have never felt at any time that war could settle anything." There was sympathy for her as she became the target for abuse and ridicule. Her act cost her a reelection, but she said she "would do it again." (And she did. After reelection to the 77th Congress, 24 years later, she cast her vote against our entry into World War II. In this case, hers was the sole congressional "No.")

A NEW CALL TO ARMS

Now came the tremendous mobilization.

"It is not an army we must shape and train for war," said the President, "it is a nation."

Congress, realizing that a sufficient fighting force could not be obtained solely through enlistments—a situation exactly the reverse of that in the Spanish-American War—passed a law adopting military conscription. That was on May 18, 1917.

State Governors were called upon to establish draft boards composed of prominent citizens. On June 5, every man in the country between 21 and 30, both inclusive, was required to register for the draft. Nine and a half million men registered that day.

On June 17, Gen. John J. Pershing arrived in France with his staff, followed by 20,000 soldiers who successfully ran the U-boat gauntlet, the first U.S. regiment landing on June 26.

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On July 20, the Government held a formal drawing of lots to determine which numbers should be called first. The ceremony took place in Washington, in the public hearings room of the Senate Office Building. The Secretary of War, Newton D. Baker, blindfolded, drew the first number from a large glass jar—it was 258.

And so, all over the country, in each district, the men whose draft cards bore the number 258 were summoned.

Other numbers were drawn until the Army had grown as large as required. (A total of 687,000 men had to be raised by the selective draft, the total figure being apportioned to the States according to their populations.)

A total of 4,757,240 men were inducted into the U.S. forces in 1917 and 1918. Of those reporting to camps after acceptance by draft boards, 740,304 were found to be physically or mentally unacceptable—a valuable screening, through careful medical examinations, that compared favorably with the outrageously superficial induction "examinations" held at the beginning of the Civil War.

PROTECTION OF U.S. FIGHTING FORCES

Concurrently with the patriotic fervor for raising an adequate Army, the Liberty Bond drives, and the singing of "Over There" and other war songs, public officials gave early consideration to the problem of protecting our fighting men and their families, both during the war and after.

At the request of President Wilson, Secretary of the Treasury McAdoo appointed a Council of National Defense. He called to his assistance experts in insurance, welfare workers, and medical authorities and educators. He also had the active help and support of influential labor leaders like Mr. Samuel Gompers and Mr. J. W. Sullivan. Mr. Gompers was a member of the Advisory Commission of the Council of National Defense, and was Chairman of its Committee on Labor. Other members of the Committee were socially minded humanitarians and persons expert in dealing with the problem of dependency, like Judge Julian W. Mack. He served as chairman of a subcommittee that drafted the amendment to the War Risk Insurance Act and worked out the details of the plan. Also serving were Dr. Leo S. Rowe, Assistant Secretary of the Treasury; Capt. S. H. Wolfe, a well-known accountant and actuary; Miss Julia C. Lathrop, of the Children's Bureau; Mr. V. Everit Macy, president of the National Civic Federation; Prof. Henry R. Seager and Thomas I. Parkinson, of Columbia University, and the staff of the Legislative Drafting Research Fund of Columbia.

The Committee, in their wisdom, recommended the passage of legislation containing a new concept of veterans benefits. Emphasis was placed on readjustment and rehabilitation rather than on monetary benefits alone. The family must be provided for during the absence of the breadwinner. The subject was one of the most widely discussed of its day, both within Congress and outside. The proposal advanced had five main provisions:

Compulsory monthly allotments from the pay of enlisted men with dependents, and allowances contributed by the Government to help support them.
Compensation for injuries sustained in active military service.

The amount varied according to the degree of disability. Compensation to families in case of death incurred in line of duty.

It established a system of voluntary insurance at peacetime rates against death and total disability.

It provided medical and surgical hospital treatment and prosthetic appliances for those injured in line of duty.

It authorized vocational rehabilitation for those injured in the service to the extent they could not resume their prewar occupations.

The Committee labored tirelessly during the summer of 1917 in ironing out differences of opinion as to the provisions of the bill. It may be said that Judge Mack was the father of this new and far-reaching law.

Judge Julian W. Mack was elected to the circuit court of Cook County, Ill., in 1903. Prior to that time, he had taught law at Northwestern University and the University of Chicago, acquiring a reputation as a teacher who not only knew the law but knew the law in action. While a student at Harvard Law School he, with five others, was responsible for the establishment of the Harvard Law Review.

In 1911, he was appointed to the Federal Circuit Court of Appeals for the Seventh Circuit and soon established an outstanding reputation as a trial judge. It became the practice to request him to preside over the trials of particularly long and difficult cases. He had the rare gift of being able to deliver his charge orally to the jury even in the most complicated case, with scarce reference to notes.

Judge Mack was also a member of the Board of Inquiry on Conscientious Objectors. A young farmer from Tennessee, who had difficulty reconciling fighting with his religious belief, asked one evening to talk with Judge Mack. They talked long and seriously. The next morning, he reported he did not wish to claim exemption—the young farmer was Sgt: Alvin York, one of the outstanding heroes of World War I.

While Judge Mack was active in behalf of the downtrodden of all races, as a Jew he was particularly affected by the plight of the Jews and labored incessantly to secure equal justice for them and a homeland in Palestine for those who wished to go there. He was chosen to act as a delegate to the Peace Conference in 1919. Judge Mack will be remembered primarily because of the time he took out of a busy career to give help and sympathy and understanding to others to get their start and to have the chance for a good life.

Judge Mack, undoubtedly in an effort to secure backing for his proposals transmitted a copy of the proposed bill to former President Theodore Roosevelt, on August 18, 1917. He wrote Judge Mack on August 22 from Oyster Bay, in part as follows:

My Dear Judge Mack: I have read the bill for compensating and insuring the soldiers and sailors with keenest interest. It marks a great step forward. It puts the United States where it ought to be, as standing in the forefront among the nations in doing justice to our defenders.

I am particularly struck by the emphasis on the family, instead of, as heretofore, on the man. When we draft men into public service, we enlist their dependents; and of these we must never lose sight. They must be cared for while their breadwinner is away. They, not he alone, must be considered in fixing the compensa-
tion for disability; and if he dies as a result of the service, they must be adequately protected, instead of being given the miserable pittance the present pension laws provide.

But I particularly like the provisions for reeducation. There is great danger, when a man knows that for the rest of his life the Government is going to give him just enough to live on, that he will be content therewith, and grow sluggishly indifferent to further effort. But life is not static. Men go forward or else they fall backward. Unless proper steps are taken, men who endure, first, terrible injuries, and then the long inactivity that necessarily follows, and who suffer some degree of permanent debility in consequence, are in grave danger of going to pieces. It is clearly in the public interest, as well as for their own good, that they should be reeducated for life wherever possible; and it is both wise and just that their economic recuperation should not lessen their compensation for loss of limb.

The bill is a real and constructive measure. I believe it should be passed, and should go into effect when the first men of the new National Army are called out. I know of nothing more important than to lift the fears of men that their families may become objects of charity, and to hearten the wives and children and parents of this country to respond bravely and gladly to the Nation's call.

Very sincerely yours,

(S) THEODORE ROOSEVELT.

The bill was transmitted by the Secretary of the Treasury to President Wilson on July 31, 1917. In his transmittal letter, Secretary McAdoo voiced the new philosophy of benefits for servicemen as compared with the previous pension system which had obtained in this country from its earliest days.

The Secretary advised the President as follows:

The proposed provision for the men and their dependents should not be offered as gratuities or pensions, and they should not be deferred until the end of the war. The wives and children, the dependent mothers and fathers of the men should not be left, as in previous wars, to the uncertain charity of the communities in which they live. The minds of our soldiers and sailors should be put at rest, so far as their loved ones are concerned, by the knowledge that they will be amply provided for by their Government as a part of the compensation for the service they are rendering to their country. In like manner they should know in advance that if they are killed in battle, definite and just provision has been made for their dependents, and that if they are disabled, totally or partially—if they come back armless, legless, sightless, or otherwise permanently injured—definite provision is made for them, and that they are not going to be left to the uncertain chances of future legislation or to the scandals of our old pension system. Every man should know that the moment he is enlisted in the military service of the Government these definite guarantees and assurances are given to him not as charity but as a part of his deserved compensation for the extrahazardous occupation into which his Government has forced him.

Furthermore, it must be borne in mind that the Government will not escape these expenditures if this plan of compensation and insurance should be rejected, because the pension system would then be resorted to, and the cost would likely exceed that of the proposed plan. At the same time the pension system would not provide the same benefits nor cover the subject in the same comprehensive, humane, and equitable way. No provision is made under our pension laws for family allowances while the men are at the front, nor for rehabilitation, life insurance, etc.

The President replied to the Secretary as follows:

MY DEAR MR. SECRETARY: I have examined the inclosed papers very carefully and take pleasure in returning them with my entire approval.

(S) WOODROW WILSON.
DIFFICULTIES IN ADMINISTERING THE BUREAU OF WAR RISK INSURANCE

It will be readily realized that the Bureau of War Risk Insurance faced a colossal task in organizing and establishing procedures to carry out the provisions of the act. This vast and far-reaching governmental enterprise eventually affected a military force of nearly 5 million men and women during World War I and, in addition, almost 1 million dependents. Forms had to be devised, procedures for expediting applications formulated, policies established.

The nucleus of the organization to meet these problems was 20 persons located in four rooms in the Treasury Department, having no equipment to perform such work, no building space and a paucity of additional personnel available.

During the hearings on the amendment of October 6, 1917, to the War Risk Insurance Act, much publicity had been given throughout the country to the provisions thereof. As a result, 2 days before the passage of the act, 20 bags of mail had been received by the Bureau. It was realized that failure to act promptly would result in severe hardships to the dependents of the men in service, and many pitiful cases of need came to the attention of the Bureau. This was especially true during the winter of 1917 when coal and fuel of all kinds was very expensive and difficult to obtain. It was plain that the families of the fighting men needed the assistance of the Bureau as quickly as possible and that every effort should be made, even at considerable sacrifice, to get checks to the families of these men at the earliest possible moment, under the allotment and allowance provisions.

To meet such a problem effectively would have been most difficult, even though an efficient and trained corps of clerks had been available. This was not the case and help of any kind, efficient or inefficient, was not available. Ordinary tables, desks, typewriters, as well as other laborsaving devices that should be used in a modern office could not be found, nor was there any adequate office space available.

Even though it was known in the beginning that it would be necessary to recruit and train clerical forces which would probably run into the thousands, this was almost impossible to do, due to the tremendous expansion of the War and Navy Departments in Washington. They had already drawn the more efficient people.

A recruitment campaign for help ensued throughout the country. Gradually, thousands of people—90 percent of whom were women—were brought to Washington. They were for the most part untrained, and included young girls, mothers, and grandmothers. All alike were pressed into service.

There was no single building or group of buildings in close proximity to house the Bureau. Practically all available buildings were used. These spilled over an area of several miles and included warehouses, stores, garages, dancehalls, office buildings and clubhouses.

In October 1917, the largest space obtained under one roof was in the National Museum on Constitution Avenue between 10th and 12th
streets, and the Director, Mr. De Lanoy, occupied an office here. Stuffed animals and innumerable cases of historical exhibits were pushed back to make room for the War Risk Insurance Bureau personnel.

The first staff group to be employed were assigned at the museum. They were given copies of the amendment to study. Desks and other office equipment, mostly in a dilapidated state, were finally received. At that time, the amount of mail stacked on the loading platform at the rear of the building continued to grow. There were literally hundreds of mail bags containing applications for both insurance and allotment allowance. The latter were given preferential attention. Practically the whole office, both officials and clerks, worked voluntarily on several occasions, for 24 hours without stopping, in order to get the monthly checks out.

At the time of the passage of the Amendatory Act, the Bureau was faced with the task of dealing with an Army of almost 2 million and a Navy of 200,000 scattered over this country, at sea, and approximately 100,000 more were in Europe. This number was increased steadily by about 200,000 to 300,000 per month.

On November 8, 1917, an office was established in Paris for the purpose of handling insurance applications as well as those for allotments and allowances. Capt. S. H. Wolfe was in charge of this office and had a staff of eight officers and 15 enlisted men. They were seriously handicapped by insufficient information regarding the act, and the pertinent regulations, lack of equipment, inadequate office accommodations, and insufficient personnel.

Before the insurance application blanks were received, or even a copy of the act itself, this small group secured nearly one hundred million dollars' worth of insurance, principally over the counter at the Paris headquarters.6

Blanks were improvised and printed in Paris for this purpose, but the applications for troops at or near the front were made on sheets of brown wrapping paper, simply stating the name of the applicant, his beneficiary, and the amount of insurance desired.

In some instances, the personnel of the Paris office carried these lists even to the frontline trenches in order to secure the signatures before the men went over the top—perhaps never again to have the privilege of putting their signatures on such material things as insurance blanks.

The actuary of the Bureau of War Risk Insurance, in the Director's annual report for the fiscal year ending June 30, 1919, mentions one instance of a soldier writing on the wall of a dugout his insurance application, inasmuch as he had not received the forms provided for this purpose. He was killed shortly thereafter and a photograph was taken of the writing on the wall and sent to the Bureau in Washington. On this basis, an award was made to his beneficiary.

One member of this group of insurance officers relates some of their experiences as follows:

From 5 o'clock in the morning until 9 o'clock at night field squads were at it. Speeches were made in the YMCA huts and at mess and everywhere that the men could be gotten together. After the speechmaking there was personal work. Every man was approached directly. If the proposition was not quite clear to him it was explained in detail; if his attitude remained indifferent all the ingenuity of the insurance squad was bent toward his conversion. They wrote insurance all the way from the farthest western training camp to the most easterly port of debarkation and the receiving ports in France. They wrote insurance as near the frontline trenches as any noncombatant was permitted to go, and when they could proceed no farther they sent blank insurance applications into the front trenches on the very eve of battle.

In the Insurance Division of the Bureau of War Risk, locked up in a steel cabinet, is now treasured the original paper, grimy with the soil of the trenches, but bearing the names of boys who “signed up” on it for insurance of varying amounts the night before they went out at daybreak into No Man’s Land, some never to return. Across the names of these is written simply the word “Dead.” But these applications, collected by insurance officers who had gone into the trenches during a stiff German offensive, have been treated as the last will and testament of those soldiers, and the beneficiaries mentioned are receiving Government insurance upon as valid a contract as if it had been formally made and taken in triplicate, as was the custom.

With the formation of the American Expeditionary Force War Risk Section in Washington, provision was made for the training of insurance officers detailed by the Army and Navy. After 3 weeks’ training a detachment of 35 officers and 65 enlisted men sailed from New York on December 11, 1917, arriving at Liverpool on Christmas Eve 1917. They were then divided into groups and dispatched to various field locations, and, by February 12, 1918, they had succeeded in reaching all of the units which at that time formed the American Expeditionary Forces. Their activities, of course, extended to distributing applications for troops arriving after that date.

During the war, insurance totaling $1,425 million was written by the war risk section located in Europe.

In the meantime, at the Bureau’s headquarters in Washington, there were approximately 20,000 letters being received each day. The average clerk without previous experience did not possess the knowledge or judgment to adequately answer these communications. A school for training correspondence clerks was organized on May 1, 1918, each course lasting between 2 and 3 weeks. This continued until August when 994 people had attended this school. All but 10 percent, or 99 individuals, remained with the Bureau. From October 6, 1917, until June 30, 1918, 3 million letters had been answered.

At that time (June 30, 1918), there were approximately 13,000 employees. The turnover rate, however, was very high owing to unsatisfactory living conditions in Washington. During the month of September 1918, one-twelfth of the clerical force resigned.

To add to the woes of the Bureau, other than insufficient personnel, were the errors in the applications of the enlisted men, such as in the spelling of names or addresses of allottees and the submission of required information. There were many tangles to be unraveled; for example, there were thousands of instances in which men named their sweethearts as their wives in order that the girls might get allowances.
There were cases in which men named their mothers as their wives so that they might get increased allowances. In one instance, a soldier named 19 different persons as dependents upon him for support. There was not enough space on his application blank for all the names, for he represented himself to be the sole support of the entire family from his great grandmother down to an infant child. This case looked queer, but investigation showed that all 19 lived in one small house.

There were also cases where an enlisted man failed to make an allotment to a dependent, due sometimes to a desire to escape responsibility and sometimes to a misunderstanding of the questions; neglect in changes of address; failure of the dependents to give certain identification to identify the enlisted man. Considerable difficulty was experienced in the spelling of the proper names where an allottee adhered to foreign spelling, whereas the enlisted man gave the anglicized version.

Another problem which existed then, and exists to this date, was the great number of identical names. A man’s name will seldom identify him absolutely. There are literally thousands of men with the same name. In March 1920, the files of the Bureau of War Risk Insurance contained listings for 51,950 Smiths, 3,412 of whom were named William. There were 48,000 Johnsons—2,138 John Johnsons. There were 170 William Williams, 280 Willie Williams, and altogether there were 47,000 Williams listed. There were 900 John Andersons, 800 Carl Andersons, and 600 Charles Andersons, with a total of 23,000 Andersons. And there were 18,500 Walkers.

One of the surprises for the searchers came when a letter was received from a John J. O’Brien who identified himself by the fact that his beneficiary was his wife, named Mary A. O’Brien. A search revealed that there were 50 John J. O’Briens whose wives and beneficiaries were named Mary A. This problem was magnified greatly during World War II. However, the clerical help at that time was experienced in various methods of identifying the claimants as many of them had served in the Bureau during World War I and remained on.

It was soon recognized that certain identification could be insured only by assigning each serviceman of the Armed Forces a number. Therefore, on February 28, 1918, a serial number was assigned each man and it was ordered that these numbers be attached to all applications sent to the Bureau. This procedure, too, resulted in considerable difficulty. There were errors in telegraphing of numbers, duplicate numbers were given, initials only were sent in, rather than full given names, resulting in errors in attaching the proper serial number to the application.

The Bureau finally decided to utilize their own series of numbers for identification. A "C" number was used as a preface for a claim for any benefit other than insurance. Prefix "T" was first used for insurance numbers, and, upon conversion, changed to "K." Certain
low insurance numbers were set aside for those in the military service who, for exceptional conduct or outstanding war records, were deserving of consideration. A converted No. 1 was assigned to Gen. John J. Pershing; No. 2 to Adm. William S. Sims; No. 3 to Col. Henry D. Lindsley, and No. 4 to Gen. Peyton March.

Before anything could be accomplished, space must be procured. There was no single building in close proximity which would meet the needs of this expanding organization. Most available office space in Washington was occupied by other governmental agencies. It was necessary to secure whatever was available and at one time 17 different locations were being used. But, finally, one building was secured which could house practically all of the departments of the Bureau of War Risk Insurance.

It was fortunate for the Bureau that in 1918 there was a building in process of construction, adjacent to Lafayette Square. This was the site of the old Arlington Hotel which had been razed in 1912 and since had remained an open pit surrounded by a high board fence.

The property was on Vermont Avenue and occupied the block between H and I Streets. It was originally the site of the homes of Senators Charles Sumner and Reverdy Johnson, later Minister to Great Britain. Prior to 1869, the homes of Presidents James Buchanan and Benjamin Harrison were located here, as well as those of Secretaries of State William L. Marcy and Lewis Cass.

In 1869, the Arlington Hotel was erected here following the razing of these structures. One of the most celebrated and exclusive hotels in the country, it catered to family patronage and the congressional and diplomatic sets. Travelers from all over the world made it their stopping place when in Washington. Guests from every quarter of the country were entertained there, including Financier J. Pierpont Morgan and Tom Platt, Republican Congressman, New York, 1873-77 and later Senator 1897-99. Every President from Grant to McKinley stayed there awaiting their inauguration. It was also the home of the Gridiron Club, which helped make the hotel famous. It was the site of the most celebrated birthday dinner ever given in the United States up to that time. This was the occasion of the 70th birthday of “Uncle Joe Cannon,” in 1900.

Early in 1912, it was decided by the owner to tear down the old building and erect a new one, larger and more spacious in its appointments. This was done, but was followed by a series of unfortunate incidents to the owner. J. Pierpont Morgan who, it was alleged, was going to finance the enterprise, died, and the project failed. Court proceedings, and foreclosure sales ensued. The unsightly excavation was an eyesore for the next 4 years. The property then was offered for sale under a mortgage held by the Equitable Life Assurance Co. early in January 1914. It was purchased by a company in Richmond, Va., for $847,000, which formed the Arlington Building, Inc.  

1 Congressional Record, Senate, p. 6710, May 19, 1918.
purchasers made a downpayment of $150,000, and commenced construction. Following this transaction, the company ran into financial difficulties. They abandoned the idea of erecting a hotel and decided upon an office building. They made a proposition to the Navy Department whereby the company would rent the building to the Navy upon completion. However, Congress considered the matter and refused to authorize a lease on the property.

They then offered to sell the site and the structure when finished to the Treasury Department for the use of the Bureau of War Risk Insurance, which was agreeable to the Secretary of that Department. It was to be an 11-story structure above ground, with three basements.

10 H. Rept. 325, 65th Cong., 2d sess., "The Purchase of the Arlington Hotel Property."
It was originally intended to erect a building facing Vermont Avenue only. The Treasury Department made certain changes in the original plans, limiting the height above ground to 10 stories, with the 11th floor to be recessed and used as an attic. Realizing this would not be sufficient space for the Bureau, plans were drawn up for an extension on I Street. As of February 13, 1918, the date of the sale, the two subbasements had been completed and the steelwork of the upper structure extended up to the second story level. Eighty percent of the rest of the steelwork had been fabricated and the cutting of stone facing the building was underway. Improvement in design was necessary and strengthening of the floor construction so as to make it suitable for the Bureau's use. Requirements for changes in design and strengthening were also included in the purchase price.

There was considerable debate in Congress as to whether the money should be taken from an emergency fund authorized to the President for war uses, or whether this should be a separate and distinct appropriation. However, the President, within his authority, authorized the purchase of the building. The actual proposal submitted was for $4,119,072, but the Treasury added $80,928 for contingencies and necessary expenditures to make the building ready for occupancy. The original building would be completed by October 1, 1918, and the I Street extension by February 1, 1919. This gave a total frontage of 351 feet on Vermont Avenue, 69 feet on H Street, and 315 feet on I Street.

It was the intent of the Treasury Department to house the entire force of the Bureau of War Risk Insurance in this building, as well as part of the Internal Revenue Service, but Internal Revenue Service was not allotted space in this building.

In February 1919 the first units of the Bureau started to move into their new home, which was known as the War Risk Building. On January 25, 1920, all available space was utilized, but still it was not large enough for the approximately 14,000 employees. Certain units had to remain in outlying buildings.

The cornerstone was laid in 1918 on the Vermont Avenue and H Street corner of the building. It reads as follows:

Erected Anno Domini 1918
Under the Direction of
WILLIAM G. McADOO
Secretary of the Treasury
James A. Wetmore
Acting Supervising Architect
Wyatt and Nolting
Architects

Although this building was purchased for the specific use of the Bureau of War Risk Insurance, it is odd that no mention was made of this in the plaque on the cornerstone.
WAR'S END APPROACHES

As the huge war drew toward its close, the Public Health Service and the Bureau of War Risk Insurance worked together to prepare for the deluge of medical and hospital problems they would jointly inherit from the military, once the war was over. Their joint responsibility lay in the fact that while the Public Health Service was to provide these vast medical services, they were to be paid for by the Bureau. The appropriation bill for sundry, civil expenses of the Government for the fiscal year 1921, approved June 5, 1920, made available to disabled veterans medical services in National Homes for Disabled Volunteer Soldiers, and also Army and Navy hospitals, for the beneficiaries of the Bureau of War Risk Insurance.

The Public Health Service was furnishing a major portion of hospital care and treatment to disabled veterans on a reimbursable basis. Twenty Marine hospitals (7,200 beds) and 119 relief stations were then being operated by the Public Health Service.

On September 17, 1918, 2 months before the end of the war, these two agencies met with the Army and Navy to discuss the medical future.

On the day following the conference, the Surgeon General of the Public Health Service sent a memorandum to the Secretary of the Treasury requesting $9.5 million for expanded hospital and outpatient facilities. On second thought, the Surgeon General sent another memorandum, this one directed to Congress, recommending an additional appropriation of $12,049,000.

There was considerable discussion of these two recommendations in both the House and Senate, which felt that since $90 million had been spent during the war by the military for hospitals located at some 32 cantonments throughout the United States, why—now that the war was over—couldn't they be converted for the care of veterans? But the Public Health Service felt that they were not suitable for the hospital needs of veterans returning from overseas, and that they would soon become “white elephants.”

But Congress, as a result of these recommendations, on March 3, 1919, appropriated funds for and authorized the hospital expansion.

THE ARMISTICE AND THE AFTERMATH

With the cessation of hostilities on November 11, 1918, the Bureau of War Risk Insurance and the Public Health Service faced a grave situation. Insofar as the disabled veteran was concerned, the country was as woefully lacking in preparedness for peace as it had been in preparedness for war. Here was a situation unparalleled in the history of war, medicine, or government.

According to figures compiled by the House of Representatives, the number of U.S. soldiers “wounded not mortally” in World War I totaled 204,000.11

11 House Committee Print No. 69, 87th Cong., First sess., 1961.
Now, for the first time, the new benefits provided against this day were to be put to the test. The healthy were demanding jobs. The disabled wanted compensation, medical care, and a chance to be retrained to overcome their handicaps. Five agencies of the Government were handling various aspects of the new benefits.

At the Bureau of War Risk Insurance, the insurance program by this time was on a fairly level keel. The activities involving allotments and soldiers and sailors relief dropped off rapidly, but the demands for compensation were beyond anything envisioned.

The medical activities of the Bureau consisted of rating claims and authorizing hospitalization. Few doctors were required, most of whom had been detailed to the Bureau by the U.S. Public Health Service.

Staffs were both inexperienced and inadequate. The processing of claims was agonizingly slow. Backlogs were building up. At the end of June 1919, 233,000 compensation claims had been filed and more than half of them were still pending. Disability compensation cases required medical examinations, and proof of eligibility was necessary in death cases. Many of the veterans who filed claims were found to be ineligible, but all applicants had to be thoroughly examined. The wheels of Government were grinding to a slow stop.

NEED FOR SPEED

Some way had to be found to speed up activities in both the Bureau and the Public Health Service. Public Health decentralized its examining and outpatient functions to 14 district offices, greatly speeding up medical services. (Not until 1922 were both organizations able to report that their work was essentially current.)

The old Pension Bureau still handled pensions—this involved only veterans of previous wars. The Rehabilitation Division of the Federal Board for Vocational Education, which handled schooling and rehabilitation benefits, was swamped with requests from service-disabled veterans.

The National Homes for Disabled Volunteer Soldiers continued to operate their branches as separate and distinct, although their functions now overlapped some of the medical provisions.

The Public Health Service was attempting to carry out the medical and hospital benefits with inadequate staffs and facilities.

All of these services seemed to overlap at some point. Disorder reigned supreme. Veterans wandered about in a state of bewilderment. Seeking compensation, they found themselves in the Bureau of War Risk Insurance. Reporting to the Public Health Service for medical care, they discovered that they needed proof of eligibility from the Bureau of War Risk Insurance, or, going to the Federal Board for Vocational Education, they found that they had to wait for
their eligibility to be established by medical authorities before anything whatsoever could be done.

Confusion was piled on confusion as, daily, more men were being discharged from camps and military hospitals. Before the demobilization was over, approximately 5 million veterans were added to the rolls potential beneficiaries under the new laws.

It was impossible to estimate how many of these would seek to exercise their rights. Hospitalization and prosthetic devices had been authorized in 1917, but there had been little activity in these fields prior to the armistice. Up to that time, hospital and related care had been carried out to a great extent by the armed services.

Part of the problem faced in dealing with veterans' medicine stemmed from the inability of the military to carry out their policy of retaining all military personnel in hospital until they had reached complete recovery, or as near complete recovery as could be expected.

To accomplish this, the military had designated certain hospitals as reconstruction centers and had provided them with special staff and equipment to carry out this objective. Vocational and psychiatric aids were trained to carry out this work. The American Red Cross was active both in training and in carrying out the program.

But with the signing of the armistice, the military program crumbled. Hospitalized servicemen wanted to go home, take up their old jobs and be with their families. They could not be held against their wills, even though they had not received the "maximum benefit" of hospital treatment. More than 300,000 of them needed further care.12

While it was believed that most of their needs could be met through compensation and insurance, their release added greatly to the burdens of both the Bureau of War Risk Insurance and the Public Health Service.

PUBLIC LAW 326

Public Law 326, March 3, 1919, which transferred certain military hospitals to the Public Health Service, also authorized new hospitals at Chicago, Ill. and Norfolk, Va., plus the purchase of one in the District of Columbia, and the enlargement of a hospital at Stapleton, Staten Island, N.Y.

Additional funds were provided for technical services and clerical help, and authority was given to pay transportation, and burial costs not to exceed $100, for any patient dying in a hospital.

In addition to granting the requested funds, the act fixed the responsibility for hospitalization and related care mainly on the Public Health Service. The hospitals transferred to the Public Health Service included: Camp Cody, N. Mex.; Joseph E. Johnston Hospital, Florida; Camp Beauregard, La.; Camp Logan, Tex.; Camp Fremont, Calif.; and the nitrate plant at Perryville, Md. The National Home for Disabled Volunteer Soldiers at Hot Springs, S. Dak., was also made available for a period of 5 years. Authority was given for the transfer of other suitable military hospitals, should they become available and needed. The bill appropriated $750,000 for remodeling, renovating, and changing these properties, and opened the door for further funds, should they be needed.

At the time, the Public Health Service had neither sufficient staff nor facilities to meet the oncoming load. It was fortunate indeed for

12 "Public Health Reports," vol. 36, No. 21, May 27, 1921.
veterans that the law permitted the continued use of contract hospitals, where the average cost in private hospitals was $3 per patient per day, and $1 in State institutions.

Even with the institutions transferred to the Public Health Service—as well as their existing hospitals—it was still evident that insufficient facilities were available to meet the demand. New hospitals would have to be built, outpatient and dispensary facilities provided. (From September 1919 to June 1920, there were 19,610 admissions to contract hospitals.) This was only a beginning: 2 years later there were 47,962 admissions in non-Federal hospitals.

FIRST STEP TOWARD WORLD'S LARGEST HOSPITAL SYSTEM

Though it was a far cry from what was needed, Public Law 326 was a first step toward what was to become the world's largest hospital system.

Even before these new responsibilities were dropped in its lap, the Public Health Service was straining at the seams. Now, handling these transfers, modernizations, and renovations fell squarely on the hospital division at the central office of the Public Health Service. At that time, the hospital division had a total employment of less than 10 people.

Physicians were sought in all parts of the country. Those who were qualified, and could be persuaded to accept, were commissioned in the Public Health Service and assigned to duty in the hospitals. Others were made acting assistant surgeons and assigned either part or full-time duty. Consulting physicians were brought into the hospitals on a fee basis, while others, known as "designated examiners," were assigned most of the physical examinations.

In 1920, the staff of the Public Health Service was enlarged to include 72 regular physicians on duty at the Bureau of War Risk Insurance. The rolls showed that physicians working in the field totaled 478 commissioned officers, 956 acting assistant surgeons, 877 attending specialists, 33 interns, and 2,471 designated examiners.

NEED FOR MORE BEDS, MORE MONEY

Hardly was the ink dry on Public Law 326, of March 3, 1919, transferring hospitals to the Public Health Service for veterans' hospitalization, before Secretary of the Treasury, Carter Glass, presented to Congress a request for more beds and more money to build them.

(In the history of veterans' affairs, the various Secretaries of the Treasury during the administrations of Presidents Wilson and Harding: Carter Glass, David F. Houston, William G. McAdoo, and Andrew W. Mellon, deserve mention. All four of them sent strong recommendations to Congress in behalf of legislation and appropriations which looked to the betterment of the economic and medical welfare of veterans. In all four cases, the combination of their personal as well as official prestige proved effective.)

Secretary Glass made his request in a summary known as "Document No. 481," dated December 5, 1919. The document was

accompanied by a computation prepared by Dr. W. Charles Rucker, Assistant Surgeon General of the Public Health Service, who had been detailed as Chief Medical Adviser to the Bureau of War Risk Insurance. Document No. 481 was actually a draft of a bill "to provide additional hospital and outpatient dispensary facilities for all discharged, sick, and disabled soldiers, sailors, marines, Army, and Navy nurses (male and female) * * *

Dr. Rucker, in his computation, completely and unequivocally supported the position of the Public Health Service. He pointed out that he was using every available bed in their hospitals. Ten thousand men, he said, had been discharged from the Armed Forces with still active tuberculosis. The tuberculosis sanitarium at Fort Stanton, N. Mex., was already filled to overflowing and he was finding it almost impossible to get more patients into contract hospitals.

He asked for an additional 30,000 beds and pointed out that 25,000 of them would be needed within the next 2 years. The average cost per bed was set at a little more than $3,300, with an additional cost of $300 per bed for furniture and equipment, bringing the total request to $84,445,000.

The Public Health Service, on June 30, 1919, half a year after the end of the war, was operating 20 Marine hospitals and the tuberculosis sanitarium at Fort Stanton, N. Mex. During the last 3 months of fiscal year 1919, 10 new hospitals were opened, known as "Public Health Service Hospitals," rather than "Marine hospitals." Nine of these were former Army hospitals, and, in addition, a hospital was leased in Washington, D.C. In June 1920, the Public Health Service had increased its total available beds to 11,639 in 52 hospitals. To further ease the situation, the act making appropriations for fiscal year ending June 30, 1921, authorized the use of available beds in Army and Navy hospitals for the benefit of Bureau of War Risk Insurance, as well as appropriate beds in the National Homes for Disabled Volunteer Soldiers.

Congress finally appropriated $18,600,000 for additional hospitals. This bill, Public Law 384, 66th Congress (41 Stat. 1364), was signed into law by President Wilson on the day he left office: March 4, 1921.

BUREAU OF WAR RISK INSURANCE DIRECTORS

The first Director of the Bureau, Mr. William C. DeLamoy, resigned October 5, 1918, to accept the position of manager of the section of marine insurance of the Railroad Administration. There follows his resignation and the reply from the Secretary of the Treasury:

Hon. William G. McAdoo,
Secretary of Treasury,
Washington, D.C.

My dear Mr. Secretary: On September 2, 1914, you appointed me Director of the Bureau of War Risk Insurance to care for war risk insurance on hulls and cargoes of American vessels. I organized and started the office with an assistant and three clerks.

Shortly after the entrance of the United States into the war, Congress created a new division of the Bureau to insure masters, officers, and crews of the American merchant marine. This rendered necessary increasing the force to about 30 people.

On October 6, 1917, by enactment Congress further created the military and Naval Division of the Bureau, and for the past year I have devoted myself, regardless of hours and without thought of my health, to developing and perfecting its organization, which now comprises nearly 14,000 employees.
I feel that the time has now arrived when I may properly consider the imperative demands of my own health and strength, and therefore ask with regret to be relieved of my duties as Director of the Bureau of War Risk Insurance at your earliest convenience.

The pleasure and honor of serving under your direction for the past 4 years I value beyond price.

Faithfully yours,

WILLIAM C. DELANOY, Director.

DEAR MR. DELANOY: I have your letter of October 5, in which you tender your resignation as Director of the Bureau of War Risk Insurance. I need not tell you how genuinely I regret that you feel impelled to offer your resignation, but I can well understand that the exactions of this great business, which has grown with such extraordinary rapidity in number of employees and in the amount of insurance involved, have been a heavy tax upon your strength. I would not, of course, have you continue at the risk of your health, and feel obliged, therefore, to comply with your request and accept your resignation.

I want to congratulate you warmly on the admirable work you have done for your country since you came to Washington in 1914 to take charge of and develop an entirely new business for the Government of the United States—that of war risk insurance. You have performed your duties with unusual devotion and unselfishness, and the success of this great work is due in large measure to your intelligence and untiring efforts.

As you know, I have a great responsibility in the administration of the railroads of the United States and of the coastwise shipping. I have been obliged to create a section of marine insurance in the Railroad Administration, and I wonder if you would be willing to accept the direction of this marine insurance section. The work will not be so exacting as the directorship of the Bureau of War Risk Insurance, and I believe that you would not find it an undue tax upon your strength and energies.

With hearty good wishes and assurance of my high esteem, I am,

Cordially yours,

W. G. MCAuloo.

Mr. Delanoy's office, which originally consisted of five persons including himself, had grown to a total of 14,000 during his term of office.

He was succeeded by Col. Henry D. Lindsley, whose tour of duty was only 7 months—to May 17, 1919. The next Director was Lt. Col. Richard G. Cholmeley-Jones, who had served in the insurance program of the Bureau of War Risk Insurance with the American Expeditionary Forces in France.

Richard Gilder Cholmeley-Jones (Continued on p. 168)
on May 19, 1919. Due to ill health, he resigned April 27, 1921, and passed away in the Presbyterian Hospital, New York City, on February 21, 1922.

On the occasion of his death, the Philadelphia Bulletin editorial stated, "He deserves to be held in grateful memory as the man especially qualified for a particular service to his country *** and who devoted his energies and talents to it without thought of self."


Colonel Cholmeley-Jones, on taking office, inaugurated an intensive program to bring the work of the Bureau current. Within 2 months the personnel in the central office increased by 2,000.

Colonel Cholmeley-Jones also contacted all welfare agencies and service organizations, including the newly formed American Legion.
He added highly competent men to the staff, the majority of whom had recently been discharged from the service. Officers were detailed to the Bureau by the Secretary of War and Secretary of the Navy.

Realizing that the complete centralization of the work of the Bureau was a big deterrent to the Bureau’s efficiency, he recommended that, to the greatest possible extent, its activities be decentralized to 14 regional offices in the same cities in which the Federal Board for Vocational Education and the U.S. Public Health Service already had field offices.

Undoubtedly, his total dedication to the enormous task of improving the pace and quality of the Bureau’s work brought on the physical breakdown which forced him to resign on April 27, 1921. He died a year later.

The employees of the Veterans’ Administration, at a later date, provided and installed in the lobby of the VA building in Washington, a bronze plaque reading:

Richard Gilders Cholmeley-Jones, Director, Bureau of War Risk Insurance, 1919–1921

He deserves to be held in grateful memory as a man especially qualified for a service to the country in time of need. He fulfilled that service with a devotion of all his energies and talents without thought of self.

The next Director, Col. Charles R. Forbes, came to Washington from Seattle, where he had been vice president of the Hurley-Mason Co., a firm of railroad construction engineers. He had served with the AEF as a colonel of infantry and also in the Signal Corps. He took part in many engagements, including the Battle of the Somme. He was awarded the Distinguished Service Medal.

The Washington Herald, in announcing the appointment of Colonel Forbes, stated that he had had broad executive experience, as well as active knowledge and interest in his former wartime comrades.

When he took over the assignment, he did not expect to stay in it long, as he was awaiting other job possibilities which he had been looking into, particularly with the U.S. Shipping Board. But he attacked his task with vigor.

Colonel Forbes and his stewardship as the last Director of the Bureau of War Risk Insurance and the first Director of the Veterans Bureau, which was established on August 9, 1921, will be discussed later.

TWO IMPORTANT GROUPS ESTABLISHED

Among the first acts of the Harding administration were the appointments of two important groups, which have come to be known as the White Committee and the Dawes Committee, although only the latter was a committee. The former was a group of four consultants on hospitalization. However, the deliberations and recommendations of both groups were to have far-reaching effects on the future of medical care and other benefits received by U.S. veterans.

The consultants on hospitalization, appointed by Secretary of the Treasury Andrew W. Mellon, met for the first time on March 16, 1921.

The chairman of this group was Dr. William Charles White, medical director of the Tuberculosis League Hospital, Pittsburgh, Pa., and a member of the executive committee of the National Tuberculosis Association. He was former professor of neuropathology and clinical psychiatry at the University of Indiana, also formerly in charge of the
hospitalization of the tuberculous for the Red Cross in France and Italy.

The other consultants were equally distinguished:

Dr. Frank Billings was chairman of the American Red Cross mission to Russia in 1917, a colonel on the staff of the U.S. Army Surgeon General during the war, and dean of the faculty of Rush Medical College, Chicago, Ill.; Dr. John G. Bowman was chancellor of the University of Pittsburgh, Pa., and former director of the American College of Surgeons; and Dr. Pearce Bailey, chairman of the New York State Committee on Mental Defectives and a director of the National Committee for Mental Hygiene, was a former president of the American Neurological Association (he served as a consultant for only 3 months). Dr. George H. Kirby, who replaced Dr. Bailey, was former medical inspector of the New York State Hospital Commission and, at the time of his appointment as a consultant, director of the New York Psychiatric Institute, Ward's Island, N.Y.

Although the mission of the consultants bore entirely on the development of the veterans' hospital program, they recognized at the outset the need for a new organization to handle veterans' affairs.

On April 5, 1921, the consultants turned over to the Dawes committee—described below and meeting for the first time on that date—all of the data which they had compiled since their first meeting on the 16th of the preceding month. It was material of the highest importance in this sequence of events, for it consisted of a suggestion for a new veterans' affairs agency, a Bureau of Soldier Rehabilitation, complete with a proposed organization chart.

The proposed new agency would merge certain functions of the Bureau of War Risk Insurance, the Rehabilitation Division of the Federal Board for Vocational Education, and that part of the U.S. Public Health Service which dealt with veterans' hospitalization and medical problems. The proposal recommended that the new organization be headed by a director responsible to an undesignated Cabinet officer.

The consultants, however, did not submit their final report until February 28, 1923, almost 18 months after the establishment of the Veterans' Bureau. This will be discussed later.

**DAWES COMMITTEE**

This committee, chaired by Gen. Charles G. Dawes, was appointed later (but only a week later) than the consultants. The mission assigned to General Dawes and his 10 associates was to recommend ways and means to solve, or, at the least, alleviate, the problems faced by disabled veterans.

Specifically, the Dawes committee was charged by President Harding "to study and report upon, conditions as they now exist in the Government departments concerned with providing service to the ex-soldiers, ex-sailors, and ex-marines of the World War—and to propose a program for immediate needs, as well as a program to provide for future requirements, to the end that the intention of the Congress to give the full measure of justice to ex-servicemen may be adequately, promptly, and generously met."

General Dawes, who, before his appointment to this committee, had fought through World War I as a major up to brigadier general,
later became, in turn, the country's first Director of the Budget, Chairman of the Reparations Commission, Vice President under President Coolidge, and Ambassador to Great Britain. The famous "Dawes plan" for the reorganization of defeated Germany's fiscal system, which he submitted in 1924, brought him the Nobel Peace Prize.

His penchant for speed in getting things done is legendary, and nowhere was it more apparent than in the lightning-fast functioning of the Dawes committee. As stated earlier, it met for the first time on April 5, 1921, and, remaining in continuous session for 2 days and nights, submitted its report to the President on April 7.

During the deliberations, the general, who had banned controversial discussions among the committee members, was heard to shout, as reported in the newspapers, "Good God, let's get through. It was just 4 years ago today that war was declared. Let's don't get jobbed up with a lot of extraneous matter. We know an intolerable condition exists. Everybody does. What we want is speed. Our job is to provide the machinery. We are not concerned with details."

The disabled American veteran in need of medical care has had no more effective champion in all U.S. history than the fiery General Dawes.

The committee's amazingly speedy report consisted of a simple, direct statement of findings and a recommendation for relief. Divided responsibility was found to be the chief cause of the confusion, snarls, and redtape which kept veterans from getting the benefits provided by Congress.

The great importance of the consultants' proposal is illustrated by the fact that the Dawes committee accompanied its April 7 report with a "chart of proposed organization for soldier rehabilitation" differing from the consultants' proposal it had received only the day before, April 6, solely in (1) the name of the proposed agency, Veterans' Service Administration instead of Bureau of Soldier Rehabilitation; and (2) the recommendation that the Director be responsible directly to the President instead of to a Cabinet officer.

The Dawes report recommended that the new organization be responsible for "proper examination, medical care, treatment, hospitalization, dispensary and convalescent care, necessary and reasonable aftercare, welfare of, nursing, vocational training and other necessary services utilizing the now existing or future facilities of the U.S. Public Health Service, the War Department, Navy Department, Interior Department, the National Home for Disabled Volunteer Soldiers, and such governmental facilities as may be made available."

The Dawes committee also included among its recommendations the following:

That a continuing hospital building program to provide satisfactory care for the disabled veterans of the World War be entered upon at once. The committee of hospital consultants, appointed by the Secretary of the Treasury in cooperation with the Surgeon General of the U.S. Public Health Service, shall submit recommendations as to the type of buildings and the location of same, the necessary appropriations to provide for such permanent program to be passed at the next session of Congress.

That, in addition to the recognized medical and educational services not provided by the Government, such humanizing services be provided in the district offices and in cooperation with private agencies in the homes of the beneficiaries
as will give these beneficiaries not only financial aid and the medical and educational services at present provided by law, but such helpful neighborliness in their contact with the Government as will make them feel that the whole Nation is intimately concerned in their welfare and rehabilitation.

That the $18,600,000 appropriated by the 66th Congress for the building of new hospitals and the enlargement of existing institutions be utilized for these purposes without any delay.

A revealing sentence in the committee's eloquent report appears immediately preceding the concluding paragraph:

No emergency of war itself is greater than is the emergency which confronts the Nation in its duty to care for those disabled in its service and now neglected.

When the new Congress convened on April 11, 1921, top priority was given to the problem of improving veteran care, and one of the first orders of business was to take up for consideration the Dawes committee report.

On August 9, 1921, the Congress, incorporating most of the recommendations contained in that report, enacted the legislation—Public Act No. 47, 67th Congress—which created the "U.S. Veterans' Bureau." Note that neither the name recommended by the consultants on hospitalization, nor that recommended by the Dawes committee, was finally used.

The first paragraph of this act reads:

There is hereby established an independent bureau under the President to be known as the Veterans' Bureau, the Director of which shall be appointed by the President, by and with the advice and consent of the Senate.

Col. Charles R. Forbes, who had been Director of the Bureau of War Risk Insurance since April 28, 1921, was named by President Warren G. Harding as the first Director of the Veterans' Bureau.

Charles R. Forbes

Charles R. Forbes was born in Scotland on February 14, 1878, the son of Charles and Christine Forbes. Records do not reveal when he came to this country but it is reported in an article by Charles Mertz which appeared in the Century magazine in 1925 that he was once a drummer boy in the Marine Corps and discharged at the age of 14.

He enlisted in the Signal Corps of the U.S. Army at the age of 22 and served both in the United States and the Philippines until his discharge as a sergeant on January 29, 1907.

At age 31 he was settled in the Northwest, engaged in construction business, which later took him to the Hawaiian Islands. While there he became interested in politics and rose to the position of Commissioner of Public Works. While occupying this post he became acquainted with a Senator from Ohio, Warren G. Harding, who was touring Honolulu with a congressional delegation. This was the beginning of a long friendship.

Forbes accepted a commission as major in the Signal Officers Reserve Corps in June 1917 and was sent overseas. He was awarded the Distinguished Service Medal, and was discharged a lieutenant colonel in 1919.

He was appointed Director of the Bureau of War Risk Insurance on April 28, 1921, serving but a short time when the Veterans' Bureau was formed and he became its first Director. He resigned this post on February 28, 1923. He had much illness and passed away in Walter Reed Hospital on April 10, 1952, and was buried in Arlington Cemetery.
Col. Charles R. Forbes, Director, Bureau of War Risk Insurance, April 1921–August 1921; Director, Veterans' Bureau, August 1921–February 1923.
Chapter VII

The Veterans' Bureau (1921–30)

A Giant Step

The most important forward-looking action taken after the war was the creation of the Veterans' Bureau in August, 1921. It became apparent that this Bureau constituted a giant step in the direction of bringing most veteran benefits, medical, compensation, insurance, and vocational rehabilitation, under the administration of a single agency.

Medicine was basic to all these activities, because medical examination, and determination of service-connection, were necessary before most of the other available benefits could be rendered.

The only veterans activities not assumed by the New Bureau were those of pensions for pre-World War I veterans (remaining under the Bureau of Pensions); domiciliary care (under the National Homes for Disabled Volunteer Soldiers); and the operation of hospitals serving veterans (these remained under the U.S. Public Health Service until after their transfer, 1 year later, to the Bureau).

Consultants' Report

The consultants on hospitalization carried on their proceedings with much more deliberation than had the Dawes committee. True, after less than a month of work, they had supplied the Dawes committee with an organizational chart which, with only two changes, the committee made part of its report. However, following that swift and important early action, the consultants did not submit their final report until February 23, 1923, after almost 2 years of study and investigation, by which time the Veterans' Bureau had been in existence for a year and 7 months.

The report was comprehensive and farsighted. 1

Its preparation had been thorough and painstaking to a high degree. In assembling the extensive data on which to build a proposed Federal hospitalization program, the consultants realized, from the outset, the necessity of obtaining, tabulating, and analyzing these data as a foundation for decisions. For this purpose, they invited an Advisory Committee to serve with them.

Dr. T. W. Salmon, representing the National Committee for Mental Hygiene, chaired the Advisory Committee. There were seven other members: Dr. Haven Emerson, on detail at the Bureau of War Risk Insurance; Dr. H. A. Pattison and Mr. T. B. Kidner, of the National Tuberculosis Association; Drs. C. H. Lavinder and W. L. Treadway, of the U.S. Public Health Service; and Col. C. M. Peersall, representing the National Homes for Disabled Volunteer Soldiers.

The material supplied to the consultants by this committee consisted of figures on U.S. populations by district and State, with the numbers of draftees in each; medical examination reports supplied by the Surgeon General of the Army; the number of veterans in hospitals and awaiting hospitalization; available hospital facilities, Government and private; climate data from the Department of Agriculture; topographic maps from the Department of the Interior; etc.


Some 100 groups including Senators, Representatives, State and municipal committees, chambers of commerce, etc., requested hearings before the consultants, and were heard.

In seeking data, and formulating recommendations, the consultants were not satisfied to sit in Washington and listen to testimony. They moved out into the field and visited almost every governmental hospital then in operation, as well as the proposed sites for new hospitals. Because of this experience, their advice and recommendations were invaluable to the newly established Veterans' Bureau in launching its tremendous program of hospital expansion.

The final report delved into the overall hospital problems of the Nation. Many of its recommendations, though not acted on at the time, have now served for many years as guides in the planning and construction of hospitals. It pointed out that hospitals for veterans were being constructed in locations without regard to the veteran population in those areas, so that some hospitals had surplus beds while in others there was a shortage. Because of this situation, the committee recommended that population distribution be made a prime consideration in planning hospital location, as veterans and their families tended to resent having to travel long distances.

The report also recommended that hospitalization of veterans be confined to Government institutions insofar as possible, without regard to the availability of beds in civilian hospitals.

These recommendations were adopted as policy and followed by the Veterans' Bureau, and later by the Veterans' Administration, through World War II.

EVALUATION OF CONSULTANTS' CONTRIBUTION

The most practical and long-lasting impact of the consultants' report on veteran care was twofold. It resulted in the taking over, by the Veterans' Bureau, of certain U.S. Public Health Service hospitals; also, it resulted in appropriations by Congress to enable the Veterans' Bureau to carry out the consultants' recommendations as to the repair, modernization, and expansion of these hospitals.

AFFILIATION

The report also contained pro and con views on the subject of affiliation of veterans' hospitals with medical schools.

Indeed the consultants seem to have recognized themselves as a minority, for they conceded that many authorities (not named)
consulted by them feared that the affiliation of hospitals with medical schools would result in the veterans being submitted to experiment and student teaching. Therefore, the consultants did not word very strongly their position in favor of affiliation.

The consultants' own views on this important aspect are stated in a passage in the report headed "Special Medical Service," which reads, in part:

What would secure for the beneficiaries of the Government the best type of medical service? Should they be confined solely to isolated Government institutions, or should they have available such consultant and expert advice as surrounds the best type of teaching civil institutions? Which would secure the most rapid recovery and return to active participation in the duties of life?

Following this series of questions, the consultants stated that "the tendency [of 'many authorities' among those consulted] was all for centralization in Government institutions." The report added, however, that "although in the location of these hospitals the consultants had constantly in mind that they should be as near as possible to centers of medical education * * * it was felt that the effort [of the consultants in this respect] was largely wasted." (Italic added.)

This amounted to an approximation of a minority dissent within the report, an impression further conveyed by the next passage:

* * * The opinion was frequently expressed [by the consultants'] advisory committee that our soldiers were not to be submitted to experiment and student teaching, and yet the very best type of medical care is given in those institutions that come under the critical eye of students and in which teaching is carried on—to wit, Johns Hopkins, Harvard, Columbia, Chicago, and elsewhere—and it is a duty of our Government, where possible, to accept its share in opening the doors of these institutions for instruction of oncoming doctors and nurses who will in the future have to deal with those who are sick.

It will be clearly seen that the consultants were farsighted in advancing the policy which favored the affiliation of hospitals with medical schools and universities, a policy which was adopted in the medical program of the Veterans' Administration after World War II.

Their thinking on the subject of affiliation gathered dust for more than a generation. Then, following World War II, almost identical ideas were advanced by other forward-looking men and formed the basis for reorganizing and revitalizing medical practice in the Veterans' Administration.

The consultants on hospitalization, appointed in 1921, were, in their thinking a quarter of a century ahead of their time.

**NEW HOSPITAL PROJECTS**

On the recommendation of the consultants, the Bureau started work on 19 hospital projects designed to provide 6,334 beds for veterans, most of whom were suffering from tuberculosis or mental disease. Four new hospitals were constructed. Three were purchased and later remodeled. Twelve were transferred from the U.S. Public Health Service or the War Department, or were additions to existing national homes, with alterations and/or additional construction authorized.

On the completion of each project, it was turned over to the jurisdiction of the Veterans' Bureau, except where the additional construction was on the premises of a national home for disabled volunteer soldiers.
Below is a geographical breakdown of the 19 new projects:
The consultants were responsible for the location of the four new hospitals: at Tuskegee, Ala.; Palo Alto, Calif.; Jefferson Barracks, Mo.; and Chelsea, N.Y. (Castle Point). The three hospitals which were purchased and enlarged were a hospital at Augusta, Ga.; the Roman Catholic orphan asylum, the Bronx, N.Y.; and the Central New England Sanatorium, Rutland (renamed Rutland Heights in 1925), Mass. Nine Federal hospitals to be remodeled or enlarged were at Perryville, Md.; Olaou, N.C.; Luke City, Fla.; Alexandria, La.; Little Rock, Ark.; Cheyenne, Wyo.; Fort Bayard, N. Mex.; Whipple, Ariz.; and Walla Walla, Wash. New construction was authorized at three national homes: Dayton, Ohio; Marion, Ind.; and Milwaukee (Wood), Wis.

All of these hospitals, with the exception of those at Rutland Heights and Fort Bayard, continue in operation today as part of the Veterans' Administration system.

A CHRONOLOGY

The final report of the consultants further listed events which caused numerous conferences with the Veterans' Bureau and the Federal Board of Hospitalization. Chronologically they were:
April 7, 1921: Dawes committee.
April 19, 1921: Transfer of all Public Health Service functions dealing with veterans (except hospitals) to the Bureau of War Risk Insurance.
August 9, 1921: Conversion of Dawes committee, recommendations into law by the establishment of the U.S. Veterans' Bureau.
November 1, 1921: Establishment, by Executive order, of the Federal Board of Hospitalization.
April 29, 1922: Transfer, by Executive order, of certain hospitals of U.S. Public Health Service to Veterans' Bureau.

Considering the many principles laid down by the consultants in their report which are followed to this day in the administration of Government hospitals, the work of the consultants was a minor cost (§16,000 for 2 years) to the Government, for it resulted in the laying of a firm foundation for the operation of our veterans' hospital system as it exists today.

THE MEDICAL DIVISION

Although the amendment to the War Risk Insurance Act of October 6, 1917, provided for medical and hospital service to service-connected veterans, this was not implemented until March 3, 1919, when responsibility for this phase of the amendment was assigned to the Public Health Service. The work of the Medical Division of the Bureau of War Risk Insurance was restricted almost solely to the rating of compensation claims, the furnishing of prosthetic appliances, special medical treatments, and general supervision of the medical services to beneficiaries.

Hospitalization in Public Health Service hospitals had to be authorized by the Bureau of War Risk Insurance after checking as to service connection.

The Public Health Service, unprepared to meet the tremendous increase in the number of World War I patients to be treated, had to
contract with numerous civilian hospitals. The Bureau of War Risk Insurance also could authorize, when necessary, direct hospitalization in civilian hospitals.

During those early days, the medical service was headed by a U.S. public health officer who served as medical adviser to the Director of the Bureau of War Risk Insurance, until the title of the position was changed, in May 1923, to Medical Director.

The following physicians were on detail from the Public Health Service as medical advisers:

Dr. Charles E. Banks: May 1918 to June 1919.
Major W. C. Rucker: June 1919 to November 1920.
Dr. Haven Emerson: November 1920 to September 1921.

Dr. Emerson resigned and was succeeded by Lt. Col. Robert U. Patterson, who was detailed to the Veterans' Bureau by the Surgeon General of the U.S. Army in September 1921. On taking over these duties, Colonel Patterson assumed the title of Assistant Director of the Veterans' Bureau. He was recalled to the Army in February 1923.

TRANSFER OF PHS HOSPITALS TO VB

On May 1, 1922, in accordance with an Executive order dated April 29, 1922, the hospitals formerly operated by the Public Health Service for the treatment of veterans were transferred to the Veterans' Bureau. Thus the task of organizing and implementing the medical program for veterans fell, initially, on the shoulders of Lieutenant Colonel Patterson.

Concurrently with the 1922 hospital transfer, certain medical personnel of the Public Health Service were also transferred to the control, management, operation, and supervision of the Director of the Veterans' Bureau, and subject to such change in designation and organization as he may deem necessary. In addition, there was a proviso that the commissioned personnel so transferred would preserve the rank, grade, pay and allowances, promotion rights, and other privileges accorded to them as officers of the Public Health Service. Disciplinary authority was, however, retained by the Surgeon General of the Public Health Service.

On December 19, 1923, the Director wrote to President Coolidge, explaining that there were on duty, at that time, 680 full-time commissioned officers of the U.S. Public Health Service. These included 35 commissioned dentists, as compared with 796 civil service physicians and dentists. There were also 15 physicians and dentists appointed by the Director as special experts, making a grand total of 1,455 physicians and 216 dentists. He pointed out that, of the 645 physicians of the Public Health Service, their aggregate salaries amounted to $1,859,355 and their allowances to $1,001,284, totaling approximately $3 million. The salaries of the civil service physicians—796 in number—amounted to $2,610,000. These figures eloquently highlighted the inequalities of pay for the two categories of professional personnel.

In order to help the new Director of the Veterans' Bureau, Gen. Frank T. Hines, with this problem, President Coolidge issued an Executive order (No. 4023, June 7, 1924) under which the Public Health Service physicians in the Veterans' Bureau came under the authority of and were paid the same rates as those under civil service.
Most of the affected physicians grumbled; some obtained transfers back to Public Service hospitals. Some resigned while a number of the civil service physicians in the Bureau complained that they were not adequately paid.

VETERANS' BUREAU MEDICAL DIRECTORS

In May 1923, the position of Medical Director of the Veterans' Bureau was created, and Dr. Lester B. Rogers was appointed as the first incumbent. He served from May 1923 to January 1924, previously, he had been medical adviser, detailed by the Public Health Service to the Bureau of War Risk Insurance from 1919 to 1921. He then served as executive officer to the assistant director in charge of medical service, and had also been a member of the Federal Board of Hospitalization.

In January 1924, he requested a field assignment and was appointed medical officer in charge of the hospital at New Haven, Conn. He served but a short period of time there when he resigned and left for California.

As successor to Dr. Rogers, Dr. Edwin O. Crossman was appointed. He had two tours of duty in the central office, the first being from April 1924 to August 1926. He, too, sought a field assignment and was transferred to Boston, Mass.

When Dr. Crossman left central office, Dr. Benjamin W. Black was named as his successor. He had served as executive officer under Dr. Crossman from 1924 to 1926. Prior to that time, he had been an assistant surgeon in the Public Health Service from 1920 to 1924. He was a noted psychiatrist and was the author of many professional articles which were published in medical journals. He resigned in April 1928 to accept the position of medical director of Alameda County (Calif.) hospitals, and remained in that assignment until his death on December 1, 1945.

FEDERAL BOARD OF HOSPITALIZATION

President Harding created the Board in November 1921, for the purpose of coordinating the separate hospitalization activities of the Medical Department of the Army, the Bureau of Medicine and Surgery of the Navy, the U.S. Public Health Service, and the Veterans' Bureau.

For 3 years after its founding, the Board functioned under the supervision of a Chief Coordinator who was appointed by, and directly responsible to, the President. The other members were the Surgeons General of the Army, Navy, and Public Health Service, the Superintendent of St. Elizabeth's Hospital, the President of the Board of Managers of the National Homes for Disabled Volunteer Soldiers, the Commissioner of Indian Affairs, and the Director of the Veterans' Bureau.

In the early days of the Board, an antipathy arose between its Chief Coordinator, Gen. Charles E. Sawyer, who was President Harding's personal physician, and the Director of the Veterans' Bureau, Col. Charles R. Forbes, who was a Board member. The

5"An Outline of the Manner in Which Sites are Selected and Funds Authorized for the Building of Hospitals and Homes for the Care of Former Members of the Armed Forces," committee print, 80th Cong. 2d sess., printed for the use of the Committee on Labor and Public Welfare, 1946.
latter felt that General Sawyer was usurping much of his authority as the Director of the Veterans' Bureau.

In 1924, a reorganization placed the Board's activities under the chairmanship of the Director of the Veterans' Bureau and provided that its recommendations be transmitted to the Director of the Bureau of the Budget for the consideration of the President. Upon establishment of the Veterans' Administration in 1930, the chairmanship was vested in the Administrator of Veterans' Affairs.

The procedure followed by the Board required agencies sponsoring new hospital construction to submit complete reports, with recommendations, to the Board. After thorough study, the Board adopted these resolutions with recommendations.

Until the early part of 1943, projects for the provision of hospital facilities for war veterans comprised the great majority of cases referred to the Board for consideration.

Prior to 1943, the Board had no staff as such; all secretarial, statistical, and clerical assistance being furnished by employees on the rolls of the Veterans' Bureau and its successor, the Veterans' Administration. At times, the Board appointed subcommittees, consisting of employees from agencies represented on the Board. These subcommittees concerned themselves with such matters as the establishment of reciprocal reimbursement rates for Government hospitalization, the merger of Government facilities in given areas, etc.

Following the President's directive of March 31, 1943, the Board established a staff organization consisting of eight employees. This staff was paid from funds of the Veterans' Administration for fiscal years 1944-46, from the Bureau of the Budget funds for fiscal years 1947-48.

In addition to the duties incident to the review of all Federal hospital projects, the President directed that the Board undertake a study of the complete problem of the hospitalization of veterans of World War II, and the development of an overall plan for meeting this responsibility of the Federal Government. Details of the Board's organization and functions under the President's new directive were outlined in Bureau of the Budget Circular No. 419.

This circular provided that the Bureau of the Budget would review and coordinate hospital, convalescent, and domiciliary programs developed and operated by all departments and establishments. It also required each agency to develop, and submit annually to the Bureau of the Budget not later than June 1, an itemized program of all new or additional bed-producing projects which it proposed to include in appropriation estimates for the next fiscal year.

TWO INFAMOUS YEARS

Col. Charles R. Forbes, who had been Director of the War Risk Insurance since April 28, 1921, was named by President Harding as the first Director of the Veterans' Bureau.

While there was great expectation in the improvement of services to the disabled veteran by the creation of the Veterans' Bureau, the next 2 years proved to be one of the most regrettable periods in the history of veteran care.

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2 Ibid., p. 1
When Colonel Forbes first took over the assignment in the Bureau of War Risk Insurance, it was reported that he did not expect to stay long; only until something better opened in the Shipping Board. Nevertheless, he attacked his immediate task with vigor.

Few realized then that the administration of the Veterans' Bureau represented one of the most trying and difficult situations in the Government service. It was larger than most of the agencies headed by a cabinet officer, and its budget larger than the majority of them. He was given three Government agencies which had handled veterans' problems -- these he was to weld into one great machine and at the same time administer the current needs of the veterans.

He had certain advantages working for him such as the backing of the President, who was personally interested. This was fine, as long as the President acted in person. However, when General Sawyer, the President's personal physician, became the White House spokesman on matters of hospitalization, it was another story. Director Forbes considered many of General Sawyer's actions as an infringement upon his responsibilities for providing medical care to the disabled veteran.

Colonel Forbes was evidently a great believer in delegation of authority to subordinates. However, as more power was constantly given to those in lower echelons, there was an inadequate check as to whether that power was used wisely or not. Director Forbes was intentionally kept unaware of many evils. The Bureau went forward, though, gradually bringing method out of disorder, but this progress was being bought at too great a price. A friend of the Director's described his administration in this way:
The organization expanded too swiftly for any one man to keep abreast of it. Mr. Forbes sought to surround himself with able and faithful assistants. He thus came to trust too many people and to trust them too far. The goodness of his heart and his abounding faith in mankind did him injury and began to do the Bureau injury. More and more subordinates began to assume the responsibility of important decisions. Ambitious men began to scheme and conspire for the favor of the Director. An important letter or contract would be placed before him with an incomplete or imperfect explanation of its significance. It would be "Here, Charlie, I know you're busy, but sign this." And Colonel Forbes would sign. The tremendous strain of work began to show.

The above statements were disputed by many who were in the Bureau at that time.

In an article appearing in the March 9, 1923, issue of the American Legion Weekly, author Marquis James wrote that there had grown up within the Bureau what might be called a triumvirate made up of three able subordinates who, realizing the problems of the Director, sought to throw about him a protective screen. They were Dr. Hugh Scott, Executive Officer; Charles F. Cramer, Chief Counsel, and Col. Robert U. Patterson, head of the Medical Division. They were the Big Three, and were reputed to be the "powers behind the throne." The combination worked well and the Bureau made its greatest strides under this arrangement. Then there began to be differences between the triumvirs themselves. Dr. Scott is alleged to have become imbued with the idea that Patterson and Cramer were misleading the Director. Colonel Patterson was a Regular Army officer and his methods were those of the service. Dr. Scott was a civilian physician of high professional standing in the Southwest. Cramer was a lawyer and an old friend of Colonel Forbes. Contracts for construction, purchases, and leases came within his jurisdiction.

Dr. Scott is reported to have called certain differences in opinion to the attention of Colonel Forbes and received no satisfaction. Then he went to the President. What he told the President is not known. However, when Director Forbes learned of Scott's visit to the White House, he transferred him to the hospital at Muskogee, Okla.

About the same time, General Sawyer, who, in addition to his duties as Presidential physician was a close adviser on medical and rehabilitation matters, received a telephone call from Surgeon General Cummings of the Public Health Service. General Cummings protested against the sale of surplus hospital supplies at Perryville, Md., which was a large supply depot of the Veterans' Bureau. He reported that $8 or $10 million worth of material was being sold in part to certain brokers in Boston at a price much less than its true value while the Public Health Service was buying such supplies at current prices.

General Sawyer called on Colonel Forbes, who agreed to stop the sale and removal of supplies from Perryville. A few days later, General Sawyer received word that the sales were continuing. Upon learning this, he ordered his car and was driven to Perryville. As he entered the reservation, he witnessed a heavily laden truck depart and saw another one being loaded. Breaking open one of the boxes he found it contained towels, which were being sold for 20 percent of the original cost. They were of the same type as the Public Health Service was buying for present needs.

The general directed that the truck unload. He sped back to Washington to relate the story to the President. Immediately an Executive order was issued directing that such sales and deliveries cease. Later, Surgeon General Cummings protested that mattresses were being sold at great discount when other Government activities urgently needed them for their hospitals.

There was further trouble ahead for the Director in the matter of construction of hospitals and leases of land for that purpose. It is alleged that 320 acres of desert land was leased for a period of 1 year and 2 weeks, for $40,000 ($35,000 for 2 weeks and $5,000 for the next 52 weeks). This land was a part of old Camp Kearny which the owners had leased to the Government for the nominal sum of $1. The land had a sale value at that time of about $25 an acre, or less. Naturally, the rental was exorbitant. The lease was signed by Mr. Cramer, Chief Counsel of the Veterans' Bureau, and Mr. J. W. Clifton, attorney for the owners. Director Forbes agreed to investigate, but within 2 days he reported that he understood the matter thoroughly and everything was all right.

Mr. Cramer denied any partnership with Clifton. He did admit that when he first came to Washington he had no office and received his mail at Clifton's office. Upon being questioned by a representative of the American Legion Weekly, he gave the following account to the reporter:

Before I go into this Camp Kearny matter, I want to tell you something about myself. I worked for an oil company in California at a very large salary, and came here to help out my friend Charlie Forbes. The first thing I did when I came to Washington was to buy President Harding's house for $60,000. That did not hurt me with the administration any. I am a member of every club in town. I am no piker.

The Camp Kearny situation was simply this: We did not consider the value of the land in arranging the terms of the lease. It was merely a question of safeguarding the interests of the sick soldiers in the hospital. If we had not paid this money out immediately these soldiers would have been thrown on the street. We had to protect them, and we took the best means at our disposal to do it.

Mr. Cramer explained that the rental agreement was $35,000 for 2 weeks and $5,000 for the following 52 weeks. This was arranged to satisfy holders of a mortgage against the land. He did not explain just how the situation of 400 veterans in the hospital would have been jeopardized by foreclosure. Long-drawn legal proceedings would have been necessary to obtain possession or a legal right to throw any veterans "on the street."

The White House received from other sources reports of Veterans' Bureau deals on the west coast. One was the purchase by the Bureau of 134 acres of old vineyard land at Livermore, Calif. It was reported that the land had been offered to the city of San Francisco in 1921 for $75,000, but the price was considered too high. Shortly thereafter, the site was inspected by a Veterans' Bureau agent and in February 1922 the Bureau bought it for $105,000.

Shortly after Dr. Scott's departure for Oklahoma, the Director was pressed to relieve Mr. Cramer. He evaded the issue and pleaded for a few days time to think it over. Mr. Cramer was urged to resign. He promised to do so. Rumor was abroad that Mr. Forbes' retirement was only a matter of a few days. When this report reached the Director, he called a conference on January 22 of all division heads and representatives of veterans' organizations. He delivered a very
forceful speech. He intimated there had been "politics," "gumshoeing," and "intrigue" within the organization and that he had taken drastic measures to stop it. During the conference, he declared he was in the Bureau to stay.

The following day he visited the President; the conference lasted 1 ½ hours. The next day, Mr. Cramer resigned and later committed suicide. One day later, Colonel Forbes departed for New York following a White House announcement that he was on his way to Europe for his health. The insiders knew differently. They knew Forbes would never return as Director of the Veterans' Bureau.

Upon leaving the country, Colonel Forbes left with the President an undated resignation, effective February 28, 1923, and subject to release by cable from Forbes. Such a cable was received on February 13. It is said that friends of Colonel Forbes cabled him, advising withdrawal of his resignation, as he was under fire. It was reported that on the 14th the White House received such a cable. The President ignored it and on the next day, February 15, he made public Director Forbes' resignation.

Frank Thomas Hines

Frank Thomas Hines was born in Salt Lake City, Utah, April 11, 1879, the son of Frank L. and Martha (Hollingsworth) Hines.

In 1898, shortly before the completion of his second year at the Agricultural College of Utah, at Logan, he enlisted in the 1st Utah Volunteer Artillery.

He served with distinction in the Philippines during the Spanish-American War. Upon cessation of hostilities, he applied for and was accepted as a commissioned officer in the Regular Army, where he served continuously until 1914, when he was granted leave of absence to accept a special assignment for a commercial concern which took him to Europe at the time World War I broke out.

He then returned to the Army and was chief of the embarkation service during World War I. He was appointed Director of the Veterans' Bureau on March 2, 1923, and held that office until it later became the Veterans' Administration, and served as head of these organizations until August 14, 1945.

He was then appointed Ambassador to Panama and remained there until February 1948 when he returned to Washington.

General Hines held the Distinguished Service Medal from both the Army and Navy, and decorations from five other countries. He was a member of the Military Order of the World War, the American Legion, American Society of Mechanical Engineers, Veterans of Foreign Wars, United Spanish-American War Veterans, and the Congressional Country Club.

He was awarded honorary degrees from Lincoln Memorial University (LL. D.), University of Alabama, and the Utah Agricultural College.

He died April 3, 1960, and was buried at Arlington Cemetery.

A NEW DIRECTOR: GENERAL HINES

On March 2, 1923, a new Director took over as head of the Veterans' Bureau—Brig. Gen. Frank T. Hines—whose tenure with the Bureau, and after 1930 as Administrator of Veterans' Affairs, was destined to last 22 years.

(Continued on p. 128)
General Hines had not been anxious to take the position; in fact, President Harding had offered it to him three times before he accepted. He said to the President: "I don't like politics and I don't know anything about politics." The President suggested that the general leave the politics to him and run the Veterans' Bureau as a business. On that basis he consented.

By this time, the newspapers of the country had published many articles most critical of the Veterans' Bureau, especially of Colonel Forbes' administration. The adverse publicity reached such proportions that a Senate investigation was authorized by Senate Resolution No. 466, dated March 2, 1923, reading as follows:
Whereas complaints are being made against alleged delay by the Veterans' Bureau in the adjustment of claims for relief of invalid and disabled veterans of the World War under the various acts of Congress; and

Whereas it is claimed that there has been great and needless delay in the construction of hospitals and in providing proper hospitalization for the relief of disabled veterans, as a result of which much unnecessary suffering exists; and

Whereas it is claimed that an unnecessarily large proportion of the appropriations made by Congress for the relief of the veterans is being improperly consumed in overhead expense; duplication of duties; excessive rent of properties and quarters; and in the employment of an unnecessarily large number of agents, doctors, inspectors, instructors, and other persons; and

Whereas it has been charged that certain sales of surplus property belonging to the Government and under the supervision of the U.S. Veterans' Bureau were made improperly: Therefore, be it

Resolved, That a committee consisting of three Senators, Members of the 68th Congress, to be appointed by the President of the Senate, is authorized and directed to investigate the leases and contracts executed by the U.S. Veterans Bureau or the Treasury Department for vocational schools and hospitals and for the purchase, rentals, and sales of real estate and supplies used or to be used directly or indirectly by the Veterans' Bureau for the benefit of the veterans of the World War and the matters and conditions in the premises set forth and to report their findings, together with recommendations for the improvement of such conditions, to the next regular session of Congress. Such committee is authorized to sit during any recess of Congress and send for persons and papers, to administer oaths to witnesses, and to incur necessary expenses for clerical and other services not exceeding $20,000, which shall be paid out of the contingent fund of the Senate.

The select committee consisted of Senator David A. Reed, of Pennsylvania, chairman; Senator Tasker L. Oddie, of Nevada; Senator David I. Walsh, of Massachusetts; with Maj. Gen. John F. O'Ryan, of New York, as counsel to the committee.

After the announcements of his resignation, Colonel Forbes immediately returned to the United States. When the Senate investigation was authorized he expected to be called immediately thereafter as a witness. Learning that the investigations of complaints were to be made nationwide before hearings commenced, Colonel Forbes left for California. Shortly thereafter, he became ill and was hospitalized. When it was announced formal hearings would commence, he voluntarily proceeded to Washington.

THE SENATE INVESTIGATION

Prior to the actual hearings of the Select Committee on Investigation of the Veterans' Bureau, the counsel to the committee sent letters to all Senators and Congressmen inviting them to submit any information in their possession which might indicate criticism or information as to the organization and operation of the Veterans' Bureau. Letters in a similar vein were addressed to State commanders of the Veterans of Foreign Wars, the American Legion, and the Disabled American Veterans of the World War. Assistance was sought from the State bar associations, asking for the designation of six lawyers in each State who would be of aid to the counsel in the investigation. Similarly letters were addressed to the presidents of all State medical societies asking them to recommend from 10 to 20 medical men in each State who would be willing to aid the committee and give them advice.

As a result, approximately 596 lawyers and 541 physicians volunteered their services without compensation. Nearly all of them had served in the World War.

Less than one-half of these were called upon to do any actual work, but the group was organized to be available whenever called upon.
and its membership responded to every demand that was made. There were only a few instances in which any one man was called upon to investigate more than one matter.

Shortly after the committee was organized the counsel began to receive complaints from individual veterans regarding their claims.

At the time of the first public hearing these aggregated 1,083 in number. Of these, only 32 pertained to hospital care and 5 of these were disposed of as having no grounds; 5 were settled favorably; the balance were pending at that time. Each of these complaints was referred to one of the representatives apparently equipped professionally to make an investigation. These were generally most painstakingly prepared and were of great value to the new Director of the Veterans' Bureau, not only because of the disinterestedness of the investigators, but because of their ability and experience.

Actual hearings before the select committee of the Senate occurred from October 22 to November 7, 1923, and from November 12 to December 5, 1923. The counsel for the committee, Maj. Gen. John F. O'Ryan, opened the hearings by stating that more than $467 million had been expended by the Veterans' Bureau during the fiscal year ending June 30, 1923, and yet, in spite of these lavish and unprecedented expenditures, there had existed during 1922 a growing feeling of dissatisfaction among the disabled. This feeling was shared by veterans generally and by their service organizations as well.

All complained of delays in giving relief, of arbitrary and unreasonable rulings denying relief, the insufficiency of hospital facilities, and the ineffective organization of the Bureau and its methods of conducting its affairs.

General Hines, who favored the investigation, was the first witness. He stated that previous to his appointment he had but scant knowledge of the work of the Veterans' Bureau. What little he had, he acquired, as did most officers, by taking up with the Bureau claims of disabled men and in assisting them. He also had read articles appearing in the public press relative to the Bureau.

General Hines said that upon assuming office he spent considerable time analyzing the organization and familiarizing himself with the law. His preliminary survey occupied his attention for about 3 weeks. He stated that he had still carried on such a study from the time of his appointment March 1923 to the date of his testimony, October 22, 1923.

He found in several cases there was a duplication of work with a resultant delay. He had eliminated a district office division which dealt with the field and through which the work of inspection in the field flowed. He thought that this was the bottleneck. The routine contacts with the field offices were not taken up directly by the main divisions.

General O'Ryan stated further that there had developed rumors that the business of the Bureau was not always conducted honestly and for the best interests of the disabled. There were statements abroad that hospitals were selected in some cases to satisfy the demands of those who had land to sell. In other cases charges were leveled that inordinate profits were derived from the sale of lands and divided among those immediately concerned.

A great many people testified, including officials of the Veterans' Bureau, representatives of service organizations, as well as other
people involved in activities concerning ex-servicemen. It was the opinion of the select committee that the seriousness of the disclosures in the hearings warranted submission to the Department of Justice. This was done and the matters were presented to a grand jury impaneled in Chicago. After this action, General O’Ryan felt that no further action needed to be taken by the committee regarding conditions in the Veterans’ Bureau, inasmuch as General Hines had assumed directorship in March 1923.

The committee submitted to the Department of Justice a transcript of the hearings involving Colonel Forbes and Mr. Thompson, a St. Louis and Chicago contractor. The grand jury, after hearing testimony for more than 9 weeks, indicted both Colonel Forbes and Mr. Thompson on charges of conspiracy to defraud the Government in contracts for veterans’ hospitals. As a result, each was sentenced to prison and fined. Both of them issued statements denying their guilt and declaring that they were victims of circumstances. However, the penalties were enforced and afterward Colonel Forbes took up residence in various parts of the country, the last being in Florida. He passed away at Walter Reed Hospital, Washington, D.C., on April 10, 1952, and is buried in Arlington Cemetery.

Thus ended an era in the history of the Veterans’ Bureau of which no one can be proud. However, the future was bright with the affairs of the organization being in the hands of such an honest, worthy, and competent man as his successor.

CLOSEUP VIEW OF GENERAL HINES

General Hines, when he accepted the appointment of Director of the Veterans’ Bureau from President Harding, had had long experience in the military. He had achieved a national reputation during World War I as Chief of the Army’s Embarkation Service. He was largely responsible for the development of this service and for its success in transporting 2,208,000 soldiers to Europe over a period of 18 months and, as well, returning them after the armistice in much less time.

He was a slight man, partially bald, with a military bearing. On first acquaintance, he seemed reserved, even cold. Upon more intimate contact he proved to be a man of much quiet humor, cordiality, and understanding. He ran the enormously complex Veterans’ Bureau in a methodical, machinelike efficiency. Yet, he was a man of warm sympathies and deep insight into human problems.

Because he resigned his commission in the Regular Army and assumed the appointed post as Director and Administrator, which were not under civil service retirement provisions, he would have no annuity when he relinquished his post. As early as 1939, an effort was made in Congress to provide a retirement for him to compensate his outstanding service. Finally, on March 10, 1944, the President signed Public Law 250, which provided authorization for the President to appoint any former officer of the Regular Army who, after military service of more than 15 years, resigned his commission and had subsequently served as Administrator or Director of the Veterans’ Bureau for a period of more than 15 years. It further provided that, while holding a civil office, he would not be entitled to retirement pay by virtue of his military status.
It will be seen that this was a bill designed primarily for the general, although his name is not mentioned. It is very doubtful whether any other person could in the future meet the two stipulations—15 years in the Regular Army and 15 years or more as Administrator of Veterans' Affairs.

GENERAL HINES AND PRINCIPAL ASSISTANTS

These are the men who shaped many VA policies and procedures which are still in effect (the picture was taken shortly after General Hines became Administrator. He is seated at a desk, front row. While many of the staff came into the Veterans' Bureau in lesser positions, the titles below are the positions to which they ultimately were promoted:

First row (left to right):
- Robert L. Jarnigan, Chairman, Board of Veterans' Appeals; George E. Brown, Director, Veterans' Claims Service; Maj. Omer W. Clark, Deputy Administrator; James H. Brady, Solicitor.

Second row:
- Maurice Collins, Director, Finance Service; Col. Louis H. Tripp, Director, Construction Service; Maj. John D. Cutter, Director, Supply Service; Harold W. Breining, Assistant Administrator for Finance; Dr. Charles M. Griffith, Medical Director; A. D. Hiller, executive assistant to the Administrator; Col. George E. Ijams, Assistant Administrator in Charge of Medical and Domiciliary Care, Construction, and Supplies; Hon. John Garland Pollard, former Governor of Virginia, and Chairman, Board of Appeals.

Third row:
- George Henderson Sweet, Director of Personnel; Harold V. Stirling, Deputy Administrator; Edward E. Odom, Solicitor; Eldon L. Bailey, Deputy Administrator; Horace L. McCoy, Director of Insurance; George E. Hughes, Deputy Solicitor; Col. B. K. Cash, Director, National Homes Service; S. M. Moore, Jr., Budget Officer and Chief of Statistics.

Although the Government provided the Administrator with a Cadillac limousine, the same as those furnished the heads of other executive departments, he never used it for his personal affairs. He traveled to and from his home by bus and usually arrived at his office around 7 a.m. He usually had a briefcase with him, indicating that he had continued his office hours at home.
The general endeavored to see all who desired to talk with him, consistent with a gruelling schedule. Leniency in this respect almost resulted in tragedy in one instance. A deranged veteran managed to get into his office and, picking up a heavy glass inkwell, threw it at him, hitting him on the head. Fortunately, no serious injury resulted. In order to prevent a similar occurrence, a guard was stationed outside his door. Upon learning of this, the Administrator countermanded this arrangement, as he considered it an unnecessary expense to have a guard stationed there.

Despite the criticisms and misrepresentations of his regime as Administrator, it must be remembered that he originated the concept, and was instrumental in the passage of, the law which provided hospitalization for veterans with non-service-connected disabilities who needed hospitalization and who were unable to pay for it. This, undoubtedly, was, and remains, one of the greatest benefits ever extended to U.S. veterans.

A DEVELOPMENT OF HIGHEST IMPORTANCE: CARE OF NON-SERVICE-CONNECTED CASES

General Hines initiated sweeping changes in the operation of the Bureau. Many of them were organizational and procedural in nature, and therefore did not affect the progress of medical care.

One step, however, proposed by the Director and approved by Congress and the President, resulted in drastic changes being made in hospital operations and procedures, in the character and scope of medical care, and in the patient load to be absorbed into various hospitals.

This proposal was launched on its legislative career in a letter written by General Hines to President Coolidge on December 10, 1923. In the letter, the Director made numerous proposals, one of which is of immediate interest:

To authorize the hospitalization, in the discretion of the Director, of all honorably discharged veterans of any war in need of hospitalization wherever facilities are available and sufficient thereof.

In support of his proposal, he quoted from the President's address to the Congress of less than 2 weeks before, as follows:

At present there are 9,500 vacant beds in Government hospitals. I recommend that all hospitals be authorized at once to receive and care for, without hospital pay, the veterans of all wars needing such care, whenever there are vacant beds, and that immediate steps be taken to enlarge and build new hospitals to serve all such cases.

It may be presumed that the President got this idea from the Director, and that the Director took its inclusion in the President's speech as encouragement, because, later in his letter, the Director wrote:

This proposal, originating I believe with me, has been generally endorsed by the service organizations, who likewise urge a sufficient appropriation for completion of the present hospital building program.

Two years previously, Congress had authorized the hospitalization of Spanish-American War veterans without reference to the origin or

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1 Seminative file, World War Veterans' Act, pt. 11, General Hines' letter to the President, Dec. 10, 1923.
cause of the disability. The recommendations, submitted jointly by General Hines and the American Legion, the Disabled American Veterans, and the Veterans of Foreign Wars, had a much broader scope and opened the doors for the care of non-service-connected cases. This is one of the most important benefits ever provided for the medical care of the American veteran.

General Hines was of the opinion that not too many veterans would take advantage of this. He could not know that future years would bring another World War, as well as the Korean conflict and our involvement in Vietnam, resulting in the establishment of one of the largest hospital systems in the world.

These recommendations were submitted to the House Committee on World War Veterans' Legislation in February 1924. This committee, established at that time, was the first to be created solely for the consideration of World War I veterans' legislation. It was the forerunner of the present House Committee on Veterans' Affairs.

These recommendations, and those of the select committee of the Senate, resulted in the passage by the Congress of what is known as the World War Veterans Act of 1924, June 7, 1924, Public Law 242 68th Congress (43 Stat. 607).

Lester Brooks Rogers

Lester Brooks Rogers was born March 5, 1884, in New York City, the son of Lewis L. and Emily (Blackburn) Rogers.

He received his M.D. degree from New York University in 1906 and engaged in private practice in New York City for several years, later becoming a member of the surgical staff of Bellevue Hospital.

He served in the Army Medical Corps with the 7th Division of the American Expeditionary Forces from 1917-19. Following World War I he joined the U.S. Public Health Service and was Medical Adviser to the Bureau of War Risk Insurance, 1919-21, and Chairman of the Federal Board of Hospitalization.

In May 1923 he was appointed Medical Director of the Veterans' Bureau, which position he held until January 1924. He then requested a field assignment and was appointed Medical Officer in Charge of the Veterans' Bureau Hospital at New Haven, Conn. Upon resigning this position, he left for California and held various hospital administrative assignments in that State until his retirement in 1949. He then became a medical adjudicator at the Veterans' Administration Hospital in Sawtelle, Calif., which position he held until his retirement in 1954. He died on October 3, 1963.

Dr. Rogers was a member of the Hospital Association of California (president, 1934-35); American Medical Association; American Public Health Association; Western Hospital Association; Hollywood Academy of Medicine; Nu Sigma Nu.
Dr. Lester B. Rogers, Medical Director, Veterans' Bureau, May 1923-January 1924.

HOSPITALS

As previously stated, President Harding signed an Executive order on April 29, 1922, transferring to the Veterans' Bureau all of the hospitals then being operated for veterans by the U.S. Public Health Service. Fifty-seven hospitals were transferred. However, 11 of them had been closed for various reasons, so the Bureau actually received 46 hospitals and a total of 12,069 patients and 11,006 employees. In addition, construction or remodeling was underway at three locations, and sites for two other hospitals had been obtained. The going per diem rate for tuberculosis hospitals was $6.27; for
general medical and surgical hospitals, $6.25; for neuropsychiatric hospitals, $4.91.

When, in March 1923, General Hines took over the direction of the Bureau, it was operating 45 hospitals: 15 for tuberculosis patients, 19 general medical and surgical, and 11 neuropsychiatric, with a total bed capacity of 15,402. There were at that time approximately 17,000 veteran patients in Veterans' Bureau, Army, Navy, and U.S. Public Health Service hospitals, and an additional 6,000 still in private hospitals under contract.

**OUTPATIENT CLINICS**

The Bureau, at the time of its establishment in 1921, operated 114 dispensaries to provide an important medical benefit for veterans which had been authorized by Congress; namely, outpatient treatment for service-connected disabilities not severe enough to necessitate hospitalization.

The Bureau's dispensaries were located and staffed on the basis of veteran population and the scope of medical need.

In May 1923, a study of these clinics having revealed that the demand for services had diminished to a point where some of them could no longer be justified, 21 were closed, leaving 97 still in operation. This affected a considerable economy. Another economy measure put through at that time was the transfer of a number of part-time physicians to a fee basis. This cut costs without materially affecting the quality of services.

**MEDICAL COUNCIL**

From the date of its establishment, the Veterans' Bureau consistently made effective use of outstanding medical men as consultants. They served as advisers—in the field and in the central office—to both the Director and the Medical Director on matters of procedure and practice, as well as offering guidance in their own medical specialties.

This procedure was formalized in 1924 when General Hines appointed a Medical Council consisting of 34 prominent physicians, whose specialties included the fields of neuropsychiatry, tuberculosis, internal medicine, surgery, public health, medical statistics, hospital and dispensary administration, and research.

(Continued on p. 130)

**Edwin O. Crossman**

Edwin O. Crossman was born in Windsor County, Vt., December 15, 1864, and was educated at the schools in his native State and New Hampshire State University. After obtaining his medical degree at the University of Vermont, he practiced in that State and in New Hampshire. During World War I, he served as major in the Medical Corps of the U.S. Army.

While practicing his profession in New Hampshire, Dr. Crossman became interested in politics. He was a member of both houses of the State legislature and for 9 years was collector of Internal Revenue for the District of Maine, New Hampshire, and Vermont.

In 1920, he joined the Veterans' Bureau in Manchester, N.H., and was later appointed district manager of the Bureau's New England headquarters in Boston.
In 1924 he was invited to come to Washington, D.C. as Medical Director of the Veterans' Bureau, and he remained in this position until April 1926, when he requested transfer to assume charge of the hospital at West Roxbury, Mass.

Upon the resignation of Dr. Black as Medical Director, Dr. Crossman returned to that position in Washington in April 1928, and served there until June 1929. Being taken ill at that time, he returned to his home in Bedford, N.H., where he died on June 26, 1929.
The Council held its first meeting in Washington on July 22 through 24, 1924, and elected the following officers:

Chairman: Dr. Ray Lyman Wilbur, president of Stanford University and president of the American Medical Association.
Vice-chairman: Dr. Kennon Dunham, head of the Department of Tuberculosis, Medical College, University of Cincinnati.
Secretary: Dr. Malcolm T. MacEachern, associate director for hospital activities of the American College of Surgeons.
Executive committee secretary: Dr. Roy D. Adams, clinical professor of medicine, Georgetown University, and chief consultant to Veterans’ Bureau Diagnostic Hospital, Washington, D.C.
Bureau representative: Dr. John R. McDill, general medical consultant to the Medical Director.

For effective operation, the Council members were divided into five groups: hospitals, dispensaries, and general medical welfare; general medicine and surgery; neuropsychiatry; tuberculosis; and investigation and research.

General Hines addressed the Medical Council at its first meeting, emphasizing that he would welcome their advice and assistance. He said, in part:

I have long been an advocate of doing whatever is necessary to bring into the working of the Veterans’ Bureau the highest type of medical talent. I am sure you will agree with me that in such institutions as Veterans’ Bureau hospitals, and particularly in the new ones where they have the last word in equipment and facilities, we should have the necessary efficient personnel.*** One of the most important problems concerning which the Bureau needs your advice *** is how to develop the desired medical personnel. I feel there is great danger of the Veterans’ Bureau isolating itself in the handling of these great medical questions. It does seem to me that these hospitals, being national, would challenge the interest of the Council. *** They are institutions of the people of the United States, and it is their business to get men well and not keep them in the hospital.

I expect to do everything that is possible *** to bring about an efficient medical service, and, in doing that, I expect to have to fight many battles in the way of having medical personnel adequately compensated. I feel that at the first opportunity it is essential to bring forth a medical corps for the service in order to assure its permanency *** and along with it, of course, goes proper compensation.

The Medical Council was enthusiastic in its belief that it could improve the standards of veterans’ medicine, on the one hand, and on the other, bring about closer relationships between veterans’ hospitals, medical schools, and local hospitals throughout the country. Thus, the best care could be given our veteran patients, while, at the same time, medical knowledge would be advanced. The Council consistently held that the administration of the hospital program should be in the hands of professional medical personnel. This was to be a subject of controversy until after World War II.

(Continued on p. 138)
Benjamin Warren Black

Benjamin Warren Black was born at Fillmore City, Utah, May 21, 1887. He received his B.A. at the University of Utah in 1910, and was graduated cum laude, M.D., from the University of Pennsylvania Medical-Chirurgical College in 1916.

In September 1917 he was commissioned first lieutenant in the U.S. Army Medical Corps and served in France as regimental surgeon with the 157th Infantry, AEF. He was honorably discharged in 1919, holding the rank of major.

He was then appointed acting assistant surgeon in the U.S. Public Health Service, Washington, where he served from 1920 to 1924.
During 1924-26, he was Executive Officer of the Veterans' Bureau in Washington, and from 1926 to 1928 he was Medical Director of the Bureau.

In 1928 he was appointed medical director of Alameda County, Calif., remaining in that position until his death.

A noted psychiatrist, Black served often as alienist in court cases where insanity was an issue. He was the author of many articles in professional journals.

He was a fellow of the American College of Hospital Administrators, and the American Psychiatric Association; a member of the American Medical Association, American College of Physicians, and many other professional societies. He was president of the American Hospital Association, 1940-41.

He died in Berkeley, Calif., December 1, 1945.

The Council believed, and continued to urge, that—

Research should be encouraged and rewarded.

Research centers should be established for the continuing study of specific conditions, particularly chronic diseases and the problems of old age, to the end that these might benefit not only veterans but the entire human race.

Veterans' hospitals should be affiliated with teaching medicine, so that the clinical load of the hospitals could aid in the advancement of medical knowledge. Close association with local institutions would be to the benefit of both.

There should be legal establishment of the position of Chief Medical Director, so that there could not be any attempt to interpose lay authority between the Medical Director and the Director of the Bureau.

On the recommendations of the Council, a section of research was formed within the Medical Service. In addition, two diagnostic centers were established for the exhaustive study of cases presenting difficult problems. One center was at the Cincinnati hospital and the other at Washington, D.C. Later, two more such centers were opened—the Hines Hospital (Chicago) and at Palo Alto, Calif.

The Medical Council made another forward-looking contribution to the Bureau's Medical Service when it arranged for the American College of Surgeons to conduct a survey of Veterans' Bureau hospitals in order that they might be accredited. This survey of all 50 veterans' hospitals then in operation was completed in October 1925, with the result that 45 were fully approved, two conditionally approved (Tuskegee, Ala., and Tupper Lake, N.Y.). These two were speedily accredited shortly. Three were not approved (Fort Lyon, Colo., Sheridan, Wyo., and Excelsior Springs, Mo.). The latter three were approved soon thereafter.

The members also gave their attention to studies involving the standardization and improvement of outpatient treatment and social service, the causes of turnover in lower grades of hospital personnel, a survey of hospitals for discharge of patients no longer requiring hospitalization, study of the future hospital load and outpatient examinations and treatment, the transfer of maximum benefit cases to domiciliary care, and other questions of medical policy.

The original plan of the Council was to hold quarterly meetings. These were changed to semiannual, later to annual, and finally, "at the call of the Medical Director."

Also in 1924, General Hines petitioned Congress to pass legislation authorizing a Veterans' Bureau Medical Corps with salaries that were equitable and uniform. Between 1924 and when the Veterans' Administration was formed in 1930, nine bills were introduced. These bills were either not reported out of committee, or, having passed the
House, they were not passed by the Senate. Some were so diluted that they were of no assistance.

Twelve similar bills calling for a Medical Corps were considered during the 1930's and early 1940's, but nothing came of any of them. Altogether, over a period of 21 years from 1924 to 1945, 21 bills looking to a Veterans' Bureau or Veterans' Administration Medical Corps were weighed pro and con. As Congress wavered as to what should be done, so too did General Hines. The problem was not solved until Public Law 293 was passed on January 3, 1946, by which time General Hines had left the agency.  

*For a more detailed history of proposed legislation in behalf of a medical corps, see app. A.*

Dr. Winthrop Adams, Medical Director, Veterans' Bureau, July 1929–July 1930; Medical Director, Veterans Administration, July 1930–July 1931.
Winthrop Adam was born in Cambridge, Mass., on May 18, 1887. He obtained his M.D. degree from Tufts University School of Medicine in 1915.

He served in the Medical Corp of the U.S. Navy in World War I. From 1919 to 1921 he served in the U.S. Public Health Service, later transferring to the Veterans' Bureau. He held various assignments in that agency, becoming Medical Director in July 1929. In July 1930, when the Veterans' Administration was created, he became its first Medical Director. In July of 1931, he requested reassignment to the New England area and was appointed head of the VA hospital at Bedford, Mass., from 1931 to 1958 when he retired.

Dr. Adams was a member of the American Medical Association and the Massachusetts Medical Society. He was elected a fellow of the American College of Physicians in 1930, and was a diplomate of the American Board of Psychiatry & Neurology.

He died on March 12, 1964, at Bedford, Mass.

REORGANIZATIONS

From its beginning, the Veterans' Bureau was organized on a chain-of-command basis, following the military system. At the top was the central office in Washington, with a Director responsible directly to the President.

Below this there were 14 district offices. The country had been divided into 14 districts—like the setups of the U.S. Public Health Service and the Rehabilitation Division of the Federal Board for Vocational Education. The Bureau felt that these offices would provide close supervision of field stations, guide them and supply information on policy. It was intended that these district offices would keep the central office in closer touch with the field stations' needs.

Regional offices were established to serve veterans on matters relating to compensation, vocational rehabilitation, and insurance.

Finally and perhaps the most important to the agency were the hospitals which answered directly to the central office.

In 1923, a reorganization of the field was instituted to bring the regional offices and hospitals closer to the central office, provide faster communications, and improve services by delegating more authority to operating stations. The district offices were then abolished and the field stations made directly responsible to the central office. In addition to faster communication and better service, this change was intended to effect economies.

A year later, the central office was reorganized. Here again more efficiency and economy was sought. The medical services and the vocational rehabilitation activities were combined under the direction of an Assistant Director, not a physician.

This organizational pattern met with immediate opposition, and proved to be a continuing bone of contention through World War II. Veterans' organizations, prominent physicians, and members of Congress protested that the Medical Service was the crux of the entire organization. They contended that all other activities were dependent on medical service to a certain degree, and that medicine
was entirely too important to be relegated to a secondary position under the immediate supervision of a layman responsible to the Director.

General Order No. 267 was issued on June 23, 1924. The consolidation of the two services was dissolved and the Medical Service again became responsible directly to the Director. The order stated, in part, that—

The Medical Division is hereby taken from the Medical and Rehabilitation Service—and established as a separate service to be known as the Medical Service of the U.S. Veterans' Bureau.

The Chief of the Medical Service shall be designated the Medical Director and shall have the charge of medical activities as an Assistant Director with scope of authority, responsibility, and duties as outlined in the following paragraphs of this general order.

In this document, under "scope of authority," each paragraph emphatically stated that the authorization given to the Medical Director was subject to the Director only.

In view of this action, it is difficult to understand why the old line of authority was again adopted when the Veterans' Administration was reorganized in 1931 a year later. The Medical Service was consolidated with other services under the direction of an Assistant Administrator for medical, supply, national homes, construction, and real estate. Protests and criticism developed again and continued to be heard until the Veterans' Administration's next reorganization after World War II.

CONSOLIDATION RECOMMENDED

From the time he became Director of the Veterans' Bureau in 1923, General Hines had been concerned about the adverse effect on veterans of several agencies administering their benefits. These were the Veterans' Bureau itself, the national homes for disabled volunteer soldiers, and the Bureau of Pensions.

He realized that this confusing spread of authority created a situation similar to that encountered by veterans who, on their return from service in World War I, were irritated with having to deal with the Bureau of War Risk Insurance, the U.S. Public Health Service, and the Federal Board for Vocational Education, each in turn handling veterans' benefits.

In 1929, General Hines asked President Hoover to name a committee to propose means to eliminate the administrative hodgepodge of veterans' benefits.

The President appointed a committee comprising the Honorable Ray Lyman Wilbur, Secretary of the Interior, Chairman; General Hines; Gen. George H. Wood, President of the Board of Managers, National Soldiers' Homes; Mr. Walter H. Newton, Secretary to President Hoover; and Col. C. D. Hodges, secretary.

The committee reported back on October 1, 1929, and recommended that Congress give the President the power to bring under a common head all forces of the Government providing veterans' relief.

In his message to the two Houses of Congress, on December 2, 1929, President Hoover indicated strong concurrence with these words:

It has been the policy of our Government almost from its inception to make provision for the men who have been distroled in defense of our country. This policy should be maintained. Originally, it took the form of land grants and pensions. This system continued until our entry into the World War. The Congress
at that time inaugurated a new plan of compensation, rehabilitation, hospitaliza-
tion, medical care and treatment, and insurance, whereby benefits were awarded
to those veterans and their immediate dependents whose disabilities were attribut-
able to their war service. The basic principle in this legislation is sound.

** ** These principles have been to some degree extended. Veterans whose
diseases or injuries have become apparent within a brief period of time after the
war are now receiving compensation [and] the doors of the Government hospitals
have been opened to all veterans, even though their diseases or injuries were not
the result of their war service ** **.

I am convinced that we will gain in efficiency, economy, and more uniform
administration and better definition of national policies if the Pension Bureau, the
national homes for disabled volunteer soldiers, and the Veterans' Bureau are
brought together under a single agency. 

** THE PROPOSAL HAD ITS FRIENDS AND DETRACTORS

While the American Legion, the Veterans of Foreign Wars, and
the Disabled American Veterans were supporting the proposal, the
Grand Army of the Republic, the Spanish-American War veterans' organizations, representatives of the Department of the Interior (includ-
ing the Bureau of Pensions), and representatives of the national homes for disabled volunteer soldiers, voiced strong objections.

On July 3, 1930, H.R. 10630, 71st Congress, was signed into Public
Law 536, 71st Congress, by President Hoover.

The law authorizing the consolidation differed from the bill only
by an amendment changing the name of the new agency from Admin-
istration of Veterans' Affairs to Veterans' Administration.

On July 21, 1930, as authorized by the new law, the President
issued Executive Order 5308, which established the Veterans' Admin-
istration.

* Message of the President of the United States communicated to the two Houses of Congress at the be-
ginning of the 71st sess. of the 71st Cong., Dec. 3, 1929 (H. Doc. 170), Government Printing Office, Wash-
ington, D.C., pp. 21-22.
PREDECESSORS OF THE VETERANS ADMINISTRATION

BUREAU OF PENSIONS 1833

NATIONAL HOMES FOR DISABLED VOLUNTEER SOLDIERS 1866

MARINE HOSPITALS 1798, BECOMING PUBLIC HEALTH SERVICE 1902, AND THOSE PHS HOSPITALS SERVING VETERANS ASSIGNED TO VETERANS' BUREAU 1922

BUREAU OF WAR RISK INSURANCE 1914

REHABILITATION DIVISION OF FEDERAL BOARD OF VOCATIONAL EDUCATION 1917

VETERANS' BUREAU 1921

VETERANS ADMINISTRATION 1930
Chapter VIII

The Veterans' Administration (Established in 1930)

General Hines Continues in Charge

It is not surprising that the Veterans' Bureau's incumbent Director, Gen. Frank T. Hines, was appointed and confirmed as the Administrator of the Veterans' Administration.

Having been head of the Veterans' Bureau for 7 years, he wished to avoid any impression that that organization would receive any preference over the other two components of the new agency. To this end, he made few immediate changes in the plan of organization of all three. He also vacated his office in the VA building and moved to the Department of the Interior for the first year of the life of the Veterans' Administration. During this year, 1930–31, the three component agencies functioned as bureaus of the Veterans' Administration. Col. George E. Ijams was first appointed Acting Director of the Veterans' Bureau, and became Director 2 months later.

Edward W. Morgan was appointed Acting Commissioner of the Bureau of Pensions, which later became part of the Compensation and Pension Service. Gen. George H. Wood was named President of the Board of Managers of the National Home for Disabled Volunteer Soldiers. The general was replaced shortly after his appointment. His successor was Col. C. W. Wadsworth as Director of the NHDVS, which was later renamed the National Homes Service.

Dr. Winthrop Adams, the Veterans' Bureau Medical Director, was continued on in the same capacity in the Veterans' Administration until July 1931, when Dr. Charles M. Griffith succeeded him. Dr. Griffith was to occupy that position longer than any other Medical Director in VA history, serving until 1945.

A Single Point of Contact

In general, the work of consolidation of the three agencies was slowed down by several pieces of legislation enacted by Congress during the early days of the Veterans' Administration.

On June 2, 1930, increased pensions were authorized for veterans of the Spanish-American War, resulting in 56,000 claims being filed.

The amendment of July 3, 1930, to the World War Veterans' Act, provided for payment of a disability allowance. During the first year after passage of the law, 541,943 applications for this benefit were received and 448,441 adjudicated.

On February 27, 1931, the World War Adjusted Compensation Act was amended, and 2,063,576 loans were made.1

However, by the time the Veterans' Administration was a year old a single point of contact for veterans of all wars had been established. They could now turn to any office or hospital of the VA for consideration of benefits to which they were entitled. The final stage of

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1 Veterans' Administration Annual Report, June 30, 1940, p. 42.
care of wounded and disabled veterans of our Armed Forces became a permanent function of our Government.

**RISING HOSPITALIZATION DEMANDS**

Those were the days of the great depression, and students of mass psychology pondered the possibility of a connection between hard times and illness. Do people put off hospitalization, particularly elective surgery, until they are out of work and have free time? Do joblessness and attendant worry escalate the incidence of mental illness?

Whatever the answers are to these questions, the combination of a depression and the opening of hospital doors to veterans of all wars created an unprecedented demand for hospitalization.

Almost immediately there developed maximum utilization of existing facilities—and this materially affected the future VA hospital construction program. It became possible to base plans on the construction of new installations capable of expansion as either hospitals or domiciliaries.

**Bone of Contention**

On the minus side, the hopes of the VA's Medical Service received a severe setback when, instead of absorbing the National Homes into its jurisdiction, it found itself (1) under an Assistant Administrator, and (2) not having achieved its rightful professional status, which the medical world in general believed it should have.

Previously, in the last years of the Veterans' Bureau and the first year of the Veterans' Administration, the Medical Director had been responsible to General Hines. But in 1931, a reorganization of the Veterans' Administration put its new Medical Director, Dr. Charles M. Griffith, under an Assistant Administrator, the previously mentioned Col. George E. Tjams.

The colonel was a brilliant, articulate, administrative expert, but as a layman believed that medical men should practice medicine and not be "burdened" with top-management responsibilities. Under his administration the Medical Service, the National Homes, Construction, and Supply were organizationally separate and equal.

Under this arrangement, the central office directors of each of these services could issue orders to the medical officer in charge of a hospital on matters within their jurisdiction. This did not provide a sound organization at the field level, since many of the officials in charge of these activities at the hospital felt that they were responsible to their particular director in central office, rather than to the head of the hospital, whose Washington superior was the Medical Director.

Insofar as the general operation of the hospital was concerned, the Medical Director was under the jurisdiction of an Assistant Administrator, not a medical man, through whom any contact with the Administrator had to be made.

This type of organization had been tried in the early days of the Veterans' Bureau, when Medical was combined with Rehabilitation. After a short 6 months' trial, Medical was separated from Rehabilitation and the Medical Director functioned under the Director of the Bureau and the VA Administrator until the VA reorganization of 1931. The layer of authority thus interposed between the Administrator and the Medical Director, who was responsible for a large and growing
hospital and medical care program, created more of a psychological bone of contention than any serious head-on collisions between the Medical Director and the Assistant Administrator. Professional men in the field, as well as the agency's medical consultants continued to object to this form of administration. It was not until 1945 that the head of the Medical Service was again made responsible to the Administrator only.

In fairness to Colonel Ijams, it should be said that he was never known to interfere in the medical care aspects of VA's hospitals. But in medicoadministrative matters he did exercise considerable influence for many years.
Charles Marion Griffith

Charles Marion Griffith was born in Jasper, Tenn., on May 22, 1882. He spent most of his youth in Tullahoma, Tenn., and was graduated from the University of Tennessee College of Medicine, receiving his M.D. degree in 1908.

He engaged in private practice, with his father, from 1912 to 1916 in Tullahoma. He joined the National Guard in 1916.

At the outbreak of World War I he was commissioned as a surgeon in the 109th Infantry Regiment, 28th Division, and was discharged in 1918 with the rank of major.

He was then commissioned in the U.S. Public Health Service and in 1924 he was transferred to the Veterans' Bureau. He had been stationed at Public Health Service hospitals in Corpus Christi, Tex., and Alexandria, La., as Chief of the Surgical Service. He was transferred to Washington, D.C., and appointed the first Chief of Medical Service, then as Executive Officer of the Medical Service. Following the formation of the Veterans' Administration in 1930, he was appointed Medical Director, which assignment he held until 1945.

In 1945 he was appointed manager of the Mount Alto Hospital of the Veterans' Administration, in Washington, D.C. He remained in this position until his death December 19, 1954.

Dr. Griffith was a fellow in the American College of Physicians and the American College of Surgeons. He was president in 1935–36 of the Association of Military Surgeons.

LONG TERM OF SERVICE

Dr. Charles M. Griffith, as noted earlier, served as Medical Director of the Veterans Administration from 1931 to 1945. He was born in Jasper, Tenn., in 1882, and spent his youth in Tullahoma, in that State, where his father was engaged in medical practice. He graduated from the University of Tennessee College of Medicine in 1908, and in 1921 and 1922 took postgraduate courses in surgery at the University of Maryland.

From 1912 to 1916, he practiced medicine with his father in Tullahoma. After service with the Medical Corps in France during World War I, he was discharged with the rank of captain and joined the U.S. Public Health Service. He was transferred to the Veterans' Bureau in 1925.

He served as surgeon at Veterans' Bureau hospitals in Corpus Christi, Tex.; Alexandria, La.; and Tuskegee, Ala. In this type of responsibility, he was so successful that Dr. Edgar O. Crossman, the Veterans' Bureau's Medical Director, transferred him to Washington to become Chief of the General Medical and Surgical Division of the Medical Service in the central office. In 1930, when the Veterans' Administration was formed, he became Executive Officer of the Medical Service, and, in 1931, Medical Director.

An "organization man," Doctor Griffith was respectful and deferential toward the two authorities above him—Colonel Ijams and General Hines—and in times of difficulty and stress he was patient, at least outwardly, to the point of complacency. When attacked by outside critics who placed the responsibility of the VA medical program entirely on him, he was forebearing. He was inclined to be philo-
sophical rather than combative. Toward his equals and subordinates, he was soft spoken, courteous, and he was trusted by them for his integrity. No one questioned the sincerity of his belief that the Veterans' Administration should give veterans the kind of medical care they were entitled to, namely, the best.

Medical care of veterans developed quantitatively during the long Griffiths-Hines administration (it cannot be described as an exclusively "Griffith medical administration"). This medical program was to be subjected to severe strains during World War II. However, between 1931 and 1941, that entire decade before Pearl Harbor; the number of VA hospitals increased from 64 to 91, and bed capacity rose from 33,609 to 61,849.

On the qualitative side, Doctor Griffith was active in organizing special training programs for VA physicians and nurses. In addition, he believed in medical research and wanted more of it than he was permitted to initiate.

What principally plagued him was the inability of the Veterans' Administration and Congress to see eye-to-eye on the formation of a Medical Corps for the agency. This had also been true of the Veterans' Bureau and Congress. As a Public Health Service doctor, Griffith was not always satisfied with the doctors available to the VA through the Civil Service Commission. Their backgrounds, in his opinion, were often not impressive enough to qualify them for the care of veterans. He was successful in interesting scores of able, dedicated medical men in working for the agency, and he did not wish to dilute their efforts by introducing among them, as colleagues, men of far less professional background and standing.

Over a period of years, dating back to 1923, the Veterans' Bureau and the Veterans' Administration had offered numerous proposals for a Medical Corps for the agency. But Congress was generally indifferent, and when alternative plans were offered by Congress itself, the agency found technical objections to them. Certain legislators were not inclined to disrupt civil service pay schedules, even though civil service salaries for professional men were admittedly low. Other legislators feared that a VA Medical Corps would become semimilitary in character.

Probably a fair evaluation of Dr. Griffith as Medical Director of the VA would be that he was equal to the quantitative demands of his responsibility, and that professionally and temperamentally he was equal to the qualitative demands as well. This man, who insisted on taking postgraduate courses at a time of life when most other men have settled into a routine, obviously would not want mediocre physicians around him if he could get better ones.

Some of his ablest assistants remained loyal to him and to the VA during World War II. They felt, like other men, that they should be involved in direct military service themselves; but they stayed on with Dr. Griffith and their veteran patients. Other VA physicians had been taken from the agency and still others had resigned from it for more exciting or more lucrative practice elsewhere. Many opportunities became available due to the number of physicians leaving their practice to enter the armed services. The agency was left critically short of medical manpower. Ironically, superficial critics of the VA blamed Dr. Griffith and his friends for the shortage. The con-
scientious, resolute men who were holding the agency together during those critical times were the subject of their invective.

The VA medical program was modernized and strengthened after World War II. It became intensely education and research minded. A number of the men, who had been in the program since its inception, stayed on and became the stout defenders of the new program. With the creation of the Department of Medicine and Surgery, it was natural that they would assume positions of responsibility in the central office. Among them were Dr. Robert C. Cook and Dr. Roy A. Wolford, who rose to Deputy Chief Medical Director; Dr. John Baird, Chief of Neuropsychiatric Service; Dr. Frank Brewer, Area Medical Director and later Assistant Chief Medical Director for Operations; Dr. Kelso Carroll, Assistant Chief Medical Director for Professional Services. He was succeeded by Dr. William W. Fellows in that position. All of these men had been transferred from the Public Health Service to the Veterans' Bureau in 1923. Many other physicians were likewise elevated in Washington and in the field.

By war's end Dr. Griffith was weary from overwork, frustration, and criticism. He was weary but not embittered, and still the same courteous gentleman as always. General Hawley appointed him manager of Mount Alto, the VA hospital in Washington, D.C., where he served from 1945 until his retirement in 1951. When he died in 1954, he was hailed for having devoted the major portion of his professional career so successfully in behalf of veterans.

Before he became Medical Director, his predecessor had detailed Dr. Griffith to the veterans' hospital at Tuskegee, Ala. Although he went there as a surgeon, his real duty was to plan for the replacement of white physicians comprising the staff of this hospital, by colored physicians. He was so successful in this endeavor that he was appointed Chief of the General Medical and Surgical Division in the central office in Washington.

Those who knew him could honestly say that he was always good, that his loyalty to those in authority was almost unbelievably superior, and his honesty and integrity unquestioned. He was very soft spoken, pleasant, and considerate of all employees.

Dr. Griffith was Director of the Medical Service longer than any other man before or since, and he was devoted to the care of the disabled veterans of the Nation. In all his years of service to veterans, he gave of himself to the utmost, and his sole endeavor was to give the best possible medical care to patients.

THE "BONUS MARCH"

As early as 1919, there had developed serious discussion of an important obligation of the Nation to the ex-servicemen of World War I. Everywhere there was discussion of providing economic balance between them and non-service persons who had benefited from war-time industry. In 1919 alone, 55 bills had been introduced in Congress to bring about this adjustment between the low pay servicemen received while in service and the higher rates they might have received had they stayed at home.

At its first national convention, held November 10-12, 1919, the American Legion adopted a resolution in favor of "adjusted compen-
sation.” The Legion together with the Veterans of Foreign Wars strongly favored the passage of such enabling legislation.

A bill to accomplish this was introduced in March 1920 and, although it passed the House of Representatives, did not become law.

In June 1921, a similar bill favorably reported out of the Senate Finance Committee was opposed by Secretary of the Treasury Mellon and President Harding on the grounds that it would impose excessive burdens on the Treasury. It was recommitted.

The same bill, introduced again in December of that year, passed both Houses by August 1922, in spite of opposition from the Federal Reserve Board and, again, the Treasury Department. President Harding vetoed it in September.

Finally, on May 19, 1924, a third bill, passed over President Coolidge’s veto, became Public Law 120, 68th Congress.

Briefly, the new law provided “adjusted compensation” for eligible veterans of World War I by allowing $1.25 for each day of overseas service and $1 for each day of home service. It further provided that where the amount of credit was not more than $50, it would be paid in cash. Where it was more than $50, there would be issued, by the Director of the Veterans’ Bureau, an adjusted service certificate.

The certificates were, in reality, a form of an endowment policy. They equalled the total amount of earned credit, increased by 25 percent, computed on the basis of the number of per diem credits. They generally had a face value of $1,500 and would be payable 20 years from the date of issue, or at the death of the veteran, whichever was earlier.

Loans on the certificates could be obtained by placing promissory notes with any bank or trust company, or directly with the Veterans’ Bureau, using the certificates as collateral.

By the 1930’s, with the depression deepening and unemployment increasing, a rumble of discontent began to be heard. Demands were made for economic relief, especially by the veteran population. Not the least of these demands was one for immediate payment, in full, of the “bonus,” as the dollar value of the “adjusted compensation” had universally come to be called.

In March 1932, a small group of veterans from Oregon started marching toward Washington, bearing a banner proclaiming: “We’re on our way from Oregon to get some cash in Washington.”

The fever spread. Soon little groups of jobless veterans could be found walking and riding along the main highways of the country—on their way to Washington “to collect a bonus.” They hoped to force immediate payment of their adjusted service certificates, due some 13 years later.

The march was opposed, without avail, by the leading organizations of ex-servicemen, the American Legion, the Veterans of Foreign Wars, and the Disabled American Veterans.

There is no way of knowing how many joined the “Bonus Expeditionary Forces,” as the marchers called themselves. It is known that the Veterans’ Administration financed the trip home for nearly 5,200 of them.

By June 1932, thousands of marching veterans began arriving in Washington.
EMERGENCY VA MEDICAL CARE FOR MARCHERS

They camped wherever they could. Some moved into old and partially dismantled buildings which the Government had taken over. Others built primitive shacks that were a fire hazard. Still others erected tents. A "shanty town" was set up on the mudflats across the Anacostia River.

So many men living in such primitive conditions caused a sanitation problem, which in turn caused a health problem.

To cope with this dangerous situation, the Veterans' Administration enlarged its hospital facilities in the District of Columbia area by establishing an emergency hospital on a War Department reservation at Fort Hunt, Va.

The old post hospital at Fort Hunt, closed since 1919, was reopened with a capacity of 47 beds and later increased to 107. Some 300 patients were treated there during the tumultuous stay of the bonus marchers in the Capital. The majority of these were discharged recovered and in good condition.

THE MARCHERS MARCH

On the night of June 7, 1932, the bonus marchers staged a big night parade down Pennsylvania Avenue to the foot of the Peace Monument.

On June 17, a large group laid an orderly siege to the Senate, as a bill proposing immediate payment of the bonus was being considered.

The measure was overwhelmingly defeated.

The veterans, with no other hope in sight of achieving their objectives, lingered on in their shacks, huts, and tents. In the meantime, the VA paid the rental of a meeting hall for the marchers to discuss their problems.

The District of Columbia Police began to lose patience with the bonus marchers who stubbornly remained on the scene. Minor clashes began to break out.

Matters grew rapidly worse.

On July 28, a group of Treasury Department agents, protected by the local police, attempted to evict the veterans from certain locations. Riots became more numerous. Outnumbered police were experiencing some serious injuries. Likewise, one veteran was killed and another died later of his injuries.

The District of Columbia then appealed to President Hoover for "the assistance of Federal troops" on the grounds that it was "impossible for the Police Department to maintain law and order except by the use of firearms, which will make the situation a dangerous one."

Whereupon Secretary of War Patrick J. Hurley ordered the Army Chief of Staff, Gen. Douglas MacArthur, to dispatch troops to "surround the affected area and clear it without delay." The orders specified that "any women and children who may be in the affected area be accorded every consideration and kindness."

This order was carried out.

However, it was a complicated and trying task to remove, without anger and with objectivity, an emotionally overwrought mass of some 3,500 men, many with their families, who had dug in with the inten-
tion of remaining indefinitely on the scene. The most difficult and hazardous moments came with the resisting veterans expressed their grudge by setting fire to some shacks and huts.

Some unjustified public criticism of the War Department's efficient operation did develop, primarily due to a lack of full understanding of the highly explosive situation that did exist.

The Veterans' Administration played no part in the expulsion of the bonus marchers from the city.

However, as noted earlier, Congress authorized the Veterans' Administration to pay the transportation expenses of the marchers to their homes, together with a subsistence allowance of 75 cents a day. Some 5,200 persons took advantage of this opportunity. The Veterans' Administration advanced nearly $77,000. The American Red Cross advanced similar travel expenses to the wives and children who had accompanied the veterans to Washington.

In a statement, regarding the bonus march, by Secretary of War Hurley, he concluded:

No one was injured after the coming of the troops. No property was destroyed after the coming of the troops, except that which was destroyed by the marchers themselves. The duty of restoring law and order was performed with directness, with effectiveness, and with unparalleled humanity and kindness.

Thus ended the bonus march of 1932.

It had proved to be a totally ineffective way of influencing Congress or public opinion. But the organizers and leaders were undaunted and tried again in the ensuing 2 years.

However, the bonus marches of 1933 and 1934, triggered by reaction to the "Economy Act," described below, were pale echoes of the 1932 march. A fourth march, projected in 1935, never got beyond the planning stage.

As for adjusted compensation, the Veterans' Administration had, by June 30, 1937, certified to the Treasury 3,465,519 applications from World War I veterans for settlement of their certificates. This equaled 99.9 percent of all applications received. The remaining ones were soon thereafter processed. The face, or maturity, value of the certificates was almost three and a half billion dollars. In this way a veterans' benefit provision of World War I put money into the hands of veterans, and eventually into national circulation, during this period of economic depression.

THE "ECONOMY ACT"

When Franklin D. Roosevelt became President in 1933, the Nation was still experiencing the depression, and he was faced with the dual problem of (1) balancing the budget, and (2) reducing expenditures.

Among other Government programs, he studied Federal activities in behalf of veterans. Directly following his inauguration, he proposed legislation to Congress which became law on March 20, 1933. Officially known as an act to maintain the credit of the United States, it was commonly called the Economy Act. (Public Law 2, 73d Cong.)

For the second time in history, the United States revoked benefits for veterans. The first time had been in 1820, when many Revolutionary War pensioners were dropped from the rolls because of lack of money to pay them.
The new act erased all laws dealing with medical and hospital treatment, domiciliary care, compensation, and pension to veterans and their dependents of all wars from the Spanish-American War on. It did not affect benefits going to veterans and dependents of veterans of earlier wars.

Having wiped clean the slate, the act went on to write an entirely new system of veterans benefits, much less liberal than the earlier system. From the start, it became a target of bitter protest from thousands of veterans.

The act itself served merely as a framework. The teeth in it consisted in the authority it gave to the President to issue Executive orders (Veterans Regulations 1 through 12 of 1933) on veterans affairs.

The general effect of these regulations was to reduce the amount of pensions (the word “compensation” was dropped) and the number of veterans qualifying for admission to Veterans' Administration hospital domiciliaries. Regulations for pensions and for eligibility for Veterans' Administration medical care were tightened.

Probably the most drastic provision of all was one which stipulated that non-service-connected pensions for Spanish-American War veterans under 62 and for World War I veterans were limited to total disability. In addition, the rate was fixed at $20 a month. The pensions could go only to unmarried persons with annual incomes of $1,000 or less, and to married persons and those with minor children, with incomes of under $2,500 a year. This practically did away with service pensions for all except Spanish-American War veterans over 62.

The new regulations also cut deeply into the categories of veterans eligible for medical, hospital, and domiciliary care. Stripped of eligibility were thousands, most of them victims of the depression, who needed care for non-service-connected conditions.

Washington was showered with letters, telegrams, and resolutions of protest. Veterans' affairs have always been largely a concern of Congress. Consequently, on March 28, 1934, the legislative branch, exercising its prerogative, overrode an executive veto and restored veterans' benefits pretty much as they existed before the Economy Act. The 1934 legislation restored the word “compensation” and defined it more carefully from “pension” than ever before. Provisions in the fields of monetary, medical, and hospital benefits were created which were to become the basis of future veterans' legislation.

**The 1935 Hurricane**

To offset the hardships of the depression, authorities realized the importance of the employment opportunities made available by the Government to the marching veterans. Many of these opportunities were at the instigation of General Hines. They lay in three categories: enrollment in the veterans' contingent of the recently formed Civilian Conservation Corps (CCC); assignment to rehabilitation camps operated by the Federal Emergency Relief Administration (FERA) in Florida and South Carolina; and assignment to Works Progress Administration (WPA) projects.

From the bonus army of 1933, 2,663 were enrolled in CCC camps; an added 568 enrolled from the 1934 group. From June 1934 through October 1935, 7,003 more were attracted to the CCC. All of these
veterans had journeyed to Washington at some time during that 16-month period.

The rehabilitation camps, approved by President Roosevelt on the recommendation of FERA, were established for the employment of those veterans who could not qualify physically for the CCC camps. The Veterans' Administration had no responsibilities as to the establishment, maintenance, or operation of the FERA camps, the sole VA function being that of verifying that those selected by FERA were in fact veterans.

During the period between October 12, 1934, and August 9, 1935, 2,724 transient veterans were sent to rehabilitation camps in Florida, 4,275 to South Carolina.

Thus it will be seen that from 1933 through 1935, over 17,000 veterans, transient, usually stranded, in Washington, D.C., had been placed in employment in CCC camps, FERA camps, or with the WPA.

The FERA camps in Florida employed these men in a State-sponsored and State-administered relief project to construct a motor highway over the Florida Keys, connecting Miami and Key West. The average age of the veterans assigned to this work was 41. Their physical condition was generally poor. Some were ill-clad, most were undernourished. They were, in various ways, a deprived group.

FERA had set up three camps for the project, all in the same area, 80 miles south of Miami. One was on Windley Island, the other two on Lower Matecumbe Key.

In the fateful month of September 1935, 694 veterans were living at the three camps and working on bridges for the new highway. They were lodged in regular construction-type buildings, worked 6 hours a day 5 days a week, and were paid a minimum of $1 a day plus food and clothing. As distinguished from the CCC camps, there was no military type discipline at the FERA camps. The men were free to come and go as they pleased. Over the weekends, many of them visited Miami or Key West.

**DISASTER STRIKES**

On Sunday morning, September 1, 1935, the Weather Bureau issued a hurricane warning in the area of these FERA camps. At first, it was thought that the storm would miss the Keys. Not even the most experienced meteorologists thought, at that point, that the storm would turn out to be one of the worst hurricanes of the century, registering the lowest barometric reading ever recorded at sea level in the history of hurricanes worldwide, 26.35 inches of mercury.\(^2\)

It was never suspected that during the morning the storm would change course and hit the Keys squarely in the Windley Island-Lower Matecumbe sector at 6 p.m. that evening with 150 mile-an-hour winds and a 25-foot tidal wave. It killed 282 of the veterans in the camps and injured 402 others.

There was an immediate public uproar, although news of what had actually happened was scarce for several days.

Because of the breakdown in communications, details of the disaster did not reach Washington until Wednesday, September 4.

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President Roosevelt, VA Administrator General Hines, and Harry Hopkins, Federal Emergency Relief Administrator, set an investigation in motion. Aubrey Williams, Deputy Administrator of the FERA, and Col. George E. Ijams, Assistant Administrator of Veterans' Affairs, were ordered to the area. They reported their findings to the President on September 8.

This report, signed by Messrs. Williams and Ijams, described the havoc on the scene and concluded "the responsibility for this disaster does not lie with any of the human factors involved, * * * the delays in securing help were probably unavoidable," and finally, "it is impossible for us to reach the conclusion that there has been negligence or mistaken judgment on the part of those charged with responsibility for the safety of the men engaged on the Keys project. To our mind, the catastrophe must be characterized as 'an act of God' and was by its very nature beyond the power of man, or instruments at his disposal, to foresee sufficiently far enough in advance to permit the taking of adequate precautions capable of preventing the death and desolation which occurred."

The Williams-Ijams report to President Roosevelt listed the "identified" dead as 44, the "missing and unidentified" dead as 238, the "identified injured" as 106, and the "unidentified injured" as 296. In all there were 684 casualties.

The public clamor increased. Much of the protest was focused around the moot point of who was responsible for the late arrival of a Florida East Coast Railroad train which was summoned at 2 p.m. to evacuate the veterans from the Keys but did not arrive from Miami until after 8 p.m. By that time the storm was raging in full fury. The train never did make its destination for it was toppled off the tracks by the combined force of the gale winds and a huge tidal wave.

Demands mounted for a congressional hearing. Hon. John E. Rankin called such a hearing for March 26 to May 9, 1936. Twenty-three witnesses were heard. As a result of these hearings, H.R. 9486, for the relief of dependents of the veterans who died in the hurricane, was passed by the 74th Congress.

The FERA camps in Florida and South Carolina were closed later that month. Those veterans who survived the "act of God" disaster were given the opportunity to enroll in the CCC upon special authorization of the Director of Emergency Conservation Work.

Altogether, about 225,000 veterans enrolled in the CCC's veterans' contingent. Nearly 600,000 veterans and their dependents received direct monetary benefits from this program in the form of wages and allotments.

THE YEARS OF PEACE

The smoke of the 1933 Economy Act having cleared away, and the aftermath of the 1935 hurricane having subsided, a period of relative quiet prevailed in the realm of veterans affairs.

Prior to World War II, changes in pension and compensation laws were made on a time-to-time basis. Several of the changes made it easier for dependents of deceased veterans to apply for benefits. Another change liberalized the steps that the Veterans' Administration could take in determining service connection of a veteran's disability.
The VA's hospital and medical activities grew during the 1930's. The proportion of patients with non-service-connected ailments continuing to rise.

But of more significance was the fact that the patient load in the 1930's had taken on characteristics quite different from those of the midtwenties, when the preponderance of patients had been tuberculous (41 percent), with 39 percent neuropsychiatric and only 20 percent general medical and surgical. By the mid-thirties, the character of the patient load had changed radically. More than half (56 percent) of the country's hospitalized veterans were afflicted with neuropsychiatric disturbances, while 31 percent were general medical and surgical, with only 13 percent tuberculous—due to the advances made in the treatment of this disease.

**FURTHER LEGISLATION BROUGHT ADDITIONAL BEDS**

Subsequent to passage of the Economy Act, further legislation outlined a policy to provide sufficient hospital beds to meet the maximum requirements of beneficiaries with neuropsychiatric diseases and tuberculous conditions, and to confine the hospitalization of beneficiaries with non-service-connected disabilities of the general medical and surgical type to the limits of existing Veterans' Administration facilities.

By June of 1937, the demand for additional hospital beds still existed. The Administrator of Veterans' Affairs outlined a policy regarding future construction of hospital facilities. This provided, essentially, for (a) the acquisition of as many additional beds as might be needed to meet the peak load of neuropsychiatric patients, (b) additional general beds in those areas only where the existing and authorized facilities were disproportionate to the veteran population served, and (c) such additional beds for tuberculous patients as might be necessary to correct unsatisfactory local conditions or deficiencies. This policy was approved by President Roosevelt on September 20, 1937.

On April 18, 1940, the Federal Board of Hospitalization submitted to the President a comprehensive study and survey of the future institutional needs of the Veterans' Administration. A 10-year construction program was recommended and later approved, in principle, by the President on May 8, 1940. However, it was understood that the proposed program would be reviewed annually and coordinated with the then-existing laws, and in accord with the policy of future hospital construction, placed the maximum institutional needs of the Veterans' Administration at 100,000 beds of all types. It was expected that this number would meet the peak load within the next decade. The Board concluded that approximately 40,000 beds would be needed within the next 10 years to meet the peak load of the psychiatric group. However, there was no apparent necessity, according to the report, to increase the number of beds for the tuberculous group. It was determined that there were 18 areas throughout the country where the existing and authorized general medical and surgical beds were disproportionate to the population served. It was further determined that an additional 2,405 beds would be required to insure beneficiaries residing in those areas the same opportunity for obtaining hospitalization as existed in other comparable areas. The Presi-

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2 Lindley, Clyde, "History of Veterans' Hospitalization," VA paper prepared August 1958, pp. 12-14
dent approved this report in principle. However, these plans were developed prior to any national defense legislation and without reference to probable defense needs.

THE WAR CLOUDS DEEPEN

International events were now racing headlong toward the terrible climax of American involvement in World War II. At the same time intensified planning was underway at the VA.

The VA, which had been routinely engaged for several years in fixed peacetime responsibilities, reacted to the impact of the expanding national defense program. The agency geared itself to meet its greatly enlarged duties. For example, it was recognized that new U.S. emphasis on mechanized forces, together with the vast enlargement of our U.S. firepower, made inevitable a numerical increase in accidental injuries and deaths during military training.4

It was also obvious that the Armed Forces would drain off key personnel, especially in the categories of physicians and dentists.4

Italy had conquered Ethiopia in 1936. Japan's aggression in China, begun in 1931, was renewed in 1937. Germany had occupied Austria and the Czechoslovakian Sudetenland in 1938. Early in September of 1939, Hitler conquered Poland.

A week later, President Roosevelt declared a limited national emergency. Most Americans agreed with the President's policy of neutrality for the United States, but felt that involvement in the war would be difficult to avoid. It was an uneasy neutrality, as the flames of war were spreading wider and intensifying in Europe and Asia. However, it proved to be a highly practical neutrality which gave America time to strengthen her defenses.

Now Mussolini had moved into Albania and Hitler overrun Denmark, Norway, the Netherlands, Belgium, and France. Japan occupied Indochina and, as well, British and Dutch possessions in southeast Asia.

In 1940, the Rome-Berlin-Tokyo Axis was formed to pledge mutual military assistance should the United States enter the war. This same year Churchill took over leadership of Great Britain from the "faltering hands" of Chamberlain, and proposed to his countrymen only "blood, sweat, and tears." Then he promised: "We shall not flag or fail * * * until, in God's good time, the new world, with all its power and might, steps forth to the rescue and liberation of the old." 5

This was May of 1940.

In August, the "new world" took a huge step in the direction of preparedness by ordering to active duty members of Reserve components and retired Regular Army personnel. The order called for service for 1 year, not outside the United States or its possessions.

An important forward-looking policy change was adopted by the Federal Board of Hospitalization and approved by President Roosevelt in September 1940. This policy, updating that of April the same year provided (1) that the additional requirements of the Armed Forces, due to their expansion, be met by the VA's giving up the beds it occupied in Army and Navy hospitals and by the construction of new beds to existing service hospitals; (2) that, in areas where manu-

vers were held, the temporary general hospital needs of the Army and
the Navy be provided by the nearest general hospitals of the VA; and
(3) that, in the event of a major national emergency, the general
facilities of the VA be utilized by members of the Armed Forces who
are injured or incur disabilities in service and whose physical rehabili-
tation by the Army is not feasible.

In September 1940, the VA was assigned the status of a "defense
agency." This enabled the agency to operate under civil service
rules and regulations promulgated for agencies with wartime priorities.
This accelerated all transactions and enabled the agency to hold onto
employees desiring transfer elsewhere. However, it never was the
policy to interfere with employees who could improve their status by
transfer. In spite of being a "defense agency" the Veterans' Admin-
istration did not request deferment of those called for military training
or for those reservists called to active duty.

THE SELECTIVE SERVICE ACT

Meanwhile, debate was raging in Congress over the need for another
step of far more drastic proportions—a draft of America's young men.
The need for the bill proposing the draft—the Burke-Wadsworth
bill—was summed up neatly by a Senator who stated: "I'd rather
have it and not need it than need it and not have it."

However, congressional debate on the first peacetime draft in
American history lasted from August 6, 1940, to September 7.

Finally, on September 16, 1940, the bill went to the President for
his signature and became the Selective Training and Service Act of
1940. Under the act, every male living in the United States, between
the ages of 21 and 36, was obliged to register with his local draft
board. Thus he became liable for military training and service of
1 year. This service, however, was limited to the Western Hemi-
sphere and U.S. territories and possessions.

The President was authorized to induct up to 900,000 men, and
more, in case of war. Those inducted were entitled to "the same
pay, allowances, pensions, disability, and death compensation and
other benefits" then available on a peacetime basis to others on
active duty. The benefits available after discharge included dis-
ability and death compensation (service connection required) of
about 75 percent of wartime rates, VA hospital and domiciliary care
for those with service-connected disabilities, employment preference,
burial benefits, and low-rate insurance.

On October 16, 1940, a little less than 1 month after the signing
of the act, the first registration of men between the ages of 21 and 35
was carried out.

Between November 1940 and August 1945, 17,954,000 draft regis-
trants were examined. Of these, 9,840,216 were inducted into service;
6,418,700 were rejected for physical unfitness. Another 1,794,009
were deferred because their draft board decided their civil work
was considered essential to national defense or they had dependents
whom for financial, medical, or other sound reasons, they could not
leave.6

* Material on selective service passim from two documents: (a) "Selective Service in Peacetime: First
Report of the Director of Selective Service," 1940-47, Washington, 1942; (b) "Selective Service and Chron-
Less than a month after the Selective Training and Service Act went in effect, a vast new system of servicemen’s and veterans’ insurance was created by the National Service Life Insurance Act of October 8, 1940. Proponents of the new system of insurance offered many reasons for adopting NSLI, rather than extending the World War I U.S. Government life insurance (USGLI). For one thing, they pointed out, the age difference between World War I veterans and most of those entering service in 1940 was more than 20 years—nearly a generation. A single system of insurance for both groups would have been unfair to the younger men, for their premium rates would have had to reflect the advancing age of their elders.

Second, they added, the U.S. Government life insurance program had become a stable, smooth-running operation, geared to the needs of veterans during years of peace. Throwing the doors open to newcomers would have created administrative havoc. So for these and other reasons, the new insurance program was adopted. The 1940 insurance law contained these six features:

1. The act put a stop to the purchase of USGLI, unless applicants were entitled to it because of service in World War I. All others eligible could get the new NSLI.

2. A person entering active service could apply for NSLI within 120 days of the date he got in, without having to take a physical examination. Evidence of good health was required after that time.

3. Like USGLI, NSLI was available in multiples of $500, from a minimum of $1,000 to a maximum of $10,000.

4. NSLI was issued at first as 5-year level premium term insurance. Before the end of the term period, it had to be converted to either ordinary life, 20-payment life, or 30-payment life.

5. The basic law contained no indemnity against permanent total disability. But it did have a provision that waived premiums in the event of continuous total disability for 6 months or more for those under 60.

6. Under the original measure, the insurance was payable only to a widow, widower, child, parent, brother or sister. If the first beneficiary was under 30 years of age when the veteran died, the insurance would be paid in 240 equal monthly installments. If the beneficiary was over 30, payments would go on for life.

Cost of administering the huge insurance program was to be borne by the Government, and not by the policyholder. VA was given responsibility for administering NSLI. Servicemen had no problem with premiums because they were taken out of the paychecks of policyholders each month. Once a serviceman was discharged, however, he was expected to make payments on his own to the VA if he wanted to keep his insurance in force.

Soon after the NSLI measure was enacted, it was amended to give $10,000 free NSLI to servicemen taking flight training. After they completed their training, the amendment stipulated they could continue the insurance at their own expense, the same as all other policyholders in uniform. VA approved its first application for NSLI on November 22, 1940, 6 weeks after the law was passed.
VA ON THE EVE OF WAR

By late fall of 1941, America was and was not at war. There was uneasiness in the air. The emphasis everywhere was on national defense. Men in uniform were conspicuous in every city and town across the land.

It became necessary for many ingenious steps to recruit replacements. Women replaced men. Minimum age and physical requirements were pared wherever possible.

At the outset of World War II, VA employed 45,000. For every one at its central office in Washington, five were located in VA field offices and hospitals throughout the country.

The agency was charged with administering three major benefits at that time. These were medical, hospital, and domiciliary care, pensions and compensations, and insurance. There were other smaller scale activities such as a guardianship program, a Board of Veterans' Appeals, and a program of certifying veterans to the rolls of the Civilian Conservation Corps.

World War I veterans comprised the major portion of the workload. Yet a sprinkling of younger men could be found in VA hospitals then on VA's pension and compensation rolls. VA began to feel the impact of these newcomers in uniform, particularly in the administration of the expanding national service life insurance program.

During those cloudy days of part war and part peace, VA was operating 91 hospitals with a total capacity of 62,000 beds. Some 18,000 beds were set aside for domiciliary cases. More than half a million veterans were on disability compensation and pension rolls in December 1941. Eighty percent of these had seen service in World War I.

Another quarter of a million payments were going to dependents of deceased veterans who had served from the War of 1812 to World War I, as well as during the peacetime.

VA's insurance workload was fairly evenly split between U.S. Government life insurance, held by World War I veterans, and the national service life insurance being taken out by the World War II group. About 600,000 USGLI policies, having a face value of $2.5 billion, were in force; NSLI policies numbered 724,000 and were valued at $2.7 billion.

In the field of medicine, during the latter part of 1941, the VA placed scores of its physicians and psychiatrists on a part-time basis at the service of the National Research Council and Selective Service. Qualified and thorough examination of draft registrants, suspected of neuropsychiatric disorders, became very necessary.

The Veterans' Administration, during the previous decade, had acquired tremendous experience treating mentally ill World War I veterans who had been accepted for military service with less than thorough exams. VA had become a leader in emphasizing mental health as an important factor in overall physical health. Its advice was sought during the preparedness period. Its recommendations for the physical examination of draft registrants were sought and followed.

VA's ample clinical and laboratory resources were used extensively by the Armed Forces, particularly for X-ray examinations and electrocardiographic tracings with interpretations. While military hospitals
at training camps were under construction, beds in neighboring facilities of the VA were used for ill or injured soldiers and sailors. At two VA stations—Kecoughtan, Va., and Fort Custer, Mich., entire wards were allocated to Army patients.

In May 1940, Churchill spoke those prophetic words “the new world steps forth to the rescue and liberation of the old.” Not until the Japanese attack on Pearl Harbor on December 7, 1941, did the United States, then the “arsenal of democracy” for the “old world,” actually enter the gigantic conflict of World War II.

(Courtesy of Dept. of Defense)
December 7, 1941, “Pearl Harbor Day” and one of the darkest days in our history, forced our country into full participation in the Second World War.

It was a Sunday, a day of worship. Armed Forces chaplains were conducting services in numerous chapels and on board the warships berthed at Pearl Harbor. Without warning, the Japanese perpetrated a savage, highly successful, aerial attack on the military installations and naval fleet at Pearl Harbor.

Pearl Harbor has been a powerful U.S. Navy base located on the island of Oahu, Hawaii. The following day the Japanese followed up with air attacks on U.S.-held Wake Island and, as well, on Clark and Iba airfields north of Manila in the Philippines. On December 12, they were successful in invading and occupying the island of Guam, another U.S. possession.

At 1:45 p.m., on December 7, Washington heard the news almost accidentally. An alert to the Navy Department was intercepted. It said: “From CINCPAC, to all ships present Hawaiian area. Air raid on Pearl Harbor. This is no drill!”

The next day, President Roosevelt summoned Congress to a joint session and asked a declaration of war against Japan. Congress promptly voted his request with only one single dissenting vote, whereupon the President issued a proclamation of war. (Representative Jeannette Rankin of Montana, who had also voted against our entry into World War I in 1917, once again dissented.)

Three days later, Germany and Italy, already teamed with Japan, declared war on the United States. The United States promptly retaliated with a declaration of war on them.

Within days, nearly the entire world was engulfed in war. In America, preparations were stepped up to a feverish pitch for the trying days ahead.

WAR INVOLVEMENT CALLED FOR PATIENT RELOCATION

The Nation’s sudden active involvement in the war brought many problems to the VA.

Within 72 hours after the first bomb fell on Hawaii, it became obvious that the relocation of some 800 West Coast patients was imperative.
Three west coast VA installations were considered dangerously exposed should the enemy attack the west coast of the United States.

Involved in the emergency move were the hospital and diagnostic center at Fort Miley, San Francisco, and the huge neuropsychiatric, general medical, and surgical hospital in Los Angeles.

The Fort Miley installation, just above the Golden Gate, was in close proximity to several U.S. Army batteries of large-caliber guns which when pressed into use could shatter windows and render the facility untenable.

In less than 3 days, all nonambulant patients in this installation were safely transferred to VA hospitals further inland.

Simultaneously, all patients were removed inland from the VA's neuropsychiatric hospital in Los Angeles. Likewise, all but the ambulant patients at the general medical and surgical hospital in that city were relocated. Only those patients who could care for themselves in case of emergency were allowed to remain.

The mass transfer of the NP patients was especially noteworthy, considering one psychotic patient presents a number of problems. In this huge operation, doctors, nurses, and attendants were required to accompany the patients in the five separate train movements that were involved. The outer windows of each coach were blocked on the outside, all cars were stripped of curtains, towels, door handles, and whatever else might be used by the patients to injure themselves or others. Although some of the patients had the potential of "suicide, escape proclivities, destructive and homicidal trends," only one dangerous act of misbehavior was recorded. A patient attempting to escape wrestled an attendant off the steps of a coach with the train in motion. Neither was seriously injured.¹

ADEQUATE STAFFING BECAME A PROBLEM

Despite the VA's status as a defense agency, it lost some 7,000 employees, who left the agency the first year to join the war effort in some other capacity. VA refused to take advantage of its status and did not ask for deferments. Although the agency lost personnel in nearly all job categories, it felt the pinch initially among the hospital personnel.

The shortage of nurses became critical in many hospitals. The lowering of the high standard of VA medical care was avoided by Presidential action.

In June of 1942, the War Department agreed not to call VA doctors holding reserve commissions to active duty.² It further agreed to present temporary inactive commissions in the U.S. Army to other doctors up to age 64. This alleviated the situation somewhat. However, it was through the efforts of Administrator Hines that the Secretary of War, on December 7, 1943, issued a directive that gave active duty status in the VA to those physicians and dentists who could meet the qualifications set forth. Those who could qualify were (a) medical and dental reserve officers on an inactive status who had not passed their 59th birthday; (b) Army of the U.S. medical and

dental officers on an inactive status who had not passed their 59th birthday; and (c) civilian physicians and dentists who had not passed their 45th birthday. (This latter age limit was raised to 63 in March 1944. The total number of doctors and dentists in the VA then rose to a high of 1,566, including a small number detailed by the Armed Forces.)

In addition to being plagued by shortages, the agency needed more and more hospital beds to care for disabled servicemen coming back to civilian life. The agency saw that the need for beds would reach unheard of levels, once the war came to an end. Building activities were continued in the face of difficulties encountered because of the agency's low Federal priority rating. It was extremely difficult to obtain labor and materials.

The VA did, however, manage to build two hospitals during the war. One was a replacement at Fort Howard on the outskirts of Baltimore, Md., and the other at West Roxbury, Mass. The agency also managed to increase bed capacities in a number of other hospitals. At four of them, for example, it converted dayrooms to wards. At others, it simply added more beds to existing wards by placing beds on sun porches and converting two domiciliary homes to neuropsychiatric hospitals.

In addition, the agency managed to build additions to a number of its hospitals.

Despite all these efforts, VA hospital facilities continued to be overtaxed.

CONGRESS REACTED QUICKLY WITH VETERANS' LEGISLATION

During the 24 days between Pearl Harbor and the end of 1941, Congress rushed through several veterans' laws. Three of these rate discussion since they attempted to solve pressing war-created problems.

Compensation at wartime rates

One of the laws passed on December 19 provided compensation at wartime rates for officers and enlisted men of the Armed Forces disabled in line of duty. This included men disabled at Pearl Harbor, before the United States was formally at war, and also men disabled in extra-hazardous service—such as training maneuvers. If the disablement resulted in death, there was provision for the veteran's dependents.

National Service Life Insurance

On December 20, Congress added a provision to the National Service Life Insurance Act of October 8, 1940, to aid the families of servicemen killed or totally disabled before they had a chance to take out insurance. The new law automatically granted $5,000 in insurance to the families of servicemen who did not have that much at the time of their deaths. The same amount of premium-free insurance was given to noninsured servicemen totally disabled for 6 months or more, as well as to those taken prisoner before they had a chance to take out insurance. Death or disability had to occur on or after October 4, 1940, and within 120 days after passage of the law. The latter deadline was later extended.
**Service-connected disabilities**

Usually, when the VA determines whether a veteran has a compensable service-connected disability, a careful study is made of his medical records while in service. But what of the man wounded in combat, where records often were not kept at all? Early in the war, the VA adopted a policy of being as liberal as possible with claims of men disabled in combat and unable to prove service-connection because of the lack of records. If necessary, it accepted merely sworn statements describing circumstances surrounding the disability. On December 20, 1941, Congress placed the stamp of approval on the VA's policy by making that policy law.

**MILITARY MEDICINE IN WORLD WAR II**

Between World Wars I and II, remarkable progress was made by the Medical Corps of the U.S. Army. The death rate from wounds in World War II was less than half that of World War I. Medical science had produced the new sulfa drugs, penicillin, and plasma for blood transfusions. Tremendous strides had been made in treatment techniques for neuroses and for burns, especially the terrible burns caused by bursting shells and Japanese kamikaze tactics. The practice of prompt evacuation of wounded from combat areas was introduced. Preventive measures were stepped up, such as vaccination and other inoculation programs. About two-thirds of all wounded were returned to active duty in World War II. Deaths from noncombat causes were reduced to less than 1 percent of military personnel annually.

Other dramatic improvements in military medicine were higher standards of physical fitness for induction; abundant food; better clothing; and more and better hospitals competently staffed. The health of the U.S. military during this war compared favorably with that of the civilian population in the same age groups. It will be remembered that in the Civil War, deaths from wounds far exceeded the number of those killed outright. In the Mexican War and Spanish-American War, disease greatly outnumbered battle as a killer.

The increasing role of artillery and bombing in modern warfare is illustrated by the fact that, while 94 percent of Civil War wounds were caused by rifle bullets, 72 percent of wounds in World Wars I and II and the Korean conflict were caused by shell fragments.

**HOSPITALIZATION OF WORLD WAR II VETERANS**

Until 1943, World War II veterans were permitted hospitalization only if they had a compensable service-connected disability. Veterans of earlier wars who had no service-connected disability could be hospitalized if (1) they stated under oath they could not pay for the service elsewhere, and (2) beds were available.

However, on March 17, 1943, the President signed Public Law 10, 78th Congress, an act that was to play an important part in the purpose and growth of the Veterans' Administration hospital and medical programs in the years to come.

The new law set eligibility requirements for World War II veterans identical with those for veterans of World War I. However, the

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impact on the VA hospital system was delayed because there were not, as yet, many World War II veterans around. Guadalcanal's final battle had just been won and the Allied landings on Sicily were still in the planning stage. On June 30, 1943, for example, less than 3,000 World War II veterans were being treated in VA hospitals for non-service-connected conditions.

Millions of future veterans were still fighting a war. Later, their demands for hospitalization were to cause a revamping of VA plans for expanding hospitalization and medical care. Their needs were to require that more than 70 new hospitals be built.

**VOCATIONAL REHABILITATION ACT**

On March 25, 1943, 8 days after signing Public Law 10, President Roosevelt signed Public Law 16, the Vocational Rehabilitation Act, another far-reaching piece of veterans' legislation.

World War II left many men physically disabled to such an extent that they could not return to their former occupations. Their courage, ability, and drive, aided by the provisions for rehabilitation under this law, gave many veterans a start toward a new career.

It provided up to 4 years of training to honorably discharged veterans who needed it in order to overcome the handicap of service-connected disabilities. Reports submitted by both the House and the Senate prior to the enactment of the law stated that the measure contained provisions "designed to profit by the experience in administration of rehabilitation for World War I veterans by the Veterans' Administration, and will minimize duplication by existing agencies."

**R. & R. ADMINISTRATION**

In February 1944, President Roosevelt selected General Hines as Administrator of the Retraining and Reemployment Administration, to be set up as part of the "Baruch plan," designed by Bernard M. Baruch for war and postwar adjustments.

The new administration was to handle employment and such rehabilitation provisions authorized under the plan, supervising all such activities for veterans administered by agencies other than the Veterans' Administration.

The R. & R. Administration, which grew out of the prevalent national realization that veterans' problems could not be treated as separate and unrelated, was not established until October 3, 1944. On that date it came into being under the authorization of the War Mobilization and Reconversion Act.

The Retraining and Reemployment Administration went out of existence 3 years after the termination of World War II.

**SERVICEMEN'S READJUSTMENT ACT OF 1944: THE "GI BILL"**

There was little disagreement, early in the war, that something extraordinary would eventually have to be done to ease the transition of millions from military ways back to civilian living. Proposals were numerous, ranging all the way from adjusted compensation, or a bonus similar to that given to World War I veterans, to a system of Federal loans for veterans who wanted to go to school.
Normally, Congress initiated veterans' legislation. However, on November 13, 1942, President Roosevelt exercised his prerogative and appointed a committee of educators to study "postwar educational opportunities for service personnel." Brig. Gen. Frederick H. Osborn was named chairman.

This committee on July 30, 1943, reported back a single omnibus measure covering all phases of readjustment. The details changed considerably during the 6 months they were under consideration. Its broad outline did remain firm. Education and training, a loan program, unemployment pay, job-finding assistance, an adequate hospital program, quick settlement of disability claims were its features. The complete measure was studied by the House of Representatives Veterans' Affairs Committee. In the Senate a veterans' subcommittee of the Finance Committee analyzed it. The concept of the veteran as a single individual with many problems was the main concern of both branches. The headaches and heartaches of providing for World War I veterans was still in the minds of all.

Everyone felt that one agency should administer benefits to veterans. All agreed further that this agency should be the Veterans' Administration. U.S. Employment Service was assigned the functional responsibility of finding jobs for veterans.

The GI bill became law on June 22, 1944. Officially, it was Public Law 346, 78th Congress. It provided an extensive program of education and training benefits; loans for the purchase or construction of homes, farms, and business property; aid in the employment of veterans; and unemployment benefits in the form of monetary allowances.

The law gave veterans new opportunities to recover from the years spent in the military. These were not handouts. They offered the discharged veteran the chance to raise his level of educational, cultural, and economic life.

Section 100 of this now famous public law designated the Veterans' Administration "to be an essential war agency and entitled, second only to the War and Navy Departments, to priorities in personnel, equipment, supplies * * *." One way this provision aided the agency was that it permitted approximately 1,200 ASTP (Army specialized training program) and V-12 (Navy medical training program) physicians to remain with the agency for 2 years. They had agreed to serve inasmuch as the Government had paid for their medical education. Students under the cadet nurses program were likewise detailed.

Section 101 of the GI bill directed the Administrator of Veterans' Affairs and the Federal Board of Hospitalization to expedite and complete construction of additional hospital facilities for war veterans. It provided for the acquisition of more hospitals. Most unprecedented was the section's authorization of an appropriation of $500 million for the acquisition and construction of new hospitals.

* The Special Medical Advisory Group is formed.*—During 1944, Administrator Hines decided to recreate a smaller version of the VA's former Medical Council. The earlier advisory body which ceased to exist in 1939 had proved to be cumbersome and ineffective. The attendance at its meetings had been very poor.

The Chairman and Secretary of the Executive Committee of the previous Medical Council agreed with the proposal for a new group. The new medical and surgical practices, the "wonder" drugs developed during World War II, and the increasing patient load in VA hospitals, dictated that the Administrator should have modern specialized medical advice.

A Special Medical Advisory Group to the Administrator of Veterans' Affairs was formed. This group comprised of 16 men, outstanding in major fields of medicine. Each served at the call of the Administrator.

The members of SMAG were:


The new SMAG held but three meetings but its recommendations were far reaching. The first meeting was from February 28 to March 1, 1945, the last on June 27-28 of that year. The group's recommendations stressed the VA's need for a Department, or Bureau of Medicine to be responsible for the added medical load. The group felt that medicine, because of its overall importance in the VA, should report directly to the Administrator.

SMAG also suggested outpatient treatment for all veterans with non-service-connected disabilities. It recommended that residencies and teaching fellowships, as well as research programs, be established in VA hospitals. Furthermore, SMAG emphasized that VA hospitals be located in areas adjacent to and affiliated with the teaching program of a medical school.

**MAGAZINE ARTICLES TAKE VA TO TASK**

Early in 1945, articles began to appear in national media which attacked in a sometimes accurate, sometimes inaccurate fashion, the quality of VA medicine. These articles stressed the care being given World War II veterans and the administration of the VA in general.

Articles by Albert Deutsch were published in the New York newspaper *PM*. The first of 11 installments appeared on January 7, 1945, and was titled, "Vets' Setup Needs Revamping Now to Avert Scandal." This article established the pattern for those that followed. Others were called "Hines: Darling of the Economy-Minded Conservatives," "Veterans' Hospitals Called Backwaters of Medicine," etc.

The article on General Hines described briefly the conditions that existed immediately after World War I under Col. Charles R. Forbes.

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*History file No. 306, Medical Council, policy files 1945.*
The Forbes era was compared to the tenure of General Hines, with special emphasis on the honesty of administration of the Hines regime. The author brought out that few public figures possessed the degree of congressional confidence enjoyed by General Hines. He stressed that his budget requests were seldom questioned. Deutsch stated that the general prided himself on the number of occasions the VA was able to return unexpended balances to the Treasury.

Deutsch also portrayed General Hines as the paradox of a conservative Republican who likewise was one of the most powerful figures in the Roosevelt administration. The author described General Hines as one who placed undue stress on paperwork and bureaucratic procedures. He alleged that anything new was described by the Administrator as being likely to get us into trouble.

The third article, "Veterans' Hospitals Called Backwaters of Medicine," appeared on January 9. The writer took to task the location of VA hospitals, medical libraries, clinical research, and "lack of cooperation with the local medical profession."

The articles that followed were in a similar vein. Various complaints, evidently submitted to the author by dissatisfied patients, claimants, and employees were aired.

The February installments, for the greater part, severely criticized the treatment of the veterans suffering from tuberculosis and those with mental disorders.

Shortly thereafter, a two-part article written by Albert Q. Maisel, appeared in the March and April 1945 issues of Cosmopolitan. They were captioned, "Third Rate Medicine for First Rate Men."

For the record it should be noted that 7 months later in the same magazine, Cosmopolitan, Maisel wrote highly laudatory articles about how Gen. Omar Bradley, with the assistance of Gen. Paul Hawley, was overhauling and modernizing the VA hospital system. The Cosmopolitan article was condensed by Reader's Digest in its December 1945 issue.

This barrage of unfavorable publicity caused deep concern throughout the country. Relatives and friends of disabled veterans were distressed at reading such widely disseminated accusations of unsatisfactory treatment.

The seriousness of the situation was fully recognized by General Hines. Early as February 5, 1945, he invited all members of the Committee on World War Veterans' Legislation to personally visit field facilities in order to see for themselves the work being accomplished. He also extended a similar invitation to the national commanders of the American Legion, Veterans of Foreign Wars, and the Disabled American Veterans. These three organizations agreed to undertake a survey of the Administration's 95 hospitals and report their findings to the Congress, to the veterans themselves, and to the public.

Administrator Hines' concern was particularly about many unsubstantiated accusations and wild distortions of the truth that were alleged in these articles. Finally on March 21, 1945, he wrote to the editor of Cosmopolitan:

** ** [The] article purports to be written by Albert Q. Maisel, but you did not indicate any reservations with respect to the alleged facts or the conclusions stated therein. If you [had been] fully advised of the facts, I wonder if you feel that any and desired to be attained [by the article] would justify the worry, apprehension, and lack of confidence that it necessarily has caused thousands of relatives of veterans, the veterans themselves, and others interested in the medical
treatment and care of veterans not only of this war but of prior wars entitled to hospitalization in facilities operated by the Veterans' Administration. * * * In any future article you may contemplate publishing concerning veterans or the Veterans' Administration program, may I suggest that you may desire, where factual information is included, to verify these facts with our official records?

The Administrator then included a complete factual résumé of one of the cases distorted in the article, “the allegations and the facts being arranged in parallel columns.” Of this presentation, the general stated: “No opinions or conclusions are expressed, but I would welcome a critical evaluation of the facts by any authoritative medical source.”

**STRONG SUPPORT FOR THE VA**

The newspaper, National Tribune, in a forceful editorial entitled “Deliberate Sabotage,” printed on March 22, 1945, upheld the Veterans' Administration programs and performance. Pointing out that “* * * our veterans are being discharged from armed service in World War II at the rate of 100,000 a month,” that, “battle casualties are being returned to this country at the rate of 1,200 a day,” and that, “we expect that as many as 5 million discharged veterans may require hospitalization in VA facilities,” the newspaper stated that “we know that the type of article published this month [in Cosmopolitan] can do more to undermine the faith of our people in what the years have proved to be a splendid institution than any other single thing.”

Further pointing out that “hundreds of the best [physicians] are at present overseas in uniform and will return better prepared to treat our sons in postwar days, what now applies to doctor shortages is equally apparent in every other department of the Bureau [i.e., the VA]—nurses, attendants, engineers, construction men. However, in times past, now, and as time goes on, the best medical brains in the Nation are, have been, and will be attached to our veterans' hospitals, either as staff members or in a consultant capacity.”

The editorial concluded with a prediction that all veterans' leaders would back General Hines and the agency to the hilt and called the articles “deliberate sabotage of one of the finest gifts the American people have given to their fighting sons—the Veterans' Administration.”

**CONGRESSIONAL INVESTIGATION REQUESTED**

The next step taken by the Administrator was to request the Committee on World War Veterans' Legislation of the House of Representatives to conduct an investigation of hospital treatment in VA facilities. This was authorized by House Resolution No. 192, 79th Congress, on March 19, 1945. Hearings began on March 22 and they continued intermittently until October 15, 1945. Many witnesses, representing the Veterans' Administration, the medical profession, the veterans' organizations, and other interested citizens were heard during this time.

In addition to the Administrator, the VA was represented by Col. George E. Ijam, Assistant Administrator in Charge of Medical Construction, Supply, and National Homes; Dr. Charles M. Griffith, Medical Director; and Edward E. Odom, Solicitor for the agency; and other members of the staff.

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1 Legislative records, VA file 111, H. Res. 192, 79th Cong.
Those allegations concerning the care of veterans suffering from tuberculosis were answered by Col. Roy A. Wolford, Assistant Medical Director, Tuberculosis Division. He disproved, item by item, the various criticisms involving the treatment of tuberculous patients. In a similar manner, Col. John M. Baird refuted the charges involving the hospitalization of veterans suffering from mental disabilities. Their testimony was printed verbatim in the Congressional Record (June 8, 1945, pp. A-2963—A-2969 (Colonel Baird) and June 11, 1945, pp. A-3000—A-3011 (Dr. Wolford)).

There was evidence that some mentally disabled patients had been handled either ineptly or inhumanely by new attendants, but this was contrary to a rigidly enforced VA regulation. Many trained, experienced attendants had left the agency to go into service or enter war industry. It became necessary to replace them with limited-service personnel, on loan from the Armed Forces, or with conscientious objectors. Any evidence of inhumane treatment of mentally ill patients led to immediate transfer to other work or discharge of that employee.

MRS. FRANKLIN D. ROOSEVELT CALLS FOR PUBLIC REACTION

As the investigation progressed, an uproar of controversy spread throughout the country as to the treatment of the returning veterans. In a press conference, Mrs. Franklin D. Roosevelt charged that the people of the Nation had neglected knowing what is going on in the Veterans' Administration hospitals. She said she had read the Maisel articles, and, when asked if she agreed, she replied: "I am not going to say anything except that as citizens we should know the veterans' hospitals in the community. We should visit the hospitals and pay attention to what we see." She said that "complaints should first go to General Hines and the people responsible for the conditions in the hospitals," and suggested that the wives of veterans write to the general or to their Congressmen if they were uncertain of the benefits due their husbands under the GI bill of rights.

At this point, President Truman began to react to the public's demand for improvement. In a news conference he called on May 15, 1945, the following conversation took place:

Q. Mr. President, there is a report that you were about to shake up the Veterans' Administration, and that part of the shakeup will be to appoint Bennett Champ Clark?*

The President. I can't—I don't hear the question—I am not planning a shakeup but I don't know what it was about.

Q. Veterans' Administration.

The President. No; I am not planning any immediate shakeup in the VA. The VA, of course, will have to be expanded to meet the situation which we will face as soon as the soldiers return in large numbers. And the VA, of course, will have to be put on a basis to meet this situation just as it was put on a basis to meet the situation after the First World War. That will be done. I don't think it necessitates any serious shakeup.

Q. You said you did not see any immediate shakeup.

The President. That's what I meant.

Q. Can we quote the word "immediate"?

The President. No; I wish you wouldn't for this reason: Because I don't want it to appear in any way that I have the intention of immediately discharg-

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* Public Papers of the Presidents, Harry S. Truman, 1945.

* Bennett Champ Clark was Senator from Missouri from 1933 through January 1945; then associate justice, U.S. court of appeals, until his death in 1954.
ing anybody. I am trying to get this "mess" to operate and I want you to be as lenient with me as you possibly can. The VA will be modernized; let's put it that way. That should be done as soon as possible, but I can't do it immediately.

Q. The second part of my question, Mr. President, was: Do you intend to appoint Bennett Champ Clark?

The President. I do not.

On June 7, 1945, at another news conference, the President started the press corps with the following:

I want to announce the resignation of Brig. Gen. Frank T. Hines as Veterans' Administrator, and of the other job he has, and Gen. Omar Bradley will be appointed in his place. [Low whistles and expletions.]

And I want to remind you of a statement that was made at the press conference here, on May 15, in which I said the VA will be modernized and that should be done as soon as possible. But at that time I was not ready to do the job immediately because I hadn't obtained the consent of the War Department for General Bradley's discharge.

Q. Mr. President, will General Bradley be retired before—

The President. He will not. He will still be a four-star general while he is in charge of the Veterans' Bureau.

Q. Will he have the other job, too, reemployment and retraining?

The President. I don't think so. I think I am going to dispose of that in another way at a little later date.

Q. Mr. President, when is General Hines' resignation effective? Immediately?

The President. No. General Hines' resignation is effective at my pleasure, and that will be when General Bradley can wind up his duties in New York and take over. That will probably take 30 to 60 days to be accomplished.

I wrote General Hines a letter and here is the way I wind it up. You will get copies of both these letters, my letter and his letter of resignation, too.

(Reading):

I want you to know that I have always had, and shall continue to have, complete confidence in you, and in your handling of public matters. In fact, I shall ask you within the near future to take another post of public importance and I hope you will accept it.

"And he told me personally that he would."

Q. Mr. President, on that point can you say anything about—now—about the construction of the medical divisions of the Veterans' Bureau? Any change contemplated there?

The President. I would rather not discuss it now because I'll discuss it at a later date. When General Bradley takes over here, I will give you the complete layout of it—what we propose to do.

Q. Mr. President, you mean there will be a reorganization?

The President. It will be modernized, let's put it that way. It will be a Veterans' Administration for World War II. That was the setup for World War I and has been very adequately handled for World War I. But as a World War I soldier, I wouldn't have been happy to have had the Spanish-American War veterans running the VA, and I don't think the new veterans would. I think they would much rather have a general of their own war in the place. And General Hines thought so too, after we discussed it.

GENERAL HINES WINDS UP 22 DEDICATED YEARS

Below is the exchange of letters between General Hines and President Truman:

JUNE 7, 1945.

HON. HARRY S. TRUMAN,
President of the United States,
The White House.

MY DEAR MR. PRESIDENT: I am sure you are familiar with the fact that I serve as Administrator of Veterans' Affairs at your pleasure.

I have served in this capacity 22 years the 2d of March 1945. I feel after such long service that you may desire to make some change here, and with that in view I submit my resignation to take effect at your pleasure.

With every best wish, I am,

Sincerely yours,

(5) FRANK T. HINES, Administrator.
THE WHITE HOUSE,  
Washington, June 7, 1946.

Brig. Gen. Frank T. Barnes,  
Administrator, Veterans' Administration,  
Washington, D.C.

Dear General Barnes: With regret I accept your resignation as Administrator of Veterans' Affairs and as Administrator of the Retraining and Reemployment Administration. These resignations are to take effect upon the qualification of your successor in each instance.

You have served faithfully, loyally, and efficiently in charge of the affairs of veterans for more than 22 years. It has been a record of accomplishment and of service to your fellow veterans in which I am sure you and those associated with you must feel great pride.

I am accepting your resignation only because of a feeling which I have long held that the veterans of this war should have as the Administrator of their affairs another veteran of this war. For that reason I am asking Gen. Omar N. Bradley to take over the affairs of the Veterans' Administration.

By the time General Bradley's duties will enable him to assume office, the congressional investigation, which was begun at your own solicitation, will have been completed.

I want you to know that I have always had and shall continue to have complete confidence in you and in your handling of public matters. In fact, I shall ask you within the near future to take another post of public importance, and I hope that you will accept it.

With kindest personal regards,

Very sincerely yours,

(S) Harry S. Truman.

On August 25, 1945, the President passed the mantle to General Bradley when he issued the following statement concerning veterans' hospitals:

A program for the construction of new hospital beds for the treatment of veterans was recently recommended by the Veterans' Administration.

When these recommendations reached my desk, I had decided to accept the resignation of General Barnes as Veterans' Administrator, and to appoint Gen. Omar N. Bradley as his successor.

In all fairness to General Bradley, I thought he should have an opportunity to make his own recommendations, as he would be held responsible for his administration. In order that he might have this opportunity, I approved the program for the construction of 28,000 beds but withheld approval of any locations.

I expect General Bradley will expedite the submission of a program recommending locations for the beds. This will be acted on as promptly as possible.

In a special message to the Congress on September 6, 1945, President Truman presented a dramatic 21-point point program for the reconversion period.

He had this to say about the medical program of the Veterans' Administration:

More than 200,000 World War II veterans have already been afforded hospital care in VA facilities.

At the time of Pearl Harbor, the Veterans' Administration and the Federal Board of Hospitalization had underway a hospital building program which, by 1949, estimated peak of needs for World War I veterans, would have provided a total of 100,000 beds for hospital domiciliary care. Since Pearl Harbor, the hospital building program has been expedited.

The Veterans' Administration now has approximately 82,000 hospital and 14,000 domiciliary beds; 13,000 beds are now under construction and funds are available for 15,000 more.

The Servicemen's Readjustment Act authorizes appropriations to the extent of $500 million for the construction of veterans' hospitals and also the transfer to the Veterans' Administration of suitable facilities of the Army and Navy after the end of the war, when surplus to their needs. The program of the Veterans' Administration and the Federal Board of Hospitalization contemplates keeping abreast of developing needs through such transfers and additional construction. To this end, a plan has just been approved for construction of 29,000 additional beds.
Since World War I, there have been more than 3 million admissions in veterans' facilities—and most of them since 1925. Considering that the total number of veterans of World War I and all living veterans of prior wars did not exceed one-third the number of veterans of World War II, it can be readily seen how important it is to provide hospital privilege.

The subject is one which should receive the most careful consideration from the point of view of the extent and quality of facilities to be provided and maintained. In the last analysis, if we can insure the proper economic conditions, we may be sure that the genius and initiative of Americans who met successfully all demands of the greatest war in history, both on the fighting front and on the production front, will make certain the reintegration of veterans into an expanding civilian economy. Anything else would not meet the country's obligations to its veterans.

Promise of another appointment to a permanent public post for General Hines was not an idle one. On September 14, 1945, his appointment of the general as Ambassador to Panama was confirmed by the Senate on September 14, 1945. General and Mrs. Hines left the country shortly thereafter. In December of 1947, he announced that he would retire within 2 months. He returned to Washington and was elected a director of the Acacia Mutual Life Insurance Co., a member of its executive committee and military consultant to that organization. He continued these activities until shortly before his death on April 3, 1960.

**GENERAL HINES' TESTIMONY**

The problems of the medical division of the Veterans' Administration were multifold during the war years. The Administrator's testimony before the Committee on World War Veterans' Legislation, July 3, 1945, brought to light many of them. He gave a careful, detailed analysis of the agency's problems. Some he pointed out were beyond his control due to the fact that the country was in an all-out war. He was careful to detail the action he and the agency took to cope with these situations.

General Hines' testimony at this hearing was actually his valedictory statement for he had already submitted his resignation a month early and was awaiting General Bradley's takeover.

**THE GENERAL'S TESTIMONY HIS FAREWELL**

On July 3, 1945, General Hines appeared before the House Committee on War Veterans' Legislation. His testimony was, in effect, a recitation of his stewardship as Administrator. His commentary was sometimes proud, sometimes defensive. It was his "swan song."

Point by point, the general set forth what he felt were the accomplishments and the failures of his administration. His testimony was candid.

I was gratified—

He said—

to have an opportunity of having the hospitals of the Veterans' Administration appraised not only by the servicemen themselves but by the Members of Congress, and you have had before you some outstanding doctors.

It has been stated that some of our hospitals are isolated. That is true. I can name two that are too much isolated. One is in Dawson City, Ky., and the other is at Fort Huayard, N. Mex., and there are others that are cut off, but those were selected and taken over at a time of emergency ** **.

The question of location of hospitals has an important bearing on the veteran himself. Of course, you could not possibly place all the hospitals we have now
or will have near large medical centers ** *. Now we have always felt for the recovery of the patient that it was important, if he was to be retained in the hospital a great length of time, he should be located where his family and friends would pay him periodic visits ** *. It is better to have these hospitals near the center of veterans' population ** *. Neuropsychiatric hospitals should be out in the country convenient to good transportation ** *.

At no time has there been a lack of funds available. Congress has appropriated money as rapidly as it has been needed.

In his testimony, General Hines contrasted the increase in the workload of the agency with the decrease in its staff.

He said—

that the program has progressed rapidly and, of course, this committee knows without telling you that when we undertook to take in the non-service-connected cases of this war we ran into an unusual load that neither the committee nor the VA could anticipate, and that has brought about a situation which is more responsible for any crowding than anything else ** *

I think it would be interesting at this point if I call your attention to the effect of the load on the Veterans' Administration. A total of 107,325 cases of World War II have gone into a VA hospital ** * service-connected cases, 47,806 ** * non-service-connected, 117,084.

As for the decrease in staff "we lost," the general said, "the services of 450 physicians, 988 nurses, 106 technicians, 15 dentists, five dental assistants, and two dental hygienists." It became impossible, he went on, to replace hospital attendants who were leaving in droves due to the draft or the lure of higher wages in private industry. It became necessary for the Army to detail about 8,000 enlisted men to hospitals as attendants to fill this gap.

Our doctors—

The general pointed out—

were not commissioned and put on detached duty until the President himself issued the order. There was a difference of opinion and finally I went to President Roosevelt and told him that we could not lose any more doctors and could not replace them. I told him the best thing was to put them on detached duty and he issued the order. I am not sure it was agreeable with the War Department at that time but they did it.

When Congresswoman Rogers expressed concern about what the Veterans' Administration was doing for female veterans, the general had statistics available. He stated that there were in seven facilities 442 beds available for psychotic women, and that in addition the agency had contracted for 654 beds for women at 11 facilities across the country. "We have," he assured the Congresswoman, "a staff competent to take care of women."

Asked by Mrs. Rogers if he would be willing to approve a Veterans' Administration Medical Corps bill, the general replied that he had recommended such legislation not long after he was appointed Director of the Veterans' Bureau. He had not pressed his recommendation too hard because the proposed bill did not have the wholehearted endorsement of the veterans' service organizations nor, in fact, of many of the Bureau's doctors themselves. "If," he admitted at a later point in the testimony, "I knew we were going into another war, I would certainly strongly advocate ** * the Medical Corps bill."

The testimony bringing out how General Hines had proposed legislation to establish a Veterans' Administration Bureau of Medicine and Surgery, the committee chairman, Congressman Rankin of
Mississippi, remarked, "General, I want to compliment you for your action in that matter."

When the general revealed that the Veterans' Administration had spent $17 billion in the care of veterans since he took office, Congresswoman Rogers stated that "his honesty would not be questioned by anybody in the tremendous handling of money and the possibility of irregularities. I think that is remarkable."

Chairman Rankin then added:

Of course, I think General Hines has done a wonderful service, and the servicemen paid tribute to him. They owe him a lasting debt of gratitude. Being this may be the last time that the general is here before the committee before retiring, gentlemen, I think it is appropriate that this committee pay its tribute to General Hines for his faithful and large service to the Government. I make that motion.

The chairman ended the hearing with this accolade:

You know, the country has a great deal of confidence in you, General Hines, and this committee is no exception to the rest of the country.

General Hines replied:

Thank you, Mr. Chairman, I hope I can retain it.

The one major result of the long hearing was general sentiment in favor of the sort of Veterans' Administration Medical Corps bill that General Hines himself, somewhat tentatively and not too strongly, had long ago advocated. The World War II frame of mind, among all interested parties, was more sympathetic to such legislation than the frame of mind of the post-World War I period.

Following the hearing, the committee, issued two reports, one by the majority and one by the minority.

The first, an "interim report," published on September 17, 1945, was only three pages long. It dealt solely with the "extreme emergency" of the need for adequate space and personnel for the VA and stated that "additional reports will follow."

The only additional reports on the hearings came out March 20, 1946, and were also brief, consisting of a 1½-page committee report and a four-page minority report. These were combined in House Report No. 1795.

The committee report was in no way a condemnation of the agency. Its major conclusion was:

This investigation disclosed that conditions in veterans' hospitals were neither as bad as portrayed by the periodicals or individuals, nor were they everything desired by this committee.

The report continued:

Wartime exigencies required the use of inexperienced civilians, untrained conscientious objectors, and soldiers who were discontented in their assignments. Some abuses did exist. The personnel responsible [and] subject to military control were court-martialed, and the civilians responsible were indicted.

Noting that "the end of the war" had brought "partial relief of the manpower shortage," the committee report added:

To enable the Administrator to correct * * unsatisfactory conditions, this committee prepared and presented to the Congress remedial legislation which was enacted as Public Law 292, 79th Congress, approved January 3, 1946.

The minority views report, signed by 8 of the 20 committee members, was somewhat less favorable. Although granting that "a number of deficiencies * * * were created by general wartime conditions, others apparently [were] present for years preceding the out-
break of war, and were intensified by the tremendously increased load during the war.” It also agreed that “according to the evidence, some of the criticisms of the Veterans’ Administration were found to be unsubstantiated.”

However, the minority members did list 20 findings it found unsatisfactory. Most serious among those were: “The VA, as set up, was not equipped to provide the best quality of modern medicine” and “complacency and inflexibility of the administrative heads.”

They submitted 19 recommendations for improving the hospital and medical program of the Veterans’ Administration; among them, that the Administrator have authority to employ and discharge medical personnel; that the head of the Department of Medicine and Surgery be a physician responsible only to the Administrator; that the Special Medical Advisory Group be maintained on a permanent basis; that medical research and training be encouraged; that the program for internship and residencies be rapidly installed; that physicians be encouraged to attain medical specialty certification; that paperwork by the medical staff be reduced; that salaries be increased; that there be speedy use of special equipment and improved techniques in treating neuropsychiatric disorders; that outside specialists be called upon to conduct hospital teaching rounds, rather than to treat only individual cases; and that expanded hospital construction be expedited.

Most of these recommendations were taken care of by subsequent legislation introduced by the entire committee; namely, Public Law 293.

It is undoubtedly true that one of the principal weaknesses of the medical program under General Hines lay in the failure to establish a medical corps within the Veterans’ Administration. As early as 1924, he proposed legislation for the establishment of such a corps upon the advice of his Medical Council. Approximately 26 bills of a similar nature were subsequently introduced. Some had his endorsement, others did not.

The entire course of medicine within the veterans’ hospital system could have been changed had his original bill passed. A highly qualified medical staff could have been recruited and retained.

The general vacillated because he felt the medical program should not be singled out for preferential treatment. “We should keep in mind,” he said, “that the medical setup of the Veterans’ Administration is only a small part of the total setup. We have a large insurance company and a large adjudicative system, with a very large supply system.”

The location of many of the veterans’ hospitals also compounded the situation. Starting with the White Committee’s recommendations, the determination of site was largely based on (1) centers of veteran population, and (2) transportation facilities. However, as early as 1923, Dr. White felt that the finest type of medical care was given in those institutions located in close proximity to medical centers.

In 1924, Dr. E. O. Crossman, then VA Medical Director, criticized the plan of locating these hospitals. He said that “for years to come the government and the ex-servicemen will suffer from the result of misplaced Veterans’ Bureau hospitals. Practically all tuberculosis hospitals have been placed in isolated, out-of-the-way places; incon-
venient to medical consultants; and far from the advantages of the cities.” In retrospect this philosophy of hospital location is understandable for at the time most of the specialists in the treatment of tuberculosis felt that the patient should be located away from the noise and dirt of the cities. In the early 1920’s, it is also felt that altitude was a factor in the treatment of this disease.

Likewise, specialists in the treatment of neuropsychiatric illnesses believed that a minimum of 400 acres was necessary for each mental hospital to provide farming and related activities. This was regarded as a major form of therapy. Obviously, such areas of land could not be obtained in or near metropolitan centers.

Most of the Veterans’ Bureau’s general medical and surgical hospitals were located, when possible, in or near metropolitan centers where consultants would be readily available. During the early 1920’s no thought was given to affiliating with medical schools.

The first real move in the direction of affiliating VA hospitals with medical schools was made when Dr. Roy Kracke, dean of the Medical College of Alabama, wrote to General Hines suggesting that a veterans’ hospital be built in Birmingham and affiliated with the medical college. General Hines vetoed the suggestion in his reply to Dr. Kracke on September 18, 1944. He wrote in part:

In view of the existence of the hospitals now located in the part of the country in which Birmingham is situated, I am of the opinion that the establishment of an additional facility at Birmingham will not be required. * * *

In any event, however, its establishment in connection with the School of Medicine of the University of Alabama, or in connection with the medical center to be established, will not be possible.

The finality of the above statement indicated the firm stand of General Hines on the medical center-hospital relationship of that time. This was despite the following:

1. The repeated recommendations of his advisory groups for the adoption of this plan.
2. The proposal of the University of Cincinnati College of Medicine as far back as 1922.
3. The comments of Dr. White, Chairman of the White Committee, contained in his report of February 1923.
4. The resolution of the American Legion at the Milwaukee national convention of 1941, recommending adequate training of specialists in the various fields of medicine.

Again, on November 28, 1944, a similar recommendation was received from Dr. Irvin Abell, chairman of the board of regents of the American College of Surgeons. He forwarded to General Hines a resolution adopted by the regents calling attention to the desirability of locating veterans’ hospitals near large, active scientific medical centers, so that the veterans of World War II would continue to receive the best scientific care. Among its advantages would be the proximity to (1) the consultation of specialists, and (2) availability to the regular staff of the VA of the scientific knowledge and postgraduate education in the nearby medical schools.

The Administrator answered upon December 10, 1944, with a rather noncommittal letter. He assured Dr. Abell that, in selecting sites in the future, consideration would continue to be given to locations where adequate consultant staff was available. He avoided any reference to affiliation with medical centers.
In November 1944, General Hines was visited by Dr. J. Roscoe Miller, dean of the Medical School of Northwestern University, and Dr. Paul B. Magnuson, one of Chicago's outstanding orthopedic surgeons who later became Chief Medical Director of VA's Department of Medicine and Surgery. Both advised the general that the quality of medical care could greatly improve by affiliation with the medical schools of the country and the initiation of residency training programs.

The Administrator listened politely, but he was not convinced. The idea of medical residents introducing "veteran-guinea pig" experiments was too strongly embedded in his mind.

There were other factors that worked against rendering the best of medical care in the VA at that time. There was little interest in the development of a broad research program. Very small sums of money were allocated for this purpose and the number of projects undertaken very limited.

Other circumstances over which VA had no control contributed to the unsatisfactory situation:

- Many doctors and nurses had left VA and entered service;
- The comparatively low salaries that could be paid those who were available;
- The delay in securing registers of eligibles from the civil service;
- The inability to secure priorities in construction materials in the early part of the war delayed the building of new hospitals; and
- The isolation and avoiding of VA doctors by organized medicine. This was due in most cases to the requirements of local State medical societies, as well as the American Medical Association. Most of these organizations required that the doctor be licensed to practice in the local community. Inasmuch as the physicians were full-time staff members in a Federal hospital, they could not qualify for local membership.

Finally, many of the complaints and criticisms of the Medical Service could be traced to its status in the VA organization. The Medical Director reported to the Administrator through a third party, the Assistant Administrator for Medical, Construction, Supply, and National Homes. Even though the Medical Director testified in congressional hearings that he had no difficulty in contacting the Administrator, the lack of a direct line of authority was at least a psychological deterrent both within and without the Veterans' Administration. For the record, Colonel Ijams, the Assistant Administrator in charge of medical, construction, supply, and national homes, was honest and straightforward in his disagreements with the Medical Director. He had the firm conviction that the Medical Service should confine its activities to the professional care of the veterans. He felt strongly that other phases of hospital administration were outside their domain.

During the 22 years' tenure of General Hines, the number of hospitals increased from 45 to 97. Likewise, the bed capacity grew from 15,448 to 81,133. The number of patients treated during this time approximated 2 million, and the amount expended for veterans' benefits of all kinds, including hospital care, totaled about $17 billion.
With very few exceptions, the 80,000 who were daily provided hospital treatment or domiciliary care by the agency, got the best care it was possible to supply under the circumstances.

While the general had disagreed with medical authorities on certain important aspects of the hospital program, such as location of hospitals, the training programs, and extensive research, he never tried to interfere in the professional aspects of patient care. He respected the professional opinions of the physicians. In turn, even those doctors who disagreed with him respected his straightforwardness and integrity.

He was beloved by the entire employee group of the Veterans' Administration. A huge reception honoring General and Mrs. Hines was held shortly before he left the Veterans' Administration to assume the ambassadorship to Panama.

Eight years later, the employees paid for and caused to be installed in the lobby of the Veterans' Administration building, a bronze plaque which reads:

FRANK T. HINES
BRIGADIER GENERAL, U.S. ARMY RETIRED

AS DIRECTOR OF THE VETERANS' BUREAU AND AS ADMINISTRATOR OF VETERANS' AFFAIRS, HE SERVED UNDER FIVE PRESIDENTS FOR 22 YEARS FROM 1923 TO 1945, HIS SERVICE TO VETERANS AND TO HIS COUNTRY WAS OUTSTANDING IN INTEGRITY, EFFICIENCY, AND KINDNESS.

1953

WORLD WAR II ENDS

On May 7, 1945, the Germans signed an unconditional surrender at Allied headquarters in Rheims, France. On September 2, 1945, the Japanese signed the “Instrument of Surrender” on the deck of the U.S. battleship Missouri, in Tokyo Bay.

Following the surrender, Gen. Douglas MacArthur addressed a broadcast to the American people which began: “Today the guns are silent. A great tragedy has ended. A great victory has been won. A new era is upon us * * *.”

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Omar Nelson Bradley was born in Clark, Mo., on Lincoln's birthday, February 12, 1893, the son of John Smith Bradley and Sarah Elizabeth (Hubbard) Bradley. His father died in 1908 and with his mother he moved to Moberly, Mo.

He was graduated from Moberly high school in 1910 and was appointed to the U.S. Military Academy, West Point, N.Y., from the Second District of Missouri, in 1911. He graduated with the famous class of
1916; the year book for the class has this to say about General Bradley:

"His most prominent characteristic is getting there, and if he keeps up the
clip he has started, some of us will be bragging to our grandchildren that:
'Sure, General Bradley was a classmate of mine.'" In keeping with this
prophesy, he was the first member of the 1915 class to reach the rank of
general.

Upon graduation from West Point on June 12, 1915, he was commis-
sioned a second lieutenant of Infantry and promoted to first lieutenant
July 1, 1916. During World War I he rose to the temporary rank of
major, serving with the 14th Infantry regiment. Subsequent to the war,
he reverted to the rank of captain in 1920, due to the general postwar
reduction in the Army.

He held various assignments throughout the United States and Hawaii
as instructor, attending advanced courses until February 1941, when he
was promoted from the rank of lieutenant colonel to brigadier general.

Upon this promotion, he then became commander of the infantry
school at Fort Benning where he instituted the infantry officer candidate
program. He so organized the school that it could handle 14,000 pro-
spective officers at one time. Eventually, this program commissioned more
than 45,000 combat leaders before the end of World War II.

Within 2 months after Pearl Harbor he was given his own division, the
82d Infantry, and on February 15 he was promoted to major general.
He then changed commands to the 28th Infantry Division at Camp
Livingston, La.

Early in 1943, General Eisenhower selected General Bradley as his
personal representative in the field in North Africa, and he was given
command of the II Corps. It was this group that smashed through the
units of the Afrika Korps in northern Tunisia and ended the war in that
country.

He was instrumental in planning the invasion of Sicily which was
accomplished July 10, 1943. Later that summer he was selected to
command the 1st U.S. Army in the Normandy invasion. He arrived in
England in October and was given duty as commanding general of the 1st
U.S. Army group in London, which later was to become the 12th Army
group. His headquarters were in London, and on June 6, 1944, the 1st
Army, with General Bradley commanding, landed in France to break the
Atlantic wall. The next month they smashed through the German lines
at St. Lo, and opened the way for the speedy liberation of France. He
then divided the American divisions into two armies, the First and the
Third, with General Hodges commanding the First and General Patton
the Third. General Bradley then assumed command of the 12th Army
group, and, after the American Armies had smashed through the German
winter attacks, broken down the Siegfried line and pushed on to the Rhine,
he was given his fourth star. Three weeks after VE Day President
Truman drafted General Bradley to become head of the Veterans' Ad-
ministration. He served in this position from August 15, 1945, to
December 1, 1947.

He then returned to the Army and became Chief of Staff on February 7,
1948. The next year he became the first Chairman of the Joint Chiefs
of Staff in the Department of Defense, and was reappointed for a second
2-year term.

In 1950, he was nominated for promotion to General of the Army,
making him the fourth five-star Army general officer, which rank he
still holds.
Since serving as Chairman of the Joint Chiefs of Staff, he has held many important assignments both in this country and in Europe, especially in the North Atlantic Treaty Organization involving 12 American and European countries united for mutual defense.

He holds many military decorations, both from the United States and from other countries. He has also been awarded a great many honorary degrees from educational institutions abroad, as well as his own country.

He resides in Washington, D.C., conducts an office in the Pentagon, and has numerous interests in commercial and educational fields, which cause him to lead a most active life.
Chapter X

The Postwar Period

The Doughboys' General Becomes the Veterans' General

Shortly after V-E Day, Gen. Omar N. Bradley was having lunch with Marshal Ivan Stepanovich Konev, the Russian commander of the Ukrainian army group which was stationed near his headquarters.

Returning to his billet, the general found he had received a call from General Eisenhower, who was at his headquarters at Rheims and had asked that the call be returned. During the telephone conversation General Eisenhower asked General Bradley to take a plane to Rheims and spend the night there. He arrived after dark and was met at the airport by Eisenhower's British aide, who escorted him to the general's billet.

Upon entering, General Eisenhower said, "Brad, you better go over there and pour yourself a good stiff drink before I read you this cablegram." This Bradley did. Eisenhower then informed him of the contents of a cable he had received from the President of the United States. President Truman wished to know if Bradley would serve as Administrator of Veterans' Affairs.

Bradley's reply was, "Of course, you don't refuse a request of the President," and thus he accepted.

The coveted title of "doughboys' general" was earned because of Bradley's skill in organizing and his capacity for understanding. He was selected by the President as "the man to get the job done", the one to clean up the Veterans' Administration's backlog and get its operation onto a current basis. The President knew that he could do it, that he was especially fitted to bear the responsibility of the readjustment and the care of veterans who knew that he had their interests at heart. Bradley therefore became the "veterans' general" with the same respect and affection as his wartime title.

Many cities were then planning victory celebrations. All requested the return of certain heroes of the European theater to the United States to participate in these activities. General Bradley was among those to return and was accompanied by his aide, Lt. Col. Chester B. Hansen. They landed in New York on Sunday, June 3, 1945, and immediately went to Philadelphia where they participated in a victory parade. The group then separated, each proceeding to a designated city for further celebrations. General Bradley went to St. Louis and had an opportunity to visit his hometown of Moberly, Mo., where he was honored as their most distinguished citizen.

Upon returning to Washington, and after visiting the President, he and Colonel Hansen called upon General Hines. It was decided that Colonel Hansen would be immediately detailed to the VA to become familiar with the organization and its operations. Between that time and until General Bradley's assumption of office, Colonel Hansen was instrumental in preparing for the change in Administrators in
such a manner that the transition was smooth and created little or no apprehension on the part of either the veterans or the VA employees.

Leaving Colonel Hansen as his "eyes and ears" in the VA, General Bradley returned to Europe to wind up the affairs under his command. He came back to the United States shortly after the Potsdam Conference, and, for the first time in 13 years, took a vacation.

Before leaving Europe, General Bradley had selected a certain group of men in whom he had the most implicit confidence, and who possessed professional and administrative abilities in varied fields, to come to the Veterans' Administration on detail. Quite a number, upon release from the service, stayed on with the VA in a civilian capacity. (Outstanding among these was Lt. Col. William J. Driver, who was to rise up to become Administrator of Veterans' Affairs nearly 20 years later.)

As Executive Assistant Administrator, General Bradley selected Col. Eldon L. Bailey, who had served with him in the Headquarters of the 12th Army group.

However, the majority of the top staff who had served under General Lines were retained. They were:

Assistant Administrators:
- Maj. O. W. Clark (Claims).
- Harold W. Breining (Insurance).
- Col. George E. Ijams (Construction and Supplies).
- Maurice Collins (Finance).
- George H. Sweet (Personnel).
- Harold V. Stirling (Vocational Training, Rehabilitation, and Education).

In addition, the following officials remained:
- R. L. Jarmigan, Chairman, Board of Veterans' Appeals.
- Edward E. Odom, Solicitor.
- E. McE. Lewis, Director of Public Relations.

WHAT KIND OF A MAN IS OMAR BRADLEY?

The outstanding trait of this high-ranking military commander is that he never loses his temper. His aids declare he never has been known to raise his voice in anger, or forget to be polite. An incident is related that, when a particularly difficult German prisoner was being interviewed, an aid nervously fingered his rifle and, accidentally, a bullet whizzed past the general's ear. "Can't you be a little more careful with that darn thing—please," General Bradley asked, calmly.

The general is a quiet man with kind eyes. He is firm and diplomatic. His voice is high and clear but he speaks so gently that he cannot be heard very far away. He is never nervous; he has no superstitions, and does not smoke. When walking, he takes such long swift strides that, on his arrival in Washington, a bystander was heard to remark: "Now I know how we got to Germany in such a rush."

He is an expert with a rifle and is a fine athlete. He was a second-string football man at West Point and a regular on the baseball team. He is a good golfer and likes bridge and poker. He keeps a "special poker fund" so that any losses will not affect the family budget. He is also an ardent hunter and fisherman.
The late Ernie Pyle, famous war correspondent, once wrote:

If I could pick any two men in the world for my father, except my own dad, I would pick Gen. Omar Bradley or Gen. Ike Eisenhower. If I had a son, I would like him to go to Bradley or Ike for advice.

In order to protect Bradley’s rank and grade of general, it was necessary to introduce legislation to authorize the President to appoint him as Administrator of Veterans’ Affairs without affecting his military status. Private Law 140, approved July 5, 1945, provided that so long as he held the office of Administrator of Veterans’ Affairs he would retain the rank and grade of general in the Army, and receive the pay and allowances (including personal money allowance) payable to an officer serving on active duty.

It was further provided that General Bradley should be subject to no supervision, control, restriction, or prohibition other than that which would apply if he were in no way connected with the War Department or the military establishment of the Army of the United States. While he received his salary from the War Department, it was on a reimbursable basis paid by the VA during the time he served as Administrator.

Such was the man who became the new Administrator of Veterans’ Affairs, a job which had been characterized by Franklin Delano Roosevelt as “the hardest task in the country next to the Presidency.” Bradley had commanded a victorious army of one and a quarter million in Europe, but he was now taking over the direction of an activity that would affect many times that number.

General Bradley assumed office on August 15, 1945, the day after President Truman had announced the termination of the war with Japan. The swearing-in ceremony took place in the VA building, the oath being administered by Associate Justice Harold M. Stephens, of the District of Columbia appeals court. General Hines, newly appointed Ambassador to Panama, and Congressman John E. Rankin, chairman of the Committee on Veterans’ Affairs, were present, as well as representatives of the VA, other Government departments, and service organizations.

PRESS CONFERENCE

After he was sworn in, General Bradley held a press conference and, among other things, he said:

I don’t think there’s any job in the country I’d sooner not have nor any job in the world I’d like to do better. For even though it is burdened with problems, it gives me the chance to do something for the men who did so much for us.

He added:

I don’t think most veterans are going to have to adjust themselves to civilian life. I rather think it’s going to be the other way around—

Meaning that the civilians would have to make the adjustments.

Most of the veterans are better prepared to take their places than when they went away—

He said—

Many have been trained in leadership and in special skills.

The general stressed that the return of the veterans to their rightful places in civilian life could be aided by the local communities—that their adjustment was not the problem of the Veterans’ Administration alone but rather of more than 130 million Americans.
General Bradley said he had read in the press statements that he planned to make changes in personnel of the agency. He remarked that people seemed to know more about his mind than he did and added that he expected to continue the policy he had followed in Europe—that if anyone proved he couldn't do a particular job, he would be replaced.

When asked about the criticism of veterans' hospitals and the congressional investigation which had been underway for several months, General Bradley indicated he would rather not comment on that situation at that time. He also preferred not to discuss the pending bill to set up a Bureau of Medicine and Surgery with sweeping authority within the Veterans' Administration. He wanted more time to find out "what it was all about."

General Bradley made it clear that the main object of the Veterans' Administration, as he saw it, was to furnish topflight medical care to the disabled; and to help returning veterans, whenever they needed
help—whether for education, training, to get back to gainful employment, buy homes, or businesses—to get back to normal life in their communities as soon as possible.

General Bradley paid tribute to General Hines as an official who had worked faithfully and energetically for 22 years to help the veterans.

After the ceremony and interview with the press, General Bradley and General Hines called at the White House and conferred with the President.

**STATEMENT TO VA EMPLOYEES**

General Bradley issued the following message to the employees of the Veterans' Administration as he took office:

Today, I have assumed the duties of Administrator. You and I have been engaged by our Government to administer laws providing certain benefits and opportunities for our veterans. The task is a big one. Large numbers of veterans from previous wars, together with those of this war, will be increased greatly by discharged servicemen in the months to come.

These veterans have served their country faithfully; in many cases with severe hardship and pain. They have fought that we might continue to live as free men. We must see that they receive every benefit our Government has granted them. I expect each of you to do your best every day just as our soldiers, sailors, and marines continued—almost beyond human endurance—to accomplish the missions assigned them.

In order to meet the increasing load, certain changes in organization and methods may be necessary. These changes will be made when and if thorough study indicates them desirable.

To help me in my duties, I have been given several Army and Navy assistants. Most of these officers have served overseas. All are intensely interested in the welfare of our veterans. Eventually, I expect to visit each of our veterans' installations. This will take some time, so I must depend upon these assistants to see to things for me. I ask that you give them your help. We are working together for the same objective—service for the veterans.

Frankly, this work is new to me. I will learn the job as quickly as possible. I am greatly concerned with the lot of our veterans. I have personal knowledge of what they have done. I will do everything I can to see they receive promptly every benefit, help, and opportunity to which they are entitled. I expect you to do the same. In carrying out our mission, I ask your energetic and loyal support.

**STATUS REPORT ON VETERANS AND THE VA**

An excerpt from a statement made at a press conference by General Bradley on February 1, 1946, gives a quick statistical overview of the veterans' situation in the United States (1) as of the preceding August, when he took over as Administrator; (2) as of the day of the press conference; and, looking into the future (3) an estimate of what the situation would be 15 months later, in May 1947:

Last August, when I took office, there were an estimated 6,688,000 veterans (in the United States), of whom only 2 million were World War II veterans potentially eligible for service from the Veterans' Administration. In the 6 months since then, this figure has increased to 13,490,000, an increase of 6,802,000, or more than double the number at the time I took office. It is estimated that this increase is greater than that expected in the next 15 months, during which time the total veteran population is expected to increase to 20 million.

As of June 30, 1965, the "total—all wars" figure for the number of living U.S. veterans was 21,834,000, according to the latest statistics available as this history goes to press (House Committee on Veterans' Affairs "Summary of Veterans' Legislation Reported," Nov. 29, 1965, p. 14).
The Veterans' Administration was operating 97 hospitals in 45 States and the District of Columbia, with a total bed capacity of 82,241. Other Government hospitals made available to the VA an additional 5,438 beds. This was supplemented by 14,078 beds for domiciliary care. Thus, there was available to these veterans a total of 101,767 beds, either in hospitals or in domiciliaries.

While there were approximately 71,000 veterans hospitalized in August 1945, it was realized that many more disabled would soon be coming back and provision must be made for them. In May 1946, the average daily patient load rose to 86,272. During General Bradley's regime, it was to increase to over 105,000.

Hospital construction was then in progress at 31 locations which would result in 13,594 additional beds. This was through construction of new hospitals or additions and alterations to existing ones. Funds had been made available for the construction of 25 more new hospitals and additions to 11 others. This would yield another 12,706 beds; but, at that date, work was not yet underway.

There were about 2,300 full-time doctors on duty in VA hospitals; 1,700 of these had been detailed to the VA from active military duty. There were also approximately 1,200 (ASTP Army and V-12 Navy) physicians assigned for the 2 years they had agreed to serve, inasmuch as the Government had paid for their medical education. There were about 4,500 VA nurses. They were assisted by approximately 700 senior cadet nurses, who were in a training program supervised by the U.S. Public Health Service. There were 207 full-time dentists on duty with the VA, of whom 152 were commissioned officers detailed from the Army and Navy.

The demobilization grew by leaps and bounds, despite planning for a more orderly procedure. Within a little over 7 months after General Bradley took office, the total number of veterans was to jump to 15,296,000, of whom 11,310,000 served in World War II.

The existing VA hospitals, as well as others furnishing beds for veteran use, were soon filled to capacity. There were waiting lists for admission at practically all hospitals. On March 31, 1946, there were 935 applicants with service-connected disabilities seeking admission to Veterans' Administration hospitals. The majority of these were already hospitalized in other institutions, either Federal or civilian, inasmuch as the law provided that service-connected cases could be so hospitalized in the event a bed was not available in a VA hospital. There were 26,057 non-service-connected cases on the list in need of hospitalization.

**CONSTRUCTION SPEEDUP ORDERED**

General Bradley's immediate task therefore was to expedite the construction program which had been authorized. From the end of World War I to June 30, 1945, a total of $364,347,560 had been made available to the VA for construction purposes. Presidential approval had been secured for the construction of 72 new hospitals. Together with improvements and enlargements to existing hospitals, and for this purpose an additional $403 million had been appropriated. This was a greater sum than that spent for construction during the entire 26 preceding years; it was one of the most comprehensive hospital construction programs ever undertaken.

General Bradley sought the help of the Army Corps of Engineers in the designing of the new construction, described by General Bradley
as "the most gigantic hospital building program in the history of the world." However, sick veterans could not be cared for by blueprints, and the Navy and Army came to the rescue by increasing the number of beds available in their hospitals until the new or enlarged VA hospitals became available.

General Bradley, in addition to securing the advice of officers detailed by the War Department, men he knew and in whom he had confidence, also sought from prominent citizens ideas for revamping the veterans' program.

BARUCH'S PROPOSALS

His friend, Mr. Bernard M. Baruch, statesman and adviser to Presidents, had made a study of the problems of the returning veteran. General Bradley was aware of this and asked him to give the benefit of his findings.

The day after Bradley assumed office as Administrator, Mr. Baruch, having spent a good deal of time on the question of veterans, offered his services and those of his staff to the Government. He outlined a full-scale veterans' program, emphasizing medical care. While most of his recommendations were similar to others which had been previously advanced, they did indicate Mr. Baruch's keen interest in medicine, especially in physical rehabilitation. The son of a doctor, Baruch regretted that he had not been encouraged to become one himself.

He had made very substantial contributions to Columbia University and the Medical College of Virginia for research in physical therapy. He also was instrumental in training of doctors in physical medicine, as well as therapists. Together with Dr. Howard Rusk, they established the Institute of Rehabilitation and Physical Medicine at New York University-Bellevue Medical Center. This institution is located adjacent to the Veterans' Administration hospital, at 23d Street and First Avenue, New York City.

Among Mr. Baruch's recommendations were the following pertaining to medical care:

*Release doctors, hospitals.*—Make certain that doctors, nurses, and hospitals are released from military service in proportion to the discharges of wounded and reductions in troop strengths.

*Artificial limbs.*—Step up and coordinate the artificial limb program, unifying the work of all agencies, so that all amputees are given the best possible limbs immediately, and replacements provided for those who have received inferior limbs. (This program had lagged due to the fact that no one Administrator had taken full responsibility for organizing such a program. General Bradley heeded this advice early in his administration.)

*Create a new medical service.*—Establish a clean-cut division, in the veterans' agency, between medical and nonmedical matters, creating a new veterans' medical service under the head of an outstanding medical man.

*Impartial medical study.*—Name a small, fast-working, independent committee to make an impartial study of every aspect of veterans' medical care and submit a public report of recommendations for completely transforming the new Veterans' Medical Service to one that provides a challenge to all that is progressive in medical practice.

*Merit, not seniority.*—Substantial increases in salaries of doctors, nurses, and technicians in the new Medical Service;
promotion on professional ability and skill against waiting in the line of seniority; freeing doctors of needless paperwork through more efficient hospital administration; ample opportunities for doctors to grow professionally through postgraduate and refresher studies and through effective ties with centers of medical education and skill; ample research facilities and encouragement of research by veterans' doctors.

Psychiatric program.—A training program especially in the psychiatric field and establishment of mental hygiene clinics throughout the Nation.

Residencies.—Establishment of a system of internships and residencies in veterans' hospitals.

Hospital location.—Location of future veterans' hospitals so that closer contact can be maintained with established medical centers.

General Bradley issued a statement in reply to Mr. Baruch's proposals on September 5, 1945, which was included in the Congressional Record of September 11 at the request of Hon. Edith Nourse Rogers of Massachusetts and which reads in part:

I have received Mr. Baruch's letter and have had an opportunity to read it and consult with him. I agree with his statement that the solution of veterans' problems cannot proceed alone. These problems are not separate and distinct from other problems facing the Nation. They cannot be solved by any one agency or even by the Government alone.

The problems of veterans are part of the postwar readjustment which involves millions of displaced workers as well as veterans. Any solution must consider all elements and rests squarely on the shoulders of every one of 135 million people who make up this Nation.

The men who have borne the burden of the war are entitled to advantages and to employment privileges that will assure them equal opportunity with those who stayed at home and bettered themselves in civilian jobs. This is only fair.

Since the veterans are again civilians, they are primarily citizens, and I believe they desire to take up their obligations as citizens to build a strong nation.

Mr. Baruch has also made specific recommendations for operation and reorganization within the Veterans' Administration. These are the result of some 18 months of study on his part.

** ** Many of the conclusions I have reached closely parallel the recommendations made by Mr. Baruch. Committees similar to the ones he suggested are already at work investigating and reporting on operations within the administration. These committees are made up of men with whom I have worked for a long time and whose judgments I have learned to respect. They are men who are specialists and experts in their various fields. ** **

PERIOD OF ADJUSTMENT

General Bradley and the staff he brought with him, most of whom were younger men, injected new life into the organization. Most of those who had served with General Hines had been in the VA for years and had become accustomed to doing things in a certain way to the extent they had become somewhat stagnated. The infusion of a fresh viewpoint from the younger men acted as a tonic to most of the older staff. However, this was not true in certain cases, because the resignations of several key officials followed within a few months after General Bradley's appointment.

At first, there was resentment on the part of some of the new incumbents who felt that those who had served in the Hines regime were outmoded and a hindrance to progress. Conversely, there was initially a feeling of antagonism among certain of those of the Hines
era toward the Bradley contingent—a belief that they were arrogant and inexperienced.

This situation lasted but a very short time and soon all were united into one working organization which, operating under extreme difficulties, faced one of the most tremendous tasks in governmental history.

During the Administrator’s first several months in office, turmoil prevailed. The general realized he had Washington’s “hot potato” in his hands. Typically, he remained calm and gave intensive study to the biggest problem of all: that of the administration and speeding up of services for those men and women who had every right to expect nothing less than the best.

STRENGTHENING THE BRIDGE

General Bradley visualized the program of veterans’ benefits as a bridge built to carry the veteran from service into civilian life, and, at the end of the war, the timbers of the VA were growing wobbly when the heavy traffic started to cross. Within 8 months, that bridge had been reconstructed with a solid foundation that enabled the VA to carry the load. During that time, Bradley replaced the ancient timber with modern steel construction and then the bridge was open for business.

Prior to August 1945, the VA was a tightly knit organization with authority and activities centralized in Washington. General Hines, with his Assistant Administrators, and Executive Assistant Administrator, the Chairman of the Board of Veterans’ Appeals, and the Solicitor, were overworked almost to the breaking point. It was evident that the grip of this tight, compact organization must be broken if the service to veterans authorized by Congress was to be expedited.

VA IS COMPLETELY REORGANIZED

On September 15, 1945, Bradley ordered a sweeping reorganization of the entire agency. To bring benefits right down to the grassroots level, 13 branch offices were created, each to be nearly a self-sufficient, small-scale VA within itself, supervising, under a Deputy Administrator, all activities within its area. These were located in the following cities: Boston, New York, Philadelphia, Richmond, Atlanta, Columbus, Chicago, Minneapolis, St. Louis, Dallas, Denver, Seattle, and San Francisco. Each branch office was fully staffed with representatives of each of the VA programs. The managers of the hospitals in each area reported through their branch medical director to the Deputy Administrator. The latter had been given supervisory control over virtually all operations of regional offices and hospitals in his district.

In the Central Office, eight Assistant Administrators were named, splitting up on a functional basis the duties formerly performed by four. Under the new plan, the VA now had Assistant Administrators for each of the following: claims, vocational rehabilitation and education (GI bill and Public Law 16) training; insurance (for both World War I and World War II veterans); finance (expanded to home and business loans and GI readjustment allowances); legislation; personnel; contact and administrative services; and construction, supply, and real estate. In addition, the offices of the Solicitor and the Board
of Veterans' Appeals were both placed on a par with the Assistant Administrators. In addition, the offices of coordination and planning, public relations, insular and foreign relations, and special services were created, each headed by a director.

Of prime importance was VA's medical service, which was reorganized as the Office of the Surgeon General, to be responsible only to the Administrator. With the passage of Public Law 293 on January 3, 1946, medical operations were once again reorganized.

And that basically was the reorganization of the Veterans' Administration. Its purpose was a large-scale attempt to functionalize and localize benefits for veterans. The VA again warned the public not to expect any sudden miracles. Time was needed for the newly installed gears to mesh and start turning. But a beginning had been made.

One of the major problems had been the shortage of personnel. The Appropriations Committees of Congress, however, were most sympathetic with General Bradley's efforts to cut redtape and streamline the functions. His financial needs were met. Consequently, from August 31, 1945, to February 28, 1946, the personnel in Central Office rose from 10,966 to 22,008. During the same period, there was an increase in the field from 54,689 employees to 96,047. In other words, in 6 months 46,400 additional employees had been placed on duty.

During the early postwar years, Congress furnished two special benefits to two groups of seriously disabled veterans.

World War II veterans, who had lost, or had lost the use of, one or both legs at or above the ankle could obtain automobiles equipped with driving-made-easy hand gadgets. The VA footed the bill up to $1,600 of the cost. This benefit was authorized by Public Law 663, August 8, 1946.

And veterans of all wars and the peacetime service so seriously handicapped that they could not get about without special aids, such as wheelchairs, were given grants for specially designed homes suitable for wheelchair living. VA provided up to 50 percent of the price of these houses, with a $10,000 maximum. This benefit came into being through the provisions of Public Law 702, June 19, 1945, and was liberalized by a later amendment, Public Law 286, September 7, 1949.

CRITICISM BY AMERICAN LEGION

While the general had the good will and cooperation of Congress and of practically all of the citizens of the United States, certain elements of the American Legion were very critical of him. To begin with, a small segment of the Legion was opposed to his appointment because of his military status. They felt that a businessman should be appointed to run the agency. The national commander at that time, Mr. John H. Stelle, was most vociferous in his criticism.

Another serious situation involved the applications for compensation. Shortly after V-E Day and V-J Day, these applications were being received at the rate of about 400,000 per month, the veterans having been advised by various sources to put in a claim anyway, whether they believed they had any justification for it or not. Many
thousands of such claims were received, and they took more administrative time to disallow than a claim that was granted.

The Administrator had set up a number of additional rating boards, but the most they could handle was from 230,000 to 240,000 per month. This brought on a backlog. However, General Bradley had a graph prepared showing the rate of action per month on these claims as compared with the rate of demobilization. This indicated that the claims situation would be current by June 1946. The service organizations, especially the American Legion, clamored for more boards.

Within the first 6 months after General Bradley assumed office, complaints of his handling of veterans' affairs mounted. This was spearheaded primarily by the national commander of the American Legion, and by a small percentage of high officials of that organization.

The backlog of correspondence was attacked. The number of men awaiting hospitalization drew fire. It was charged that the deadwood of the Hines regime had not been fired and that not enough young veterans of World War II had been employed.

The National Executive Committee of the American Legion called a meeting in Indianapolis on February 21, 1946, to consider these charges. General Bradley had twice been asked to attend this conference for a respectful hearing to tell his side of the story. The Administrator declined the invitation:

Frankly, I was prepared to go and discuss veterans' matters, but when this telegram came offering a respectful hearing I didn't think it was up to me to be tried by anybody but the President of the United States or Congress.

There had been some alleged disagreement between the national commander and the Administrator regarding the site for a proposed hospital at Decatur, Ill. Although Commander Stelle denied it, he was angry over the allegation.

General Bradley had been invited to serve on the Legion Advisory Committee for the Education of War Orphans. The general said it was his policy not to serve on veterans' organization committees. Again the national commander was irked.

While the Executive Committee of the American Legion backed Mr. Stelle in his criticisms of the Veterans' Administration, they deplored that personalities have been injected into this and have clouded the true issue. The committee maintained that the Legion stood ready to cooperate with General Bradley and that the American Legion has not and does not demand the resignation or removal of General Bradley as Administrator.

Another development which drew the ire of Commander Stelle concerned vocational training under the GI bill. On the Administrator's recommendation, the Congress had passed a public law which limited the amount of subsistence allowance which could be paid to a veteran undergoing on-the-job training, where he received remuneration from the trainer, in addition to the Government stipend. This was Public Law 679, 79th Congress, approved August 8, 1946.

Early in that year, the VA detected unfair practices within the law. It was possible for a man training on the job to receive his full subsistence allowance and a salary from his employer that in some cases totaled $500 to $600 a month.

However, a veteran enrolled in a course of educational training in a school, college, or university, and gainfully employed fulltime, was
denied subsistence allowance. It was obvious that this was not equitable to both classes of trainees. Those undergoing training because of a service-connected vocational handicap could be gainfully employed and draw subsistence.

The 28th Convention of the American Legion was held in San Francisco, Calif., September 30 to October 4, 1946. On the opening day, Monday, September 30, the national commander vigorously protested Public law 679, 79th Congress. Among his comments were: “In making his recommendation to Congress, the Administrator broke faith, not only with the returning veterans but with labor and management, who accepted the original GI bill in good faith and spend their time and money setting up training facilities and machinery to carry out the provisions of the bill.”

A FORTHRIGHT SPEECH BY GENERAL BRADLEY

The VA Administrator had accepted an invitation to appear before the convention on Wednesday, October 2, 1946, 48 hours after Mr. Stelle’s remarks. He delivered what was probably one of the most forthright speeches of his career, when he said:

Forty-eight hours ago, while I was en route to your convention as guest of the American Legion, my host—your national commander—accused me of breaking faith with the American veteran.

At the same time, my host—your national commander—said, and I quote: “I do not hold the general entirely responsible. The Veterans’ Administration is first a Government agency and secondly a veterans’ agency.”

My host—your national commander—was prompted in his attack by a law enacted by Congress. This law prevents a privileged minority of veterans from profiting unfairly by the GI bill.

The American Constitution has guaranteed democratic government for all citizens of the United States. There is no agency of our American Government that dares place its special interests before the interests of this Nation. The Veterans’ Administration is first an agency of Government. It is, therefore, an ally of the veteran.

While I am Administrator of Veterans’ Affairs, the Veterans’ Administration will do nothing to surrender the welfare of this Nation to the special interests of any minority.

The American veteran is first a citizen of these United States. He is thereafter a veteran.

He will find that the opportunities to work, earn, and prosper as a self-reliant American citizen far outweigh the special benefits granted him as a veteran.

I refuse to believe that the American veteran will do anything to endanger the country for which he fought.

As Administrator of Veterans’ Affairs, I owe a solemn duty to 17 million veterans who fought this country’s wars. And yet, I am positive that the huge majority of these veterans will support me in my conviction that I owe an even more compelling duty to all Americans and to the Nation in which they live.

I am charged by my host—your national commander—with breaking faith with the veteran because I have sided with Congress in an effort to defend the rights of all veterans against the encroachments of a privileged few.

My host—your national commander—has elected to be the spokesman for this minority group of veterans whose incomes exceed the level beyond which Congress will no longer supplement their wages in training.

He has chosen to jeopardize the rights of more than 13 million other veterans of World War II to benefits of the GI bill.

If we dare countenance such abuse of any portion of this bill, we shall have to reckon with the danger of public distrust and ultimate rejection of all its essential provisions.

The abuse of their privileges by a small minority of unthinking veterans can poison the American people against all veterans.
If we ignore this danger, we shall have to reckon with the loss of confidence in these young men who won the war.
We shall break faith with the veteran only if we cause the country to lose faith in him.
I shall not surrender my responsibility to these men. Instead, I shall defend at all costs the integrity of every honest American veteran in his use of the GI bill.
Experience has demonstrated to us that a ceiling is essential to the honest conduct of on-the-job training. Congress concurred in this conviction when it passed the ceiling law.
Within the Veterans' Administration we are conducting a continuing study of the fairness of these ceiling levels. If it is determined that these levels have been placed too high—or that the cost of living renders them too low—we shall have no hesitancy in going to Congress again with recommendations for change.
My host—your national commander—has inferred that Congress is off on an economy spree that will pauperize the American veteran.
He is manifestly unfair to a Congress which this year voted more for the veteran than ever before in the history of our country. His accusation, I believe, is an affront to the millions of American citizens who this year will gladly devote a substantial share of their earnings for the veterans' benefits they provided.
Your national commander did not mention that Congress has authorized an $800 million hospital construction program for the care of your sick and wounded comrades.
He did not tell you that Congress has provided a flat 20-percent increase in disability and pension payments to more than 3 million veterans.
He neglected to say that Congress repealed restrictions on payments to disabled veterans in hospitals.
He ignored the free automobiles provided by Congress for amputees.
He did not indicate that Congress has liberalized veterans' insurance and had put it on a peacetime basis.
He declined to tell you that Congress doubled the Government guarantee on veterans' home loans.
He failed to reveal that Congress had repealed the veterans' 25-year age limit for education and training.
I ask you, Do these new laws smack of the pruning knife? Do they sound like a doublecross?
This is not the first time I have been forced to differ publicly with your national commander. This is not the first time he has questioned our sincerity and impugned our motives.
Last February my distinguished host—your national commander—asserted in a letter to Congress there had been a tragic breakdown in the administration of veterans' affairs.
He cited figures in his effort to show our work a failure. His only mistake was in being too kind. The situation he depicted was, if anything, far better than the one we revealed.
At that time your national commander also predicted that thousands of disabled veterans would be kicked out of our hospitals.
He ignored the anguish and anxiety caused thousands of bedridden veterans and their families by this false assertion.
Seven months have now passed since those claims and predictions made headlines.
Did your national commander refer to them in his address before you Monday?
Did he tell you that as of today there are 7,000 more non-service-connected cases of World War II veterans in our hospitals than when he predicted we would kick them out?
More dangerous than the German Army is the demagoguery that deceives the veteran today by promising him something for nothing.
The American veteran is not for sale. His loyalty and duty to the Nation cannot be purchased at the price of a dole or a bonus in the guise of job training.
There are among the ranks of the high-salaried professional veterans those who forget that the veteran has paid, and is paying, for all that he gets.
The American veteran is a citizen as well as a veteran. As a citizen he pays taxes.
Neither you, nor I, nor Congress, nor the American people, can give the veteran anything but opportunity—opportunity for job security that will enable him to live as a self-respecting, self-reliant, self-supporting citizen in the free and independent America.

I regret that my host—your national commander—forced me to reply publicly to him today.

Many of you will recall that last year I asked the help of your American Legion in the difficult job we knew lay ahead.

Not once during the entire year has your national commander come to me with a sincere offer to help.

Instead, he has deliberately obstructed our effort. He has impaired our progress by misrepresenting our objectives.

What we have been able to accomplish during this year in the Veterans' Administration has been achieved not because of, but in spite of, your national commander.

I say this with no malice toward those thousands of posts of the American Legion throughout the country where you have joined willingly and helpfully in the work we are doing.

To the tens of thousands of you who have given your time and your interest to the American veteran—we are as grateful to you as I am certain the veteran is.

The general then left the platform and the convention hall.

After his speech, Commander Stelle again addressed the convention, taking issue with a number of statements that General Bradley had made, and defending his own position. Shortly thereafter, the atmosphere was cleared by the election of Paul II. Griffith as the new national commander. General Bradley and Commander Griffith issued the following joint statement less than 3 weeks later.

Our meeting this morning is an example of the cooperation we are agreed shall exist between the American Legion and the Veterans' Administration during the coming year. With our principal aids and assistants, we have discussed frankly our responsibilities and our objectives. We clearly understand that the veteran can be helped toward a life of useful citizenship only when the Government, organized veterans, and the great body of American people pull together. This we are determined to do.

The American Legion will cooperate wholeheartedly with the Veterans' Administration in such a way that the Legion may better serve all veterans. The Veterans' Administration will continue to welcome the aid of the American Legion and of all citizens of these United States in its vital program of medical, social, and economic rehabilitation.

Only by working together can the American people find for the veteran those fair opportunities that he must have to work, earn, live happily, and prosper. We hope that our relationship in the coming year may help establish that pattern and point the way toward better cooperation among us all.

Paul II. Griffith,  
National Commander, the American Legion.

Omar N. Bradley,  
General, U.S. Army, Administrator of Veterans' Affairs.

The San Francisco incident, however, created much comment throughout the country and a goodly percentage of the editorials in the Nation's press applauded General Bradley's "rare moral courage," "character," "integrity," "wisdom," and "devotion to the public welfare." Likewise, there were many letters received from prominent people throughout the Nation, most of which expressed favorable reaction to the Administrator's speech. This was equally true of the service organizations.

THE PENDULUM SWINGS

However, criticism continued to mount, mostly from those who did not realize the difficulties of handling such a huge organization which, at that time, was the largest independent agency in the Government. The war had been over for approximately a year and a half. The magazines no longer carried feature articles about the returning veteran. The service flags had been taken out of the
windows. The “welcome home” signs had been disposed of. No longer were there parades and banquets for the war heroes.

But the administrative load placed upon the Veterans’ Administration grew steadily. The statutory benefits such as compensation, pension, readjustment allowance, education and training, GI for housing and small business had to be dispensed. Congress was required to provide sufficient funds for these. Legally, the only reductions which could be made by an economy-minded Appropriations Committee were the medical and administrative fields. The “honeymoon with Congress” was over.

General Bradley was criticized by certain members of the Appropriations Committee for not utilizing more beds in the hospitals being closed by the Army and Navy. These were isolated hospitals that were difficult to staff because of their distance from core cities. Their location, far from available consultant service, precluded their use for medical care to veterans, particularly the type now demanded by the American public.

The service organizations were protesting expanding waiting lists though most of them had no service-connected disabilities. General Bradley thought back to that warning given him by Congressman Rankin shortly after he assumed the office of Administrator. The Congressman told him, “General, remember you have only been through a war up to this time. It may look like a sewing circle by the time you get through with this job.”

The general was not hypersensitive to criticism but he did resent unwarranted attacks on the administration of his organization. These attacks did not slow down his aggressive efforts to wipe out the VA’s backlog. Some Members of Congress thought he spent too much money; others suggested he had not spent enough.

However, the general was successful in charting a course between the conservatives and the liberals. Here was a man who had reached the pinnacle of his career, an outstanding military commander of the 20th century, who stood up to relentless criticism of the manner in which he was performing a job he did not want.

Regardless of his personal feelings, he never did let down any veteran or, for that matter, VA employee, either.

MORE MONEY NEEDED

Early in 1947, it was apparent that additional money would have to be provided for the fiscal year ending June 30, 1947. When the budget for that fiscal year was submitted, early in 1946, it was not anticipated that the demobilization would be as rapid as it turned out. Planners had underestimated the numbers who would be entitled to compensation, pension, training, hospitalization, and all other benefits under the GI bill.

To add to the fiscal squeeze, compensation rates, some pension rates, and salaries, especially in the Department of Medicine and Surgery, had been increased without new appropriated funds.

The public demanded the finest medical care for veterans. This ate up huge sums. New drugs, particularly the so-called wonder drugs, were coming into existence. They were expensive. Hometown medical care for service-connected veterans had been introduced, more money. The administration of all these programs called for more employees, likewise a bigger budget.
Facing up to reality, General Bradley placed his mounting problem before the House Appropriations Committee. He desperately needed additional funds to keep the VA going.

The general, in a move to put his house in order, triggered a number of administrative controls designed to cut all fat out of his budget.

UNPRECEDENTED CRITICISM DEVELOPED

He sent a telegram on February 19, 1947, to all 13 VA branches throughout the country to freeze personnel at existing levels, suspend promotions, eliminate all but critical travel, and curtail, as far as possible, the use of fee basis medical examinations and treatment. This represented a severe budgetary clampdown.

An avalanche of criticism fell on the general. Consternation engulfed the Department of Medicine and Surgery. The stop order convinced many doctors they should return to private practice. They were convinced that VA would revert to the so-called mediocre type of medical care it used to have. As an example of this concern, General Bradley read a letter to the Appropriations Committee he received from Dr. Karl A. Menninger, then manager of the Topeka, Kans., VA hospital. Dr. Menninger expressed his feelings with:

We all realized that this is not your idea but that your hand is being forced and that certain Members of Congress think that this is just a political item.

They should know that there are many who are not politicians and not disposed to submit to political maneuvers. I came into this thing because I saw the possibility of developing a great thing for the veterans and for the Nation, under your leadership and that of General Hawley. * * *

But I, and many others like me, will drop it like a hotcake if penny wise, pound foolish politics are forced upon me.

I have read this letter to the administrative staff of my hospital and received their unanimous endorsement as to its accuracy and faithful representation of the local situation. * * *

The chairman of the committee was irked with this testimony and so expressed himself. He said:

General, I am almost of the opinion after listening to this statement of yours and to this much of the letter, that the attitude of the VA is that no intelligent suggestion should be made to it on any subject. That the committees of the Congress should in no way ask any questions about what you are doing or what the basis for the appropriation is, or to try in any way to bring about the efficiency of its administration. I am almost of that opinion from that statement that the Administration resents the idea of having to answer any questions or make any statements to the congressional committee.

The general replied:

I assure you that is not our attitude. We have nothing to hide; we welcome suggestions from anyone. I am not trying to build this up. I did not ask for this job. I only took it because I was asked to do so and I am trying to do the best I can until I can be replaced, which I hope will be as soon as possible, because it is a thankless job no matter how done, and I am just trying to make the best of it and to do the best I can and carry out what I think Congress intended.

In time, the Appropriations Committee voted the funds General Bradley felt were needed to carry on the medical program for the balance of that fiscal year. However, it was given in two installments. The first was an urgency deficiency, to last until April 1947 pending further study. Then, the entire balance was allowed. Certain economies were made in other programs but not to the extent that they would affect the medical care and treatment of the disabled veteran.
The general's statement before the committee that he would try to do the best until he could be replaced and "hoped would be as soon as possible," gave rise to a rumor that he was about to leave the Veterans' Administration.

A LETTER TO THE STAFF

Prior to his appearance before the Appropriations Committee for the 1948 budget, General Bradley sent a letter, on May 2, 1947, to all Assistant Administrators and Deputy Administrators. It stated:

Next week I shall go before Congress to show why we shall need $7 billion for the VA in 1948.

However justified our requirements may be, those vast expenditures offer a challenge to reductions in Government spending.

Even the accepted necessity for our veterans' program cannot save the VA from the budget director in this effort to reduce the budgets.

The VA has sought reductions wherever those reductions might be made without imperiling our operations. But if further reductions in the name of economy threaten to cripple our program and dull its objectives, I feel it my duty to point out the danger. * * *

Where reductions in expenditures for hospital treatment might threaten standards of medical care, I shall oppose such reductions and defend the budget we shall need.

Our role, unfortunately, is an awkward one. At a time when other agencies can trim their budgets to peacetime needs, we are compelled to increase ours to pay for the effects of war. As far as expenditures for veterans are concerned, the war has only begun. We cannot hold out a promise of substantial reductions and at the same time provide the services and benefits voted by Congress. It is not possible to legislate benefits on one hand and refuse to pay their cost on the other. It would be folly for the American people to anticipate anything other than a period of unprecedented high expenditures for veterans' benefits for half a decade or more.

I have no doubt that Congress and the American people will pay willingly for the benefits voted veterans of this and previous wars. But they will not tolerate extravagance and waste. Certainly they will not tolerate surplus or incompetent employees.

It is true that * * * expenditures could be reduced by lowering our standards of medical care. However, I cannot countenance any reduction that might imperil our medical program and endanger the results we have obtained. If the American people risk this program's decay in their effort to save money, they shall reckon its cost the rest of their lives in the loss of health and human resource. I shall not be party to any retrenching that might threaten to drag this agency into the backwaters of American medicine.

From the outset * * * I did not hold you to pennywise administration of the law, but asked you to do the job as promptly, effectively, and as inexpensively as you could. The speed with which we tackled the task resulted in some waste, some inefficiency, and some extravagance. This is unavoidable in an emergency operation. Even waste was preferable, however, to the loss that might have resulted had we concentrated on costs instead of results. The results indicate that in 20 months a target in this effort to save money, they shall reckon its cost the rest of their lives in the loss of health and human resource. I shall not be party to any retrenching that might threaten to drag this agency into the backwaters of American medicine.

Medicine in the VA has advanced until today it ranks as the outstanding medical program in the world. Veterans entering our hospitals are assured of treatment at the hands of physicians who are among the most qualified in the Nation. This goal has been achieved primarily because the doctors of this country responded wholeheartedly to our call for help and brought into our hospitals the vast resources of their skills, training and knowledge. We met this crisis not because we depended upon ourselves, but we said, "This is not a problem for the Veterans' Administration. It is a problem for American medicine. More than that, it is a problem for the American people." This achievement, made possible through the fullest use of outside resources, is our best example of the new thinking and the new techniques that guide all operations of the VA.

In 20 months we have discharged more than 685,000 patients from our rapidly growing hospital system. With improved medical care we have more than doubled the rate of turnover of patients. We have added more than 23,000 hospital beds in VA hospitals alone. We have provided almost 8 million outpatient examinations. We have given almost 6 million outpatient treatments.
We have established 13 branch offices, 14 new regional offices—have moved 28 regional offices from remote locations to downtown centers of metropolitan areas—established 721 contact offices in the smaller towns—305 advisement and guidance centers—opened 29 additional hospitals including surplus at Army and Navy institutions—152 outpatient clinics—31 clinics for mental hygiene.

He cited the amounts paid out for pension and compensation to veterans and their dependents. The GI and direct loan program, readjustment allowances, and education and training. He told how the VA had been able to meet, with only rare exceptions, the demands of more than 14 million veterans of World War II during the critical period of their readjustment. He admitted there was some satisfaction in the rapid return of more than 11 million veterans to jobs and the enrollment of 3,200,000 veterans in education and training.

He pointed out the emergency expansion period was at its peak and that prompt processing of workloads was imperative. He firmly believed that the GI bill would terminate and sizable reductions in both employees and costs could be accomplished.

He expressed concern that some employees failed to exercise full authority in meeting local problems. He conceded that VA's Central Office sometimes issued confused, complicated directions that were couched in difficult language. On the other hand, he directed that correspondence with the public be frank, courteous, and easily understood.

He criticized a tendency on the part of some employees to look upon their jobs with almost divine right. To quote him:

The VA is not a proprietary bureaucracy. It belongs to the people, not to the employees. We are simply servants of the public ordained to represent their wishes through administration of the laws of Congress.

The rumor that he was to leave the VA persisted. Perhaps it was fanned by his recent statement before the Appropriations Committee.

He closed his letter to the staff with:

Many of you have probably been reading in the newspapers that I am tired and discouraged, and want to quit. I am no more tired than many of you. Certainly I am not discouraged, I mean to do my best and I shall not quit of my own accord.

THE MILITARY RECALLS GENERAL BRADLEY

Shortly after this series of events, the Army ordered him back to duty. He was sent to Europe for an inspection trip of the Army's installations.

Upon his return, he left his post as Administrator on December 1, 1947. General Eisenhower, then Army Chief of Staff, had been appointed president of Columbia University. General Bradley was slated to succeed him. He spent the next 2 months familiarizing himself with his new duties and the current problems of the Army. He then assumed the position of Chief of Staff, U.S. Army.

Later he was honored as the first Chairman of the Joint Chiefs of Staff and served in this capacity for 3 years. During this time, he was promoted to general of the Army. As such he became the fourth five-star general in U.S. military history.

An officer of this rank never retires. This is literally true in General Bradley's case. He has many interests in industrial, financial, and general welfare circles. He maintains a sincere interest in the welfare of the veteran and, as well, the serviceman. Today, and forever, he will be the doughboys' general and the veterans' general.
President Truman, at a news conference November 21, 1947, announced that General Bradley would leave the Veterans' Administration and return to the War Department. Simultaneously, he announced the appointment of Carl R. Gray, Jr., of St. Paul, Minn., vice president of the Northwestern Railroad Co., as Administrator of Veterans' Affairs, effective January 1948.

Major O. W. Clark, then Deputy Administrator, served as acting head of the agency for the interim period.

Gen. Paul R. Hawley, Chief Medical Director, Veterans Administration, September 1945-December 1947.
Paul Ramsey Hawley

Paul Ramsey Hawley was born in West College Corner, Ind. January 31, 1891, the son of William Harry and Sabina Cora (Ramsey) Hawley. Both his father and grandfather were doctors in his hometown.

He received his B.A. degree from Indiana University in 1912 and then continued on at the College of Medicine at the University of Cincinnati in 1914. He returned to his home to practice with his father as a family doctor. Having been attracted to military medicine, he accepted a commission as a first lieutenant in the Army Medical Reserve 4 months later. In October 1916, he was on active duty as a student in the Army Medical School, Ft. Thomas, Ky.

Six days before the United States declared war against Germany, Hawley was appointed a first lieutenant in the Regular Army Medical Corps. He was rapidly promoted to major, and sailed for France with the 334th Infantry, returning to the United States in June 1919.

He then was assigned to various posts of duty in the United States, the Philippines, and Nicaragua. During this time he enrolled in a course in preventive medicine at Johns Hopkins University and was awarded a doctor’s degree in public health. In 1931, he was appointed Executive Officer to the Army Medical Center, Washington, D.C., and later completed a 2-year course in the Command and General Staff School at Ft. Leavenworth, Kans. Following this, he was promoted to lieutenant colonel and assigned to the Medical Field Service Hospital, Carlisle Barracks.

A few months before the United States entered World War II, he was ordered to the European theater of operations, and, after increasingly responsible assignments, he was made Chief Surgeon of the European theater in January 1943, attaining the rank of major general. In recognition of his services in the ETO, General Hawley was awarded the U.S. decoration of the Legion of Merit, the Distinguished Service Medal, and the Bronze Star. He was also an Honorary Companion of the Bath, and the Order of St. John of Jerusalem was conferred upon him by the British. Other foreign decorations received were: Officer of the Legion of Honor and Croix de Guerre with Palm (French); Commander of the Order of the Crown (Belgian); and the Presidential Medal of Nicaragua. He received honorary degrees of LL.D. from Indiana University, University of Cincinnati, and the University of Birmingham, England. He was a fellow of the American Medical Association, the Royal College of Physicians, Royal Society of Medicine, England, and Royal College of Surgeons in Edinburgh (Scotland). He was a member of Delta Omega, Phi Delta Theta, and Phi Rho Sigma.

General Hawley served as Chief Medical Director of the Veterans' Administration from March 1946 until he resigned December 31, 1947. He accepted a position as chief executive officer of the Blue Cross-Blue Shield group, in Chicago, after which he became director of the American College of Surgeons until his retirement in January 1963. He then moved to Shady Side, Md., where he resided with his wife, Lydia, until his death on November 24, 1964.
PEACE UNSHACKLES THE VA MEDICAL PROGRAM

The adverse publicity that developed in the early months of 1945 was firmly implanted in the minds of the public. Certainly a grim picture was told of the medical care available to veterans. The general needed someone with sufficient professional experience and prestige who could shoulder this enormous responsibility.

It was only natural that General Bradley would be attracted to an individual who had organized and directed this vast hospital system and that this individual would be an ideal choice to head and revitalize the VA’s medical department.

When General Bradley returned to Europe in June 1945, he called General Hawley, Chief Surgeon of the ETO, who, at the moment was visiting a hospital 20 miles outside Paris. General Bradley suggested to General Hawley that he would like to discuss with him the medical program of the Veterans’ Administration.

At that time, General Hawley knew very little about veteran medicine. His impression of its caliber was not the highest. Never having been inside a VA hospital, he asked General Bradley if he might bring with him Gen. Elliott B. Cutler, Chief Consultant, Surgery-Medical Section, Headquarters ETO Services of Supply, U.S. Army, one familiar with veteran medicine as practiced in Massachusetts. General Bradley agreed.

It was recognized that the European theater offered outstanding medical care because its medical units were affiliated with leading medical schools of the United States. These units, which remain practically intact, provided instruction and supervision to 36 general hospitals in the ETO. This arrangement was similar to that in World War I.

Generals Hawley and Cutler felt strongly that the medical care of veterans required that VA hospitals be affiliated with teaching institutions. Some of the ablest administrators and physicians in the world agreed and an idea was born.

General Bradley tells about “picking General Hawley’s brains” at that first meeting. The two had met several times during their Army careers, and Bradley was aware of Hawley’s reputation and accomplishments in the ETO. As the meeting ended, General Bradley asked General Hawley to help him plan an improved Veterans’ Administration Medical Service.

General Bradley stated that to help him in revitalizing the VA he was taking back to the United States in addition to General Hawley, a group of men in whom he had complete confidence because of their professional and administrative abilities in varied fields. These men were to act as Bradley’s advisers.

HAWLEY JOINS BRADLEY

General Hawley had been an Army doctor almost as long as he had been a physician and recognized an order when he heard one. He went with some misgivings.

General Cutler volunteered his services for as long as required to make sure millions of veterans of all wars who now were entitled to medical services received the best.
On September 15, 1945, General Hawley reported for duty. He was assigned an office adjacent to the Administrator's suite on the 10th floor of the VA building. Dr. Charles M. Griffith, not yet relieved as Medical Director, was in his office on the eighth floor.

HAWLEY VISITS FIELD INSTALLATIONS

Within days, Hawley decided to visit, for the first time, a VA hospital. General Bradley approved the idea and suggested a special trip to the neuropsychiatric hospital under construction at Tomah, Wis. This hospital was about half completed. Some $5 million had already been spent on the structure. Since Tomah was located in a very isolated spot in Wisconsin, General Bradley doubted it could be staffed and that an affiliation with a medical school was impossible.

General Hawley flew to Tomah and observed the situation. At first brush he recommended the project be canceled.

His itinerary included VA hospitals in Illinois, Wisconsin, and Minnesota, and a stop at Madison, Wis.

Here an informal dinner was given in his honor at the Madison Club by the dean of the University of Wisconsin Medical School, one Dr. William S. Middleton, who later became Chief Medical Director of the Veterans' Administration. Dr. Middleton had served under General Hawley in the ETO as chief consultant in medicine. Others at the dinner were Dr. Edwin B. Fred and Dr. William F. Lorenz, respectively, president and professor of psychiatry at the University of Wisconsin.

General Hawley told of his visit to Tomah. He suggested that the construction project stop. General Hawley realized that his decision would be politically unpleasant and unpopular, but he could not see building a hospital at that location. Dr. Lorenz suggested the hospital be used for the care of long-term psychotics. To back up his suggestion, he offered to furnish the staff, together with consultants and attending physicians. General Hawley vacillated and suggested that assistance from the University of Wisconsin was sufficient to authorize the completion of the hospital.

Tomah was finally opened to long-term psychotics. Word was sent out to neighboring VA neuropsychiatric hospitals and trainloads of patients were sent there.

General Hawley went on to Chicago, where he dined with Dr. Loyal Davis, an eminent neurosurgeon, and friend, and with a number of other prominent doctors he met in the European theater. Hawley related the number of physicians VA would be needing. He told how many patients VA had in its many hospitals. He anticipated the future needs of VA.

HAWLEY INVITES MAGNUSON TO JOIN VA

Dr. Paul B. Magnuson, an outstanding orthopedic surgeon of Chicago was listening. During the evening, General Hawley invited Dr. Magnuson to come to Washington with him.

Hawley knew of Magnuson's interest in the veteran medical program. It was General Bradley who pointedly stated that VA hospitals should affiliate with medical schools and that a residency training program should be established in VA hospitals when possible. Now
Dr. Magnuson reiterates the same philosophy. He said: "One thing I am sure of is that if the Veterans' Administration is going to command the services of really good doctors and those who want to be good doctors, it will have to offer possibilities of teaching to older men and training the younger men." General Hawley was ahead of his time in that his ideas lacked legal authority. Older VA doctors were convinced that such a training program could only lead to the use of veterans as "human guinea pigs."

The next day, Dr. Magnuson told General Hawley he would be willing to go to Washington. He agreed to an appointment as consultant. Later he was appointed Chief of Research and Education at an annual salary a fraction of his former earnings.

Dr. Magnuson and his friend, General Cutler, dug in. The VA medical program got off to a good start. Unfortunately, General Cutler, an ill man who had overtaxed his strength, died shortly thereafter.

MEDICAL SERVICE MODERNIZED, AT LAST

During September 1945, the reorganization of the Veterans' Administration, which had been in the planning stage for months, was put into effect.

The Medical Service was separated from construction supply and real estate. General Hawley was designated as Acting Surgeon General, responsible directly to the Administrator, though still on active military duty. Dr. Griffith became a sit-in medical director. The Acting Surgeon General, sympathetic to the situation, assigned Dr. Griffith to the Mount Alto VA Hospital, Washington, D.C., as manager. Dr. Griffith remained at this post until his retirement in 1951. He died in 1954.

Hawley pressed forth a three-point program for improving the quality of medical care to veterans. These were medical care, medical research, and medical education. Funds would be needed, facilities would be needed, staffs would be needed. General Hawley stressed the necessity of affiliation and close cooperation with the Nation's medical schools. When all of these needs were fulfilled, he believed the VA could begin to attract the best personnel, medical and nonmedical, and assure the highest quality of care with upgrading of the entire VA hospital system.

With the arrival of General Hawley, a new life was injected into VA's Medical Service. The general assayed the problems which he was to overcome with the same energy and foresight he used in organizing the vast medical activities of the European theater.

He decided that the returning veteran was entitled to medical care "second to none" in the world.

He realized that the type of a reorganized Medical Service he wanted could not be accomplished by himself alone. He felt his plan needed the assist of the Association of American Medical Colleges and the American Medical Association.

Hawley, having been in the military service practically all of his adult life, had not been in too close contact with these organizations. He chose to surround himself with persons intimately acquainted with leaders of medicine and medical education in the United States, foremost of whom was Dr. Paul B. Magnuson.
Dr. Magnuson's first assignment was the enlisting of the aid of the medical schools plus the establishment of residency training programs. General Hawley devoted himself to another major problem. He wanted a medical corps of some type in the Veterans' Administration. This had long been in the making.

He realized that he was picking up a cudgel futilely wielded by all previous medical directors. Since 1923, 23 bills proposing a medical corps had been introduced in the Congress without success. There had never been any real enthusiasm for such legislation on the part of General Hines.

Congress was particularly anxious to pass some bill to alleviate the situation before it adjourned. Finally, General Hawley, with General Bradley's concurrence, together with some experienced VA doctors, and a specially formed subcommittee of the House Committee on World War Veterans' Legislation, drafted a bill—H.R. 4717.

This bill dropped many of the provisions of previous bills which proved unacceptable to the VA but included a number of innovations recommended by Hawley. Most important among these were the provision for residency training programs, 25 percent additional allowance (with a ceiling of $11,000 per annum) for those doctors who had been rated as specialists in various medical fields by American specialty boards recognized by the Administrator and postgraduate study, as well as attendance at meetings held for the promotion of medical and related sciences, at Government expense.

Qualifications spelled out for key personnel, as well as for doctors, dentists, and nurses, who no longer would be subject to civil service. All other personnel retained their civil service status. The retirement system of civil service was to benefit all.

Hearings were held by the House Committee on World War Veterans' Legislation. Both Generals Bradley and Hawley made strong pleas for an early passage of the bill, without amendments. General Hawley told how important it was to take doctors, dentists, and nurses out from under civil service. He related the many difficulties which had been experienced by securing doctors from the list of eligibles submitted by the Civil Service Commission. He made the following statement:

I am not a lawyer and I am not sufficiently familiar with civil service law to make a suggestion to the committee. May I say, I am not making any criticism of the Civil Service, but I do believe, so far as professional people are concerned, the civil service laws are not quite applicable.

For example, when we want to employ doctors, we have lists sent to us from the Civil Service. These people are all accepted by the Civil Service and, of course, when we do not employ No. 1, No. 2, or No. 3 on the list, we have to show cause.

Now, for many months, coming over as No. 1 on the list is a physician 87 years old. No. 2 is a lady physician, age 76. There are people on the list who have been committed to mental institutions for insanity and for alcoholism. Of the 80-odd people on the list sent over to us, 60 percent are over the age of 60.

I merely make that comment to show you that it is rather difficult to employ physicians under civil service.

The recommendations of the two VA leaders were heeded. The bill passed the House December 7, 1945. It was then referred to the Committee on Finance of the Senate.
At the hearings before this group General Hawley told the committee that between 15,000 and 20,000 physicians had already left the armed services and more were being separated each day. Many of these men were at the crossroads of their careers, he pointed out. If immediate attractive offers could be made, he was sure that a “goodly number” of highly qualified physicians could be attracted to the Veterans’ Administration. Up to that time, only an insignificant few had displayed any interest.

HAWLEY’S VIEWS

He went on to say that he had had individual contacts of his own with many doctors. He had had 16,000 doctors under his command in Europe, and many of these, returning, came in to see him. He advised the Senate committee that he knew 50 highly qualified specialists who would be immediately attracted by this bill. He was sure that the VA would be able to get them. In his words: “If that is the kind of bunch that you are going to have, I want to belong.”

He continued:

Let me give you an idea of the work these men have done. First, they complete their medical course. Then they go into internship. Following that there are 3 or 4 years of residency at very poor pay, $2,400 a year or less, and maintenance. They train for a specialty, they pass their board examinations, and get their certification. Then, they have got to go out and look for a practice. There is a period for many of them or most of them of very hard work.

Just about the time they succeeded in establishing a practice, the war came along. By that time they were 32, 33, or 34 years of age, and many of them were in debt as a result of pursuing their specialist education.

These men came into the Army. They have spent 4 years maybe, or longer, they have worried along 3 or 4 years trying to build a practice and they have had small incomes. Some of them, at 38 or 39, or even 40, the age at which they will be leaving the Army, have no money.

These men will look ahead. Such a man will say: “Here I am, 42 or 43 years old. I will only have 20 or 25 productive years. I have no private practice. I have a family. I have children to educate.”

He will consider the future: “If I attempt to go back and start a practice, it will be 5 years before I get a practice. If anything happens to me physically, I am out.”

Now the provisions of this bill will be very attractive to such men. This bill offers them a reasonable salary. The salary is not munificent but it compares readily with full-time salaries in academic institutions in our country.

It will offer them some security. They will pay in 5 percent of their pay to a retirement fund, the same as in civil service. They can look ahead, at 65, to having an equity in retirement.

General Hawley added that—

Unless H.R. 4717 is enacted into law at once, before the recess of Congress, the Medical Service of the Veterans’ Administration will suffer further grave consequences, which may be irreparable. In the interests of the thousands of disabled veterans who have by their sacrifices earned better medical care than they are now receiving, I urge immediate action on this bill.

The Senate committee heeded General Hawley’s most urgent appeal and passed the bill on December 20, 1945. It went to the White House for the signature of the President.

Naturally, the U.S. Civil Service Commission did not favor the bill. The Commission argued that the same results could be accomplished through civil service procedures. Based on past experience, the Veterans’ Administration felt differently.
While the bill was awaiting Presidential approval, word was received unofficially that the Bureau of the Budget was recommending a veto. This information was relayed to General Bradley, who was out of town. He returned immediately and sought a conference with the Presidential assistant on personnel matters.

General Hawley hurried back from New York and accompanied the Administrator to the White House. Both stated once more their case for the passage of this legislation.

When it became obvious their arguments might be of no avail, General Bradley turned to General Hawley and asked: "Paul, do you think you can carry on under civil service?" General Hawley replied: "I do not think so, but if you want me to make the try, I am willing to try it for a time until we are convinced."

General Bradley then told the Presidential assistant, "All right. If I find out that it won't work, I'm going to quit." He was very emphatic in this statement. That conference ended on those exact words of General Bradley.

Both generals departed the White House, not knowing whether the bill would be vetoed or passed. However, General Bradley had been so forceful in his remarks that on January 3, 1946—the deadline for the Presidential signature (further delay would have resulted in a "pocket veto")—he was advised by the President that he was signing the bill.

It became Public Law 293, the "Magna Carta" of the Department of Medicine and Surgery of the Veterans' Administration.

Referring back to that conference between the Presidential assistant and General Bradley and Hawley, an interesting aftermath developed. When General Hawley announced in 1947 that he was leaving the Veterans' Administration, that same Presidential assistant, who since had left the Government service wrote Hawley a letter that said he thought it would have been a great mistake to have vetoed H.R. 4717 and that the VA had done a great job for medical care.

Following the signing of the bill into law on January 3, 1946, the President himself wrote to the Administrator:

DEAR GENERAL BRADLEY: I have today given my approval to H.R. 4717, an enactment to establish a Department of Medicine and Surgery in the Veterans' Administration.

I recognize the emergency situation which confronts the Veterans' Administration at the present time in the recruiting of physicians, dentists, and nurses.

It is my desire that, in carrying out the provisions of this law, you develop a system of recruitment and placement which will grant priority to qualified veterans and which will also provide against any possibility of discrimination because of race or creed.

I hope that this legislation will enable you and your associates to move forward in your determination to provide the veterans of this country with a progressive, up-to-date Department of Medicine and Surgery. Much progress has been made in this direction, and I shall watch with real interest the additional steps which will be taken by you under this new law.

Very sincerely yours,

HARRY S. TRUMAN.

On the same date, the VA issued a statement which is of sufficient interest to be quoted in full:

President Truman's signature today on the medical bill will make it possible for the Veterans' Administration to carry out the instructions that the Chief Executive gave Gen. Omar N. Bradley to streamline and modernize the practice of medicine for veterans.
Up to now, it has been difficult for VA to revamp its services because of the inability to obtain medical and other professional personnel in its hospitals, officials said.

With approximately 90,000 veterans now receiving medical care and additional beds from Army, Navy, and civilian hospitals being negotiated, the new act will permit VA to employ applicant doctors, dentists, and nurses promptly to meet the present critical situation. Present vacancies in VA include 1,125 doctors, 1,200 nurses, and 100 dentists.

When General Bradley became Administrator on August 15, the President told him to modernize and streamline VA so that the veterans would obtain the best possible treatment, medical and otherwise. Today's action reinforces the President's initial instructions.

Additional beds in existing hospitals, where virtually all of the available reserve beds are filled, and those earmarked for transfer from the Army can be promptly brought into use as the necessary doctors, dentists, and nurses to staff them are recruited.

VA officials explained it has always been the employment practice of the agency to give veterans even more preference than is provided in the Veterans Preference Act. The greatest single source of medical personnel is expected to be discharged medical officers from the Army and Navy. These men are to be preferred because of their interest in the men they have taken care of. Realizing they have somewhat lost touch with the civilian practice many of these are enrolling for refresher courses in universities.

Working through medical schools and universities the VA hopes to interest many of these veterans in joining its medical staff.

Under the civil service setup previously in existence, it was found that few of these being discharged were interested in employment in the VA. Numerous individuals, VA officials said, have reported that they were interested only if the bill was approved and better professional opportunities were offered.

Officials believe that establishment of the Medical Department will make it possible to advance materially the program of Maj. Gen. Paul R. Hawley, Acting Surgeon General, to give veterans the best medical treatment and care obtainable.

In one VA hospital, 53 doctors, all veterans of World War II, stood by to commence their positions as resident physicians until the Medical Department was approved. (Sec. 14 of the new law authorized the establishment of residencies without regard to civil service; the conditions of employment, the customary amounts and terms of pay to be set by the Administrator.)

Among the provisions of the new act which VA officials believe will aid in meeting the current critical shortage of personnel, are the following:

1. Specialists certified by VA will be paid 25 percent more salary up to a ceiling limit of $11,000 a year.
2. Appointments and promotions will be made on recommendations of special VA boards similar, in general, to the Army and Navy selection boards.

General Hawley, commenting on the President's action, said: "With the signature of the Medical Department Act, our objective is clear—a medical service for the veteran that is second to none in the world. Around the splendid nucleus of excellent men and women in the VA medical service, we shall build such an outstanding service."

General Hawley surrounded himself with outstanding physicians who had recently come out of military service, as well as those who had been with the Veterans' Bureau and the Veterans' Administration for years. In an article published in the Medical Times in October 1946, he had this to say about the VA medical staff which he had inherited:

The new law * * * enables us to reward those faithful and competent physicians who have spent some years in the VA without recognition and with inadequate compensation. With all its handicaps, the old Medical Service of the VA produced some very able men. We have men with years of service in the VA that I will match with faculty members of our leading schools of medicine. For the first time, these men now receive adequate recognition.

General Hawley, by virtue of his military training, as well as his ability as an administrator, delegated authority for many of the programs to his Deputy and Assistant Chief Medical Directors. The actual operation of each medical program was largely the responsibility
of the 13 branch Medical Directors, working under General Bradley's reorganization plan.

No matter how much authority General Hawley delegated, he still carried on his shoulders an almost inconceivable burden of administrative problems which he alone could solve. Here, he enjoyed the complete confidence of General Bradley. He was given freedom of action enjoyed by few.

Now VA was about to take one giant step forward in the direction of top medical care for veterans. The Department of Medicine and Surgery was emerging as a reality.

This Department, long needed and long fought for by the VA, had a catalytic effect on the entire Veterans' Administration particularly in the marked improvement noted in that agency as we know it today.

In the specific language of the act—

the Medical Service in the Veterans' Administration, as at present constituted, is hereby abolished, and, in its stead, there is authorized and established * * * a Department of Medicine and Surgery under a Chief Medical Director. The functions of the Department of Medicine and Surgery shall be those necessary for a complete medical and hospital service to be prescribed by the Administrator of Veterans' Affairs.

Section 6(a) of the act reads:

Appointments of doctors, dentists, and nurses shall be made after qualifications have been satisfactorily established in accordance with regulations prescribed by the Administrator, without regard to civil service requirements.

BOARD OF CONSULTANTS ESTABLISHED

Based on their experience in the European theater, General Hawley and General Cutler organized a Board of Consultants to the Medical Service. Its members were topflight specialists in the various fields of medicine: allergy, tuberculosis, thoracic surgery, neuropsychiatry, pathology, etc. This Board was chaired by General Cutler, and, in reality, constituted the professional services for VA medicine. The members were responsible for inspecting the functioning of their specialties in the hospitals throughout the system. They appointed an appropriate consultant in each branch office to actually do this. In addition they examined the qualifications of the existing chiefs of services as well as those applying for similar positions in the Veterans' Administration. The approval of the appropriate consultant had to be secured before an appointment could be made.

This Board, while remaining a part of the professional services, was reconstituted, in February 1946, as the Council of Chief Consultants. Monthly meetings were held, initially, but as the pressing problems became less frequent, fewer meetings were scheduled. Finally, meetings were held subject to the call of the head of their specialty in the professional services in VA's Central Office.

PREDICTIONS COME TRUE

General Hawley's prediction to the Senate committee came true. Almost immediately, hundreds of able physicians were attracted to VA. Many outstanding doctors chose to practice in VA hospitals. Throughout the system, the staff increased from 2,300 doctors on June 30, 1945 (1,700 of whom were detailed by the military) to 4,000 full-time staff physicians as of June 30, 1946.
This upsurge can be attributed partly to more attractive salaries than heretofore authorized, opportunities for postgraduate study and attendance at meetings, as well as affiliation with the top medical schools of the country. However, the truly important inducement was the independence of the Department of Medicine and Surgery from the civil service regulations.

The classification procedure of the Civil Service Commission pegged the salaries to the duties performed. Many a good clinician had given up patient care to assume administrative duties in order to secure a promotion. Under the new law, doctors, dentists, and nurses could be paid according to their qualifications regardless of rank in a hospital.

The day after the bill was signed, Northwestern and the University of Illinois put 56 residents in Hines. Three weeks later the University of Minnesota placed 26 residents in the St. Paul (Fort Snelling), Minn., VA hospital. The program of affiliation with medical schools and the appointment of deans’ committees was off to a flying start. The arrangement was of mutual advantage. The deans’ committees, composed of the schools’ outstanding men, would recommend consultants and attending physicians for appointment. Residents would
attend the medical school for basic sciences and training in pediatrics and gynecology. In this way, the cream of the medical profession could be obtained to care for veterans.

General Hawley wrote what became known as policy memorandum No. 2, outlining the relationships between the deans' committees and the hospitals. Even today this is used as the basic operating policy. Both General Hawley and Dr. Magnuson then traveled extensively throughout the country explaining the details of this plan of affiliation to the medical schools and national medical organizations. Within a short period of time, physician residency programs were put into operation in 32 VA hospitals.

These were exciting days in the VA and especially busy ones for General Hawley. In addition to a great deal of traveling, he was continually setting up new programs and streamlining old ones.

"HOMETOWN" PROGRAMS

One important function of a good medical program is to keep the veteran out of the hospital, if possible, by treating him before he requires hospitalization.

Recognizing that many admissions could be avoided by treating a veteran before he needs hospitalization, General Hawley, in December 1945, instituted a plan for "hometown" medical and dental care at Government expense for veterans with service-connected ailments. Under General Hawley's plan eligible veterans in their own communities would be treated by VA-approved doctors and dentists of their own choice. This "hometown" program was successful only because it met with the wholehearted cooperation of local, county, and State medical societies throughout the Nation.

At the same time, a similar "hometown" plan as put in operation where drugs could be purchased from the veteran's local pharmacist, as prescribed by his physician.

In addition, General Hawley planned a 3-year program of prosthetic research to secure the most modern appliances for amputees, to cost $1 million annually.

Policy Memorandum No. 2

January 30, 1946.

Subject: Policy in association of veterans' hospitals with medical schools.

1. General considerations:

(a) Necessity for mutual understanding and cooperation.—The Department of Medicine and Surgery of the Veterans' Administration is embarking upon a program that is without precedent in the history of Federal hospitalization. It would, therefore, be most unusual if numerous problems did not arise for which no fully satisfactory solution were immediately apparent. Such problems frequently can be solved only by trial and error; and, until workable solutions are found, both parties in the program must exercise tolerance if the program is not to fail.

There can be no doubt of the good faith of both parties. The schools of medicine and other teaching centers are cooperating with the threefold purpose of giving the veteran the highest quality of medical care, of affording the medical veteran the opportunity for postgraduate study which he was compelled to forgo in serving his country, and of raising generally the standard of medical practice in the United States by the expression of facilities for graduate education.

The purpose of the Veterans' Administration is simple: affording the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service.

The purposes of both parties being unselfish, and there being no conflict of objectives, there can be no serious disagreement over methods. It will be recog-
nized that the Veterans' Administration is charged with certain legal responsibilities in connection with the medical care of veterans which it cannot delegate, if it would. Yet the discharge of these responsibilities need not interfere with the exercise by the schools of their prerogatives in the field of education.

All medical authorities of the Veterans' Administration will cooperate fully at all times with the representatives of associated schools and other centers. It is the earnest desire of the Acting Chief Medical Director that our relations with our colleagues be cordial as well as productive.

(b) General division of responsibility.—The Veterans' Administration retains full responsibility for the care of patients, including professional treatment, and the school of medicine accepts responsibility for all graduate education and training.

2. The Veterans' Administration:

(a) Operates and administers the hospital.

(b) As rapidly as fully qualified men can be had, will furnish full-time chiefs of all services (see par. 5 below) who will supervise and direct the work of their respective staffs, including the part-time attending staff furnished from the school of medicine, insofar as the professional care of patients is concerned. Nominations by deans' committees for such full-time positions will be welcomed; and, unless there be compelling reasons to the contrary, will be approved wherever vacancies exist. These service chiefs are fully responsible to their immediate superior in the Veterans' Administration.

(c) Appoint the consultants, the part-time attending staff and the residents nominated by the deans' committee and approved by the Veterans' Administration.

(d) Cooperate fully with the schools of medicine in the graduate education and training program.

3. The schools of medicine:

(a) Will organize a deans' committee, composed of senior faculty members from all schools cooperating in each project, whether or not furnishing any of the attending or resident staff.

(b) Will nominate an attending staff of diplomates of specialty boards in the numbers and qualifications agreed upon by the deans' committee and the Veterans' Administration. (See 6(e)).

(c) Will nominate, from applicants, the residents for graduate education and training.

(d) Will supervise and direct, through the manager of the hospital and the consultants, the training of residents.

(e) Will nominate the consultants for appointment by the Veterans' Administration.

4. Hospital managers:

(a) Are fully responsible for the operation of their hospitals.

(b) Will cooperate with the deans' committee, bringing to its attention any dereliction of duty on the part of any of its nominees.

5. Chiefs of service:

(a) Are responsible to their superior in the Veterans' Administration for the conduct of their services.

(b) Will bring to the attention of their superior, for his action, such cases as they are unable to deal with personally of dereliction of duty or incompetence on the part of any full-time or part-time staffs under their control.

(c) Will, together with the part-time attending staff, under the direction of the manager, supervise the education and training program.

(d) When full-time employees of the Veterans' Administration, will be diplomates of their respective boards and will be acceptable to the deans' committee and to the specialty boards concerned. It is the urgent purpose of the Veterans' Administration to place full-time fully qualified and certified chiefs of service for all services in each hospital associated with a school of medicine. Except in cases where the chief selected has local affiliations, which might embarrass or prejudice his relations with one or another of the associated schools, his initial assignment may not be cleared through the deans' committee. In all cases, when it has been conclusively demonstrated that a chief of service cannot cooperate with a deans' committee, he will be transferred (if efficient otherwise) and replaced by another.

Until this purpose can be fully accomplished, however, in order that a hospital may obtain approval for resident training by one or another specialty board, it may be necessary to appoint part-time chiefs of services who meet the requirements of the boards. This will be done; but it will be done with the understanding that the part-time chiefs will be replaced with qualified full-time chiefs as rapidly as they become available. The duties and responsibilities of part-time chiefs will be the same as those of full-time chiefs.
6. Part-time attending staff:
(a) Will be responsible to the respective chiefs of service.
(b) Will accept full responsibility for the proper care and treatment of patients in their charge.
(c) Will give adequate training to residents assigned to their service.
(d) Will be veterans unless approval in each case has been given by the Chief Medical Director.
(e) Will be diplomates of their respective boards and acceptable to such boards for direction of resident training. Exception may be made in the case of a veteran who has completed the first part of his board examination, but whose completion of the examination was interrupted by the exigencies of the military service.
(f) Will hold faculty appointments in one or another of the associated schools of medicine, or will be outstanding members of the profession of the caliber of faculty members.

7. Consultants:
(a) Will be veterans unless approval in each case has been given by the Chief Medical Director.
(b) Will be members of the faculty, or professorial rank, of one or another of the associated schools of medicine.
(c) Will, as representatives of the schools of medicine, direct and be responsible for the education training of residents.
(d) Will afford to the manager and the proper chief of service the benefit of their professional experience and counsel.
(e) Will conduct their duties through, and in cooperation with, the manager and the proper chief of service, and also, in matters of education and training, with the part-time attending staff—always, however, coordinating with the chief of service.

GIGANTIC HOSPITAL CONSTRUCTION PROGRAM PUSHED

Both Generals Bradley and Hawley continued to hasten the construction of the new hospitals which had been authorized, insisting that they be located adjacent to a medical school wherever possible.

At the outbreak of World War II, the Veterans' Administration was operating more than 80,000 hospital and domiciliary beds in 91 hospitals throughout the country. At that time, America's veteran population was under 5 million, most of whom had served during World War I. The VA had begun a 10-year building program to add 20,000 beds. The war prevented this undertaking from ever getting out of low gear.

SIXTEEN MILLION NEW VETERANS

World War II added nearly 16 million young veterans, all potentially entitled under Public Law 10 (passed in 1943) to VA hospitalization on the same basis as veterans of previous wars. VA was frightfully lacking in hospitals and beds to care for them.

The original GI bill gave the VA priority that proved not to be too effective. VA was placed second to the War and Navy Departments, in obtaining personnel, equipment, and materials for new hospitals. Shortly after the end of the war, the GI bill was amended by Public Law 138, 79th Congress (July 6, 1945), and VA's priority was given teeth. Now VA's priority was "equal to the highest granted any department or agency of the Government." The agency's program could now get off the ground. The GI bill also provided that the Army and Navy transfer surplus hospitals to VA. This actually rescued the veterans' medical program. Though these hospitals were of temporary construction, and could not be expected to offer permanent relief, they went a long way toward easing the load while VA's own hospital building program was going on.
Both Generals Bradley and Hawley determined to take the selection of hospital sites out of "pork barrel politics." Their criteria was to have the hospital near a medical center where the best doctors were available. General Hawley observed quite candidly: "To hell with the scenery. We want the best doctors."

It was expected that the cost of VA's hospital expansion program would be three-quarters of a billion dollars. This tremendous program would provide an additional 66 ultramodern hospitals having 37,000 beds.

In between his duties at the central office and visiting field stations, General Hawley was called upon frequently to address medical societies, faculties of medical schools, and many other organizations. His idea of medical care "second to none" soon aroused enthusiasm of the medical profession and the general public alike. The future of veteran medicine certainly was bright.

**RECRUITMENT PROBLEM EASED**

In the meantime, doctors were being released in great numbers by the military. The enviable reputation of the Veterans' Administration medical program was attracting them by the hundreds.

General Hawley also directed his attention to hospitals not located near medical schools. He dropped the expression "teaching hospital" because, as he said, "while they may not be affiliated with a medical school, all hospitals are teaching hospitals." However, the teaching responsibilities could not be carried on by full-time staff alone. VA would have to look to consultants and attending physicians to augment the regular staffs. Whereupon, some of America's leading specialists took over the supervision of professional work at these nonaffiliated hospitals, carrying on teaching programs and making their services available in many other ways.

The pay these eminent men received was but a fraction of the income they might have had by remaining in their individual offices on the days they served the Veterans' Administration. Their real compensation was the knowledge that they were playing a key role in building an outstanding system of medicine. Attending physicians were appointed to work directly with the resident staff as well as with the patients.

After 2 years and 3 months, General Hawley's efforts were bearing fruit in a big way. VA had the cooperation of organized medicine and an excellent reputation.

**"NEW" SMAG ESTABLISHED**

Public Law 293 provided for the establishment of a Special Medical Advisory Group, to counsel the Administrator through the Chief Medical Director, and to offer recommendations on the operation of the Department of Medicine and Surgery. The members of this group were not chosen because of their particular specialty, but rather because of their reputation and standing in the various fields of medicine. By law, they are required to meet quarterly, and their tenure of membership is limited to 5 years.

It will be recalled that General Hines had a Special Medical Advisory Group which met but three times before the general left office. None
of the members on this last-mentioned group were reappointed by General Hawley. General Hawley felt he needed a new group with a fresh outlook. The capabilities of most of those on the Board of Chief Consultants and the Special Medical Advisory Group were well known to Generals Hawley and Cutler from service in the European theater.

General Hawley reestablished SMAG with an entirely new membership. Practically all of the American specialty boards were solicited for nominations. Although the selections were made in the various specialties, each member was expected to provide general advice, not merely as a representative of any particular branch of medicine. Dr. Charles W. Mayo, noted surgeon of Rochester, Minn., was appointed Chairman of the “new” SMAG. Since then, some of the most prominent physicians in the United States have, serving as members of SMAG, helped develop and promote the VA medical program.

VA MEDICINE WAS “SECOND TO NONE”

Under General Hawley’s leadership, the medical system rose as one of the most modern and progressive in the world.

Even Albert Deutsch who had been most critical of the medical care veterans were getting under General Hines’ administration was complimentary. In PM, dated November 14, 1946, he bylined an article called “A Bright Spot in the VA Picture.” Here he wrote that Hawley “has shown extraordinary ability as a farsighted planner and administrator * * * he has infused the whole hospital program with a spirit of modern scientific medicine. The Hawley revolution is far from completion * * * but Hawley and his aids know where the flaws in the system are, and they are gradually being eliminated.”

HAWLEY RESIGNS

General Hawley had retired from the U.S. Army on September 16, 1946. By law he was not able to draw both Army retirement and his salary of $12,000 a year as Chief Medical Director. The general was not a wealthy man because he had devoted practically his entire career to the military. On his VA salary he found himself slipping further into debt. He observed, “I know of no shorter way to the poorhouse than traveling on $6 a day. I have taken this financial strain to the breaking point and I regret only that I am not in the position to take it any longer.”

He resigned on December 31, 1947, 1 month after General Bradley, and later accepted the position of chief executive officer of the national Blue Cross, Blue Shield group. Still later, he was destined to become medical director of the American College of Surgeons.

The general had seen his dream of “medical care second to none” for the American veteran come true. He looked back on this phase of his career as the most interesting and important part of his life.

But General Hawley did not completely sever his connection with VA’s Department of Medicine and Surgery. He retained his interest in its continuing development and was of valuable assistance to subsequent Chief Medical Directors.

General Hawley proved that Federal and civilian medicine could work together. He produced and directed the teamwork and brainstorm that created a milestone in the history of American medicine.
Upon his retirement, General Hawley moved to Maryland. He passed away on November 24, 1965. He was buried in Arlington Cemetery with full military honors.

Carl Raymond Gray, Jr.

Carl Raymond Gray, Jr., was born in Wichita, Kans., on April 14, 1889, the son of Carl Raymond and Harriette (Flora) Gray.

He attended the Western Military Academy in Alton, Ill., and then entered the University of Illinois, where he studied railroad administration. He received his B.A. degree in 1911 and accepted a position with the St. Louis-San Francisco Railway as a yard clerk. He held increasingly
important jobs in the railroad business, becoming assistant to the general superintendent of the “Frisco” line. In 1916 he was assistant engineer of the Consolidated Coal Co., in Baltimore, Md., and was appointed president of the Peach Bottom Slate Corp. in the same city.

During World War I he served with the U.S. Army as supply officer in charge of Army supplies for 800,000 troops in nine States. He was discharged in April 1919 with the rank of lieutenant colonel. He served as colonel, Corps of Engineers Reserve, during 1921-28, and in 1939 he became general manager of the Military Railway Service with inactive status.

Following the war, he returned to positions with various industrial corporations, returning in 1925 to the railroad business.

He was called to active service in World War II on May 15, 1941, and served overseas for 34 months in charge of the Military Railway Service. He received many military awards for his military engineering service: The Legion of Merit, and the Oak Leaf Cluster, the Distinguished Service Medal, Bronze Star Medal, Order of the Crown of Italy, Knight Commander of the British Empire, Legion of Honor, and Croix de Guerre with two palms, Order of the Crown of Belgium, and the Italian War Cross for Merit.

When Gray was relieved of duty in February 1946 he held the rank of major general. He returned to Chicago & North Western Railway System on May 1, 1943, as its executive vice president, but retired from this position when President Truman appointed him in November 1947 to become Administrator of Veterans’ Affairs. He was sworn into office on December 31, 1947. His appointment received general public approval and was commended by leaders of the veterans’ organizations.

He was a member of the Society of Military Engineers, the Society of Mayflower Descendants, the Order of Founders and Patriots of America, the American Legion, Military Order of the World War, the Reserve Officers Association, and Sigma Alpha Epsilon.

He resigned as Administrator of Veterans’ Affairs on June 30, 1952, and with his wife returned to their home in Hudson, Wis. General Gray kept an active interest in veterans’ affairs until his death on December 2, 1966.

THE VA “SUPERCHIEF”

Gen. Carl R. Gray became Administrator of Veterans’ Affairs in January 1948. Upon his return from active duty in World War II, he served as vice president of the Chicago & North Western Railway system until appointed Administrator of Veterans’ Affairs. General Gray and Mr. Truman had met in Kansas City during World War I. After the war, they were active in veterans’ affairs of that city. Mr. Truman liked and admired General Gray. Later, their lives took different courses, but they kept in touch with each other. When in Washington, General Gray would drop by to visit Senator Truman and in later years he called at the White House several times to visit his old friend.

The general’s only contact with the VA before taking oath of office was a 3-hour conference with General Bradley. He declined to visit VA’s central office or any hospitals, or to participate in any VA activities, until he had been sworn in.

One of his first tasks was to select a Chief Medical Director to replace General Hawley. When he asked the advice of Generals
Bradley and Hawley and the Special Medical Advisory Group, they were unanimous in the recommendation that this post be filled by Dr. Paul B. Magnuson, who was then serving as Assistant Chief Medical Director for Professional Services. Dr. Magnuson was promoted to Chief Medical Director on January 14, 1948. This appointment was to end in controversy.

During General Bradley's administration, there had been, of course, mass discharges from the military, and General Gray found himself heading an agency that was to serve approximately 10 million living veterans. This was almost double the number for which General Bradley had been responsible. Hospitals had been increased from 97 to 125, with an increase of 20,000 beds. The domiciliary patient load had risen, by approximately 3,000, to 14,000. In addition, when General Gray assumed office, 7,000 patients were being treated in Federal hospitals, or in civil, State, or municipal institutions. There were over 20,000 veterans on the waiting list, most of these with non-service-connected disabilities.

A veteran with a service-connected disability could get hospitalization at Government expense in a private institution if no bed was available in a VA hospital or other Federal hospital.

**NINETY NEW VA HOSPITALS PLANNED**

Plans called for the construction of 90 new hospitals. Contracts had been awarded for 28 of these and the remainder were in various stages of planning. These new hospitals would provide over 50,000 additional beds. Relief for those on the waiting list was in sight. Until the new hospitals were completed, existing VA hospitals were operating at top capacity.

Public Law 293 continued to improve the professional image of the Veterans' Administration's medical activities. Under General Hawley and Dr. Magnuson, the number of medical schools affiliating with our hospitals through the deans' committees continued to grow. By June 1948, there were 60 such affiliations. The quality of care was never so high. The length of hospitalization was shortened so that more veterans could be treated within the same bed capacity. The number discharged with maximum hospital benefits increased and the death rate declined.

The new Department of Medicine and Surgery attracted some outstanding physicians, dentists, and nurses.

By January 1948, 2 years after the creation of the Department, the full-time professional staff had grown to 3,536 physicians, 947 dentists, and 11,065 nurses. There were also approximately 2,000 part-time physicians; 700 consultants or attending physicians. On the other hand, the 1,200 ASTP (Army) and V-12 (Navy) physicians, and 100 cadet nurses, detailed to the VA, had completed their obligation of 2 years' service by July 1, 1948.

It was possible to make replacements, except at certain isolated stations and in some categories, such as neuropsychiatry, neurology, radiology, anesthesiology, and pathology. These shortages, however, were a reflection of conditions existing also in civilian medicine.

By now, the residency program had attracted 2,000 young doctors. This program, as well as those in dentistry and in the paramedical fields, continued to increase in size.
During General Gray's tenure, all available residencies were filled. The Chief Medical Director, knowing how important it was to give these young men an opportunity to complete their specialty training in a VA hospital, made arrangements for apprenticeship training in nonaffiliated hospitals where there were outstanding certified board specialists. A limited number of residents were placed in this way, and received credit and the approval of their particular specialty boards.

MEDICALLY, THINGS WERE LOOKING UP

Thus General Gray faced a rather rosy picture of VA medicine, as compared with that which confronted General Bradley. Gray was especially interested in the medical program. This may have been partially prompted by the fact that his brother, Dr. Howard Gray, was a very successful surgeon in Rochester, Minn.

General Gray was closely associated with General Hawley while on active duty in the European theater of operations. As director of military railways in Europe, Gray was most helpful in the operation of hospital trains. When the General Staff said that the railroads were carrying all the traffic they could bear, General Gray, according to General Hawley, could always squeeze in a hospital train.

SIXTEEN-THOUSAND-BED CUTBACK

The program for hospital expansion authorized in 1948 would result in approximately 152,000 beds upon completion of 90 new hospitals. The big question was: Could the VA staff this number of hospitals? Previously, General Bradley and General Hawley, in House hearings, had stressed the difficulties in staffing hospitals, particularly those in isolated locations. Dr. Magnuson also was in doubt about this, and therefore, took steps to reduce the number.

The staffing of this number of beds had also been of concern to the Special Medical Advisory Group. Dr. Magnuson and his associates felt that the most the agency could man would be 120,000 beds.

He unofficially presented his opinion, as well as that of the Special Medical Advisory Group, to the Bureau of the Budget. They even recommended, at the hearings on the 1949 appropriations, that a cutback be made. Obviously, President Truman was briefed; for in his budget message for the fiscal year 1950 he stated that the construction of 90 authorized hospitals would result in serious overbuilding. He also announced that he had directed the Administrator of Veterans' Affairs to eliminate 16,000 beds from the original authorization.

In December 1948, General Gray complied by ordering elimination of 16,000 beds from the construction program, and asked Dr. Magnuson to recommend where the cuts should be made. The Chief Medical Director promptly suggested the cancellation of 24 hospital projects—all of them still in the planning stage—and a reduction in the planned capacity of 14 additional hospitals. Currently, there were 31 hospitals under construction, which, with the closing of some emergency and temporary beds, would result in 131,171 beds—27,638 more than the 103,533 then being operated.
A VA news release, issued Monday, January 10, 1949, announced that the following proposed hospitals were to be canceled and others reduced in size:

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<tr>
<th>Location</th>
<th>Size (number of beds)</th>
<th>Type</th>
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<tr>
<td>Americus, Ga.</td>
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<td>GM.</td>
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<td>Chattanooga, Tenn.</td>
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<td>GM.</td>
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<tr>
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<td>Detroit, Mich.</td>
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<td>El Paso, Tex.</td>
<td>800</td>
<td>NP.</td>
</tr>
<tr>
<td>Gainesville, Fla.</td>
<td>1,000</td>
<td>NP.</td>
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<tr>
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<tr>
<td>Toledo, Ohio</td>
<td>1,600</td>
<td>NP.</td>
</tr>
<tr>
<td>Tupelo, Miss.</td>
<td>200</td>
<td>GM.</td>
</tr>
</tbody>
</table>

1 (GM-General medicine and surgery; TH-Tuberculosis; NP—Neuropsychiatric.
2 New 480-bed GM hospital being constructed—completion date March 1949.
3 Reduced by 500-bed former naval GM hospital, April 1948. Eliminated need for new construction.
4 Eliminated need for new construction.
5 This to be in addition to the new hospital constructed at E. 24th St.
6 Built in 1938.
Dr. Paul B. Magnuson, Chief Medical Director, Veterans Administration, January 1948-January 1951.

Paul Budd Magnuson

Paul Budd Magnuson was born in St. Paul, Minn., June 14, 1884, the son of Charles A. and Melinda (Graham) Magnuson.

He graduated from the University of Minnesota and then received his medical education at the University of Pennsylvania, graduating as an M.D. in 1908. He then went to Chicago and began the practice of medicine. The history of his early medical career is colorfully described in his book, "Ring the Night Bell; An American Surgeon's Story" (Little Brown & Co., 1960).
While in practice in Chicago, he became chief surgeon to the Chicago, Alton & Chicago Junction Railroad. He was also the first medical director of the Illinois Industrial Commission. He was attending surgeon at Passevant Memorial Hospital, and in the ensuing years he was senior consultant at Wesley Memorial Hospital, professor of surgery and chairman of the Department of Bone and Joint Surgery at Northwestern University—now emeritus.

He served in World War I as major, Medical Corps, U.S. Army, from 1917 to 1918. During World War II he was a civilian consultant to the Surgeon General, U.S. Army, from 1941 to 1946.

He left his lucrative practice in Chicago to accept a position in the Veterans' Administration, and was largely instrumental in revitalizing that service and creating the Department of Medicine and Surgery.

He became Chief Medical Director of the Veterans' Administration in January 1948 and served until January 1951.

President Truman then appointed him Chairman of the President's Committee on the Health Needs of the Nation. He then became founder and honorary chairman of the Rehabilitation Institute of Chicago, which today remains his primary professional interest.

He is in receipt of honorary degrees from Duke University, Baylor University, and Western Reserve University. He is an honorary fellow of the British Orthopedic Society, a founder member and diplomate of the American Board of Surgery and the American Board of Orthopedic Surgeons. He is a regent of the American College of Surgeons, the American Society of Surgical Associations, American Orthopedic Association, Southern Surgical Association. He is a former president of the American Association for Surgery of Trauma, a member of the American Association for Industrial Surgeons, the American Medical Association, International Society of Orthopedic Surgeons, American Academy of Orthopedic Surgeons, National Research Council, the Chicago Orthopedic Society, Institute of Medicine of Chicago, and a member of the Sigma XI fraternity.

In addition to being the author of "Ringing the Night Bell," he has written a textbook entitled "Fractures" which had its fifth printing in 1949. He also wrote a section on "Ununited Fractures, Orthopedic Subjects," for the National Research Council.

He maintains a home in Washington, D.C.

The "16,000-bed cutback" did not meet with the approval of certain Members of Congress, the veterans' organizations, or the citizens of the States and communities concerned.

Extensive hearings were held by the Senate Committee on Labor and Public Welfare. A 1,064-page summary and analysis of the proceedings was printed. During the testimony it was established that the recommendation for the bed reduction originated with the Bureau of the Budget. Without asking VA's official opinion, it had been presented to the President for a policy decision, and he had approved the proposal; it was, therefore, a fait accompli.

**THE CONTROVERSY**

Shortly after taking office, Administrator Gray left on an exhaustive tour of inspection. He traveled continuously for 7½ months without returning to Washington, visiting every VA installation except three near central office—Martinsburg, W. Va., Perry Point and Fort
Howard, Md. He talked with veterans, employees, representatives of veterans' organizations—always looking for new ways to improve service and reduce costs.

Before his arrival, each station prepared a list of projects in the planning stage, or those they felt should be accomplished. The general used these as checklists, indicating approval or otherwise.

Many of these concerned medical facilities in the hospitals. There were so many different units in central office involved in these projects, such as construction, supply, special services, etc., each independent of the other, that a lack of communication and coordination caused delays. The end result, in a number of cases, was that the Chief Medical Director was not aware of many actions taken by the Administrator until they had been accomplished. This, of course, led to trouble.

STRONG-WILLED LEADERS WITH OPPOSING PHILOSOPHIES

General Gray and Dr. Magnuson had entirely opposite philosophies of hospital management, and both were strong men with strong convictions. It was the type of organization which really brought about the controversy.

General Gray firmly believed that the Chief Medical Director should handle all professional matters pertaining to the treatment of patients, but that the other activities in hospital operation, such as supply, engineering, personnel, etc., should be under the control of lay Assistant Administrators in Washington. Dr. Magnuson felt that everything in a hospital affected the care of the patients and, therefore, should be within the scope of authority of the Chief Medical Director.

This controversy over medical versus lay management finally developed into a first-class battle between the Administrator and the Chief Medical Director.

Following his tour of inspection, General Gray abolished the VA's 13 branch offices, as such. In their place, he ordered 13 district offices to be created, to handle only national service life insurance and death claims. These 13 were later reduced to three. Also, six area medical offices were authorized, each in the charge of an area medical director responsible to the Chief Medical Director. A seventh office was added later.

The area medical offices were staffed by supervisors of each of the medical and allied programs, and were to be the "eyes and ears" of the Chief Medical Director. They were without line authority, but responsible for the supervision of their particular specialty at the field stations in their areas. Correspondence between the field stations and central office was direct, with information copies to the area offices.

The area offices were located in the following cities: Boston, Mass., Washington, D.C. (later moved to Trenton, N.J., and still later returned to Washington), Atlanta, Ga., St. Louis, Mo., St. Paul, Minn., San Francisco, Calif., and the office at Columbus, Ohio, which was established at a later date.
A "PLATEAU" REACHED

In explaining the reasons for his move, Gray said, "We have reached the leveling-off point in our operation." Now that the plateau had been reached, he added, the branch offices, "useful to the point of being essential during VA's rapid postwar expansion," were on the verge of outliving their usefulness. A temporary expedient, they had served their purpose. As a result of this action, Gray predicted that VA's efficiency would go up and costs would come down.

During the fiscal year ending June 30, 1948, the number of VA personnel did decrease from 216,753 to 195,545. It was to be further reduced to 178,502 during his term of office. With the exception of the medical program, all other VA programs reached their peak during General Gray's administration. Thus, a reduction in the number of employees became possible. The caliber of professional medical personnel now in the employ of the VA, and the extent to which the hospitals and clinics had become centers for specialized training and research, raised VA medicine to rank with the best and most modern available.

The general liked to travel and always by train. He made many trips to field stations, in addition to his "inaugural tour." He was very proud of the VA's medical activities and had the habit of making spot decisions. Several he made bordered on strictly professional matters. For instance, he determined that a certain hospital did not require a research laboratory and that another did not need a house for laboratory animals. He set the hours of meal service at certain hospitals, and decided on the purchase of certain types of dental equipment at another, etc. These activities angered his dynamic Chief Medical Director, Dr. Magnuson, and eventually caused a Senate investigation.

THE KOREAN CONFLICT (JUNE 27, 1950, TO JANUARY 31, 1955)

Before the end of World War II, there was an agreement among the Allied Powers that Korea should be divided at the 38th parallel, with Communists, supported by Russia, controlling the north (called the Peoples' Republic of Korea) and anti-Communists controlling the south (called the Republic of Korea). American forces were withdrawn from the south, because the main Communist threat to the United States, in the postwar period, was considered to be a possible Russian invasion of Western Europe.

On June 25, 1950, Communist forces from North Korea drove into South Korea. At the urgent appeal of President Truman, the United Nations, on June 27, voted to resist the invasion.

American forces, and those of 16 other members of the United Nations, with American forces predominating heavily, eventually landed in Korea and forced the invaders (who had come to be supported by Red China) back to the northern side of the 38th parallel.

And thus started, in a world just recovering from war, a new period of war that was no war (technically, it was police action). This was supposedly an era of peace, though there was no peace for troops were fighting and risking their lives; 6,800,000 Americans participated in the Korean conflict; 34,000 were killed in action, 21,000 died from other causes, and 103,000 were wounded. Not all of the close to 7
(Courtesy of Dept. of Defense)

The American Soldier, 1951.
million who participated actually landed in Korea. Some were stationed on ships at sea, others at various staging and supply areas in the United States or on islands in the Pacific. But the 6,800,000 who did participate represented more Americans than took part in World War I. Deaths per thousand, from wounds received in action and from other causes, were the lowest in the history of American military medicine. New drugs, new techniques, and the experience gained in World War II accounted for this.

In the matter of benefits, veterans of the Korean conflict were, at first, less fortunate than their older fellow veterans of World War II. Benefits they could not get far outnumbered those they could receive. The reason was that military service in Korea was technically peacetime service, and veterans of peacetime never have received the same measure of benefits as those who served in time of war. On the strength of service after the outbreak of the Korean conflict, alone, the young veterans could not get any GI bill benefits, Public Law 16 training, non-service-connected pension, hospitalization for non-service-connected conditions, care for amputees, burial benefits, and a number of others.

However, they could receive full wartime rates of disability compensation when their disabilities resulted directly from armed conflict or were received while engaged in hazardous service. Otherwise, reduced peacetime rates were payable for service-connected disabilities, and they could go to a VA hospital for service-connected disabilities; get prosthetic appliances, special help if they lost their sight or the use of their legs, and a few other benefits.

MORE WAR BENEFITS

Early in May 1951, a Korean combat veteran, suspecting that he had cancer, tried to get into a VA hospital in Tucson, Ariz., for treatment. Because his condition was non-service-connected and non-emergent, VA regretfully had to turn him down. The law had tied VA's hands; non-service-connected care for war veterans only, it read. Korean service is not war service, even though the veteran served in combat.

Newspapers and radio stations spread the story from coast to coast on May 9. Congress and the White House, shocked at the inequity created by a quirk in the law, acted within a matter of hours. The next day, the White House sent a message to Capitol Hill, urging speedy action. The prod wasn’t needed; bills already were being quickly drafted and that same day they passed both Houses. The next morning the President signed Public Law 28 and hospitalization for non-service-connected disabilities, plus a host of other benefits already available to war veterans, were now provided for veterans of the Korean conflict.

Together with Generals Bradley and Hawley, Doctor Magnuson was one of the architects of Public Law 293. Even before it became law, he had plans laid for the operation of the residency training pro-
gram and affiliation with leading medical schools, through the formation of deans' committees. This was not difficult for him, as he was personally acquainted with the deans of practically all of the medical schools in the country and could call most of them by their first names.

Doctor Magnuson realized that many young doctors had interrupted their training to enter service during the war. A residency training program would offer them a chance to continue training in their chosen fields, while at the same time contributing toward giving veterans the finest possible care in VA hospitals.

He also developed, by leaps and bounds, the research activities of the VA in the Department of Medicine and Surgery.

A POPULAR APPOINTMENT

In view of these accomplishments, it was logical that General Gray would give first consideration to Dr. Paul B. Magnuson as his choice for Chief Medical Director. His appointment to this important position was particularly popular in medical circles. He was well known as an outstanding teacher and surgeon, not only in his hometown of Chicago, but throughout the country.

Dr. Magnuson was one of the most colorful individuals ever to hold a post of importance in the Veterans' Administration. He was dedicated to the medical care of the veteran, and, although great strides had been made in this area before he assumed his new position, he continued to make many contributions.

A most dignified and professional appearing man, he possessed a keen sense of humor and a positive personality. He could be kind and sympathetic, or gruff and hard hitting, as the occasion demanded. When things did not go according to his liking, he would issue orders in clipped sentences in language that was indeed colorful.

In private practice, as in teaching, he was monarch of all he surveyed. He was not used to taking orders from anyone "except," as he used to say, "from my patients."

This was Dr. Magnuson's first association with an organization as large as the Veterans' Administration, so he was continually frustrated by the regulations and procedures necessary in such a huge agency. When told: "You can't do that because of the rules," he would answer: "Throw the rules out the window; we have a job to do and nothing is going to stop us."

RELATIONSHIP DIFFERENCES.

There was a vast difference in his relationship with General Gray when compared to that which had existed between General Bradley and General Hawley.

General Bradley gave General Hawley a free rein in the operation of the Department of Medicine and Surgery and the hospital system. It should be noted that during General Hawley's regime, and the first year of Dr. Magnuson's term of office, the line of authority ran from Central Office to the branch offices, and then to the hospitals.

When General Gray abolished the branch offices in February 1949, the Chief Medical Director lost a good deal of his administrative control. This proved to be a major bone of contention during the balance of Dr. Magnuson's tenure.
There were in VA's Central Office five Assistant Administrators, in addition to the Chief Medical Director. They were responsible for the operation of the following programs throughout the entire agency: construction and real estate; personnel; finance; compensation and pension; vocational rehabilitation. The first three programs had a direct effect on the operation of the hospitals. The Assistant Administrators concerned had authority to dictate to the hospital manager on those matters within their jurisdiction.

This had presented no problem under General Bradley and General Hawley, as there was close cooperation and teamwork between the Assistant Administrators and the Chief Medical Director, working through the branch offices.

INTERFERENCE BY LAYMEN

However, this changed radically under Gray and Magnuson, as the general felt that a doctor should not be burdened with responsibilities other than those of a strictly professional nature. During another era Col. George Ijams had his problems espousing this philosophy.

Dr. Magnuson had previously worked under the Bradley-Hawley concept of hospital administration, and was to spend most of his 3 years as Chief Medical Director trying to restore that concept. When he talked of matters affecting the care of patients, he was thinking in modern medical terminology. To him, a hospital was an entity, with everything going on within it influencing, to some degree, patient care. He believed that hospital planning—even to the maintenance of equipment and the choice of supplies—affecting the whole being of the patient.

Dr. Magnuson envisioned the authority granted the Assistant Administrators for nonmedical activities in the hospital as laymen interfering with professional duties. He felt strongly that the operation could not be divided into strictly medical and nonmedical activities.

Pressed hard for a written documentation of the exact scope of his authority when he took office, he was given a written delegation of authority which, in part, said he could act for the Administrator in all matters assigned to the Department of Medicine and Surgery which did not require the personal attention of the Administrator. General Gray, however, interpreted this as meaning only the purely professional phase of hospital operation.

As a last resort, Dr. Magnuson, on April 6, 1949, submitted the question of his authority to the VA Solicitor. He pointed out that Public Law 293 provided for the establishment of a Department of Medicine and Surgery under a Chief Medical Director, and that its functions shall be those necessary for complete medical and hospital service, as prescribed by the Administrator, for the medical care and treatment of veterans. He maintained that this proviso gave him the authority for complete control of the hospital system.

This memorandum was not submitted to the Solicitor through the Administrator, and this incurred the General's wrath. Thereupon, General Gray fired off a memorandum to Dr. Magnuson asking why he had made the request, and whether the request was motivated by himself or some other member of his staff, and, if so, who was it? Replying to General Gray's inquiry, Dr. Magnuson assumed the whole responsibility.
SOLICITOR'S RULING

The Solicitor ruled that the Administrator was responsible for all functions prescribed by law and that the Chief Medical Director, as head of the Department of Medicine and Surgery, was responsible to the Administrator for all medical functions. He further stated:

There is no well-defined dividing line between medical functions and administration. Some things are obviously the one, some the other. Some things obviously must be decided by trained professional practitioners, others by persons administratively experienced—else the Chief Executive himself must be a doctor.

Finally, he stated that—

the very genius of the act (Public Law 293) is that administrative considerations must not—and indeed they need not—prevent the best medical service [that] the science and practice of medicine can prescribe.

On July 19, 1949, the Administrator issued Circular 16, which read:

OPERATION OF VA HOSPITALS

1. The sole purpose of operating VA hospitals is the care and treatment of patients. This is the duty of the Department of Medicine and Surgery. All other personnel in the hospitals are there for the purpose of supplementing and assisting the Department of Medicine and Surgery in carrying out this duty.

2. Since the activities of nonmedical services in hospitals have a bearing on the care and treatment of patients, managers of hospitals will be responsible to the Administrator through the Chief Medical Director for the overall operation of hospitals, and through the appropriate Assistant Administrator for technical matters solely under their respective jurisdictions.

3. All major alterations to existing hospital plants when recommended shall be coordinated by the Chief Medical Director with the Assistant Administrator for Construction, Supply, and Real Estate, and a joint recommendation submitted to the Administrator for his decision.

(S) CARL R. GRAY, JR.
Administrator of Veterans' Affairs

The last phrase in paragraph 2, however, shut out Dr. Magnuson from getting what he wanted. A month later, when this circular was incorporated into the manual MEC-4 (which takes precedence over a circular), paragraph 3 was eliminated but the following was added—that the manager of a hospital was responsible to the Administrator through the Chief Medical Director, the Solicitor, or the appropriate Assistant Administrator, for the proper * * * operation assigned to these officials.

Dr. Magnuson considered this a definite change from the provisions of Circular 16, for now the responsibility to the Administrator through the Chief Medical Director for the overall operations of the hospital was omitted, as well as paragraph 3 being eliminated.

In October 1949, Dr. Magnuson called to the Administrator's attention the change in wording of Circular 16, as incorporated in manual MEC-4. He recommended that hospital managers be responsible to the Administrator through the Chief Medical Director for the overall operation of a hospital. General Gray replied in longhand at the bottom of this memorandum:

I am not willing to make this change * * * the bill is correct * * * Gray

"DEAR CARL" AND "DEAR PAUL"

This incident did not improve relations between the Administrator and the Chief Medical Director. Correspondence and memorandums continued to flow between them. They became more and more critical in nature, but always on a "Dear Carl" and "Dear Paul" basis.
The controversy came to a head when the Administrator decided to reorganize the Selection Committee. In existence for some time, this committee recommended to the Administrator the appointment of individuals as hospital managers and assistant managers. The Chief Medical Director had always been the Committee's chairman. However, because Dr. Magnuson frequently was out of the city, he often had one of his assistants act for him so that recommendations would not be delayed. However, Dr. Magnuson was always kept advised and his approval secured.

The Administrator wished to change this. On October 2, 1950, he appointed a new committee, among whose members were an Assistant Administrator not connected with the Department of Medicine and Surgery as their chairman, and the Deputy Chief Medical Director. Substitutes or alternates in membership were not authorized for this newly organized Selection Committee.

This did it as far as Dr. Magnuson was concerned. He called General Gray for an appointment. When the general indicated that he had many commitments, Dr. Magnuson suggested a Sunday meeting in the Administrator's office.

On Sunday morning, January 14, 1951, he and General Gray met in the latter's office. This was exactly 3 years from the date of Dr. Magnuson's appointment.

THE CONFRONTATION

When the doctor minced no words as he gave vent to all of his frustrations, General Gray accused him of insubordination. The doctor retorted that he had never worked for anyone in his life except his patients. Since he did not consider General Gray his boss, consequently, he felt he was not insubordinate.

Whereupon the general suggested that the doctor might be better off doing something else, perhaps in Chicago. Dr. Magnuson considered this tantamount to being fired. A short time later his memory was to be refreshed concerning a letter of resignation he had submitted during one of their encounters in 1948. That very afternoon, General Gray announced to the press that Dr. Magnuson had resigned.

When reporters asked the fiery doctor about this, he said:

"Hell, no, I didn't resign. I was fired. I don't resign in the middle of a fight and this is going to be a fight. Certain people don't want me to say I have been fired, but I am one of the few fellows in the world who can afford to be fired. My reputation has been built up based on good care of sick patients."

He refused to alter his stand, despite many requests to do so. The radio news that night carried the story; the newspapers of the country picked it up the next day. Simultaneously an announcement was made of the selection of Vice Adm. Joel T. Boone as successor to Dr. Magnuson. The timing of this announcement obviously indicated that the resignation or firing of Dr. Magnuson had been anticipated in advance of the Sunday morning confrontation.

Thus ended the VA career of the stormy petrel, Dr. Paul B. Magnuson. However, he was to carry the torch for the Department of Medicine and Surgery for years to come.

While there were many throughout the hospital system who felt that this disagreement would seriously lower the care of the American veteran, such was not the case. During the period of disagreement,
these two men never dealt in personalities, and both were devoted to continuance of the second-to-none medical care which had been achieved in an astonishingly short period of time. Both were strong, determined gentlemen, and each, in his own opinion, was doing what was best for VA's hospital system.

There were many rumors of resignations that supposedly were submitted to committees and managers. To forestall acceptance of these, Dr. Magnuson sent out the following letter the day after his interview with General Gray:

**January 16, 1952.**

*To: All doctors in the Department of Medicine and Surgery, Veterans' Administration*

*Dear Friend:* You have probably read in the paper that I am leaving the Veterans' Administration, apparently because of a personal disagreement between the Administrator, Carl H. Gray, Jr., and me. In the first place, I want to dispel that idea. The Administrator of Veterans' Affairs and the Chief Medical Director disagreed on policy and have disagreed on it for at least 2½ years. I have tried to reconcile my way of doing things and I think he has, but we are two fellows of pretty positive ideas and I felt that there was too much interference with the Medical Department in the running of the hospitals and the authority for running the hospitals.

A disagreement between two men must not be judged too hastily be either side that might be involved in the problem. Our job as doctors is to take care of sick people and if we do not do that job we are laying ourselves liable to very serious charges. As doctors we are an independent crew and our first impulse may be to resign if things do not suit us. I am writing this letter to you; I wish it could be personal with your first name in the greeting line, but the number that are in the Department precludes that intimacy.

I have known Dr. Joel Boone for a number of years. He is a man who has come along in the Navy to the highest possible station. He is a man of integrity and the highest professional qualifications and besides being able, he is a delightful gentleman. I don't know where, in this country, any better choice could have been found. I am personally very fond of him and he has the respect of a very large group of people in Washington, as well as the rest of the country. I believe that he will make a top leader for the Medical Department of the Veterans' Administration.

I ask you, as your former Chief Medical Director, and as a friend to give Dr. Boone the same loyalty that you have given to me and to the Medical Department in the past. I do not believe the ideals or ideas will be changed. We are entering into a serious period in our national life and I don't want to see anything happen that will further complicate matters. The fact that I have gone from the Veterans' Administration is not going to interfere with my interest in it and I stand ready to offer my services in any way that the authorities want to use them.

Hold tight and don't rock the boat; this thing is all going to be settled sooner or later. The Medical Department must continue in future years with the same high standards that it has now and has had since this program was started under General Bradley and General Hawley.

Thank you for your loyalty and for your support. I hope you will continue to give it wholeheartedly to the Medical Department of the Veterans' Administration and to Dr. Joel Boone for the good care of the veteran who is our patient.

With sincere personal regards.

Paul B. Magnuson, M.D.

As a result, there was but one resignation based solely upon Dr. Magnuson's departure from office.

In addition to the letter, that same day Dr. Magnuson summoned his immediate staff in Central Office, and very frankly put forth his side of the story. Among other things, he said:

The Administrator feels, and I think honestly, that so far as he is concerned, medical men are not good administrators. He told me that I am not a good administrator. I admit that and have told you that myself. To me, administration is leadership. Leadership is based on understanding, not only the individual,
but all of the factors that enter into the individual's relations with surrounding conditions. I claim that the Medical Department has conceived this institution into one of the greatest medical institutions the world has ever seen. You have done it; the men in the field have done it; I haven't done it; all I've tried to do is to stand between the doctor and his functions, which I know, and administrative complications and inhibitions which would interfere with his practicing medicine freely and with his heart in it.

Referring to the Administrator, he continued:

He has a right to state his case, and I think I have a right to state mine. I have always been Paul Magnuson, and I have not always been diplomatic. ** * * I think I know how to practice good medicine and have managed in some way always to keep in contact with men whom I believe practice good medicine ** * *. Hospitals, to me, are only places in which to take care of sick people and everything that goes on in hospitals should be under the control of medical men, directly or indirectly.

Again referring to the Administrator, he stated:

He has a very low opinion of a doctor as an administrator. Well, he is entitled to his opinion and I am to mine, and I have a very low opinion of the Administrator as a doctor, so that's even Stephen. There has been no bitterness about this; there has been no personal conflict between Carl Gray as an individual and Paul Magnuson as an individual. We have had some awfully plain talk, but I am older than Carl Gray and have talked plainly to people before; I didn't pull any punches on this occasion and I don't think he did.

I don't know where we could have found a better man than Joel Boone. ** * * I don't know whether he knows any of the circumstances which surround the firing of the present Medical Director. I insisted on being fired; I wouldn't put in a resignation. The resignation that is referred to is one which I put in when this thing first started in 1948, and he asked me to withdraw it. I didn't withdraw it because I thought it would stand as a sort of threat to accomplish this thing that we all want to have done. That's what he refers to as a "former" resignation. I did not resign this time and I don't want anybody to think I did. I want down with my fists going and my head up, and I am not very much bruised if you want to know about it. ** * * I would like to see every one of you continue here, doing what you have been doing, and when Dr. Boone comes in I would like to see every one of you continue here, doing what you have been doing, and when Dr. Boone comes in I would like to have you give him the same loyal service that you have given me. I think he will give you good leadership. I don't thing you will find him deficient in his ideals of medicine or his sense of responsibility toward the medical profession as a whole.

In November 1951, Dr. Magnuson was appointed Chairman of the President's Commission on the Health Needs of the Nation. Serving with him were several outstanding citizens, representing their various interests, including Dr. Joseph C. Hinsey, dean of Cornell Medical School; Dr. Evarts A. Graham, professor of surgery at Washington University in St. Louis; Mr. Walter Reuther, head of the United Auto Workers, and other leaders in the medical and related health fields.

The Commission's report was presented to President Truman in June 1953. Dr. Magnuson states that when the President went out of office he had his desk cleared for his successor's use; the only thing he left for Mr. Eisenhower was the report on the health needs of the Nation, lying face up on the desk right in front of the Presidential chair.

Dr. Magnuson has been of assistance to every Chief Medical Director who has followed him. He is still the "watch dog" of the Department of Medicine and Surgery, "growling" and "barking" when he thinks something might lead to a deterioration of the veterans' "medical care second to none" for which he labored so long, and in which he played a most important part.
His next endeavor was to establish a first-class rehabilitation center in Chicago. He made frequent trips to that city and was not long in raising sufficient funds for establishing the Rehabilitation Institute of Chicago, in which he still maintains a lively interest.

Testimony of the high regard in which Dr. Magnuson was held in the highest medical circles is the following letter written to him on March 12, 1951, by the distinguished Dr. Charles W. Mayo:

DEAR PAUL: The meeting of the Special Medical Advisory Group today was the first meeting after the termination of your duties as Chief Medical Director. In executive session the principles for which you worked and stood for were commented upon by all. I am writing at the unanimous request of the group to extend heartfelt best wishes to you. Those constructive principles of which you dreamed and for which you worked, and in which we all concurred, must continue and in fact must be fulfilled.

We have been assured that important steps which you advocated are to become realities. As they do, it will be satisfying to you, as it will to all of us, to know that you helped greatly in establishing a sound basis for medical care of all veterans. We shall continue to strive for that care to be second to none. If we need example in this, your effort will provide fullest inspiration.

Every member of the group joins in deep appreciation of all you did and helped to do. Your position and part in the development of the medical program is secure and has left an indelible imprint. Let us now— all of us— put our shoulders to the wheel, so that Admiral Boone may carry the torch as effectively as possible toward the ultimate goal in which we all believe so strongly.

Sincerely,

CHARLES W. MAYO, M.D.,
Chairman, Special Medical Advisory Group,
of the Veterans' Administration.

INVESTIGATION ORDERED

Immediately following the departure of Dr. Magnuson, considerable publicity was given to his leaving. Many letters of protest were sent to the President and to Members of Congress. These triggered a wary reaction in the legislative branch. To forestall any deterioration of veterans' medical care, Congress promptly ordered an investigation. A special subcommittee of the Senate Committee on Labor and Public Welfare was appointed. This group conducted hearings on February 8, 20, and 27, March 7, 8, 12, and 13, and May 10 and 11, 1951.

It was a strong group and equally strong groups and strong individuals appeared before it. Two of this distinguished committee rose to become Vice Presidents of the United States. The chairman was Senator Hubert H. Humphrey of Minnesota. The others were Senators Lister Hill, of Alabama; Paul Douglas, of Illinois; Wayne Morse, of Oregon; and Richard M. Nixon, of California.

BOTH MEN WON

The proud and bristling Dr. Magnuson presented the case for the VA's Department of Medicine and Surgery. The equally proud and firm General Gray advanced the case for the VA as a whole, while various important organizations and individuals sided either with Dr. Magnuson—as did the Citizens' Committee for the Hoover Report—or with General Gray—as did most of the veterans' service organizations. The subcommittee steered a nonpolitical course of moderation and balance, and, at the end of the hearings, both men, in effect, had won.
General Gray was not criticized by the subcommittee, nor was legislation proposed to give Dr. Magnuson the near-autonomy for VA medicine that he seemed to want. Instead, there was a gentleman's agreement to delay further action pending the completion of the management engineering report then underway. General Gray agreed to explore the possibility of so reorganizing the VA as to give the Department of Medicine and Surgery a stronger status within the agency, with less interference from the many nonmedical administrative officers.

General Gray advised that a contract had been awarded to the management engineering concern of Booz, Allen & Hamilton, of Chicago, which since the day following the resignation of Dr. Magnuson had been at work conducting such a survey.

**Reorganization of the Government, Including the Veterans' Administration**

During the latter part of General Bradley's administration, this subject received close scrutiny by the President and the Congress. The Commission on Organization of the Executive Branch of the Government, which came to be known as the Hoover Commission, was established by unanimous vote of the Congress on July 7, 1947. Its duties included:

1. Limiting expenditures to the lowest amount consistent with the efficient performance of essential services, activities, and functions;
2. Eliminating duplication and overlapping of services, activities, and functions;
3. Consolidating services, activities, and functions of a similar nature.

The Commission had authorized the Trundle Engineering Co., of Cleveland, Ohio, to study the organization of the Federal medical service. In March 1949, they recommended:

1. The formation of a United Medical Administration (similar to a Department of Health) to plan and supervise most Federal activities in the fields of medical care, medical research, and public health, thus providing, in the Commission's view, a unity of services in the national interest, rather than special services to special groups. Under this concept, it recommended that all Federal general hospitals, including those of the Veterans' Administration, be placed under control of the United Medical Administration.

None of the Trundle recommendations regarding veterans was adopted or even actively considered by Congress.

President Truman wanted to be sure the organization and administrative policies of the veterans' benefits program were the best. In 1950 he asked Dr. Howard A. Rusk, who was an outstanding physician in physical medicine and rehabilitation, to head a committee composed of the President's senior naval aide and another civilian physician. It would review the veterans' hospitalization program and the needs of the disabled veterans, especially those of paraplegics and amputees.

The report was submitted on September 22, 1950, and included the following statement:

Reiterated statements of the Veterans' Administration before your committee have led your committee to believe that the present administrative organization of the Veterans' Administration as it pertains to the VA's medical service is cumbersome and unwieldy. Because of these statements and other evidence which has come to the attention of your committee, we believe that a management survey of the organization and administrative structure of the Veterans' Administration would be of substantial benefit. Witnesses who have appeared before your committee have, almost without exception, adversely criticized the organizational structure and administrative policies of the Veterans' Administration.

On September 23, 1950, President Truman directed the Administrator to set in motion such a survey. Booz, Allen & Hamilton, of Chicago, started this survey on January 15, 1951.

Booz, Allen & Hamilton submitted their report 17½ months later. Then for 9 months more, General Gray and his assistants studied all the recommendations of this one Chicago firm plus those of Trundle Engineering, Hoover Commission task force, Citizens' Committee for the Hoover Report, the American Legion, the Veterans of Foreign Wars, and other organizations interested in veterans' affairs. When they consulted the House Veterans' Affairs Committee, the Administrator was told that they saw no reason why the reorganization should not be placed in effect.

The Gray administration had taken a long hard look at the VA and was ready for a far-reaching reorganization of the agency's administrative structure, not only in the field of medicine but in the other areas of its responsibilities.

The proposed plan was announced on November 26, 1952. It called for a revision along "major-purpose lines" in contrast to the "functional line" type of organization which had been in existence in one form or another since the creation of the Veterans' Administration back in 1930. This plan set up three departments to replace the 16 divisions. These departments would be delegated the task of carrying out the three major purposes of the VA: The Department of Medicine and Surgery to provide medical care and treatment for veterans; a Department of Insurance to conduct an insurance service; and a Department of Veterans' Benefits to provide assistance to veterans in their readjustment to civilian life as well as administer programs designed to compensate them or their dependents for disabilities or death resulting from military service. It was also to provide other benefits and services authorized by Congress.

Thus, many of the aims of Dr. Magnuson would be accomplished. The Department of Medicine and Surgery would now be master within its own household and this theory was adopted without reservation by General Gray.

The three Departments would be fully equipped with the related functional authority to conduct their affairs with substantial autonomy under general policies established by the Administrator and his advisory group. The head of each Department would be responsible directly to the Administrator. The manager of a hospital would be responsible to the Administrator, through the Chief Medical Director, for the operation of his station.

On June 30, 1953, the Executive Office of the President authorized the VA to proceed with the reorganization plan, and action to this effect started immediately.
It became Admiral Boone's job to make the new Department of Medicine and Surgery function. He did this with the least possible disruption to each of the services involved and soon welded them into one harmonious medical department. He now had under his jurisdiction not only the professional activities of all hospitals and clinics, but all the ancillary services, such as supply, finance, personnel, maintenance, engineering, registrar, chaplaincy, canteen, etc.

One segment of hospital operation still not within the Department was the special service program. However, during the 1954 fiscal year, Admiral Boone asked that its three remaining functions be integrated into the medical program. These were the library, recreation, and voluntary service activities which, previously, as an independent unit, had reported to the Administrator.

It was in 1954, too, that Admiral Boone created a Housekeeping Service. There had been considerable difficulty with cross-infection in many hospitals. Researchers found a consistent parallel between the infection rate and the level of cleanliness in the hospital. In general, hospital sanitation had been taken for granted, with little attention paid to its effectiveness beyond the reach of the naked eye.

Since its establishment as a separate and complete service, great progress has been made, with the result that all VA hospitals have well-functioning housekeeping divisions.

This activity has attracted international attention. Canada has sent representatives to study the program with a view toward setting up a similar plan in the Veterans' hospitals of Canada. The International Cooperation Administration asked the Veterans' Administration to provide trainers in this field in Central American countries.

The entire hospital team now was responsible to the Chief Medical Director, who was, in turn, responsible to the Administrator. The Department of Medicine and Survey, while not autonomous in that the Chief Medical Director reported to the Administrator, was subject to the jurisdiction of the Chief Medical Director. This aim of Dr. Magnuson was successfully attained by Admiral Boone, but not until after General Gray had left.

Approximately half way through Admiral Boone's tour of duty, General Gray resigned, effective June 30, 1953. He had been in office for 5½ years and, during this time, had given of himself freely despite a vision handicap and a circulatory ailment. He underwent observation at the Mayo Clinic in Rochester, Minn. and, undoubtedly, the findings led to his decision to relinquish office. He and his wife returned to their home in Hudson, Wis., but he kept in active touch with veterans' affairs until his death on December 2, 1955.

General Gray had rather a stormy term of office, considering the 16,000-bed cutback, his relationship with Doctor Magnuson, and the Senate hearings. In addition, there was a gradual cutback in funds appropriated for the operation of the Veterans' Administration. He weathered these storms as a strong man would. There was never the slightest doubt as to his devotion to the welfare of the veteran.

On his last day in office, General Gray addressed the officers and employees of the VA as follows:

I cannot and will not leave active participation in the affairs of veterans without expressing in this manner my deep gratitude and satisfaction for the work you have accomplished for and in behalf of veterans in the past 5½ years.
Yours is a tremendous job and an outstanding unselfish devotion to duty with a touch of human kindness mixed into it that makes it so wonderful to be associated with and to participate in such a program.

To each and every one of you I express my deep and abiding gratitude for your confidence, your loyalty, and your extreme devotion to duty. It is most difficult for me to leave, but I am advised that it is necessary, and while I am not a sick man, a continuation of this type of service would make me one and that is what I am trying to avert.

Again, thanks a million for all you have helped me to do, for without your devotion to duty, and loyalty to the cause, it could not have been done.
Joel Thompson Boone

Joel Thompson Boone was born in St. Clair, Pa., on August 29, 1889, to William Agard and Annie (Thompson) Boone. He is a collateral descendant of Daniel Boone.

He graduated in 1909 from the Mercersburg (Pa.) Academy, and received an M.D. degree from Hahnemann Medical College in Philadelphia, Pa., in June 1913.

In April 1914, he became a lieutenant (jg.) in the Medical Corps of the U.S. Naval Reserve and attached to the Naval Hospital at Portsmouth, N.H., for a short period of time. He later attended the Naval Medical School in Washington, D.C., and in May 1915 he was transferred to the regular Navy in the same rank he held in the Reserve.

He thus started a long and illustrous career in the U.S. Navy, rising from lieutenant (jg.) to a vice admiral at the time of his retirement.

After service in Haiti and on the battleship, "Wyoming," he was detached from the regular naval duty to serve with the 6th Regiment Marines and proceeded to France with them early in October 1917. It was while serving with this regiment that his bravery under fire earned him the Congressional Medal of Honor. This citation reads as follows:

** * * With absolute disregard for personal safety, ever conscious of the suffering fallen, [he] leaving the shelter of a ravine, went forward onto the open field where there was no protection and, despite the extreme enemy fire of all calibers, through a heavy mist of gas, applied dressings and first aid to wounded marines.

He also received numerous other decorations and special citations for his World War I service.

He returned to the United States in February 1919 and among other duties was director of naval affairs for the American Red Cross. In this capacity he became closely associated with the Veterans' Bureau and with the problems of the returning disabled ex-serviceman.

He was then assigned as medical officer aboard the Presidential yacht, "Mayflower," and became associate physician to President Warren G. Harding. He was later associate physician to President Calvin Coolidge, and, after Herbert Hoover's inauguration in 1929, he became chief physician at the White House. The President later renamed this position as "Physician to the White House," and Admiral Boone continued to serve in that capacity as a captain, U.S. Navy.

President-elect Roosevelt abolished the position of White House physician, at which time Boone returned to regular naval duty, serving at various posts at sea and throughout the United States.

In April 1945, he was on duty as fleet medical officer of the 3d Fleet, and was selected to be one of three officers to land in Japan to liberate allied prisoners. He was also aboard the U.S.S. "Missouri" in Tokyo Bay on September 2, 1945, and was the Naval Medical Corps representative at the surrender ceremonies.

For his Second World War service, he again received numerous military decorations. Shortly after returning from Japan, he became inspector of the medical department activities on the Pacific coast, with additional duty as medical officer of the western sea frontier. While serving as such, he was appointed medical advisor to the Federal Coal Mines Administration. This position was created as a result of an agreement between the Secretary of the Interior and the United Mine Workers that a governmental medical survey of the coal industry should be instituted. In conducting such a survey, Admiral Boone visited 22 coal producing States and their report
proved critical of housing and safety conditions, stating that "some camps are a disgrace to the industry and the Nation."

From then on until his retirement, Admiral Boone held very important assignments in the Office of the Secretary of Defense, and as inspector general of the Naval Medical Bureau.

He retired November 30, 1950, and became Chief Medical Director of the Department of Medicine and Surgery of the Veterans' Administration in March 1951.

In addition to U.S. military honors, the admiral received the Order of Fourragere (three awards), the French Legion of Honor and the Croix de Guerre with two palms, and the Italian War Cross.

Professional recognitions include honorary M.A. and LL.D. degrees and election as president of the Association of Military Surgeons; a fellow of the American College of Physicians and Surgeons, and the American Medical Association. He is a member of the Army and Navy Legion of Valor, the Alpha Sigma Fraternity, and the board of regents of Mercersburg Academy, in which he has taken a great interest since his graduation from that school.

Admiral Boone retired from the Veterans' Administration on February 28, 1955, and with his wife makes his home in Washington, D.C.

Undoubtedly, General Gray anticipated this break with Dr. Magnuson. Obviously, he had asked Vice Adm. Joel T. Boone to accept the position of Chief Medical Director. This was late in 1950. General Gray knew that the admiral had recently retired as a vice admiral, after a long and distinguished naval career which included serving as physician to three Presidents: Harding, Coolidge, and Hoover. For exceptional bravery in World War I, he received the highest military award that can be given any individual in the United States, the Medal of Honor. His extraordinary heroism, conspicuous gallantry, and intrepidity as a surgeon, under fire with the 6th Regiment, U.S. Marines, in France was the basis of the honor.

The admiral received many other citations, which are listed in his biography.

When first contacted by General Gray, the admiral was not entirely receptive to such a proposition. He had been considering a very remunerative offer from a civilian firm, one that would have allowed him to retain his retirement pay in addition to the salary received.

Furthermore, he felt he was entitled to a much earned rest after his long and exhaustive military career. For some time he and his wife had been planning a trip to Florida that would take up at least 3 months. He added that should he decide to accept the position it would have to be definitely understood that he would be free to supervise the Chief Medical Director's Office and the VA medical program without interference, after policy had been formulated, enunciated, and adopted, pertaining to the Department of Medicine and Surgery. Admiral Boone expressed his awareness that final policy determination was certainly within the province of the Administrator of Veterans' Affairs, but he felt that any new policies, plans, and programs should be decided jointly by the Administrator and the Chief Medical Director. Admiral Boone insisted that he would not tolerate any interference with supervision and direction of the Department of Medicine and Surgery, or the issuing of memorandums to the field by the Administrator when the Chief Medical Director was not
On two occasions this agreement was violated. When he found out, Admiral Boone, now Chief Medical Director, sought immediate conference with General Gray. He reminded the general of the agreement made prior to his appointment. He stated that if he was not willing to change the memorandums that had been issued without his knowledge he would quit. The memorandums were destroyed and Admiral Boone was informed that he could issue his own instructions pertaining to the same subjects.

When Dr. Magnuson resigned, the Administrator telephoned the admiral in Key West, Fla. Since his arrival the admiral had been debating General Gray's proposal. He was thoroughly familiar with veterans' affairs for he was interested in their medical care since World War I. He also felt it his patriotic duty to accept an assignment in which he could continue to serve his country and its veterans, even though it entailed financial and other sacrifices. He accepted provided that he would not have to assume office for approximately 2 months. Accordingly, he returned to Washington in late February 1951.

Admiral Boone was sworn in as Chief Medical Director on February 28, 1951, and assumed his new office the following morning.

On January 16, 1951, the Board of Chief Consultants sent a highly congratulatory message to Admiral Boone. The following day the admiral replied with an inspirational telegram of acceptance.

It should not be forgotten that the hearings before the Special Senate Subcommittee of the Committee on Labor and Public Welfare—to investigate Veterans' Administration policies with respect to hospital administration—were still in progress.

From: Remarks by Admiral Boone, attending the March 12, 1951, meeting of the Special Medical Advisory Group—18th quarterly meeting.

* * * * *

"General Gray knows that I would not assume this office without certain very positive commitments. While at Key West I received a telephone call from a newspaperman of this city. He said "I understand you are going to require General Gray to put into writing his authority to you and his instructions." I replied that "I have been in the Navy almost 37 years; I have reported to a great many admirals and generals and other people of various descriptions in military life. I have never had the confidency nor the assumption to ask a senior to put himself in writing in giving me instructions or directions. That would be the first breach of confidence." I want General Gray to have confidence in me; if he doesn't have then I don't belong here. I certainly must have confidence in him. It is just like loyalty; it works both ways. While I expect loyalty and am confident I will have it, I have no right to it unless I give it to those associated with me. I have said that I believe in this close affiliation of the VA hospitals with the medical schools and the great medical centers. I repeat here and now that I do. I also believe very firmly—and I have General Gray's support in this—that you cannot separate authority from responsibility in any worthwhile accomplishment. General Gray has assured me that I will have authority commensurate with my responsibility. We have a gentleman's agreement. I know that I am dealing with a gentleman—General Gray. I know of his great reputation and standing in industry because I inquired about it from great industrialists of this Nation. I know his family background. I know of his intimate and deep-felt feeling toward medicine, for one reason, because he has a brother at the Mayo Clinic—one of my very good friends—a man for whom I have a tremendous admiration.

General Gray said to me in the beginning: "You and I will be a team. You will be at my right hand. You will run the Department of Medicine and Surgery. Please keep me informed, and that is all I ask of you." On the day we discussed this matter of authority and responsibility, General Gray said: "Remember, Joel, I have a responsibility also." I said: "Very definitely; from the Congress
of the United States, and I will respect that responsibility. I feel that if I am worthy of this position, I can handle the affairs of the office and I shall certainly keep you informed. I will not make any policies that are not in consonance with your policies. If I feel that your policies are not in line to the best interests, as I see them, of the Department of Medicine and Surgery, I shall so advise you. As long as I am here, even though we thrash things out, we may not agree on the finest points, once you as the commanding officer (in this instance, General Gray) makes the decision, I shall certainly click my heels together and say, 'aye, aye, sir' and execute it. Otherwise I do not belong here."

Admiral Boone is a very polished gentleman with obvious military bearing. Meticulous in his appearance, he definitely impresses one as a man of distinction. He is an excellent speaker with a voice that is soft and resonant.

His keen understanding of veterans' problems, his warm personality, and sense of humor, soon won him the confidence of all with whom he came in contact, both in the central office and the field stations.

When he undertook one of his many inspections of hospitals, it was anticipated with pleasure rather than apprehension. However, his "spit and polish" Navy training made him most critical of any disorderly appearance. He is a perfectionist as to cleanliness and order are concerned, whether it be in a ward, laboratory, office, or utility shop. The pharmacist with bottles or packages on top of the shelves was told to remove them. Coca-Cola or other dispensing machines in corridors were ordered to other less conspicuous locations. Utility shops having tools scattered helter-skelter had to be put in order without delay. And so on, throughout the hospital. All criticisms were made in such a manner that the employees concerned were not resentful but rather impressed to such an extent that not only were unsatisfactory conditions corrected but remained so from then on.

Admiral Boone's Navy career trained him for working in a large complex organization. He understood a staff-and-line organization. He had many years of experience on various Navy, Marine Corps, and Army staffs and in the administration of hospital facilities.

As soon as he became Chief Medical Director of the Veterans' Administration, he developed an excellent rapport with General Gray. He accompanied General Gray on field trips and traveled 7,500 miles in the 2½ months after he took over as Chief Medical Director. The result was that in testifying before the Humphrey committee on May 11, 1951, Admiral Boone stated he could function under the existing organization, as it was not very much different from the Navy. He stated that General Gray looked upon him as similar to a Surgeon General. He said, "I correspond in the eyes of the law to the Surgeon General. Rightly or wrongly, that's fact." This was a complete reversal of General Gray's position in a statement before the Special Medical Advisory Group in March 1949.

Harmonious relations were thus reestablished between the Administrator and the Chief Medical Director. Admiral Boone promptly dispelled any apprehension which may have existed that he would not give full support to the governmental and private medicine relationship, with its joint educational medical care program. Immediately he began promoting the program established by his two immediate predecessors, General Hawley and Dr. Magnuson.

To determine if policy memorandum No. 2 was still workable, Admiral Boone ordered a survey be made. Medical schools were
asked for suggestions and recommendations. They indicated that no changes were necessary or desirable.

Before the hearings ended it became obvious that General Gray was becoming much more inclined to give free rein to Admiral Boone in running the medical program, although not agreeing to the near autonomy which Dr. Magnuson advocated.

The Senate committee chairman questioned whether Admiral Boone felt competent to supervise and administer the Veterans' Administration medical program. The admiral replied that he could if he had authority commensurate with his responsibilities. He cited his long military career of a varied and extensive nature plus his service to Presidents of the United States as their physician. The chairman of the Senate committee asked Admiral Boone whether he could define that in one word. He then said he could: if he had autonomy. However, he added that he realized full well that there was only one head of the Veterans' Administration and that was the Administrator, who was appointed by the President and who was the only VA official confirmed by the Congress. The independent authority that Admiral Boone talked of would be assumed only after policies had been formulated pertaining to the Department of Medicine and Surgery jointly by the Administrator and the Chief Medical Director. In the execution of these policies he felt he should be autonomous.

During Admiral Boone's term of office, organized medicine was highly critical of the Veterans' Administration giving hospital care to non-service-connected veterans. There was misunderstanding not only on the part of medical organizations, but by a sizable segment of the general public as well. Many felt that all veterans could now get hospital care for any reason whatsoever.

Admiral Boone made many trips addressing medical and veterans' meetings, and civic bodies, defending this entitlement to hospitalization for the non-service-connected veteran. He prepared a paper for distribution called "From A to Z" which did much to correct the prevalent misunderstanding about the VA's medical and hospital program. He pointed out the restrictions placed on the admission of veterans with ailments not related to their service.

In addition to attending meetings and conventions of ex-service men's organizations, Admiral Boone accompanied the Administrator in the dedication of new hospitals. Thus, during the 4 years he was Chief Medical Director, he had traveled many thousand miles and participated in the opening of 48 new hospitals. However, this did not keep him from being in close touch with the activities of the central office. He kept his top staff members currently informed, demonstrated confidence in them, and gave them his support.

The first new hospital to be dedicated after Admiral Boone assumed office was at Erie, Pa. General Gray invited the admiral to accompany him to the ceremony, but Admiral Boone did not feel it necessary that he be invited. He made it plain that he intended to attend and participate in the dedication of the Erie VA hospital and, as well, every hospital dedication during his term of office as Chief Medical Director.

The Mount Alto Hospital in Washington, D.C., was high on the list for replacement, but the selection of a site was a subject of considerable controversy.
At first it was felt that VA should build in the suburbs to be safe from atomic attack. This theory proved inaccurate, and, in 1950, 42.4 acres at the U.S. Soldiers' Home in Washington were selected as the eventual site for a new hospital. Later, 8 acres were returned back to the Soldiers' Home, making the present site approximately 34 acres.

When a delay in appropriations for the new installation developed, there was an attempt to have VA give up this site until funds for construction were available. Admiral Boone fought successfully to retain this acreage. In 1965, the new hospital was completed on the site purchased 15 years before. This land was obtained from the GSA at a cost of $500,000.

Approximately halfway through Admiral Boone's term of office, General Gray sought retirement for physical reasons. Mr. Harvey V. Higley was appointed to succeed him. The same close cooperation and relationships between the Chief Medical Director and Administrator Higley continued during the balance of the time Admiral Boone was Chief Medical Director. By now, things were on an even keel and the morale of the Department of Medicine and Surgery, both in the central office and in the field, was at a high level.

Admiral Boone finished his 4 statutory years on February 28, 1955, and laid down the reins of office with the respect and admiration of the entire organization. He continued to retain a very sincere interest in the affairs of the Department of Medicine and Surgery. By special appointment, he was named a consultant to his successor, Dr. William S. Middleton, and he served as such for 8 years. During those years he attended all meetings of the Special Medical Advisory Group. He has continued to maintain a deep interest in the veterans' medical program and keeps in close touch with the progress being made in veterans' medicine.

Admiral and Mrs. Boone continue to reside in Washington, where they have many interests. He writes and is very active in naval, religious, and civic circles.

SEGREGATION

The Veterans' Bureau and the Veterans' Administration, up until 1953, had always adjusted to the customs and regulations of the community in which its facility was located when it came to segregating patients. Primarily, those hospitals located in the Southern States were the only ones where it was practiced.

In June 1933 a new facility—hospital and domiciliary—was about to be opened in a Southern State. General Hines had authorized it to receive eligible patients and members immediately after July 1, 1933. No mention was made of any type of segregation. The manager of that facility wrote immediately explaining that the State law required a most rigid segregation of the races, and this applied to hospitals, schools, etc. He objected seriously to the admission of Negro veterans at that station. He said further that he could not be responsible for the safety and well-being of those Negro patients admitted.

President Truman had eliminated segregation in the Armed Forces shortly after World War II. Little or no difficulty was experienced. However, the desegregation of sick veterans presented a different problem, especially those suffering mental disorders. This was an
area in which unpredictable and often violent reactions to prejudices, and outside stimuli could be expected. It was important to approach this problem in a most careful and discreet manner.

General Gray took the first steps in this direction with the wholehearted cooperation of Admiral Boone.

Later Administrator Higley gave Admiral Boone his wholehearted support in this area. Both were assured the strong backing of President Eisenhower and his staff. President Eisenhower had, in the meantime, issued an order abolishing segregation in schools on the Federal reservations.

Admiral Boone most aptly expressed his feelings in the matter in a memorandum to the Administrator dated August 16, 1953, which is quoted here in part:

* * * my responsibilities encompass the physical and mental care of the veterans of this Nation, irrespective of race, creed, or color. The only determination is whether the individual is a veteran of the United States of America—a man or a woman who has served his or her country in its Armed Forces. When that individual wears the same uniform; shares the same vices and virtues; obeys the same rules; is awarded the same honors; gives all for country and dies for it, there should be no discrimination nor distinction in the veteran’s earned right to equal medical and hospital benefits and provisions. Any practices contrarywise in Veterans’ Administration facilities should be eliminated. It is gratifying to report to you that there are none whatsoever in any Veterans’ Administration regional office clinic. I recommend that if and where there are any, in any Veterans’ Administration hospital or domiciliary home, that they be prohibited.

Realizing the necessity for great discretion in issuing directives to managers in those localities where racial prejudice existed, Admiral Boone appointed Dr. H. D. Kretzschmar to handle the delicate task of contacting those stations where segregation existed in some form or another. The objective, of course, was the abolition of segregation in all of VA’s hospitals, but the medical care of the patients was to be the first consideration.

A survey of 166 Veterans’ Administration hospitals, conducted in August 1953, showed that in 47 installations, located mostly in the South, some form of segregation was practiced in accordance with local laws and customs. This segregation varied from the refusal to accept Negro patients to certain wards being definitely reserved for Negroes, to more limited delineation such as separate canteens for white and Negro, separate toilet facilities, etc.

Dr. Kretzschmar worked hard at administering the agency’s policies intended to abolish all forms of segregation. This required months of contact with the station managers concerned. He consistently warned each that the proper medical care of the patient came first, but that segregation was to be discontinued.

There was no publicity nor were there newspaper headlines. In one year, the VA accomplished a silent revolution. Forty-seven VA installations accomplished a social about-face and wiped out racial segregation. No real dissatisfaction on the part of the patients or the local communities was noticed.

For his extreme tact and diplomacy and human understanding, Dr. Kretzschmar was awarded the Meritorious Service Award of the Veterans’ Administration. The doctor, in turn, credited the cooperation of the hospital managers.

It was with great pride that Mr. Higley advised President Eisenhower on October 20, 1954, that segregation had been eliminated in
all of the hospitals and domiciliaries, and that the integration of VA patients had been successfully accomplished.

President Eisenhower took the time to pen his personal congratulations to Administrator Higley:

DEAR HARVEY: I greatly appreciate your report on the success of the Veterans' Administration program to eliminate segregation in all VA hospitals and domiciliaries. You and all who cooperated with you in this program are to be highly commended.

In making the success of your program possible, our people have once again demonstrated their social maturity and their determination to have in America fair play and equal opportunity. In your accomplishment, Americans everywhere can take a great and justifiable pride.

With warm regard,

Sincerely,

DWIGHT D. EISENHOWER.

Undoubtedly the desegregation in the Armed Forces, started by President Truman, made it easier for the World War II and Korean conflict veterans to accept integration in VA hospitals, having been accustomed to it in the service.

The policy has had the close scrutiny of the Medical Directors who followed Admiral Boone—Dr. William S. Middleton, Dr. Joseph H. McNinch, and Dr. H. Martin Engle. It is now an accepted way of life, with practically no criticism from either management or the patients. President Eisenhower, in his most recent book, "Waging the Peace," gives credit to the Veterans' Administration for being one of the leaders in the elimination of segregation in the Federal Government.

Harvey V. Higley

Harvey Van Zandt Higley was born October 26, 1892, in Cheshire, Ohio, the son of Dr. Edward S. and Cora (Van Zandt) Higley. He attended public schools in Glen Ellyn and Wheaton, Ill., and acquired the Ch. E. degree in 1915 from the University of Wisconsin. For about a year, beginning in 1918, he served as a first lieutenant in the U.S. Army Chemical Warfare Service.

When discharged in 1919, he obtained a position at the Ansul Chemical Co., in Marinette, Wis. In 1938, Higley was named president of the company and 10 years later he became chairman of the board.

A member of American Legion Post 39 at Marinette, he was elected Wisconsin State commander for 1941-42 and became well known to the State's 50,000 Legionnaires. Higley was chairman of the Marinette County Selective Service Board during World War II; a member of the American Legion's national executive committee in 1942 and 1944; and a member of the Legion's national retirement committee for 5 years, during 4 of them he was chairman of the committee.

On July 17, 1953, President Eisenhower nominated Harvey V. Higley as Administrator of Veterans' Affairs. This nomination was praised by veterans' organizations, and Higley was sworn in on July 22, 1953, having been confirmed by the Senate. He held this post until November 13, 1957, when he resigned.
Harvey V. Higley, Administrator, Veterans Administration, July 1953–November, 1957.

Mr. Higley is a member of the Chicago Athletic Club, Madison Club, Delta Tau Delta, American Philatelic Society, and the American Society of Refrigeration Engineers. He founded Marinette Youth, Inc., in 1944, and served on various planning commissions of the city of Marinette. He is the recipient of the second annual Distinguished National Veterans Award.

He and his wife now reside in Marinette, Wis.
A MIDWEST INDUSTRIALIST BECOMES ADMINISTRATOR

On July 17, 1953, President Eisenhower named Mr. Harvey V. Higley, of Marinette, Wis., as General Gray's successor. He was sworn in at the White House on July 22, after being confirmed by the Senate.

Mr. Higley is a chemical engineer by profession and a graduate of the University of Wisconsin. He served as first lieutenant in the Chemical Warfare Service of the U.S. Army during World War I. He served in a number of important offices in the American Legion, among these were Wisconsin State commander in 1941–42, a member of the Legion National Executive Committee 1942–44, chairman of the Legion National Retirement Committee 1943–47; and, more recently, a member of the Legion Rehabilitation Commission.

Following his discharge from the service in 1919, Mr. Higley joined the Ansil Chemical Co., of Marinette, Wis., serving successively as secretary, president and chairman of the board until entering Government service. He is still a director of the Ansil Corp.

Mr. Higley was chairman of the Marinette County Selective Service Board during World War II. He also served as State chairman of the Republican Party of Wisconsin.

After taking office, he stated:

I cannot understand why there is such criticism of the Veterans' Administration, the VA medical and hospital program, and the programs under the people who are executing them. I am determined to change that criticism to one of just praise.

He often stressed that VA deals with human beings and should tolerate only those employees who can give service with patience, sympathy, and understanding.

The highest of distinctions is service to others. However, it goes beyond merely distinction, it is gratification, especially when that service is assisting those in need. And when such service is extended to veterans, there is an extra inner feeling of satisfaction.

Mr. Higley is a tall, distinguished looking gentleman, an excellent speaker and blessed with a keen sense of humor. He turned out to be a calm, kindly and dignified Administrator. He maintained a truly "open-door" policy at his office.

EFFICIENCY AND ECONOMY

Higley adopted the Gray plan of reorganization. He set out to effect the greatest efficiency and economies without diluting service to the veteran. During his first year in office with a budget of some $200 million less than in the previous year, he found he had to carry on many services the agency could not afford.

Higley maintained excellent relations with Admiral Boone, the Chief Medical Director, all during the latter's term of office. By now, the morale of the Department of Medicine and Surgery, both in the central office and in the field, was at its highest level.
Critics of the Veterans' Administration's policies would have free medical treatment for non-service-connected cases reduced and compensation payments for minor disabilities eliminated. Mr. Higley felt the existing medical policy, authorized in 1924, should be retained unless the already overburdened civilian hospitals were ready to take on an added caseload.

The original law, sponsored by General Hines, authorized hospital care, under certain conditions, for veterans suffering from disabilities not due to their military service. Veterans seeking such care had to state under oath that they could not afford to pay for such hospitalization. Admission was granted, only if a bed was available in a VA or other Federal hospital.

This legislation had been in operation for almost 30 years when Mr. Higley became Administrator. As time wore on, the entitlement was distorted to a point that many felt that all veterans were entitled to hospital care regardless of their financial conditions.
Others voiced the opinion that many veterans with non-service-connected disabilities were receiving benefits to which they were not entitled.

Mr. Higley decided to correct such erroneous impressions. Up until this time, veterans simply had to sign a statement under oath that they were unable to pay for hospital care. Being a businessman, Higley felt that veterans who could not afford to pay for their hospitalization would not resent saying so when properly counseled.

He applied this philosophy in an addendum to the regular hospital application form, VA form 10-P-10. The information requested was very similar to that required on any credit application everyone uses. Its purpose (it is still in use) is not to enable the U.S. Government to pry into the personal affairs of any veteran, but rather to protect him from any unjust charges, as well as to prevent the imposition of penalties provided by law for fraudulent statements.

Admission procedures in every hospital were revised to provide for counseling of the applicant by an employee carefully selected for tact and understanding. This counseling is conducted in absolute privacy. In those cases where the applicant is too ill to be interviewed, his next of kin is asked to supply the data. The hospital supplies, whenever possible, an estimate of the cost of the hospitalization required by the applicant, which, when compared with his income and assets, would assist in the decision as to ability to pay.

An investigation subsequently made by means of a nationwide sampling of 500,000 veteran applications revealed that less than four-tenths of 1 percent were doubtful as to the validity of the financial statements.

The applicant is required to certify that the financial information he supplied is correct and that he is either "able" or "unable" to defray the necessary expenses of the hospital treatment for which I have applied." With hospital costs continually rising, the breakpoint between "able" and "unable" to pay is very difficult to establish. Practically all hospital insurance policies preclude payment for hospital care in a VA or other tax-supported hospital.

D. M. & S. MAKES NOTABLE ADVANCES

During Mr. Higley's administration, the Department of Medicine and Surgery made notable advances, especially in administration. The successful results of the Gray plan were beginning to appear. All phases of the medical program, as well as the services required for their effective operation, were now combined under one head, including those previously assigned to special service.

When Mr. Higley took office, there were 20,138,000 living veterans, as compared with 18,008,000 when General Gray took over. There were 162 hospitals in operation, as compared with 125 when General Gray took oath of office. An average of 104,482 patients were cared for daily, as well as 16,620 members in the domiciliaries. This was over 2,000 more than cared for under the Gray regime.

The waiting lists contained 22,613 applicants awaiting admission, none of whom were service-connected, although some of the latter were hospitalized in other than VA hospitals. The hospital staffs had been built up to 4,106 full-time physicians, 904 dentists, and 13,799 nurses. There were 8,453 attendings and consultants on the rolls.
On January 14, 1945, President Eisenhower, issued Executive Order No. 10588, setting up the President's Commission on Veterans' Pensions. The Commission was composed of General Bradley, former VA Administrator, and six eminent citizens. Its function was "to make a comprehensive survey and appraisal of the structure, scope, and administration of the laws of the United States providing pension, compensation, and related nonmedical benefits to veterans and their dependents * * * and to make recommendations to the President regarding policies which, in its judgment, should guide the granting of such benefits in the future."

With the full cooperation of the VA, the Commission and its paid staff of 54 investigators and administrative personnel put together the most comprehensive study ever made of other-than-medical veterans’ benefits. It submitted its final report to the President on April 23, 1956. Among some of the report's basic conclusions were the following:

Veterans and their families will eventually be a majority of the population of the United States.

Veterans in modern times are better off economically than nonveterans in similar age groups.

The basic needs of all citizens, veterans and nonveterans alike, for economic security are being increasingly met through Federal, State and private programs.

The Commission also recommended that certain principles be adopted as national policy for the future, particularly:

Military service in time of war or peace is an obligation of citizenship and should not be considered inherently a basis for future Government benefits.

Veterans' benefits are a means of equalizing significant sacrifices that result directly from wartime military service.

The service-connected needs of ex-servicemen should be accorded the highest priority among the special programs for veterans.

It is to be noted that the Commission, liberal in its attitude toward service-connected disabilities, was not nearly as liberal in its attitude toward non-service-connected ones.

Altogether, the general tenor of the Commission's recommendations might be summarized:

Service-connected disabilities should be treated generously.

All veterans' benefits should be meshed with the Nation's general social security system, although this does not mean that the Veterans' Administration should be meshed with the Department of Health, Education, and Welfare.

Despite the Bradley report and the opposition of President Eisenhower, the House of Representatives passed on June 27, 1956, a bill to give an estimated additional $356 million in pensions in 1957 to World War I veterans for disabilities not incurred in the line of military service. It did follow to some extent the Bradley Commission's suggestions on July 12 when it approved a bill increasing the pensions of totally disabled veterans, but this measure was not acted upon in the Senate. On August 1, however, the President signed into law a measure passed by the House and the Senate increasing payments to widows and other beneficiaries of servicemen killed on active duty.
Bradley Commission's report on veterans' benefits did not in any way affect VA medical care. The report amounted to a monumental study rather than a monumental influence.

BOONE RESIGNS; MIDDLETON APPOINTED

Admiral Boone resigned on February 28, 1955, at the end of his 4-year appointment. As a replacement, Mr. Higley selected Dr. William S. Middleton, former dean of the University of Wisconsin Medical School. This appointment was cheered throughout the entire medical system of the VA, as well as in medical education circles. Dr. Middleton was no stranger to the medical program of the Veterans' Administration, having been a consultant for many years, and a member of the first Special Medical Advisory Group established by Gen. Paul R. Hawley.

Administratively, affairs throughout the entire VA seemed to be running smoothly. However, Mr. Higley's term of office was hectic with financial difficulties, as well as the open dissatisfaction with certain activities expressed by the service organizations.

VA FUNDS REDUCED

The appropriations committees in Congress, especially on the House side, endeavored to cut down financial requests, particularly for the operation of the hospitals, to a bare minimum. This was in direct contrast to the generosity of the Congress during the Bradley regime. To continue increasing number of hospitals and patients while maintaining the quality of medical care, called for more money. This was emphasized quite strongly by Mr. Higley and Admiral Boone when they appeared before the committee. However, the funds were cut so deeply that layoffs were required in many of the hospitals. Certain stations were forced to close down beds. Others did not place newly constructed wards into service.

Certain elements of organized medicine in the United States renewed their criticism of hospitalization of non-service-connected causes. But the Administrator and the Chief Medical Director vigorously defended this policy, which had had the approval of the Congress as early as 1924.

GAO REVIEW REVEALS ERRORS

While outlining his budget needs for fiscal year 1955 to the sub-committee of the House of Representatives, Mr. Higley was told about a recent report of the General Accounting Office, whose representatives had reviewed 1,000 compensation cases and found more than 200 errors. Practically all of the cases referred to had been made during the hectic period shortly after World War II, when an inexperienced, overworked staff has to make decisions without sufficient evidence.

The Administrator and his staff carefully reviewed this report and concluded that an immediate sampling of cases should be made. The results were startling. They found errors, all sorts of errors. The sampling turned up cases that had been rated static, with no reexamination scheduled, even though the nature of the disability was such that it should improve throughout a normal course of time.
Two questions arose in Mr. Higley's mind:

"Is it right to deny increased payments to a veteran who is entitled to it?"

"Is it just to continue payments to those not entitled?"

He was convinced that a thorough review was necessary, but the question was: who should conduct it? Mr. Higley believed that the VA-trained adjudication employees were better equipped and had a fuller understanding of the philosophy of benefits than the General Accounting Office.

**REVIEW BY REGIONAL OFFICES**

In December 1954, he directed the regional offices to review all claims of veterans under 55 years of age, where entitlement was based on World War II or peacetime service.

On December 14, 1954, he set forth basic principles to be observed in this survey:

1. The benefit of a reasonable doubt is invariably to be resolved in favor of the veteran.
2. No benefits to be taken away from any veteran unless it was shown that the claim of such benefit was clearly and unmistakably in error.
3. All adjudication actions must reflect the generous intent of the law and be affected with human understanding.

This survey, called "The Running Award Review," took 8 years to complete. By the end of 1962:

- A total of 1,679,559 veterans' claims were reviewed.
- In 1,474,739 cases, or 87.8 percent, there was no change in the existing rate.
- In 33,564 cases, service connection was severed.
- In 65,428 cases, the amount of compensation was decreased as a result of a new physical examination.
- In 56,439 cases, awards were terminated as a result of a physical examination.

It was only natural that there should be many grievances and complaints from veterans whose compensation was discontinued or reduced. Most of them complained to their local service organization chapter. In turn, the service organization blamed Mr. Higley, although this review extended far beyond his term of office. Mr. Higley did not take this criticism as a personal matter. He saw it as his duty as a public official to stop payments to those not entitled while protecting those who were.

What turned out to be a major contribution to the Department of Medicine and Surgery was made by Mr. Higley, although it was not put into effect during his term of office. This concerned the maximum number of beds to be operated by the VA and the type of patients who should occupy these beds, be they neuropsychiatric, tubercular, or general medical and surgical.

General Hines, as early as 1924, when VA hospitals were authorized to accept veterans with non-service-connected disabilities, estimated that 300,000 VA beds would be required by 1970. But it was obvious that the VA could not adequately staff anywhere near that number of beds.
Each year, when budget estimates were presented, the question of the required number of beds for the next year was debated. Those who controlled the VA's purse strings felt that the existing number of beds should be reduced, whereas the Department of Medicine and Surgery believed that there should be an increase—or, at the very least, that the current level should be maintained. The Chief Medical Director felt that he and the Administrator should decide the number of authorized admissions in the various categories of disabilities.

These perennial arguments finally became a bugaboo to both Mr. Higley and the Chief Medical Director.

Higley therefore decided to lay the matter before President Eisenhower. He asked the President's approval of a maximum number of beds to be operated in the VA hospital system. He also asked that he and his Chief Medical Director be given the sole authority as to patient distribution.

Mr. Higley, the Chief Medical Director, and the Special Medical Advisory Group were in agreement that 125,000 beds would be the maximum which they could staff satisfactorily. The Director of the Bureau of the Budget, however, expressed the opinion that 87,000 was the "right" number.

A Presidential approval of the proposal of 125,000-bed maximum was not forthcoming during Mr. Higley's term of office, but was received some 2 years later by his successor, Sumner G. Whittier.

After four and a half years' service, Mr. Higley submitted his resignation to the President as of November 13, 1957. The exchange of letters between them did not explain the reason for his resignation. Mr. Higley's letter mentioned an oral request to Presidential Assistant Adams on September 9th, to be relieved of his job, and asked that his resignation be effective "as early as convenient." The President accepted his resignation; writing Mr. Higley that he did so "with reluctance and a very real sense of loss."

(Continued on p. 262)

William Shainline Middleton

William Shainline Middleton was born January 7, 1890, in Norristown, Pa., the son of Daniel Shepherd and Ann Sophia Holstein (Shainline) Middleton.

He received his medical education at the University of Pennsylvania, graduating in 1911, and interned in the Philadelphia General Hospital, Philadelphia, Pa.

He then accepted an assignment as instructor in clinical medicine. The medical school had been established on a 2-year preclinical basis. It was later expanded to a full 4-year school with an outstanding faculty and splendid new buildings. During his career at Madison, he was successively assistant professor, associate professor, and professor of medicine. In 1935, he was appointed dean of the School of Medicine, University of Wisconsin, at Madison, holding this position until his appointment as Chief Medical Director of the Veterans' Administration. He is now dean and professor of medicine emeritus.

He is in receipt of many honors, both professional and for his military service. Among the top honors professionally are: Galens Visiting Professor of Medicine, University of Michigan Medical School, May 1940; Ernest A. Sommer Memorial Lectureship (Medicine), University of Oregon Medical School, 1941; David J. Davis Lectureship, University
of Illinois, 1947; Walter Estell Lee Lectureship, Graduate School of Medicine, University of Pennsylvania, 1961.

He is a member of American Association for the Advancement of Science; American Medical Association; Association of American Physicians; American College of Physicians, (master); (president, 1950); College of Physicians of Philadelphia (fellow); American Society of Clinical Investigation; Central Society of Clinical Research (president, 1933); American Clinical & Climatological Association; Society of U.S. Medical Consultants to the Armed Forces; Society of Experimental
Biology & Medicine; American Association of History of Medicine (president, 1984); University of Pennsylvania Alumni Association; Wisconsin Academy of Sciences, Arts, & Letters; Wisconsin State Medical Society; Wisconsin Society of Internal Medicine; Medical Society of the District of Columbia; Milwaukee Academy of Medicine (honorary); Honolulu County Medical Society (honorary); Spokane Society of Internal Medicine (honorary); American Medical Writers Association; Association of American Medical Colleges; National Tuberculosis Association; American Trudeau Society; Minnesota Society of Internal Medicine (honorary); Royal Society of Medicine (honorary fellow); Royal College of Physicians, London, (fellow); King's Own Old Comrades Association (honorary); Association of Physicians of Great Britain & Ireland (honorary foreign member); Sociedad de Medicina Interna, Buenos Aires (foreign correspondent); Asociacion Medica de Puerto Rico (honorary); American Legion; Alpha Omega Alpha (honorary medicine);

He is also a member of Alpha Tau Omega; Phi Beta Pi; Phi Kappa Phi; Sigma Xi; Sigma Sigma; Phi Beta Kappa (honorary); and Army & Navy Club.


He is also in receipt of these awards: Council Award, Wisconsin State Medical Society; 1955; University of Pennsylvania Alumni Award of Merit, 1951; Centennial Award, Northwestern University, 1951.

He is a veteran of both world wars, having served as a lieutenant and captain in World War I, with the British and the American forces in France. He was discharged with the rank of captain in March 1919 and returned to his teaching post in Wisconsin. It was then he began work with veterans, with special consideration to those with pulmonary conditions in Wisconsin institutions.

From that time on, he was closely identified with medical service to this country's veterans, and served almost continuously as consultant to Federal organizations, such as the U.S. Public Health Service, the Veterans' Bureau in 1922 and to the Veterans' Administration in 1933, until the onset of World War II.

In 1942, he was commissioned a lieutenant colonel and assigned as Chief of the Medical Service at Lawson General Hospital in Chamblee, Ga., but shortly afterward he was ordered overseas.

He was assigned the exacting responsibility of chief consultant in medicine in the Office of the Chief Surgeon, European Theater of Operations.

In this capacity, as the hospitals grew from 24 to 315 in number, he interviewed and evaluated hundreds of inexperienced officers and assigned them appropriate responsibilities. He was highly effective at the same time in establishing cordial relations with the Royal Army Medical Corps of the British civilian profession.

In commenting upon his services, Gen. Paul R. Hawley (later Chief Medical Director of the Veterans' Administration)—then Chief Surgeon of the European Theater, stated in part as follows:

Colonel Middleton has displayed brilliant leadership as chief consultant in medicine for the Chief Surgeon in the ETO. * * * A program for the interchange of medical
officers of company grade from combat and tactical units with those of similar rank in fixed hospitals was conceived and initiated by Colonel Middleton. The benefits resulting from this plan have been reciprocal; front line officers were granted a much needed rest, rear echelon officers were afforded the chance to share some of the responsibility of medical work under quasi-hazardous conditions, and officers from both echelons were given the opportunity to experience the type of medical service commonplace with each respective type of hospital installation.

Colonel Middleton's promulgation of a plan for medical officers which would give them the opportunity for membership in the American Board of Internal Medicine was of considerable importance in furthering the medical education of the members of the Medical Corps under his jurisdiction. By passing written and oral examinations organized and prepared by Colonel Middleton, officers will be able to return to the States after the war fully qualified to practice as specialists. In addition, this extracurricular work has obviated what would have amounted to a 2- or 3-year loss in their professional careers. During the past 2 years, over 100 medical officers have received their final oral examinations in this field, with the resultant strengthening of the medical service in the theater.

In addition to his regular duties, Colonel Middleton has participated actively in formal academic instruction, and has taught medical officers at both the Army Medical Field Service School and the 8th Air Force Professional Field Service school. In his position as consultant, he has conducted teaching courses at countless hospitals. In the medical installations of the ETO there were serving 1,078 interns, 1,215 medical specialists, and some 8,467 general medical officers, all under his supervision.

The greatest tribute that can be paid to the medical service of the European Theater of Operations lies in the fact that for the first time in the history of war medical casualties have been lower than surgical, a direct reflection on improved medical techniques, medical care in general, and the competent direction of the chief consultant in medicine, Colonel Middleton.

For his accomplishments Dr. Middleton was awarded the Distinguished Service Medal in 1947, the citation reading as follows:

Col. William S. Middleton distinguished himself by exceptional meritorious conduct in the performance of outstanding services as chief consultant in medicine, Professional Services Division, Office of the Chief Surgeon, Headquarters, European Theater of Operations, from July 1942 to May 1945. Colonel Middleton competently established the consultation services and skillfully directed their supervision of diverse medical specialties in U.S. medical installations in the United Kingdom. His publication of directives outlining the most advanced treatment for venereal disease and neuropsychiatric conditions and his vigorous leadership as chief consultant in medicine for the European Theater of Operations were of the utmost importance in maintaining the health of the forces of the U.S. Army, and contributed immeasurably to the manpower conservation program.

Upon cessation of hostilities, he returned to civilian status and to his deanship at Wisconsin. However, this did not terminate his services to the Nation's military. The Department of Defense called upon him at least four times for highly important assistance:

- Expert and consultant, Department of the Army, August 1946 to April 1950.
- Member, Civilian Health and Medical Advisory Council, Department of Defense, April 1953 to March 1955.

In addition, he served on various councils for the Federal Government, and the National Institutes of Health, U.S. Public Health Service, and Department of Health, Education, and Welfare. He was a regent of the National Library of Medicine and a member of the first special medical advisory group of the Veterans’ Administration.
Dr. Middleton was a member of the first Special Medical Advisory Group of the Veterans Administration. This gave him an influential voice in the development of various medical research and training projects. His vision and leadership were instrumental in the establishment of the first integrated research and training program for medical doctors in the United States. Dr. Middleton was a proponent of the idea that medical education should be a collaborative effort between academia and research institutions.

When the first student arrived, Dr. Middleton was ready with a plan. He believed in the importance of a well-rounded education, where students would not only learn the theoretical aspects of medicine but also gain practical experience. He implemented a system where students would rotate through different departments, gaining exposure to various specialties.

Dr. Middleton's approach was innovative and forward-thinking. He believed in the integration of research and clinical practice, a philosophy that would become the cornerstone of modern medical education. His leadership and dedication to the field of medicine have left a lasting legacy, influencing generations of medical professionals.

Will A. Davis

Dr. Middleton and his wife made their home in Washington, D.C. Dr. Davis's contributions to the field of medicine are widely recognized, and his work continues to inspire future generations of medical professionals.
knowledge of veterans' medicine. The Veterans' Administration was extremely fortunate in securing his services as head of the Department of Medicine and Surgery.

When Dr. Middleton took over, the agency was operating 173 hospitals, 21 of them designated for tuberculosis, 40 for neuropsychiatric patients, and 112 for general medical and surgical cases. There were 106,865 patients being treated daily; 16,972 "members" in domiciliary homes, and 21,297 eligible applicants on the waiting list. None of these were patients suffering from a service-connected disability, and more than half of them were already hospitalized in non-VA hospitals, and not as beneficiaries of the Veterans' Administration.

In a census taken on November 30, 1954 of all patients in the VA hospitals on that date, it was found that 64.6 percent of the patients had been in VA hospitals for more than 90 days; 49 percent had been hospitalized for more than a year, and almost a third had been on the hospital rolls for more than 5 years. In fact, 8.4 percent had remained in the hospital for over 20 years.

Realizing that these chronic cases required long hospitalization, he knew that research in geriatrics would be one of his first considerations.

The research in chemotherapy of tuberculosis, which had been going on for 9 years, was just beginning to show results. By 1954, the peak load had been reached.

Dr. Middleton realized that a physician must continue to grow and that this is best done through "the refreshment of research." In the Army he had stimulated research in a wide variety of fields. In 1954, the Canadian Government had asked him to survey medical research in the hospitals of the Canadian Department of Veterans Affairs. His report, which Canada has since followed, contains many of the principles of research which he was later to follow.

One of his first actions after becoming Chief Medical Director was to appoint the Advisory Committee on Research to review the accomplishments so far and encourage growth of the programs, keeping them both economic and productive.

He also set up the first Advisory Committee on Problems of the Aging to deal with this field of growing national concern. Both of these committees were composed of some of the Nation's outstanding physicians. Broadening the scope of VA research required money, and in a report to Congress Dr. Middleton wrote, typically:

Renewed professional interest and vigor, observed in every hospital staff, favored by an active program of research so generated reflects itself in greatly improved veteran care. The dividends from this sound program of medical research, so invigorating to the Veterans' Administration, do not stop with the system but permeate medical thought and practice throughout the civilized world.

He prepared this first report to Congress, submitting it on August 26, 1957. He reported 3,044 ongoing research projects. This number was to grow to 7,000 projects at the time of his retirement.

Shortly after submitting this report to the Congress, the Appropriations Committee began to earmark funds for research for the first time. Soon, the mandate of Congress to the VA for "a complete medical and hospital service" was changed by the insertion of the words "including medical research" (sec. 4101, title 38, U.S. Code).

Thus, he succeeded in removing two obstacles for a growing research program, and during his administration research funds grew from
$6,368,800 in 1955 to $30,500,000 in 1963. For the fiscal year 1967 the estimated appropriation is $43,028,000.

An example of his staunch backing of the research program of the VA is illustrated by an incident involving a research project regarding the possible relationship between smoking and bronchogenic cancer. Such a study was being made by a VA doctor who made public his findings and opinions in an article published by a national magazine. This incurred the wrath of the Tobacco Merchants Association, who dispatched a telegram to the Administrator, as follows:

NEW YORK, N.Y., June 11, 1956.

HARVEY V. HIGLEY,
Administrator, Veterans Administration.

I beg to refer to interview in Life magazine accredited to Dr. ———, as representing the Veterans' Administration.

Would warmly appreciate your advice on what basis the Veterans Administration is crusading against an important industry, and on what basis a speech delivered in Detroit last Wednesday was released to a national magazine for personal publicity 4 weeks before the speech was delivered.

Obviously, both the Treasury and the Agricultural Department have more than an academic interest in the tobacco industry, as well as 6 million individuals who are gainfully employed in this industry and whose livelihood is being attacked by the Veterans' Administration. Would deeply appreciate your advice as to whether your Administration will continue this policy, and if so would like the privilege of our accredited representatives having an opportunity of discussing this with you.

————

President, Tobacco Merchants Association of the United States.

In reply, Dr. Middleton wrote the association as follows:

June 28, 1956.

President, Tobacco Merchants Association of the United States
New York, N.Y.

DEAR SIR: In acknowledging your telegram of June 11, 1956, your letter of June 12, 1956, and your letter of June 15, 1956, the last to the Administrator, may I make the following statement.

The medical profession joins the Tobacco Merchants Association of the United States in its concern over the question recently raised on the possible relationship between smoking and bronchogenic cancer. The tobacco industry has indicated its desire to derive a clear answer, in the interest of smokers, by supporting extensive research in this area. As a matter of fact, I have been personally approached as an advisor by the committee of scientists entrusted with this serious research. When proposals to underwrite the studies in the University of Wisconsin Medical School, of which I was deum, were made obviously no effort was exerted to influence the direction of such studies. Indeed, no research worker worthy of the name could have accepted grants-in-aid under compromising conditions. To this thesis, I am sure that you would subscribe.

Research in the Veterans' Administration is pursued under the same conditions. To place strictures upon the publication of such work would not only impair its usefulness but would stultify the efforts of the worker. The results represent the measured judgment of the individuals engaged in the study and cannot, by any manner, be construed as reflecting the opinion or the position of the Veterans' Administration. This position is understood in all agencies of Government as well as in private and academic institutions.

May I project this matter further, since you have raised certain personal issues. Dr. ——— is a dedicated worker. His observations in the origin of bronchogenic carcinoma have aroused widespread interest and discussion in medical circles. There has been no general acceptance of his results; but there has never been raised a question of integrity. As a scientist, he must record and report his findings objectively. Certainly, this attitude cannot be construed as a crusade against the tobacco industry; but, in the last analysis, his publications represent his personal findings with his own interpretations and not the official attitude of the Veterans' Administration.

If I may express my own opinion, as a matter of policy I should like to indicate that a censorship of scientific findings by any governmental agency would not only
impair the usefulness of such studies but would immeasurably impede scientific progress. In fairness to all concerned, may I assure you of an open-mindedness and willingness to discuss this and other matters of mutual interest with anyone of your designation, at his convenience.

Sincerely yours,

William S. Middleton, M.D.,
Chief Medical Director.

This letter resulted in a visit to Dr. Middleton by representatives of the scientific advisory board of the tobacco industry's research committee, in which they expressed their appreciation of Dr. Middleton's sympathetic understanding of the problem under discussion. It was further stated that the visit was most helpful and they would keep in touch with Dr. Middleton on matters of mutual interest. While the doctor thought that the relationship of smoking to cancer was the $64 question, he made it known that the VA did not stand in judgment of its employees, and as American citizens they are privileged to hold any opinion and take any position as long as it does not harm the good name of the agency or Government.

However, in court proceedings, an employee of the VA cannot disassociate himself from his position as a representative of the Government. In those instances when a VA doctor had been called upon to testify in court trials on the subject, he warned that in all possible instances participation in all controversial issues, where the testimony of a Government employee might carry undue weight and prejudice justice, be avoided.

Dr. Middleton was equally devoted to stepping up the educational program of the Department of Medicine and Surgery. Having been a prime mover in convincing the Nation's medical schools to institute training programs in VA hospitals, he avidly continued to support this program. During his term of office, 73 medical schools conducted training in 193 of our hospitals. Approximately 3,000 (or 82 percent) of all the medical residents in the Federal service, and 11 percent of all in the United States, received some part of their graduate training in VA hospitals. In addition, included in this program were 6,000 medical students and a large share of clinical psychologists, graduate dentists, student nurses, occupational and physical therapists, graduate students in social work, and dietetic interns. However, he limited VA training in those areas where there was great competition. In this manner he protected the medical manpower pool where there was a critical shortage in particular categories.

At the end of his first 4 years in office he was persuaded to accept a second term. This was a tribute to his outstanding accomplishments and to the esteem in which he was held throughout the entire Veterans' Administration. He acceded because there were many programs which had not yet advanced to the point where he was completely satisfied. He was truly a perfectionist.

The second 4 years of his administration saw many of his projects realized. Upon his retirement there were 169 hospitals, 18 domiciliaries, and 217 outpatient clinics in the VA hospital system. During 1963, care was provided daily for 113,000 inpatients in the hospitals, 25,000 members in domiciliaries or State homes, and 24,000 outpatients. In that year, there were 41 million days of patient care provided. It was possible to shorten the length of stay in hospitals due to new techniques in patient care and further advances in medical research. Thus, beds were released for the care of additional patients.
This accomplishment was greatly enhanced by the introduction of the prebed care program (PBC) and the "completion of bed occupancy care" program (CBOC). The former, in essence, established the same procedure as prevails in a civilian hospital where necessary tests are completed either at the doctor's office or in outside laboratories before actually being admitted as a patient in the hospital. For many years VA and the Veterans' Bureau did not render this type of service to a veteran until after his admission to the hospital. The House Veteran's Affairs Committee, taking a page from civilian hospital experience, saw how a great deal of time could be saved the veterans and, at the same time, make more beds available to other veterans if civilian procedure were followed. Under this program, blood tests, urine tests, X-rays, etc., are completed prior to admission, either in an outpatient clinic or in the hospital itself. Upon completion, the patient is then scheduled to enter the hospital within 14 days. In the first year of its operation, more than twice as many patients were admitted through this procedure than in the previous year.

Paralleling the PBC program there was established also a post-hospital care (PHC) program. This was formerly known as the bed occupancy care program. It afforded an opportunity for a patient to be released from the hospital as soon as he had reached the point where full-time hospital care was no longer required. Necessary followup is provided on an outpatient basis, either at a clinic or by return visits to the hospital. During Dr. Middleton's last year in office, 225,459 patients were able to return to their homes earlier than they might otherwise have anticipated. While the exact number of patient treatment days made available by this program for other veterans cannot be determined, some idea of the magnitude may be obtained if one were to assume even 1 or 2 days hospitalization per patient year saved.

Dr. Middleton was a firm believer in the value of area medical offices. When these offices were created they were to be considered "the eyes and ears" of the Chief Medical Director, but they had no direct authority over the hospitals. Dr. Middleton succeeded in having these offices placed "in the line" and they assumed responsibility for supervising the operation of the hospitals, domiciliaries, and clinics within their assigned geographical areas. They were responsible to the Chief Medical Director, thereby establishing a direct line of authority between them, and to the field.

During his term of office, Dr. Middleton established the position of Director for Administrative Services, who was responsible for the engineering, registrar, personnel, housekeeping, supply, and canteen services. The field fiscal service was placed under the Controller of the Department of Medicine and Surgery.

When the President approved a ceiling of 125,000 beds in the VA hospital system he also authorized the Administrator to stop designating hospitals for a particular type of treatment. This gave Dr. Middleton the flexibility he needed to provide the number and type of beds where they were most needed.

It was found that veteran population was shifting that the need for beds for tuberculosis patients was lessening, and the need for general medical and surgical beds were accelerating. At that time there was a tremendous influx of veterans and their families to California and Florida, and this was taken into consideration in the long-range planning for locating new Veterans' Administration hos-
pitals. At this time there are only two, rather small, hospitals designated solely for the treatment of tuberculosis.

Dr. Middleton believed that a hospital was for the treatment of any disease. Therefore, each of the new hospitals erected or planned while he was in office, included not only accommodations for general medical and surgical patients, but sections set up for patients suffering with mental illness and with tuberculosis. He was particularly interested in dispelling the strong dislike toward mental hospitals or insane asylums. Having all VA hospitals equipped to take care of all the ailments of disabled veterans, allowed broader staffing of our hospitals. This indeed led to the best possible medical care to all patients.

While desegregation in VA hospitals had been completed before he was appointed Chief Medical Director, Dr. Middleton was insistent upon a strict followup of this policy and tolerated no deviation from it. In addition, he encouraged the employment of qualified Negroes in more advanced positions, such as doctors, nurses, technicians, as well as clerical personnel.

He was intensely interested in the employment of the physically handicapped. The number of these persons employed rose steadily during each year of his tenure.

**STRONG ADVOCATE OF GERIATRICS RESEARCH**

Throughout his 8 years as Chief Medical Director, he stressed the need for research in the medical problems of the aged. The advent of the “wonder drugs” had played an important part in lengthening the expectancy of life. Other factors contributed as well. Dr. Middleton felt strongly that if each man’s life was to be longer, everything should be done to make those additional years useful and worthwhile. He instituted a series of workshops at three VA stations: Albany, N.Y. for selected hospitals in that area, East Orange, N.J. and Dublin, Ga.

Intermediate services were established at certain hospitals to take care of those patients who did not need intensive hospital treatment and could not qualify for domiciliary care, nor could they be considered as strictly “nursing home” cases.

He sponsored the idea of establishing restoration centers where veterans, with proper treatment, could possibly be returned to their home communities and carry on in suitable occupations. One was set up at Illies, Ill., and after Dr. Middleton retired a second center was created at East Orange, N.J.

The geriatric program was later enlarged to include nursing home patients at certain VA hospitals.

**THE 7-DAY HOSPITAL OPERATION**

Dr. Middleton was particularly concerned with the operation of our hospitals on practically a 5-day-week basis. The needs of patients, an aging population, and the new skills and treatments, created a demand that hospital beds in certain hospitals were insufficient to meet. This situation was not a problem peculiar to the Veterans’ Administration’s hospitals alone; the same fault exists in all hospitals throughout the country.
He reasoned that a hotel patron paying for his accommodations expected that all facilities will be available to him on Saturdays and Sundays as well as during the other weekdays. Yet, in a hospital where the need for service is greater, it is normal for only a skeleton staff to be on duty over the weekend. The Sunday night supper may be skimpy for the convenience of the kitchen staff. The laboratory and X-ray departments are on an emergency basis only. If a piece of equipment breaks down, personnel must be recalled from their homes to deal with it; meanwhile, the patient marks time.

Although the prehospital care program partially eliminated time-consuming waiting in the hospital before actual treatment began or surgery was performed, it did not eliminate the wastefulness of having empty beds over a weekend, sorely needed for sick veterans. In addition, a patient ready for discharge on Saturday or Sunday, might have to wait until Monday to leave.

Dr. Middleton concluded that if a bed could be used by four patients instead of three during a given period of time, the bed capacity would be increased by 33⅓ percent, without additional construction.

In 1959, the VA hospital in Coral Gables, Fla. was besieged with applications for admission from hundreds of veterans who had moved to Florida. Its 450 beds were entirely filled. Some 600 to 800 eligibles were waiting for hospitalization, but there was no room. Other eligible veterans probably did not apply because they knew their chances of admission were very slight.

Dr. Middleton, therefore, established a pilot program of the "7-day hospital" at Coral Gables. He had the hearty cooperation of the Director, Dr. Earl C. Gluckman, and his staff. Of course, such a radical change could not be made overnight. The plan was undertaken in five phases, by departments. It is not yet in full operation, but is certainly a forerunner of a new concept which may change the operation of all VA hospitals, as well as other hospitals in the United States.

Amazingly, this new staffing pattern did not greatly increase the operating cost of treatment. Actually, during the Coral Gables experiment, in 1 year, the cost per patient per day was increased by only 3 percent, whereas, the turnover of patients increased by 15 percent. The fact that the patient could return home and to his employment sooner cannot be evaluated in dollars.

Civil service employees still work on a 40-hour week basis, but their hours and days are staggered so as to afford complete coverage on major services. A few additional personnel were hired with the understanding that their time schedules were subject to frequent change, and recruitment on this basis proved to be no problem.

Although this program is not in general operation throughout the system, the early success realized at Coral Gables bring it far nearer a reality.

In a later section, the progress made by the professional services in improving the treatment of patients will be discussed. The ideas for many of the improvements originated with Dr. Middleton.

The 8 years of his service as Chief Medical Director can be regarded as one of the most inspiring and forward looking eras in the history of the medical care of veterans.

On the date of his retirement, February 28, 1963, the Administrator issued a special edition of the VA Guard, a VA house organ, distributed to all employees of the Veterans' Administration, reading as follows:
To My Associates:

We have lost, through retirement, the services of a great man.

Dr. William S. Middleton has retired after 8 years as Chief Medical Director.

To put it simply, the Veterans' Administration, the veteran, you, his coworker, and I as Administrator, owe much to Bill Middleton, a man of many accomplishments and of such preeminent stature in his profession.

As a practicing physician, as a teaching physician, as a historian of medicine, as a dean of a famous medical school, he brought to his job as leader of the largest single hospital system in the world ** * a rich background of knowledge, skills, uncommon wisdom, and modesty.

At the White House, the President of the United States paid his personal respects to our Chief Medical Director and thanked him for his service to veterans, to Americans, and indeed, to all mankind.

On page 2 of this special edition of the Vanguard is a written tribute which the President had sent in a letter prior to his visit with Dr. Middleton.

Bill Middleton has been an inspiration as well as leader, guide as well as administrator, dear friend as well as counselor.

Bill Middleton will be missed.

Sincerely,

(S) J. S. Gleason, Jr.,
Administrator.

Dr. William S. Middleton  President John F. Kennedy  Administrator John S. Gleason

On the occasion of Dr. Middleton’s retirement from the VA, February 28, 1963.
Three days previously Dr. Middleton received the following letter from the President of the United States:

THE WHITE HOUSE,

DEAR DR. MIDDLETON: From the outset of this administration, I have emphasized the great need for Americans who will dedicate their efforts to the Public interest. To all the citizens of the country, I said: "Ask not what your country can do for you; ask what you can do for your country."

On your retirement from the Federal service, I am impressed by the example your life provides of the completely selfless dedication of an individual to the needs of mankind.

Your choice in your early years of vocation as a doctor bespeaks your interest in your fellowman. The flowering of your ability as dean of the school of medicine of a great university redoubled your contribution as you taught the oncoming generations how to care for human ills.

In two wars, you answered the call of your country's need and bound up the wounds of her sons who served. This much alone represents more than most men have to look back upon. And yet, in your years of golden wisdom and maturity, you entered directly in the Government's service to the veteran.

In the past 8 years, as Chief Medical Director, Veterans' Administration, you provided vision, imagination, and leadership that molded and energized the medical program of the Veterans' Administration. Your pioneering ideas and tireless efforts to improve patient care, medical education for the staff, and advanced research have carried these programs to a pinnacle of effectiveness.

We salute you for a lifetime of achievement in which you are second to none among those who have served the medical needs of the veteran.

Sincerely,

(S) JOHN F. KENNEDY.

Dr. Middleton returned to his home in Madison, Wis., but is in no way a retired person in the literal sense. He is still a consultant to the VA hospital at Madison, and he serves on numerous national committees involved in the field of health. Dr. Middleton does considerable professional writing and, between times, finds relaxation in his rose garden.

During his whole career in the Army, the medical school, and the Veterans' Administration, and in his present activities, he has been consistently just exactly one whole unchanging being—physician, citizen, teacher, scholar, and patriot. He has played a most important role in the history of the medical care of the American veteran.

Sumner Gage Whittier

Sumner Gage Whittier was born in Everett, Mass., on July 1, 1911, the son of Edgar Holt and Eva S. (MacNeil) Whittier.

He was educated at Boston University, earning a B.A. degree. He was chairman of the Council of Everett, Mass., for 2 years and Alderman at large 2 years.

He served in the U.S. Navy during World War II for 3 years and was discharged as a lieutenant.

Mr. Whittier held various political posts in Massachusetts: he was member of the Massachusetts House of Representatives for 2 years and a member of its Senate for 6 years. He was elected as Lieutenant Governor of Massachusetts in 1953. He was nominated as the Republican gubernatorial candidate in 1956, but was defeated for this office.

He then joined the Veterans' Administration as Director of Insurance in January 1957. President Eisenhower appointed him Administrator of Veterans' Affairs in December 1957. He served in that capacity until
January 1961, when he accepted a position as executive director of the Michigan Medical Service, administering the Blue Shield program.

In November 1964 he was appointed executive director of the National Society for Crippled Children and Adults, which position he presently holds. He resides with his family in Libertyville, Ill.

As the fifth Administrator of Veterans' Affairs, and successor to Mr. Harvey Higley, President Eisenhower appointed Mr. Summer G. Whittier of Massachusetts. Mr. Whittier had been VA's Chief Insurance Director since January 1957. He took the oath of office as
Administrator at the White House on December 20, 1957. Mr. Whittier had held various political posts in Massachusetts from the time he was 27 years old, culminating in his election as Lieutenant Governor in 1952. He was nominated as the Republican gubernatorial candidate in 1956, but was defeated for this office.

He brought to the organization a sense of urgency and stimulation, which percolated through central office and the field at all levels. He worked no employee longer or harder than himself to make his personal credo the mission of the agency. What was that credo? Simply the words of Abraham Lincoln "* * * to care for him who shall have borne the battle, and for his widow, and his orphan." To indicate the mission of the agency’s employees, Mr. Whittier had plaques installed on either side of the main entrance to the VA building in Washington, so quoting President Lincoln.

Having had about a year’s experience in the agency as Director of Insurance, it was not too difficult for him to assume the reins of the top office in the Veterans’ Administration. He immediately set about to improve the efficiency of the organization, expediting service, and insisting upon sympathetic understanding for the veteran and his family.

Shortly after taking command, Mr. Whittier set about to become acquainted with all the personnel in central office. He devoted a part of each day passing through various departments to meet personally and shake hands with every employee. He believed it vitally important to emphasize the individual and human dignity in such a vast system as the Veterans’ Administration. He endeavored to have employees feel that each played an important role in the VA family. Employee conversation in the car pools and coffee breaks invariably turned to “Operation Handshake.” Mr. Whittier personally wrote the VA pledge of service: “The VA is dedicated to administer veterans’ laws effectively, expeditiously and with sympathetic understanding, and to exercise constructive leadership in the field of veterans’ affairs.”

In his rounds of meeting people, he also had an eye to the proper use of equipment and, as a result, many dollars were saved in eliminating cabinets devoted to unimportant uses.

When visiting a hospital or regional office, he adopted the same approach with employees, patients, and their families. He realized that the experience of a patient in being admitted to a hospital was traumatic and he stressed the need for gracious treatment of these veterans.

To convince himself that veterans applying for hospitalization were given speedy, courteous service, Mr. Whittier, during a visit to the Veterans’ Administration hospital at Hines, Ill., took off his coat and tie and joined the line of applicants. He gave an assumed name and went through the processing line. He was afforded such gracious treatment that he later gave an award to the lady who, having no knowledge it was the Administrator applying for admission to the hospital, handled him with such understanding and efficiency. Short of actually being admitted, this experience proved to him that the admitting routine at this hospital was being accomplished satisfactorily.

Mr. Whittier was sincerely concerned about the aging veteran. He pressed hard for measures that would assure the rehabilitation of the
spirit and mind of the aged veteran as well as the medical care he needed.

Many of the advances Mr. Whittier was fortunate in seeing through had their inception under Mr. Higley and his staff. However, Mr. Whittier recognized their value and pushed for their accomplishment. Mr. Higley brought to the agency a vast and successful experience in business methods and organization. He applied them to the vast functions of the Veterans' Administration. Mr. Whittier had the ability to recognize potential economies and improvements in service. Together they reduced the number of personnel by 10,000 in departments other than that of the hospital system. It was necessary to increase hospital employment by 6,000. The central office had a 50-percent personnel cut.

Mr. Whittier had little difficulty in securing the appropriations he recommended to Congress. Prompt action was taken by the Bureau of Budget, and relatively short hearings were held before the Appropriations Committee.

Among the progressive steps promoted by Mr. Whittier was a work measurement program which became a model for other agencies. This production yardstick program created a great deal of interest in private business, where volumes of paperwork were also a problem.

He strengthened the internal audit system inaugurated by Mr. Higley. The career development program was expanded with the aim of improving performance on the job as well as to develop a reservoir of personnel for promotion to positions of greater responsibility.

Mr. Whittier was quick to recognize the potential of automatic data processing. He had seen its application to the insurance program work so successfully with great savings to the agency and the taxpayers.
Dr. Middleton and Mr. Whittier were sure that automatic data processing could be used, not only in the operational part of the hospital system, such as payroll, etc., but in medical areas as well. A contract was drawn with the Systems Development Corp., of Los Angeles, to survey the potential of automation within the agency’s Department of Medicine and Surgery. To date, results have been very encouraging, as will be told in “A Look Into the Future”—elsewhere in this book.

The necessity for setting a maximum on the number of hospital beds to be operated by the VA was still foremost in the minds of Mr. Whittier and Dr. Middleton. Two years previously, Mr. Higley was unsuccessful in securing Presidential approval of such a plan. Both recognized that more than 125,000 would be almost impossible to staff. Techniques developed to accelerated patient turnover permitted the agency to care for greater numbers of patients within the same number of operating beds.

Even with this stepped-up turnover of patients, Mr. Whittier and Dr. Middleton decided to again endeavor to secure Presidential authority for a ceiling on operating beds.

As veterans grew older and contracted further illnesses it became more and more difficult to predict how heavy the demands would be on the Agency’s medical facilities. The percentage of those seeking non-service-connected care was steadily on the increase. The number of service-connected veterans assured of immediate care began to shrink percentagewise and were no problem. The fact that the number of these service-connected veterans is declining indicates that the need for beds for their care in the future will decrease.

Mr. Whittier wrote the President on February 2, 1959, and requested a ceiling of 125,000 beds for the VA hospital system. He also asked for authority to replace obsolete hospitals, and to modernize others, either at the same or different locations, still within this limitation. As stated earlier, the President was also asked to grant flexibility to the Administrator to shift patients or hospitals from one type of use to another as may be permitted by law and dictated by medical advances.

All of these recommendations were approved by President Eisenhower on February 26, 1959. In addition, he concurred in four suggested policies which were to govern future approvals for construction or acquisition of veterans’ hospital beds.

(1) Continuance of complete, high-quality hospital care for all veterans in need of such care for service-connected disabilities. Such care will be provided in hospitals of the Veterans’ Administration, other Federal hospitals, and State and local community hospitals in the discretion of the Administrator.

(2) Continuance, within the capacity of the 125,000 authorized beds in Veterans’ Administration hospitals, of the care of war veterans with non-service-connected disabilities, recognizing that basic responsibility lies with other governmental jurisdictions for providing hospital care for all citizens who are unable to defray the expense of hospitalization.

(3) Shifting of beds or hospitals from one type of use to another by the Administrator of Veterans’ Affairs as may be permitted by law and advances in medical treatment.

(4) With the approval of the President and subject to the availability of funds, construction to provide beds or hospitals
for replacement and modernization or to compensate for major
geographic shifts in veteran population, all within the overall
total of 125,000 authorized beds.

This authority proved to be a giant step forward for the Veterans' Administration. Prior to this the Agency's hands had been tied as far as planning the needs of a shifting veteran population, the relocation of hospitals near medical schools, and the new construction, or modernization plus programs to meet the changing character of illnesses to be treated.

Under the administrations of Mr. Higley and Mr. Whittier, 13 new hospitals were opened, and a 12-year $900 million program was developed for modernization, to be applied at the rate of $75 million a year. The first was approved by Congress for the fiscal year 1961.

"Operation Handshake" was not the only way Mr. Whittier made the central office a pleasanter place in which to work. Air conditioning was installed, new elevators and modern lighting plus the replacement of obsolete furniture were accomplished. He arranged for a display throughout the building of fine paintings loaned by the Smithsonian Institution.

VA employees' associations were revitalized at all stations. Alumni associations, consisting of retired VA employees were started. The central office newsletter, VAnguard, was redesigned as a more effective communications medium. At Christmas time, the entrances to the building, as well as the interior, were appropriately decorated. The VA building was one of the few Federal buildings illuminated in the festive spirit in Washington, D.C.

Mr. Whittier gave strong support to Dr. Middleton's interest in research and his request for annual increases in funds available for this purpose. The appropriation for research in 1953 was $5,106,000 and rose to $18 million in 1960. The Administrator felt that research gave promise of new miracles, and if programmed to automatic data processing, this 20th century advance could save many years of research time and advance our progress many decades. Mr. Whittier saw to it that positive action was taken to increase the ratio of employees to patients, and intensive efforts were made to overcome the critical shortages of medical personnel. He saw that qualification standards should be revised to meet changing personnel requirements, and to assist in recruitment. To assist in obtaining medical personnel in short supply, personnel officers were told to visit colleges and universities and to publish recruitment brochures as well as advertise in newspapers, professional journals, radio, and television.

Mr. Whittier introduced a number of other administrative speedup techniques including mechanical purveyor systems in hospitals to speed the movement of papers and materials; remote control dictating machines that allowed dictators to use telephones to a central transcription point. This innovation permitted physician in the operating room, laboratory, or his own office, to record his findings immediately, or at his convenience.

Mr. Whittier pressed hard for one agency imagemaker. He bore down on Government "gobbledygook" in letter writing. He inaugurated a campaign "plain letters," incorporating the "4-S principle: Sincere, short, simple, and strong." Over 25,000 employees, both in Washington and in the field, took training in the writing of "plain letters." It has been estimated that saving of $3 million
annually are realized through reduction in the number of written
inquiries from veterans because the first reply is now easily understood.

Mr. Whittier also established a reporting system in VA. Information
flowed to the top from the lowest echelon, assembled on the way up
and culminating in a control center, or chart room, at central office,
next to the Administrator’s office.

Here was the very nerve center of the VA’s operations, colorfully
charted for instant inspection. Early in the charting process, it
became obvious that the time allowed for reporting should be shortened
considerably to assure the early and developing trends quickly forecast.
Final recording in the Administrator’s chart room was as current as humanly possible. Mr. Whittier’s chart room dramatized
trends by a line showing where the agency had been; what its present
position was. Then the chart was extended into the future not merely
as a projection but a plan to depict where the agency should go, citing
goals in each area. Performance against that plan was measured and
reported quarterly by all elements and all levels of the vast agency.
This review and evaluation sharpened performance throughout.
Further, information gathered and recorded in the control center
(chart room) served as a briefing area for Members of Congress, the
White House staff, veterans’ organization representatives, Bureau of
the Budget personnel, or others.

In addition to all of these activities, the Administrator found time
to serve twice as chairman of the Federal health drive; twice vice
chairman of the United Fund drive. He was a member of the Presi-
dent’s Committee for Employment of the Handicapped; chairman of
the Architectural Barriers Committee. Mr. Whittier enjoyed
attending meetings of service organizations and liked to travel
extensively to field stations.

A suggestion of his that has had permanent application was his idea
to imprint on each VA official envelope in the lower lefthand corner,
the words “Hire the Handicapped—It’s Good Business.” At first,
the Bureau of the Budget ordered him to take these words off the
VA envelope. Mr. Whittier protested, won, his idea is now used
throughout the Government.

Mr. Whittier’s sense of urgency, indefatigable spirit and wealth of
creative ideas advanced the stature of the Agency.

When John F. Kennedy was elected President, Mr. Whittier sub-
mitted his resignation to President Eisenhower, effective January 20,
1961.

President Eisenhower told Mr. Whittier in a letter written 10 days
later that “you will continue to see the fruits of your labors in the
coming years as new and improved VA hospitals are constructed under
the 12-year, $300 million program. You deserve to be proud of this
major contribution to the present and future health of the Nation.”

After resigning, Mr. Whittier accepted a position as executive
director of Michigan Blue Shield. He is now executive director of
the National Society for Crippled Children and Adults; with head-
quarters in Chicago, Ill.
John S. Gleason, Jr., was born in Chicago, Ill., on February 11, 1915, the son of John S. and Mary (Maloney) Gleason. His father was a vice president of the First National Bank of Chicago.

He attended St. Gertrude's Grammar School in Chicago and Georgetown Preparatory School near Washington, D.C. He was graduated from the University of Notre Dame, Indiana, in 1936, with a B.S. degree in science and commerce.
He then attended Harvard Graduate School of Business Administration, and in October 1937 went to work at the First National Bank of Chicago, moving around among lesser jobs in all departments.

In September 1940 he enlisted in the 124th Field Artillery of the Illinois National Guard as a private. Applying for a commission, he was made a second lieutenant in February 1941. On active duty for the next 5 years, he saw service in the Pacific and the Philippines.

Discharged from active duty in 1946 he returned to work at the Chicago bank. In 1953 he became a vice president of the First National Bank of Chicago.

He became commander of Legion Post No. 985, and held various important Legion offices, nationally, until he was elected national commander of the American Legion for 1957–58.

Among his military decorations and awards are the Silver Star, Soldier’s Medal, Legion of Merit, Bronze Star with two Oak Leaf Clusters, and the Philippine Presidential Citation. He was active in the Illinois National Guard and then joined the Army’s Officers Corp. In 1956 he was sworn in as brigadier general in the U.S. Army Reserve Corps and was later promoted to major general.

Because of his long and intimate knowledge of veterans’ affairs, President Kennedy selected General Gleason to be Administrator of Veterans’ Affairs in February 1961. He served in that capacity until he resigned in January 1965, when he and his family returned to Chicago where they now reside.

A BANKER LEADS THE VETERANS’ ADMINISTRATION

It was a foregone conclusion that newly elected President John F. Kennedy would replace Mr. Whittier who was so closely identified with the Republican Party. On January 13, 1961, President Kennedy nominated Mr. John S. Gleason, Jr., to head the Veterans’ Administration. Mr. Whittier’s resignation was effective January 20, 1961.

Mr. Gleason had served as treasurer of the Democratic National Convention in 1952. During Mr. Kennedy’s campaign in 1960 he headed the Veterans for Kennedy group.

No stranger to the VA, Mr. Gleason had a long record of interest in veterans and military affairs. He was a combat veteran of World War II, having enlisted in the Army in 1941 as a private. By the end of World War II he was a lieutenant colonel. Continuing his interest in the military, he helped reorganize the Illinois National Guard. He was selected colonel in 1950, brigadier general in the Army Reserve in 1956, and major general in 1958. His association with the American Legion, began in 1946 when he was elected post commander. He went up the ladder of administrative posts to the top and was elected national commander September 19, 1957. He also joined the Veterans of Foreign Wars, the American Veterans of World War II, and the Military Order of the World Wars. For 13 years he served as a member of the State of Illinois Veterans’ Commission. He enjoyed civic and charitable activities in the Chicago area, including chairmanship or vice chairmanship of the Red Cross, Chicago Youth Foundation, Girl Scouts of Chicago, United Cerebral Palsey, and the National Conference of Christians and Jews.

Since his father was a vice president of the First National Bank of Chicago and it was natural that he would pursue a career in banking.
Upon graduation from Notre Dame, he took a postgraduate course at Harvard in business administration. In October 1937 he went to work for the First National Bank, serving for a while as messenger and moving around among lesser positions in all departments. This early experience convinced him that he should have further graduate studies, but the outbreak of World War II prevented him from fulfilling this desire at that time. However, this became possible after the war when he completed a graduate course in banking at the University of Wisconsin in 1951.

When he was discharged from active duty in January 1946, he returned to work at the First National Bank and rose to the position of vice president in 1955, at age 39, the youngest in the history of that institution.

In 1955, together with a group of friends, he bought the controlling interest in Chicago Helicopter Airways, Inc. "I never had so much fun or so much work in my life," Gleason said, "as the helicopter company provides. It's an exciting infant business with a big future that you get a bang out of helping shape." These helicopters carry passengers, cargo, and mail between Chicago's Midway and O'Hare Airports and downtown Chicago. They also carry mail to 68 northern cities in Illinois, Indiana, and Wisconsin.

With such an extensive background in both business and veterans' affairs, it was logical that Mr. Kennedy should select him for this important post. He wanted very much to be appointed to a post in the Department of Defense, but on watching television one evening at home in the company of friends, he learned that he had been selected as Administrator of Veterans' Affairs. He said, "I felt let down that I hadn't been selected for the Army. But I didn't feel at all negative about the VA. I felt sincerely that I could give the responsibility a
full mind and full heart. I undertook it happily from the beginning and happy is how I have worked at it ever since. I think that being Administrator of Veterans' Affairs is one of the most satisfying public offices in the world.”

In assuming this office at age 45, he had control of an agency which had an annual budget which equaled twice the total deposits of the bank of which he was vice president.

Mr. Gleason is a very personable man, stocky, and of medium height. He is erect, dignified, solid looking, well-groomed and with prematurely gray hair. He is an excellent speaker with a clear, pleasant voice and puts forth to his audiences the sincerity of his subject. He believes in brevity of speech; 12 minutes is his favorite length; 15 minutes he can tolerate; but will speak longer only if the circumstances or the subject absolutely demand it. He has a keen sense of humor and radiates confidence and good cheer wherever he may be.

Mr. Gleason was extremely interested in and proud of the medical and hospital program. He had the utmost confidence in the Chief Medical Director, Dr. William S. Middleton, whom he held in high esteem. He delegated authority to the Chief Medical Director to the greatest possible extent and effectively endorsed his programs.

Mr. Gleason was particularly effective in hearings before appropriations committees. He emphasized the increasing costs of medical care and the necessity for additional funds to maintain the high standards which had been set. Under his administration, the annual appropriation for medical care rose to over $1 billion for the first time in history. With sufficient funds, it was possible to continue the upswing in the number of veterans treated, shorten the hospital stay, and pay sufficient salaries so that top-notch professional people would be attracted to service in the VA hospitals and clinics.

Mr. Gleason was also particularly effective in dealings with the Bureau of the Budget. He kept a scorecard in his desk of the nine major disputes he had with the Bureau, all of which were resolved favorably for the Veterans’ Administration. He had the confidence and the ear of President Kennedy and when his arguments and urgings failed to move the Bureau, he took the dispute directly to the President.

He regarded his major contribution to VA medicine to be his insistence on carrying forward the policy initiated by Generals Bradley and Hawley and Dr. Paul Magnuson of locating new VA hospitals adjacent to medical schools. He burned his hand in many a political fire to press this principle.

Although much criticized, he declared land excess at the Hines, Ill. hospital in order that Loyola University could build its new medical school there alongside a planned new VA hospital.

He enraged certain political powers of the State of Florida when he overturned a previous decision to build a new hospital in a resort area, and won approval of the President for new VA hospitals at Gainesville and Tampa, where they could have the advantage of proximity to new medical schools.

He insisted on a downtown location for the new Memphis hospital, holding up construction until the Memphis political, business, and medical communities agreed to a location in the medical center and close to the University of Tennessee Medical School. Throughout
this engagement, he was buffeted by political influences which were set upon a suburban location for the hospital.

A similar contest developed over a new hospital for Texas. Gleason persisted in his recommendation of a San Antonio site because of plans of the University of Texas to locate a new medical school there, and won Presidential approval in the face of stout congressional opposition.

Gleason put everything into these battles over hospital locations, as well as his disputes with the Bureau of the Budget; he was proud that he never lost one, and of the ears he received.

He was an ardent advocate of increasing research in the Veterans’ Administration, especially in the field of geriatrics. The Restoration Center at Hines had been opened and was to design, test, and develop new rehabilitation techniques, widen community preparation, and return oldsters to productive life outside institutional walls.

He secured the approval of Congress for a plan to examine and perform necessary laboratory tests on patients before they entered the hospital, thus cutting down the length of time the patient would remain there. Previously, this was done after his admission and frequently required several days before he could be treated or surgery could be scheduled.

The same plan provided that a non-service-connected case could leave the hospital at the earliest possible date after completion of treatment and return later for such additional followup treatment as required, with transportation at Government expense, if unable to pay. This, too, played a major part in reducing the length of hospital stay.

Mr. Gleason continued the modernization program of his predecessors. During his regime, new hospitals were opened at Brecksville and Cleveland, Ohio, Martinez, Calif., Jackson, Miss., and Nashville, Tenn.

On all his visits to VA hospitals he not only checked into the construction progress, administration, equipment supplies, etc., but paid special attention to the patients. A relative of a patient was likely to be stopped on such a visit and asked by the Administrator if everything was OK. Mr. Gleason listened intently to these grass roots answers. He continued the drive for understandable letters to veterans, which ran close to 1 million a year. He was antigobbledygook and proplain English. A classic example is a VA reply to a long letter from a veteran complaining he was charged too much for his GI insurance. The answer was: “You’re right. We’re wrong. Here’s a check for the difference.”

In 1961, the President was endeavoring by every means to aid the economy of the country. Mr. Gleason, therefore, authorized two dividends for insurance. One was paid in February 1961 and the second in August. Dividends were also paid to Korean veterans. Thus, in his first year Gleason acted to pay out to veterans more than one-half billion dollars in dividends.

However, his actions were not based on a desire to win a popularity contest. Most Americans generally favor economy in Government, but not when it means closing a local installation. Despite this political fact of life, Gleason closed down 161 one-man VA information contact offices located in every State. A storm broke out over Gleason’s head but he held firm, treating all States equally, including his native State of Illinois, and the President’s home State of Massa-
chusetts. By the end of his first year, Mr. Gleason had not budged and one-man contact offices passed into history.

While some high officials resented what they thought was congressional interference in day to day operations, Mr. Gleason had an abiding respect for Congress. “It represents the people,” he said. “It represents you, it represents me. Congress in one way is all of us just as the President in another way is all of us.”

In a directive to the department and staff heads of the VA, as well as those in the field, he stressed that “I have never regarded congressional inquiries or contacts as a legislative intrusion in the Executive domain. * * * I would like to feel sure that when a Member of Congress contacts your office or hospital you will take immediate and personal steps to see that the inquiry is handled expeditiously. * * * When the answer is ‘no,’ say so with my full support and backing. But insure that a complete and courteous explanation is made.”

Mr. Gleason operated with trust in his staff. He did not believe in holding a tight rein on men of ability. When he gave an assistant an assignment he did not constantly peer over the man’s shoulder between the time he gave it and the deadline set. He demanded precision and thoroughness in the results, and he believed that men of ability and self-respect work better when they are trusted than when they are made to feel nervous. He always talked about “we,” not “I.” However, he was capable of chewing them out, if the results were not satisfactory or not on time, but the explosion subsided quickly and left no feeling of subsequent rancor.

He preferred serenity to tension, and the VA shop on the whole is now one of the least ulcerous in the Government. Despite outside criticism, the atmosphere of the VA is predominantly one of harmony, efficiency, and service. Credit for much of this belonged to the VA’s first Administrator, General Frank T. Hines, a serious, dedicated man who, during his long term of office, took pains to establish for the agency a better image than the old Veterans’ Bureau had during the Harding administration.

Subsequent administrators, as well as Mr. Gleason, took pains to both preserve and develop this atmosphere, and introduced procedures calculated to enhance it.

In addition to his accomplishments for the Department of Medicine and Surgery, during Mr. Gleason’s tenure, major legislation was enacted to improve the veterans’ benefits program. This included increases in compensation for veterans disabled in service, their widows and children; pension increases for veterans totally disabled from non-service-connected causes, with little or no income; pension increases for widows and orphans; reopening of the national service life insurance for service-disabled and commercially uninsurable World War II and Korean veterans. He also secured an extension of additional assistance benefits to the children of veterans totally disabled in service; liberalization and extension of the direct loan program to assist veterans in the purchase of their homes in critical shortage areas. There was congressional authorization for the establishment of nursing care beds in VA hospitals, augmented by a program to assist in providing care in State and private nursing homes, for older and more seriously disabled veterans.

Compensation rates were increased an average of 9.4 percent. These rate increases ranged up to 20.8 percent for those most seriously
disabled. A new pension act increased pension rates for veterans of World War I and World War II and the Korean conflict, and their widows and children.

The aid and attendance allowance for beneficiaries so disabled as to require special care was increased from $70 to $100 a month, and a new pension allowance of $35 a month provided for housebound veterans. The additional assistance of $110 a month, provided for children whose fathers were killed in the service or who died as a result of disabilities incurred in service, was extended to children of living veterans totally disabled due to service-connected disabilities.

In addition to working for increased benefits for veterans and their dependents, Mr. Gleason also achieved increased efficiency in the administration of these programs. The general operating expenses each year were reduced during his term of office despite pay raises which increased Federal employees' salaries by 15 percent.

Chairman David N. Henderson, of the House Subcommittee on Manpower Utilization, told Mr. Gleason during hearings by that subcommittee:

In your administration of the Veterans' Administration you have really set a pace for Government and shown, I think, the most outstanding record of what can be done by new methods, automation, and real fine top-level and intermediate management.

President Johnson also cited the VA when he convened his cabinet in May 1964 to urge that greater economies be achieved in the Federal Government.

I want us to find new ways to increase productivity. Productivity in industry has gone up each year by an average of better than 3 percent. Government productivity should increase, too, and as much. The VA insurance program alone shows an annual gain in productivity of almost 7 percent. I am proud of the people doing that job, and I expect everyone else in the Government to try and emulate that example.

Mr. Gleason took very definite steps to raise the status and increase the employment of qualified Negroes. The March 1963 issue of Ebony magazine, a leading Negro periodical, included a seven-page article devoted to the Veterans' Administration under Mr. Gleason's leadership, and called the VA "the Government's most integrated agency." The article reported that 23 percent of VA employees are Negro, the highest percentage of any large Federal agency. The article pointed out that in the 18-month period prior to September 1962 VA either hired or upgraded 11,000 Negroes; that Negro personnel officials were sent to Negro colleges to recruit employees; and an equal opportunity program adopted in every VA activity in all States. Ebony quoted Mr. Gleason's remarks to an assemblage of nationwide top VA officials:

We have got to work fast, not a lot of study conferences. If Negroes are qualified, hire or upgrade them now. You can't worry about the color of a skin. You should think of what's between the ears.

Gleason appointed the first Negro to serve as a VA area field director; the first Negro regional office manager; a Negro Director of Insurance—the first to direct a major benefits program; and Negroes to positions of director and assistant director of hospitals.

He also fostered the advancement of qualified women employees to positions of prominence at a greater rate than ever before. At the
time of his resignation, more than 1,600 women in VA were receiving
annual salaries in excess of $10,000.
Gleason appointed a woman Special Assistant to the Administrator;
a woman Director of Personnel—the first to serve as head of a major
departmental program; a woman physician as director of pathology
service—the first to serve in the medical director grade; the first
woman manager of a regional office; the first woman chief of staff of a
large hospital; and the first woman assistant manager of a regional
office.
With all of these accomplishments in back of him, Mr. Gleason
decided that he should leave public service and return to Chicago.
On November 9, 1964, he addressed the President, briefly outlining
the accomplishment of the VA, and, in addition, he stated:

MY DEAR MR. PRESIDENT: It has been an immensely satisfying experience to
have served as Administrator of Veterans' Affairs during the past 4 years. These
have been historic years, and it has been a great privilege for me to have been able
to participate in them with you and with President Kennedy.

Primarily because of the attention and leadership which you, President Ken-
ney, and Chairman Olin Teague have provided, the veterans' benefits programs
have been vastly strengthened and improved. This administration will be re-
membered among veterans for having fostered the enactment of a truly historic
program of legislation beneficial to veterans. More than any other administration
since the enactment of the GI bill in 1944, it has responded to the real needs
of the Nation's veterans and their dependents.

These accomplishments are a reflection of the leadership you and President
Kennedy have given to the Federal Government and its employees. They testify
impressively to the dedication and abilities of Veterans' Administration employees,
and to the excellence of the Veterans' Administration as an organization.

Public Service has been a tremendous and exciting challenge, as well as an
enriching and rewarding experience—one that I have enjoyed immensely. Now,
however, for many personal reasons, I must return to Chicago. I trust that it
will be agreeable to you that my resignation become effective January 1, 1965.

With many thanks and warmest personal regards,
Most sincerely,

J. S. GLEASON, JR., Administrator.

On December 26, 1964, Mr. Gleason, accompanied by Mr. William
J. Driver, his Deputy (later announced as the new Administrator),
fl ew to the LBJ Ranch at Johnson City, Tex., and had a conference
with the President.

His resignation was accepted in writing by the President the next
day, as follows:

THE WHITE HOUSE,

DEAR JACK: I understand your personal desires to want to return to Chicago
and, consequently, I accept with regret your resignation as Administrator of
Veterans' Affairs to be effective January 1, 1965.

Your term of office has been marked by the passage of significant beneficial
legislation in response to the demonstrated needs of our Nation's veterans and
their dependents. Under your guidance, the quality and coverage of medical
care to our veteran patients has increased substantially.

On your departure, I would like to have it noted that you have performed
capably and legally in the best traditions of the public service, and I wish you
every success in your future undertaking.

Sincerely,

LYNDON B. JOHNSON.

Mr. Gleason returned to Chicago January 1, 1965, to resume his
position as vice president of the First National Bank, and to devote
time to other interests which he has in that city.
Joseph Hamilton McNinch was born October 6, 1904, the son of Starrett Irvin and Amanda Belle (Hamilton) McNinch, at Indianapolis, Ind. He received his M.D. degree in 1930 from Ohio State University. During the first 2 years of college at Ohio State, he pursued a course in engineering, but then decided he wished to become a doctor and switched to medicine.

Upon graduation, he immediately entered the U.S. Army Medical Service, taking 1 year of rotating internship. He actually started his
Army career as a psychiatrist primarily because during his senior year of medical school he served some time at a State hospital.

Among other assignments he served 27 OCC camps in the 1930's, in southeastern Georgia and Florida. He was chief of the biologic production laboratory at the Army Medical School, Washington, D.C., from 1936 to 1939, as well as instructor of medical statistics. He was a laboratory officer at the station hospitals in Camp Gordon and Camp Beauregard, from 1940 to 1941; Assistant Chief, Medical Statistics Division, Office of Surgeon General, 1941-42.

He then went overseas, serving in the European Theater of Operations under Maj. Gen. Paul R. Hawley. Toward the end of the war he was rather deeply involved in the operation of the U.S. Medical Service in Great Britain, which then consisted of some 132,000 beds. Upon returning to the United States, he became Director of the National Library of Medicine (formerly Army Medical Library) and served in this capacity from 1946 to 1949.

He was then transferred to the Far East Command where he became preventive medicine officer, Armed Forces, Far East, serving from 1951 to 1954.

His next assignment was that of commanding officer, Army Environmental Health Laboratory, 1954-55. The following year he was assigned as Chief of the Personnel Division of the Office of the Surgeon General. He then returned to the U.S. Army Forces in the Far East, where he was stationed from 1957 to 1958. From 1958 to 1960 he was commanding general of the Army Medical Research and Development Command. At that time, he was transferred to Europe as a doctor in the U.S. Army where he remained until his retirement in 1962.

Because of his literary ability, he had been appointed in 1950 as the editor in chief of the medical history of World War II.

Following his military service, he accepted a position as director of research and education with the American Hospital Association and, after 1 year, resigned that post to become Chief Medical Director of the Veterans' Administration in 1963.

He relinquished this office on January 1, 1966, and returned to the American Hospital Association as director of the southern region, Atlanta, Ga., in which city he presently resides.

In recognition of his military service he was decorated with the Distinguished Service Medal, the Legion of Merit, and the Bronze Star Medal. His professional associations are: Member, American Medical Association, American College of Physicians, American Physicians Association, American College of Preventive Medicine, the Royal Society of Tropical Medicine and Hygiene (British), American Society for the History of Medicine, the American Association for the Advancement of Science, and the Medical Libraries Association.

SINCE 1963

As a successor to Dr. Middleton, retired major general of the Medical Corps, U.S. Army, Joseph H. McNinch, was selected and appointed on June 3, 1963. He had been associated with Dr. Middleton during World War II in the European Theater of Operations, and continued many of the same policies and methods of operation used by his predecessor.

Dr. McNinch is a heavy-set, tall man, with bushy hair, and a military bearing. Always pleasant, and readily available to his staff,
he held frequent conferences with them to keep abreast of developments in the medical department.

He was very frank in expressing his own opinions and once he made up his mind as to the proper solution of a problem he stuck to his guns regardless of its acceptability by others. He often became frustrated in not getting things done "the Army way" and had little or no tolerance for so-called "redtape."

Shortly after Dr. McNinch was appointed, the Congress passed Public Law 88-450, August 19, 1964, which specifically authorized 4,000 beds for nursing home care. During fiscal year 1965, nursing bed units were installed in 27 Veterans' Administration hospitals. Community nursing home programs were authorized in the areas where VA nursing beds were not available.

During Dr. McNinch's tenure, the number of applications for hospitalization continued to increase—985,302 were received in fiscal year 1964. This was 23,254 more than the previous year, and 110,000 more than in 1959. There were 634,308 veterans found legally and medically eligible.

These needs were, for the most part, met through a greater turnover of beds. More veterans, both inpatient and outpatient, were treated in the first year of his administration than previously thanks to the prebed and posthospital care programs; 41 million days of patient care were provided, this in spite of a temporary reduction in the number of beds available primarily due to modernization of certain hospitals. During the fiscal year ending June 30, 1965, 49.6 million days of care were given in VA hospitals, non-VA hospitals, VA domiciliaries, State homes, plus VA and community nursing homes. Six million visits were made to VA clinics or to fee basis physicians.

New general hospitals were completed at Martinez, Calif., and Cleveland, Ohio. These replaced the old hospitals inherited from the Army at Oakland, Calif., and the Crile hospital in Cleveland.

A new 710-bed hospital was opened in Washington, D.C., in 1965, replacing the old "Mt. Alto" hospital which contained only 335 beds.

In order to bring field supervision more closely in touch with the Chief Medical Director and his staff, on June 30, 1965 Dr. McNinch abolished the area offices located at Boston, Mass., Washington, D.C., Atlanta, Ga., Columbus, Ohio, Minneapolis, Minn., St. Louis, Mo., and San Francisco, Calif. The title of the area medical director, who had been in charge of these offices, was changed to staff assistant for field operations (SAFFO). Their headquarters were established in central office, Washington, D.C. The territories supervised by the seven former areas were reduced to five by enlarging the number of States under the jurisdiction of five staff assistants for field operations. Certain of the personnel formerly on duty in the area offices were transferred to central office, and others reassigned to field stations to reduce the number of supervisory personnel.

Dr. McNinch continued Dr. Middleton's efforts in the use of newer and more intricate medical techniques, such as open heart surgery and renal dialysis.

He urged further research, emphasizing the care of the aging. By 1965 there were approximately 2 million World War I veterans with an average age of 71.
Being long interested in the work of all of the hospitals in the United States, it is only natural to presume he felt he could contribute more to the improvement of hospital operations in the Nation as a whole than in one hospital system, even though the largest in the country. So, he resigned before his 4-year term of office was completed.

Having spent most of his adult life in the service of the Federal Government, both military and civilian, he decided to accept an offer of the American Hospital Association as director of the southeastern regional office of that organization, with headquarters in Atlanta, Ga. His resignation as Chief Medical Director was effective January 1, 1966.
William Joseph Driver

William Joseph Driver was born May 9, 1918, in Rochester, N.Y., the son of John J. and Bridget Anna (Farrell) Driver. He was graduated, cum laude, from Niagara University in 1941, receiving a B.B.A. degree. In 1952, he received the LL.B. degree from George Washington University, and the M.A. degree in 1965.

Mr. Driver served as lieutenant colonel, AUS, from 1941-46, and in the U.S. Army from 1951-63. His military decorations include the Legion of Merit, Bronze Star Medal, Order of the British Empire, Croix de Guerre. He holds the Veterans' Administration's two highest awards: the Meritorious Service Medal which he received in 1957, and the Exceptional Service Award in 1960.

In 1964, he attained national prominence when he was awarded the Career Service Award of the National Civil Service League.

Mr. Driver served during World War II as a commissioned officer with headquarters, adjutant general, European theater of operations, from 1942 until separation from active duty in 1946. During the Korean conflict he served with the Office of the Assistant Chief of Staff, U.S. Army. He returned to the Veterans' Administration in August 1953.

He was named to the post of Chief Benefits Director in February 1959, and in January 1965 he was selected by President Johnson to be the Administrator of Veterans’ Affairs. He is the first career Federal employee to hold this post.

Mr. Driver and his family reside in Falls Church, Va.

1965 CLOSINGS OF OUTMODED FACILITIES

When Mr. Driver took over as Administrator, he faced a controversial problem no other Administrator had experienced.

Having been Deputy Administrator for 4 years he was intimately familiar with all activities of the Veterans' Administration and displayed a keen interest in the agency's medical program. The most vexing problem for him and the Chief Medical Director turned out to be the operation of certain hospitals which were either built in the early days of the Veterans' Bureau or acquired from the Army. At best, they required costly modernization. Others were poorly located in view of the modern concept of locating VA hospitals close to medical centers. And there were some, particularly those primarily for the treatment of tuberculosis which had ceased to be needed for that purpose. Miracle drugs and VA research had virtually eliminated the need for large tuberculosis hospitals which by now had been converted one by one to general medical and surgical. However, they were still distant from metropolitan centers where highly trained medical assistance was available.

As stated before the veteran population was shifting, especially toward west and south, notably California and Florida. The demand for beds in these States was extremely heavy. It became difficult to justify certain outmoded hospitals in some areas of the country while eligible veterans who had moved elsewhere could not be hospitalized.
Mr. William J. Driver takes the Oath of Office as Administrator of Veterans Affairs at his home, with Mrs. Driver and their two young sons in attendance.

The operation and mission of both the Department of Medicine and Surgery and the Department of Veterans' Benefits needed revamping according to a thorough study that had just been completed. It became obvious that additional organizational changes should be made if the maximum operational efficiency and economy was to be achieved, and, at the same time, high standards of service maintained.

Within 2 weeks after being sworn in as Administrator, Mr. Driver braved the complaints and criticisms of many and issued a directive dated January 13, 1965, that ordered the closing of certain hospitals and domiciliaries as well as the merging of a number of regional offices. He assured all employees of the facilities selected that they would be offered an assignment at another field station. He emphasized that eventually there might be a financial saving to the taxpayers, but this was not the primary purpose of the move. Any financial savings would be erased when the planned building program for new and replacement hospitals was completed. The approximate cost of this was $100 million per annum.

Despite Mr. Driver's explanations an avalanche of protest descended upon him. By mid-February 1965, over 20,000 angry letters had been received. The writers included Members of Congress, from those whose States or districts were affected, plus citizens of the same communities, the service organizations, and the VA employees faced with disruption.

The Subcommittee on Veterans' Affairs of the Senate Committee on Labor and Public Welfare, and the Subcommittee on Independent Offices, Appropriations Committee of the House, as well as by the House Committee on Veterans' Affairs directed their attention to the clamor.
At the direction of the President, Administrator Driver, Dr. Marc J. Musser, the Deputy Chief Medical Director, and other central office representatives, personally visited every installation involved, and reported their findings to President Johnson. The Comptroller General was also asked to make an investigation.

President Johnson appointed a blue ribbon committee headed by E. Barrett Prettyman, retired former chief justice of the U.S. Court of Appeals, for the District of Columbia. Other members were Senator Russell Long (Louisiana); Senator Milton R. Young (North Dakota); Congressman Olin E. Teague (Texas); Congressman E. Ross Adair (Indiana); John S. Gleason, Jr., former Administrator of Veterans' Affairs; Gen. Alfred Gruenther, former president of the American Red Cross; Dr. Paul Dudley White of Boston; J. William Harwick, secretary of the Board of Governors of Mayo Clinic, Rochester, Minn.; Dr. Dana W. Atchley, professor of clinical medicine, Columbia-Presbyterian Medical Center, New York City; and Dr. Russell A. Nelson, president, Johns Hopkins University, Baltimore, Md.

The Independent Offices Subcommittee of the Senate Appropriations Committee held hearings on the proposed closings of April 9, 1965. Testimony was given by the Administrator and other officials of the Veterans' Administration, Members of Congress, and leaders of veterans' service organizations.

The Prettyman Committee submitted a unanimous report to the President on May 26, 1965. They had reviewed transcripts of the hearings held by congressional committees, reports of the VA, and direct correspondence from medical schools and others. They visited all of the hospitals and domiciliaries involved, with one exception. As a result of their considerations, they came to the following conclusions:

The VA should continue its program of associating its hospitals, to the maximum possible extent, with accredited medical schools. It should proceed with its program of building new hospitals of the most advanced design and equipment.

Coincident with the availability of new facilities, corresponding quantities of outmoded or uneconomic facilities should be discarded, taking into account, among other things, shifting veteran populations. Consequently, in some instances, the replacement facility may not be located in the community of the hospital being closed.

At the same time, during these developments and thereafter, no segment of the veteran population should be left without reasonable facilities.

The report further recommended that the proposed closings be limited to the following hospitals and domiciliaries:

**HOSPITALS**

| Sunmount, N.Y. | Clinton, Iowa. |
| Dwight, Ill. | |
| Fort Bayard, N. Mex. | |
| McKinney, Tex. | |
| Brecksville, Ohio (Broadview Heights division) | |

They further recommend that certain regional offices be merged with a neighboring one, the merger being limited to a single manager.
for the two offices, with other personnel remaining at their present stations. Albany, N.Y. merged, with New York City regional office; Syracuse merged with Buffalo; Wilkes-Barre, Pa., with Philadelphia; Cincinnati, Ohio, with Cleveland; Kansas City, Mo., with St. Louis; Shreveport, La., with New Orleans; Lubbock, Tex., with Waco; San Antonio with the Houston regional office.

Insofar as the hospitals were concerned, the Rutland Heights hospital was originally acquired by the Veterans' Bureau for the treatment of tuberculous patients in 1922. It had been changed to a predominantly general medical and surgical hospital due to the lessening in the demand for treatment of tuberculosis. The patient load had been continuously on the decline since 1960. With five other hospitals in the State of Massachusetts, it was felt that eligible veterans could be adequately cared for in these hospitals. Upon being declared surplus to the needs of the VA, it was turned over to the State of Massachusetts, who now operate it as a tuberculosis, chronic disease, and mentally retarded hospital.

Sunmount.—This hospital was built by the Veterans' Bureau and opened in August 15, 1924, for the treatment of tuberculous veterans. From 1960 to 1964 the average daily patient load had consistently decreased. Its mission was changed to that of a general medical and surgical hospital. The hospital was located in a sparsely settled area of New York State and most of the patients came from New York City and other large communities in the eastern half of the State. There are 11 other VA hospitals in New York State, strategically located so that patient care could be adequately given to all eligible veterans, even though Sunmount was closed. This hospital was finally transferred to New York State and it is now operated as a school and hospital for mentally retarded children.

Dwight.—This hospital was transferred to the Veterans' Bureau on September 20, 1923. For a short time before, this institution had been operated by the Public Health Service, which had leased it from the Keeley Institute for the treatment of alcoholics. Of the two buildings, the larger was at that time 57 years old and the smaller 19 years old. It was an outmoded plant, relatively close to Chicago, where the VA has three excellent hospitals which are better equipped and staffed for the rendering of a high level of service. Upon closing, this hospital was transferred to the State of Illinois to be operated as a school for the mentally retarded.

Fort Bayard.—The site and buildings of this facility, which was an old Army post, were transferred to the Veterans' Bureau from the U.S. Public Health Service in 1922. It was operated as a tuberculosis hospital in that year, and redesignated as a general medical and surgical hospital on July 20, 1959. It was a completely outmoded plant, any new construction having been minor in character. Requests for admission to this hospital were steadily declining. It was felt that no undue hardship would be imposed on the area's veterans, who could be readily served by the modern VA hospitals located in Albuquerque, N. Mex., and Tucson, Ariz. Upon closing, the plant was transferred to the State of New Mexico, and is now being used as a chronic disease hospital.

McKinney.—This hospital was an Army cantonment-type hospital, transferred to the Veterans' Administration at the close of World War II, on May 6, 1946. It was contemplated that it would be used
only until the additional buildings at the Dallas hospital—increasing the bed capacity there—would be finished. The distance between the two hospitals is only 33 miles. In addition, the Dallas hospital is modern in construction and completely able to absorb the patient load at McKinney. Upon closing of this hospital, it was turned over to the State of Texas, and, in turn, transferred to the Texas Educational Agency and is operating as a vocational training facility.

Brecksville (Broadview Heights division).—It is not completely accurate to say that this hospital was closed; this division was a small tuberculosis section of a predominantly neuropsychiatric hospital. Because of the decline in the number of tuberculous patients, bed utilization became insufficient, and the new hospital in Brecksville, Ohio, adequately takes care of all patient demands.

Clinton, Iowa.—The domiciliary was transferred to the VA by the Department of the Army and opened by VA in 1948. When closed, it was turned over to the Office of Economic Opportunity and is now being used as a school for the Job Corps.

Thomasville, Ga.—The domiciliary had been transferred from the War Department to the VA in 1946. The disposition of this facility is in the hands of the General Services Administration, and no definite decision as to future use has yet been made.

While the closing of these facilities meant the loss to the hospital system of 1,660 hospital beds and 1,315 domiciliary beds, the existing hospital construction program of nine new or replacement hospitals under construction, and 11 future hospitals which have been approved and funded, will result in 14,343 modern hospital beds. Some of these are replacement for outmoded facilities, others are modernization, and still others are new hospitals.

In the domiciliary category, the closing of two installations will result in a loss of 1,315 domiciliary beds. Inasmuch as the demand for this type of care constantly decreases, it can be adequately handled by VA's other domiciliaries, as well as by nursing care beds recently made available in existing hospitals or on a contract basis.

With his initial problem solved Mr. Driver has continued to be a dynamic Administrator. He was instrumental in securing the passage of Public Law 89–358, March 3, 1966, known as the Veterans' Readjustment Benefits Act of 1966, which grants the status of war veterans to those who have served on active duty since January 31, 1955, to the present. Approximately 4 million servicemen, including those in the so-called cold war and the present conflict in Vietnam, will be eligible for the following benefits, as of June 1, 1966:

- Educational opportunities;
- Home loans;
- Eligibility for medical care;
- Job counseling and placement (a function of the Department of Labor);
- Veteran preference in Federal employment; and
- Presumption of service connection for certain chronic and tropical diseases, for compensation purposes.

This bill also prohibits the eviction of a serviceman’s dependents from a dwelling renting for $150 per month or less.

Mr. Driver also recommended an increase in compensation rates for service-connected veterans and their dependents which was approved and became law December 1, 1965 (Public Law 89–311).
The same legislation provided that the Attorney General could defend civil actions brought against medical and paramedical personnel in malpractice or negligence suits. In such cases, if decision is made in favor of the plaintiff, the Government is permitted to meet the costs involved.
Another section makes statutory the 125,000 hospital bed ceiling, and declares that 4,000 nursing care beds previously authorized are in addition to the maximum number of hospital beds to be operated by the Veterans' Administration.

In addition to his duties in central office, Mr. Driver has visited many VA hospitals and offices, taking every opportunity to meet as many employees as possible.

Mr. Driver is extremely interested in the now, and future young veterans, especially those now in Vietnam. He recently made a trip to that country, with the chairman of the House Veterans' Affairs Committee, Olin E. Teague, to observe at first hand the conditions under which our troops are serving today.

Dr. H. Martin Engle, Chief Medical Director, Veterans Administration, January 1966-
Harold Martin Engle was born in Chicago, Ill., November 29, 1914, the son of Nathan Hale Engle and Sarah J. Wolson. He attended Northwestern University and Central College in Chicago before enrolling at the University of Illinois where he received his B.S. degree in 1937 and his degree of M.D. in 1939. He had his internship and residency training at the Michael Reese Hospital in Chicago.

He served with the U.S. Army Medical Corps from 1942-46, attaining the rank of major.

Following his military service, he joined the Veterans' Administration, Department of Medicine and Surgery, in 1946. He has continuously served in increasingly responsible assignments at various locations since that date.

He is presently Chief Medical Director, having been appointed on January 4, 1966.

Dr. Engle has served on the faculties of the University of Utah College of Medicine, University of Colorado Medical School, and as clinical professor of medicine, Department of Medicine, at the University of California at Los Angeles.

He received the Veterans' Administration's highest honor, the Exceptional Service Award.

He is a governor of the American College of Physicians; fellow of the American College of Hospital Administrators; diplomate of the American Board of Internal Medicine; member of the American Medical Association, Association of Military Surgeons, and Alpha Omega Honorary Medical Society.

He resides with his family at Lake Barcroft, Va.

CAREER MAN DESIGNATED CHIEF MEDICAL DIRECTOR

The sixth Chief Medical Director of the Department of Medicine and Surgery to be appointed was Dr. H. Martin Engle, the first career man, also the youngest, ever to hold this position. He succeeded Dr. J. H. McNinch on January 4, 1966.

Dr. Engle first entered the Veterans' Administration in 1946 at the age of 32. He had served in the U.S. Army Medical Corps from 1942 to 1946. Upon discharge, he accepted an appointment as a medical officer at the VA Center in Fort Harrison, Mont. His potential abilities were so obvious that in the following years he was selected for promotion at pretty frequent intervals:

June 1947 to April 1948: Assistant chief, medical service, VA hospital, Portland, Oreg.
April 1948 to September 1950: Chief of professional services, VA hospital, Vancouver, Wash.
September 1950 to February 1952: Chief of professional services, VA hospital, Seattle, Wash.
1953 to February 1955: Director, VA hospital, Salt Lake City, Utah.
1955 to March 1960: Director, VA hospital, Denver, Colo.
May 1960 to May 1964: Deputy Chief Medical Director, VA central office, Washington, D.C.
May 1964 to January 1966: Director, VA center, Los Angeles, Calif. (largest medical facility in the system).
January 1966 to date: Chief Medical Director.

To administer an organization as large as the VA, whose operations in one way or another affect a large segment of the populace, is no "one man" job. The Administrator must surround himself with people thoroughly trained in the administration of the veterans' benefits of which they are in charge; namely, the Chief Medical Director, Chief Benefits Director (including insurance), and the Chief Data Management Director.

With the appointment of Dr. Engle as Chief Medical Director, at age 51 and having had VA service since 1946, Administrator Driver completed the triumvirate of the three young career directors. The Chief Benefits Director is Mr. A. W. Stratton, age 45, and with the VA since 1944. Mr. Philip J. Budd, Chief Data Management Director, is 47 years old and, with the exception of 4 years World War II military service, has been with the VA since 1940.

Dr. Engle is a tall, slim gentleman who appears to be reserved and quiet on first acquaintance. This gives way to warmth, ready wit, and good fellowship, evidenced by further contacts. He is very professional in his bearing and extremely devoted to the mission of caring for the sick.

With the breadth of experience he has had in VA medicine in a number of different locations, he understands the problems of both the field and the central office. Therefore, it is not difficult for him to arrive at solutions with fairness and dispatch. He is respected by his fellow workers in the VA, as well as those who handle veterans' affairs in the Congress.

During fiscal year 1966, there were approximately 20,000 more patients treated in hospitals, domiciliaries, and nursing homes than in the previous year. More visits were also made to outpatient clinics and fee basis physicians.

The number of hospitals containing nursing-bed-care units has increased to 38, making a total of 2,262 such beds.

A new 498-bed hospital was opened at Charleston, S.C., also, a new hospital with 572 beds was dedicated at Atlanta, Ga., to replace the old Atlanta VA hospital with a bed capacity of 300.

During 1967, the following hospitals opened for the care of veterans:

* Oteen, N.C.—A 505-bed hospital with 445 beds devoted to the care of medical, surgical and neurological patients and 60 beds set aside for psychiatric care. The hospital was built at a cost of $10.3 million.

* Temple, Tex.—A 480-bed hospital with 240 beds devoted to medical, surgical and neurological care and 240 to psychiatric treatment. Erection cost was almost $9 million.

* Memphis, Tenn.—A 993-bed hospital of which 240 beds have been designed for psychiatric care, built at a cost of $20.08 million.

* Miami, Fla.—A 1,070-bed hospital of which 240 beds are for psychiatric patients, built at a cost of $20.1 million.

* Gainesville, Fla.—A 436-bed hospital with 246 beds for medical, surgical, and neurological treatment and 240 psychiatric beds. The erection cost was $11.4 million.

Also during 1967, a 1,160-bed addition opened at Long Beach, Calif., VA hospital at a cost of $18.7 million. The addition provides 920 medical, surgical, and neurological beds and 240 psychiatric beds.
The new Veterans Administration Hospital opened in Oteen, N.C., in 1967.

The new Veterans Administration Hospital opened during 1967 in Temple, Tex.
The new Veterans Administration Hospital in Memphis, Tenn., opened during 1967.

The new Veterans Administration Hospital opened in 1967 in Miami, Fla.
The new Veterans Administration Hospital opened in 1967 in Gainesville, Fla.

The new addition to the Veterans Hospital in Long Beach, Calif., opened during 1967.

With Dr. Engle's background, his contribution to the continued improvement of medical care of the veteran will be considerable.
CHAPTER XI

THE DEPARTMENT OF MEDICINE AND SURGERY KEEPS ABREAST OF MODERN MEDICINE

In keeping with General Hawley's aim for the Department of "medical care second to none" and imbued with the spirit, the Department has steadily sought to improve the medical care of the veteran through intensive research, as well as adopting new techniques evolved in the medical world in general.

This is made possible by the steady expansion of research and the increase in opportunities for professional personnel to attend educational seminars and courses to enhance their knowledge of new developments in their particular fields or specialties. This advantage is not confined to physicians alone, but is available to nurses, dietitians, therapists, and other auxiliary personnel. These opportunities have attracted some of the best medical personnel in the country, as either full-time or part-time employees, and on a consulting or attending basis.

In addition to keeping abreast of developments in all phases of professional care, there are certain new medical programs which have been instituted, if not pioneered, by the Department of Medicine and Surgery itself.

In the calendar year 1964, the Veterans' Administration hospitals discharged 650,000 patients. Included in this group was a very large segment of all known diseases. Heart disease and mental illness were by far the most numerous, followed numerically by such diseases as arthritis, diabetes, and tuberculosis.

For many diseases, the more or less standards types of treatment have changed little in the past 5 years. Diabetes, tuberculosis, many forms of arthritis, and most abdominal diseases feasible for surgery, fall into this category. This, however, does not indicate that the Department of Medicine and Surgery is satisfied with the standard types of treatment, even though it has been static for some time, and the research laboratories continue to work intensively and extensively on the unsolved problems relating to these diseases. It is hoped that a new understanding, with new approaches to treatment-perhaps unique or radically different-may emerge at any time.

There follows a résumé of the progress of the various professional programs, as reported by the Directors of each category.

MEDICAL SERVICE

Hemodialysis units

One of the most exciting developments in the field of medicine during very recent years has been the adoption of the artificial kidney (hemodialyzer). A survey within the VA in 1964 indicated that an average of 1,200 patients die each year as a direct result of kidney failure.
In an additional undetermined number, chronic kidney failure could well have contributed to their death.

Prior to 1960, these patients faced inevitable death, save for a small handful of identical twins receiving transplants from their counterparts. While the artificial kidney has been widely available and used for some years in the short-term treatment of acute kidney failure, it is only recently that the loss of the kidney function due to a chronic progressive disease has invariably been followed by uremia and death. Many of these patients could have been kept alive if a substitute for their nonfunctioning kidney were available. The hemodialyzer, or artificial kidney unit, is now providing that necessary substitute.

By the insertion of a plastic tube into a vein and an artery, a permanent means of access to the blood stream is created. At regular intervals, usually twice weekly, the patient is connected to the dialyzing device. The effective results of this procedure is shown by the fact that some patients who started on this treatment in its experimental stages 8 years ago are still living and well. Furthermore, evidence seems to be accumulating that some of the serious complications of kidney failure are corrected, often spectacularly, by this procedure.

In 1964, the Veterans' Administration established the first two hemodialysis centers at Hines, Ill., and Los Angeles, Calif. These were rapidly followed by nine more and all are now in operation and working close to capacity. Plans are fully developed for 17 more, and, in various stages of completion for an additional 14. It is expected there will be 42 units, each capable of handling about 21 patients on a continuing basis.

The development in the field of organ transplantation, or in some other as yet unrecognized field, may make this permanent hemodialyzer unnecessary. If this happens, the 42 planned units may be adequate; if not, additional units will be required. In the meantime, kidney transplantation is progressing to the extent where it is in the stage of transition from research to patient service. At the present time, approximately one-third of the known renal transplants in the world, to date, have been done by the Veterans' Administration staff. This, of course, has been done at the hands of highly experienced and skilled teams, and it is expected that a fully rounded program will be in operation as soon as additional funds become available over and above the normal operating costs for each hospital and laboratory engaged in this work.

Intensive care units

The new programs described above have in common the feature that they bring great sophistication in diagnosis and treatment to a large group of patients with serious or fatal chronic disease, for which little could be done until the very recent past. Many of these new programs make it possible to bring vigorous treatment to so-called poor risk patients. Finally, an intensive nursing effort is inherent in all of these new approaches if they are to realize their potential. While the new programs carry special impact on nursing requirements, all diagnostic and treatment activities in the hospitals are constantly raising their standards. This means that the demand for more and better nursing manpower is increasing faster than the supply. These problems have been partially solved by the development of intensive care units. These are nursing units of from 6 to
18 beds, where all needed facilities are provided within easy reach and especially tailored to the needs of seriously ill patients who must be under continuous observation and treatment. Special staff are assigned to these units.

At the present time, 44 VA hospitals have intensive care units on a limited scale. Nurses have been provided to bring 14 of these to full strength during the fiscal year 1966. Plans are developed for the establishment of six new units and a special task force is studying the entire program with a goal of providing orderly development as the needs of these units evolve.

**Pulmonary function laboratories**

Just as cardiac catheterization provides information about the heart and circulatory system, the pulmonary function laboratories provide essential information on the physical and chemical activities of the lungs. A progressive growth in the number of veterans suffering from chronic obstructive emphysema (lung failure) is a major problem. At least one man in 10 over the age of 45 suffers from this ailment. The number is constantly growing and there is no evidence of any slackening.

The diagnosis and determination of effective treatment of lung failure is based upon the measurement of: (a) the amount of air the lung can handle at a rate required by the body; (b) the amount of oxygen actually carried by the blood in the arteries; and (c) the amount of waste air (carbon dioxide) accumulated in the veins. These measurements are done in a pulmonary function laboratory by especially trained professional and technical personnel. The reliable diagnosis of lung diseases—one of the largest causes of prolonged disability—is based upon these studies. In addition, the surgeons dealing with patients over 45 years of age need to know whether the patient can tolerate the indicated surgical procedures. Therefore, precise knowledge of the degree of impairment of lung function is indispensable, and the pulmonary function laboratory is often of vital importance to the surgical service.

Seventy-three VA hospitals now have pulmonary function units which vary in the degree of completeness of staffing and equipment. However, at the present time, these units are being strengthened as research resources become available, and plans are being made for their establishment in 10 additional hospitals.

**Radioisotope program**

Radioisotopes became generally available to medical sciences during and immediately following World War II. They are elemental substances which have been made radioactive; that is, they give off radiation which is similar to X-ray in its effects. Because this radiation can be harmful and even fatal to anyone subjected to it, the use and distribution of these radioisotopes remains under governmental regulation.

Initially, they were utilized in the VA only in specialized research laboratories and the VA early became the leader in such research. They are an effective tool of research and of great value in the treatment and diagnosis of a number of diseases and conditions. There has been a very dramatic increase in the demand for radioisotope studies of the brain, liver, kidney, heart, spleen, and lung, because such studies can furnish quick and reliable information concerning the
location, nature, and extent of possible abnormality—such as tumors, embolisms, and malfunctioning organs—without resort to surgery, and with no injury and minimal discomfort to the patient.

Needless to say, properly trained personnel are in short supply and command good salaries. The expanding need for this program will be met by the Veterans' Administration, and there are well-developed plans for support of these units in 78 hospitals. As in other programs, future expansion and strengthening of this activity will depend upon the demand and the resources becoming available.

**MEDICAL SERVICE**

*Tuberculosis—The downward trend: Research and education pay off*

In 1900, the death rate from tuberculosis was 194 for each 100,000 population. Through research and experimentation under both civilian and Federal auspices, this was reduced to the present amazingly low figure of 5.1 per 100,000 population. The Veterans' Administration is very proud to be an important participant in this dramatic reduction of fatalities due to this disease.

When the U.S. Public Health Service transferred to the Veterans' Bureau the hospitals treating veterans of World War I, there were 13 hospitals entirely devoted to the treatment of tuberculosis, aggregating 7,168 beds. During that year (1922) 44,591 tuberculosis patients were hospitalized at a yearly cost of almost $30 million. Less than one-half were being cared for in veterans' hospitals, about one-third were being treated in contract hospitals, and over one-sixth were hospitalized in other Federal hospitals, such as those operated by the Army, Navy, and National Soldiers' Home. These beneficiaries, suffering from tuberculosis, who remained in hospitals at the end of the fiscal year 1922, represented 43 percent of the entire group. At that time, the most modern treatment consisted mostly of bed rest, fresh air, good nutrition, and surgical procedures such as collapse therapy and pneumothorax.

This treatment involved a prolonged stay in the hospital and was expensive to both the patient, away from his home and employment, and to the Government.

Because of the lengthy hospitalization, over one-fourth of the hospital discharges were against medical advice, or without official permission to leave.

Under the auspices of the White committee, locations were sought for the erection of new tuberculosis hospitals being built by the U.S. Treasury. Because of the nature of the treatment—in which bed rest played such an important part—sites were sought in isolated communities, away from the noise and dirt of the cities, and a high altitude was deemed to aid in the cure. Therefore, many of our hospitals were built far away from medical centers, which were later to play such an important part in the location of hospitals. A number of these have since been abandoned, such as: Outwood, Ky., Sunmount, N.Y., Rutland Heights, Mass., and Fort Bayard, N. Mex. Previous to their closings, they had been designated as general medical and surgical hospitals, but their locations, as well as their need for modernization, made their continuance unadvisable. Rather, they have been replaced by new general medical installations adjacent to medical centers and medical schools.
While the method of treatment of tuberculosis continued to improve in certain respects, it remained more or less static until the beginning of World War II. At that time, the number of tuberculous patients in the hospitals on a given day dropped to a new low of about 5,000. With the onset of World War II, and then the Korean conflict, there was an upward trend.

The number of veterans receiving treatment on June 30, 1954, reached a peak average daily patient load of 15,940. Considering the number of participants in both World War I and World War II, the latter was not as high a ratio as the former, although it is true that veterans of World War II had had a greater opportunity for contamination by heavily contaminated populations; also, they were demobilized at a much more rapid rate. In addition, there were available about 46,000,000 X-rays which enabled far more accurate diagnosis inasmuch as each man serving in World War II was given an X-ray upon entering service and at the time of his discharge. This was an invaluable source of research study, especially in those cases where the man was discharged because of tuberculosis. A case-finding study was established under Dr. Barnwell's jurisdiction wherein each of these men who had a history of tuberculosis was made the subject of a followup to determine the worsening or betterment of his condition. This case-finding record is continued to the present day.

To meet the peak load in 1954, 21 hospitals throughout the VA system had been designated for the treatment of tuberculosis:

- Tucson, Ariz.
- Whipple, Ariz.
- Livermore, Calif.
- San Fernando, Calif.
- Indianapolis, Ind.
- Outwood, Ky.
- Baltimore, Md.
- Rutland Heights, Mass.
- Excelsior Springs, Mo.
- Fort Bayard, N. Mex.
- Batavia, N.Y.
- Castle Point, N.Y.
- Sunnmount, N.Y.
- Oteen, N.C.
- Brecksville, Ohio
- Butler, Pa.
- Memphis, Tenn.
- Kerrville, Tex.
- Walla Walla, Wash.
- Madison, Wisc.
- Waukesha, Wisc.

In 1939 a research project was started at the Mayo Clinic by Dr. William F. Feldman, a member of the present staff of the Department of Medicine and Surgery, together with Dr. H. Corwin Hinshaw. They initiated studies involving certain sulfa drugs which proved to have a limited suppressive effect in experimental tuberculosis in guinea pigs. However, they were led to the conclusion that experimental with other drugs was warranted.

In January 1939 the discovery of streptomycin (an antibiotic produced by a soil micro-organism) was announced in a publication by Dr. S. Waksman, Dr. A. Schatz, and Dr. E. Bugie, of Rutgers University. It was held that the organisms proven to be susceptible to this antagonistic agent were "myco bacterium tuberculosis."

Doctors Feldman and Hinshaw were successful in obtaining a small supply of this drug and, after three experiments, they were convinced of the ability of streptomycin to reverse the lethal course of tuberculosis in guinea pigs.
In 1945 it was administered to 34 tuberculous patients at the Mineral Springs Sanatorium, Cannon Falls, Minn. While the drug did not exercise a rapid cure, it did modify the disease and suppress its progress. Thus, the work of Dr. Feldman and his associates at the Mayo Clinic proved that a new weapon could be placed in the hands of physicians treating tuberculosis. It was a drug which they could prescribe with confidence as an effective therapeutic agent in the treatment of this disease.

When the Department of Medicine and Surgery was created in 1946, there were over 8,000 hospitalized tuberculosis patients, and the number was expected to increase. Gen. Hawley, Chief Medical Director, knew something had to be done immediately and, characteristically, he set about to take advantage of the most modern concepts in the treatment of tuberculosis.

He was familiar with the research which had been going on in chemotherapy and therefore he sought the services of an expert in this field. He asked Dr. John B. Barnwell to head this program in the Department of Medicine and Surgery, where he would have every clinical and academic advantage. Much to the surprise of his friends, Dr. Barnwell accepted.

At the time, he was an associate professor of medicine in charge of the tuberculosis unit at the University Hospital, University of Michigan. In addition, he was a lecturer at the university school of public health and a consultant to the State department of health in Michigan and the U.S. Selective Service System. He had been president of the American Trudeau Society, whose members are the outstanding tuberculosis specialists in the Nation.

It was then that one of the most dramatic episodes in the history of American medicine had its beginning. Under Dr. Barnwell's guidance, there was to occur a revolution in the treatment of tuberculosis, which has saved an untold number of lives, as well as shortened periods of hospitalization, and conserved millions of the taxpayers' dollars. It also enabled the VA to treat more patients in the same number of beds.

Dr. Barnwell had attended several meetings of tuberculosis specialists where the discovery and use of streptomycin had been thoroughly explored. To aid him in the tremendous task ahead, he sought the services of Dr. Arthur M. Walker, who had worked with him in Pennsylvania and later joined him in Michigan. He was a distinguished scientist who had a keen interest in research in medicine, equal to that of Dr. Barnwell in tuberculosis. Together they had many conferences on this matter and were known as night owls, continuing their research into the early hours of the morning.

To elaborate on an old cliche, that "two heads are better than one," Dr. Barnwell believed that hundreds of heads are better than one. He realized that with the increasing number of tuberculosis patients in VA hospitals, as well as those in Army and Navy hospitals, this constituted the largest group of patients in the world for clinical study under a single authority.

He therefore asked the Surgeons General of the Army and Navy to join with the VA in a study of the chemotherapy of tuberculosis. They agreed to have one Army and one Navy hospital join the five VA tuberculosis hospitals designated by Dr. Barnwell, to cooperate in this venture.
The hospitals involved in the study of the chemotherapy of tuberculosis were: Fitzsimons Hospital (Army), Denver, Colo.; Sampson Naval Hospital, N.Y.; and Veterans' Administration hospitals at Summertown, N.Y.; Brecksville, Ohio; Hines, Ill.; Livermore, Calif.; and Rutland Heights, Mass.

Under his guidance, the number of participating hospitals eventually grew to 60. Tirelessly, they studied the therapeutic value of many drugs and antibiotics under a variety of regimens. Dr. Barnwell was designated as chairman and Dr. Walker as permanent secretary of the Committee. By the summer of 1946 they had worked out an elaborate protocol, setting forth the selection of cases, dosages, and the location of study units.

These ideas were presented at a forum known as the Veterans' Administration-Armed Forces Chemotherapy Conference, which held 21 meetings in the ensuing years. At an early meeting the group, in discussing the use of streptomycin, reported as follows:

The Veterans' Administration is not, and should not be, in a position to make the first clinical trial of a new drug * * *. Once a new drug has been tried, however, and has been shown to have some promise of effectiveness without undue toxicity, the VA is peculiarly, and perhaps uniquely, fitted to conduct a large-scale investigation of its effectiveness and the best regimen for its administration.1

The results of these studies were incorporated in the practice of medicine in VA and military hospitals, and, eventually, throughout the United States and the world. The fame of these conferences consistently increased, with 34 attending the first meeting, and by 1956 over 400 were in attendance.

While the number of tuberculous patients increased from 9,519 in 1946 to a peak of 15,940 on June 30, 1954, the length of stay in the hospital had been reduced, enabling the VA to take care of the Korean veterans as well as all other eligible veterans within the same number of beds. It was not necessary for them to remain in the hospital once they were on a successful standard drug regimen, as they were able to self-administer this drug at home. By these expedients, millions of dollars were saved the taxpayers and the veterans were able to return to their homes and jobs long before it had been otherwise possible.

All participating hospitals submitted reports of the trials of the chemotherapy of their patients, which were edited by Dr. Walker and distributed as quarterly progress reports.

There was also issued under his direction “technical bulletins” concerning the theory and therapy given at participating institutions. While initially prepared for distribution in the VA, they soon came to have a much wider distribution. The excellence of these bulletins was a product of the editorial genius of Dr. Walker to the extent that they have been reserved as a memorial to him. Since his death in 1955 they have been issued under a different title.

The first of the clinical trials was conducted from 1946 to 1949 and showed that a daily dosage of streptomycin was beneficial. A second series of trials began in 1949–51, and indicated that the streptomycin, in combination with another drug, PAS (para-aminosalicylic acid), was more beneficial than either administered alone. Then, a third

1 Such a statement would have allayed the fears of General Hines in his objection to a residency training program—that the veterans might be used as guinea pigs.
series of trials, started in 1951, added another drug to these two, which was isoniazid. This combination produced the best results up to that date. Since 1954, other drugs have been tested with varying degrees of success.

The cooperative studies engendered an extraordinary spirit of scientific inquiry among medical personnel of the agency, with the end result that the care of the patient with tuberculosis has greatly improved. Staff members, realizing that they had opportunities for research and education in this field, and that they had played a part in the breakthrough, remained with the Veterans' Administration instead of seeking more remunerative positions elsewhere.

A tribute to Dr. Barnwell and his staff is the fact that the VA is now known worldwide for its cooperative study approach to research. The vast resources of the VA, in terms of medical, scientific, and technical skills, and also in terms of the large number of patients in VA hospitals, make it possible for VA investigators to pursue studies on a cooperative basis in a manner not possible in smaller organizations. By this approach, with careful clinical controls the relative merits of therapeutic procedures and variations in drug regimens may best be evaluated. The practical benefits of the cooperative studies are best exemplified by the decrease in the number of patients in VA hospitals with tuberculosis from almost 16,000 in 1954 to 4,595 on May 31, 1966.

The VA-Armed Forces cooperative study on the chemotherapy of tuberculosis is still in progress, but, today, emphasis is placed primarily on how to use available drugs more effectively and how to eliminate tuberculosis completely.

As the beneficial effects of chemotherapy became apparent, tuberculosis units were established in many of the VA general hospitals. Nineteen hospitals formerly designated as strictly for the treatment of tuberculosis were redesignated for general medical and surgical patients, with a tuberculosis unit for appropriate cases. Only two are designated as tuberculosis hospitals at this time--Baltimore, Md., and Indianapolis, Ind.

Following the same pattern, other cooperative studies have been initiated, such as antihypertensive agents, evaluation of drugs in neuropsychiatry, oral medication in diabetes, pulmonary function testing, and the chemotherapy of lung cancer. The present total of cooperative studies is 47. Any degree of success in this cooperative approach is a lasting tribute to John Barnwell's vision. It was he who was responsible for seeking and securing the help of friends and associates in forming the plans for such studies and trials. With his friend, Dr. Arthur M. Walker, they spent untold hours working on problems connected with the studies. It was not always clear, even to them, where one man's idea stopped and the other's began! Dr. Walker was a rigid, exacting scientist, whereas Dr. Barnwell was brilliant, but practical, and more inclined to allow for the human element. His quiet warmth and patience enabled him to weld people of many backgrounds together for the success which resulted in his being awarded the Trudeau Society Medal in 1950.

In 1956, Dr. Barnwell was promoted to the position of Assistant Chief Medical Director for Research and Education. In 1959, the U.S. Civil Service Commission chose Dr. Barnwell as one of the top 10 career men in the Federal Government. The next year he received the highest award of the Veterans' Administration—the Exceptional
Service Award. He also received many other honors. He was very humble in accepting them and transferred all credit for them to his associates. His greatest satisfaction was the realization of the inroads made in improving the treatment of tuberculosis.

He retired in 1960 and moved to a home which he built in Blairstown, N.J., and which he named "Cabin John." He passed away May 4, 1966, and will long be remembered for his intellectual honesty, excellence in expressing himself in the written word, and as an inspiring humanitarian.

PSYCHIATRY NEUROLOGY AND PSYCHOLOGY SERVICE

The largest single category of illness treated in Veterans' Administration hospitals and clinics is mental illness. The incidence of this in its varying forms is just about the same among veterans as it is among the general population. The American Medical Association, in "Today's Health Guide"—its manual for lay readers—estimates that 50 to 70 percent of the patients going to a family doctor suffer from illness of an emotional rather than a physical nature. The American Hospital Association, moreover, reports that one of every two hospitals beds is occupied by a person who is emotionally disturbed.

Mental illness appears to be more common in the present generation than it appeared to be earlier in the century, but the appearance may be deceptive. It probably existed in the past more widely than was suspected or admitted. What has happened is that modern methods of diagnosing it have improved. What also has happened, fortunately, is that people who are afflicted with it are less reluctant to take steps to have it treated. Fortunately, too, treatment has improved enormously.

Much, of course, still remains to be accomplished. The campaign to encourage people not to bury their heads in the sand about mental illness, if they themselves or their loved ones are suffering from it, must be maintained. Methods of detecting it in its early stages in childhood and in school days must be improved even further; likewise, methods of treating it in all of its manifestations. But the recognition that mental illness is an illness, and not a disgrace, has been gaining ground, and this is a necessary beginning of victory in the battle against it.

Victory in the battle is more common than defeat. The illness can be cured, or, if not, so contained and controlled that the patient can return to normal living and lead as happy and as successful a life as his natural abilities and his education permit. The Veterans' Administration has seen this happen so often that it is the principle on which its Psychiatry, Neurology, and Psychology Service operates.

A psychiatrist is a full-fledged medical doctor who has taken postgraduate training and who has had clinical experience and been duly recognized in his specialty, the diagnosis and treatment of mental illness.

Some psychiatrists also take postgraduate training in psychoanalysis, a specialty within a specialty. Students of it undergo analysis themselves. Psychoanalysis involves prolonged exploration of the patient's personality, mainly by leading him deftly, diplomatically, to come to an understanding of, and an insight into, his personal conduct and the motivations behind it. Any genuinely intelligent
layman is loath to engage in the all too common dinner table or cocktail party bandying about of some of those terms of psychiatry which have become commonplace in general conversation. Such a layman might well be interested in part V, "Mental and Emotional Health," of the already mentioned American Medical Association's Today's Health Guide. This part of the manual, only 35 pages in length, is full of commonsense, rather than ill-informed hearsay, on mental illness. For further information it recommends to "every family" the book, "Mental Illness: A Guide for the Family," by Edith M. Stern, obtainable from the National Association for Mental Health or any local mental health society.

Collaborating with the psychiatrist, a neurologist is a medical doctor who specializes in diseases of the brain and the nerves. Certain pressures (as by tumors) upon the brain or the nervous system, or inflammations of them, or damage done to them, can affect a patient's mental health and daily conduct. Neurology, therefore, might be said to deal with that area of human action and conduct in which the physical factor, through the brain and the nerves, exerts a strong influence upon mental and emotional factors.

Psychiatric medicine, incidentally, has discovered that the mental and emotional factors can influence the physical. Certain (not all) cases of high blood pressure, peptic ulcers, migraine headaches, colitis, asthma, and hives can be psychological as well as physical in origin.

Along with psychiatrists and neurologists in the Veterans' Administration, are psychologists. A psychologist is a doctor of philosophy whose specialty is the knowledge of how people act and why they act, both as individuals and as members of society. Certain psychologists, called clinical psychologists, take courses in psychoanalysis. Working with psychiatrists, neurologists, and psychologists on the VA mental health team are those trained social workers, with master's degrees, who have specialized in the psychiatric aspects of social work. There are nurses, also, whose special training and experience have been in the field of psychiatry.

The VA Psychiatry, Neurology, and Psychology Service functions in both the inpatient and outpatient services. The part it plays in outpatient service is described in the paragraphs on day treatment centers and mental health clinics in the section of this chapter devoted to VA clinics. It also plays a part in the overall medical service in VA domiciliaries and related VA responsibilities, such as the foster home method of posthospital care.

Most mentally ill patients are not "dangerous." They can be annoying and saddening to their loved ones and companions, and a burden to themselves, until with professional help they gain that grip on themselves which enables so many of them to live normally again. Only a minority of them have suicidal or homicidal tendencies. For this minority, in the VA as well as other mental hospitals, good psychiatric care devotes the most minute attention to the kind of clothing they wear and the kind of furniture intended for their comfort. The very wood finishes and the very upholstery colors of the furniture are given the most thoughtful and experienced consideration.

Veterans' Administration experience in psychiatry goes back to the earliest days of the Veterans' Bureau medical system of the 1920's. As many psychiatrists as were available for the demands made upon the Bureau, and upon its successor, the Veterans' Administration,
during the 1930's, were enlisted for VA medical staffs. The psychiatric care of veterans, in general, may be said to have engaged in a sincere and successful effort to keep pace with the psychiatric knowledge and skill of those two decades. The acknowledged shortage of Veterans' Bureau and Veterans' Administration psychiatrists reflected a general shortage, and a general national shortage of psychiatrists still prevails in the 1960's. The present VA could use more psychiatrists, but it does not now have the same difficulty in obtaining them that it had before World War II. The opportunities it now offers for psychiatric treatment and research have attracted some of the best practitioners and scholars in the profession.

One of the notable differences between prewar and postwar VA psychiatric therapy, both in the VA and elsewhere, has been the very considerable reduction in shock treatment. At one time used in many cases, it is now used only in those of extreme depression, and in those only when other, newer, treatments fail to produce the desired results.

Among the newer treatments, the VA has been prominent, for example, in the use of tranquilizers for psychotics and neurotics. Psychotics suffer from specific mental illnesses ranging from mild delusions, hallucinations, or irresolutions, to serious ones—all the way to schizophrenia, or split personality. Neurotics, in popular language, suffer from what is called nervousness, a feeling of fear, anxiety, and depression in face of the realities and problems of living. Most people are neurotics in some degree at some period or other in their lives. Not all neurotics or psychotics always need extended treatment. Tranquilizers, administered in appropriate dosages prescribed for individual cases by psychiatrists (and even at times by general practitioners), can often reduce the disturbance in a patient's mind to the point where, with sound advice from psychiatrist or psychologist, he can think his way through, and out of, his problems, and substitute intelligent habits for foolish ones. Tranquilizers, by shortening the period of hospitalization, have been a moneysaving and timesaving boon in thousands of cases.

In modern medicine, tranquilizers have served in psychiatry much as antibiotics have served in internal medicine and chemotherapy of tuberculosis. Tranquilizers, however, can be habit forming; therefore, they should be taken only when, and in the amounts, prescribed by a physician. To become a patient of two or three physicians so that one can obtain tranquilizers in excessive amounts is one of the most dangerous dishonesties a mentally ill person can practice. It defeats the purpose of psychiatry, which is to so advise and so indoctrinate its patients in helpful procedures and disciplines that they will not have to depend on tranquilizers at all.

Another procedure of VA psychiatry which has been closely followed by the profession in general has been its practice of inducing mentally ill patients to fraternize. Such patients often have a tendency to be "loners," to "retreat into their shells," to be self-centered and unsociable. The VA provides them with every opportunity possible to socialize with others. They are encouraged to talk with each other, to play card games together, to work on chores together, and in this way to help each other to adjust to the give-and-take of normal society and normal living.
After successful pilot studies undertaken at five of its hospitals beginning in 1958, the VA is extending a revolutionary unit system of psychiatric treatment to all of its hospitals. Simple in principle, the unit system reorganizes a patients' hospital life to retain him in one patient group with physicians, nurses, social workers, and therapists assigned to that group only. This contrasts sharply with the practice of most mental hospitals.

A patient is placed in an observation ward on admission. After diagnosis, he goes to an acute treatment area for the indicated therapy. If he responds favorably, he moves on to advanced wards, receiving weekend and trial visit privileges to the homes of his family and his friends.

In the conventional method of dealing with neuropsychiatric illnesses, patients are in contact with patients in many different treatment groups, and with the doctors in charge of them, but they don't learn much about one another. In the VA unit system, a patient is assigned immediately to a group of from 200 to 400 patients, in which nearly all types of mental illness will usually be represented. There he remains until discharged.

Whenever possible, the same professional staff is kept in attendance throughout the patient's treatment period. Should he require medical and/or surgical treatment in another area, he still comes back to his unit and familiar associations. If he goes home on a trial visit and then requires readmission, he returns to his old group and, generally, the same treatment staff. Physicians and their staffs get to know every patient intimately and will usually become friendly with members of the patient's family.

Patients have responded favorably, even remarkably, to the unit system treatment. Particularly is this true in the area of personal behavior. Disturbed patients react quickly to displeasure shown by other patients and tend to adopt the more normal behavior of the group as a whole. In the unit system there are few locked wards and none of the oldtime physical restraints which used to be imposed on mentally ill patients.

The ties that a patient forms with the small community of his unit in a VA hospital are carried over by VA psychiatry when he is discharged from hospital into the larger community of normal living. The psychiatry, neurology, and psychology service, aided by the VA voluntary service, has inaugurated what it calls Project Anchor. In this project, community volunteers are sought who are familiar with local resources and opportunities and are willing to lend a hand to the veteran in reestablishing and maintaining his community ties. The volunteers, or "anchor men" as they are called, are given the same type of training and recognition for working with former patients as is given to volunteers who work in VA hospitals. They introduce the veteran to recreational, occupational, and religious activities and help him to find new companions and social activities through club and fraternal organizations.

The VA believes that a patient suffering from mental illness has certain fundamental human rights, based on these human needs:

Understanding by the family and by the community and its officials.
Acceptance by individuals and by a group.
Opportunity to work in a job appropriate to his skills, with help in receiving proper training, placement, and supervision.
A home—a place where he can have his own belongings and privacy.
Means of obtaining material support—housing, food, clothing, and spending money.
Leisure-time activities—recreation and relaxation.
Sense of belonging to a civic or social group.

Since World War II, the trend in the Veterans' Administration, initiated by its postwar chief medical director, General Hawley, has been to have a certain number of general medical and surgical beds in its psychiatric hospitals, and a certain number of psychiatric beds in its general medical and surgical hospitals. One of the reasons for this is that no veteran, and no veteran's parents, wife, or children, need say that he is a patient in an "insane asylum." He is just simply another patient in a hospital, a human being undergoing medical treatment.

At the end of 1965, there were approximately 55,000 psychiatric patients in all VA hospitals. Of this number, 49,000 were in psychiatric hospitals and 6,000 in general medical and surgical hospitals. Attached to VA hospitals and clinics there were 1,003 psychiatrists, 97 neurologists, and 791 psychologists.

Present long-range plans envision a total of 55,800 beds available for psychiatric patients by 1980. This represents a projected net reduction of beds for treatment of psychiatric patients in the range of 3,000 to 5,000 beds. It is felt that this reduction is justifiable by several factors, including increased emphasis on outplacement programs, increased turnover rates, and reclassification of many patients as nursing home patients. No longer valid is the assumption, or superstition, that the mentally ill are "hopeless cases." The Veterans' Administration experience is that large numbers of them, rather than being isolated more or less permanently, can return to the society of their fellow men.

Surgical service

The Department of Medicine and Surgery has been a leader in inaugurating new and improved programs. Among these is the introduction into the VA hospital system of open heart surgery. Valvular heart disease and diseases of the large arteries in the chest, abdomen, and neck, can now be successfully controlled by surgery. A significant proportion of evidently fatal cases of high blood pressure are now known to be due to diseases of the major arteries of one kidney. The correction of this deficiency cures the high blood pressure. The Department has embarked on a well-organized approach to problems of the large arteries, and the opportunities that are present for cure or relief, through the establishment of centers for open heart surgery. The methods and equipment employed, or the production of medical research, carried on both within and without the Veterans' Administration, now have reached a degree of perfection that permits replacement of diseased heart valves and blocked arteries, with substitutions made of plastic or other materials.

In 1964, about 4,000 cases of chronic valvular heart disease were discharged from the VA hospitals. At the present time, 13 open heart surgery units are getting into operation throughout the system, and when fully activated they will have close to 1,000 open heart operations per year. Additional units will be established as the need is indicated.
and trained personnel become available. These procedures permit
the otherwise severely disabled cardiac cripple to return to productive
life in society.

The success of this surgery on the heart frequently depends upon
cardiac catheterization. This is a diagnostic technique in which a
long, slim tube is inserted into an artery of the arm, thigh, or neck.
Under X-ray observation, such a tube can be guided so that it can be
placed in the appropriate locations in the arterial system or specific
chamber in the heart. Contrast substances can then be injected, and
cinefluorographic studies made, or samples taken, for the necessary
analyses.

When this procedure is applied directly to the heart, it is called
“cardiac catheterization.” When applied to arteries related to other
areas, it is referred to as “angiography.” It is obvious that these
tests require highly trained personnel, as well as special equipment.
The relatively high cost, however, is offset by the fact that this cath-
eterization provides the necessary information to the surgeon for open
heart and major arterial operations, which have saved so many lives.

PHYSICAL MEDICINE AND REHABILITATION SERVICE

Physical medicine and rehabilitation is one of the newest specialties
in medicine. It was formally recognized by the American Medical
Association in 1947. The recognition was based, in part, on the status
it had already achieved in the Veterans’ Administration.

The American Board of Physical Medicine and Rehabilitation
defines the areas with which this specialty is concerned:

- Arthritis and the various rheumatic diseases.
- Neuromuscular diseases, such as poliomyelitis, cerebral palsy,
and paraplegia.
- Musculoskeletal diseases (those affecting muscles and bones),
including the large number of traumatic and orthopedic
conditions.
- Lungs.
- Heart and blood stream.
- Mental illness.

Medicine is not reconciled to accepting a patient’s condition, no
matter how serious, as being hopelessly fixed or static. Instead, it
believes in the possibility of at least a measure of adaptation by the
patient to the normal realities and conditions of living. To expand
this concept is the aim of physical medicine and rehabilitation.
“It is not the disability, it is the ability, that counts.” So developing
a patient’s ability, despite his physical limitations, as to help him
become as self-reliant as possible, is the foundation on which this
essentially optimistic medical discipline is based.

The first objective of medical rehabilitation (in full consultation
and cooperation with other specialties) is to eliminate a disability
entirely, if that is possible. The second objective, if the disability
cannot be eliminated entirely, is to reduce or alleviate it to the greatest
extent possible. The third objective, if the patient has a residual
disability which is judged to be permanent, is to train him to live and
to work as fully as he can, despite his handicap.

Note in this description of these objectives the thought of the extent
which is possible. Not to accept this extent as fixed, but to stretch it,
to expand it, is the characteristic professional attitude of physiatrists, which is the name given to physician specialists in physical medicine and rehabilitation.

This specialty, although recognized in the middle 1940's, did not originate overnight. Its roots go far back into the centuries, but the present day concept of the physical and mental rehabilitation of handicapped or disabled men, women, and children developed notably during and after World War II.

Franklin Delano Roosevelt is probably the best-known example of physical rehabilitation. The disability he incurred from polio did not deter him from holding great position and achieving great fame. He mastered it with the help of braces, crutches, canes, and exercises, especially swimming, and with that willpower which is indispensable in all cases of rehabilitation.

The Veterans' Bureau of the 1920's and the Veterans' Administration, during the 1930's, made extensive use of the physical medicine and rehabilitation methods of their times. If those methods were not as advanced as the methods of today, they nevertheless represented effort and hope, rather than a fatalistic acceptance of a seriously disabled veteran's physical status quo. Veterans who had the physiological and psychological capacity to adapt themselves to their disabilities were given treatment and training aimed at helping them to live to the best of their ability, and in many cases, to work gainfully. “Paying his own way,” in whole or in part, is a bracer to a man's morale and self respect.

When the Veterans' Bureau, in 1922, took over the operation of certain Public Health Service hospitals in which veterans were being cared for, it continued a “reconstruction service” which had been introduced into them after World War I. The service was headed by a physician whose title was Reconstruction Officer. Later the title was changed to Chief, Reconstruction Service. This operational pattern prevailed until World War II, when the name of the service was changed from Reconstruction to Physical Medicine.

At the termination of World War II in 1945, the position of Assistant Chief Medical Director for Medical Rehabilitation was set up. This was evidence of the recognition by the VA Administrator and Chief Medical Director that a comprehensive and intensified medical rehabilitation program was essential, as a part of the “second to none” care of veterans during the postwar period.

Then, in 1947, with physical medicine and rehabilitation having achieved specialty status within the American Medical Association, as well as full recognition within the Veterans' Administration, it was the consensus that it no longer, for prestige or protection, needed to be headed within the agency by an Assistant Chief Medical Director. It was made a division, on a par with internal medicine, surgery, psychiatry, and the other specialties. Eventually the designation Division was changed to Service, the term in use for all the VA medical specialties at the present time, with each Service headed by a Director.

Physical medicine and rehabilitation treats the disabled by the application of heat, cold, water, electricity, and a variety of exercises. Some of these exercises call for muscular adaptations of which people in normal good health might not think the body is capable. But the resources of the body, if properly elicited and trained, are amazing,
and one of the best of all therapies, psychologically, is for a beginning
patient, attempting to overcome a disability, to see what an experi-
enced patient can accomplish. Showing beginners what experienced
patients can do is an integral part of the VA rehabilitation program.

The rehabilitation therapies in effect within the VA are: Corrective
therapy, educational therapy, manual arts therapy, occupational
therapy and recreation, physical therapy, and speech therapy, follow-
ing the modern trend of subordinate “specialties within a specialty.”
Some VA hospitals and regional office clinics have all seven of these,
others have fewer, depending on local demands and local facilities.

It may, however, be said that any veteran in need of any particular
one of these will receive it, either at a VA hospital or clinic near as
possible to his home and his relatives or at a private hospital or
clinic by arrangement under VA auspices.

The major objectives of this therapy program are fourfold:

1. To contribute to the recovery and shorter hospital stay of
   patients with acute medical or surgical conditions through
diagnostic techniques, evaluation methods, and specialized
treatments;

2. To assist the long-term or severely handicapped patient
   in adjusting to the demands of an appropriate posthospital
   economic and social environment in order to reduce the possibility
   of readmission;

3. To help the patient whose discharge from the hospital is
   improbable to reach a measure of self-reliance within the hospital
   which will be reflected by savings in the cost of his hospitalization;

4. To provide a program of maintenance therapy for the
   aging domiciliary member or hospital patient, with physically and
   mentally stimulating activities aimed at helping him to preserve
   the fullest possible measure of well-being and self-reliance.

At the end of 1965, there were approximately 500 certified physical
medicine and rehabilitation specialists in the United States. Since
the physical medicine and rehabilitation career residency training
program was started in July 1955, 167 have come into this type of
training. To date, 102 have completed training, and 41 are currently
in this program. In addition, about 50 have been trained via the
regular residency program. The large part, therefore, that the VA
has played in the development of this modern specialty is obvious.

In its obligation to disabled veterans, it will continue to play
this part of leadership. Among its research projects ongoing at the
beginning of 1966, 63 were in the field of physical medicine and
rehabilitation, under a research coordinator. No area of therapy
that offers reasonable hope is left unexplored. Particularly for
psychiatric patients, the necessity for bridging the gap between
hospitalization and community living has become critical. To help
bridge this gap, an area in certain Veterans Administration hospitals
is set up to look like, and to operate like, a factory. The therapist
assumes the role of a foreman and contracts are secured from neighboring
industries for work in assembly, subassembly, packaging, labeling,
machining, and the like. One hospital currently has 35 such con-
tracts. Patients are paid on an hourly wage basis by the contractor
and work volume and work proficiency are expected of them. The
patients take pride in their achievements, and they feel that they are
on their way to the major goal of physical medicine and rehabilita-
tion—return to the community.
Although the majority of Veterans' Administration hospitals and clinics had X-ray services prior to World War II, they were not always staffed by qualified radiologists. Physicians furnishing readings and interpretations often had received no formal training and were only devoting a fraction of their time to "film reading." Much of the equipment was obsolete and replacement was on a "hit or miss" basis. There were no adequate criteria for the number of units required, for radiographic rooms, or for radiologists and technicians.

Shortly after World War II, million-volt X-ray therapy units were installed at the VA hospital, Bronx, New York City, and at the VA hospital, Memphis, Tenn., for use in the treatment of cancer. The first cobalt unit was installed in 1954 in the VA research hospital, Chicago, Ill. The next cobalt unit was installed in the Bronx facility in 1957. Because there has been a continuing increase in the number of cancer patients among veterans, cobalt units are now in operation in nine VA hospitals, and units will be installed in five additional hospitals during fiscal year 1966. The first 6-million-volt linear accelerator will be installed in the new hospital at the VA Center, Wood, Wis.

Every VA hospital and clinic has diagnostic X-ray equipment ranging from simple conventional units to expensive, sophisticated apparatus capable of taking X-ray films in thousandths of a second. At the end of World War II, the VA obtained surplus equipment from the Armed Forces. Much of this soon required replacement. In addition, the development of new techniques in vascular surgery and neurosurgery required complex equipment capable of visualizing blood vessels in every portion of the body. Manual film processing was replaced by automatic systems that reduced the time for processing from 1 hour to 6 minutes. A few units can now process films in 90 seconds. Present VA X-ray equipment is valued at $15 million. Obsolete equipment is being replaced at the rate of 10 percent each year.

The radiology work load has shown rapid acceleration. This has been due not only to the necessary expansion of departments and therapeutic procedures, but also to the opening of new hospitals. The complexity of modern diagnostic and therapeutic procedures has necessitated employment of technical personnel in highly specialized fields. The technician is no longer someone who pushes a button and takes a picture. He must be familiar with anatomical detail and the proper handling of seriously ill patients, and he works as member of a highly skilled professional team.

The already heavy radiology work load has been intensified by such time-consuming procedures as angiography (X-ray of the blood vessels), myelography (X-ray of the spinal cord), lymphangiography (X-ray of the lymph glands), cineradiography (the use of moving picture film in X-rays), and retroperitoneal air injection (the X-raying of kidneys and adrenals by injecting air into the muscle planes.) The number of films used annually has been increasing at the rate of 6 percent. During fiscal year 1966, VA hospitals used 9 million sheets of X-ray film.

At the end of World War II, many radiologists discharged from service entered the Veterans' Administration program. Affiliation
with medical schools led to the initiation of a residency program in radiology. At present, there are 150 regular residents and 36 career residents. Radiology coverage is furnished by 274 full-time radiologists, and 40 part-time radiologists. In addition, coverage is furnished by contract radiologists and consultants.

The continued demand for diagnostic services and the anticipated increase in the number of patients with cancer will, no doubt, create a need for additional diagnostic equipment. Long-range plans call for further modernization of X-ray departments and replacement of equipment as it becomes outmoded, and for the acquisition of such therapeutic tools as linear accelerators and betatrons where the patient load justifies the purchase of this expensive type of medical apparatus.

**PATHOLOGY AND ALLIED SCIENCES SERVICE**

Pathology is that specialty of medicine in which biologic and chemical analysis of tissue, bone, blood, urine or other fluid, and any abnormal growth inside the body or on the surface of it, is performed for purposes of diagnosis, prognosis, treatment, and clinical research. In medicine, the “what is wrong” must be known before the “how to make it right” can be intelligently undertaken.

Veterans’ Administration pathologists and technicians conduct approximately 46 million laboratory procedures a year. Twenty years ago, about five tests per patient were considered satisfactory for diagnostic purposes. Today, 100 or more tests per patient are not uncommon.

Review and confirmation diagnoses by pathologists can prevent unnecessary operations, such as removals of eyes or amputations of limbs. Clinical pathology examinations can give guidance on what specific medications should or should not be taken internally by a patient, what ointments should or should not be applied to wounds or sores on his body, and what injections might or might not be helpful to him.

Generally thought of as the diagnostic area of medicine, pathology also borders closely on the treatment area and greatly assists the physician in the evaluation of cases. It is of special importance in dealing with diseases of the blood, the skin, the lungs, the bones, the endocrine glands, the reproductive organs, the brain, the heart, and the gastrointestinal tract.

It is small wonder, therefore, that the pathologist, dealing as he does with so much of the human body, is sometimes called the doctor's doctor. The allied sciences with which he collaborates are: medical technology, biochemistry, microbiology, serology, immunology, parasitology, and physiology, to mention a few. The techniques and procedures of these sciences, along with those of pathology, are used to investigate the causes of disease and to search for means of treatment. Pathology, in short, is not simply a special form of biology or chemistry; it is a form of the practice of medicine, and its work supports practically every branch of medical science and medical art.

Like all medicine, pathology is interested mainly in the preservation and improvement of life, but it also performs the necropsies (autopsies) which are studies of the body after death to determine the causes, and the sequence of events, which lead to life's passing. In the Vet-
erans' Administration, permission for autopsy is granted to almost 80 percent of the requests, as a means of contributing to medical knowledge and improving the medical care of other veterans.

There were 330 pathologists, 1,831 technicians, and 676 technologists in VA's Pathology and Allied Sciences Service at the end of fiscal year 1966. This Service conducts 13 training programs for about 75 technologists a year, and two training programs for about 10 certified laboratory assistants.

The Service is closely associated with the Armed Forces Institute of Pathology.

On July 8, 1946, the then Secretary of War, Robert P. Patterson, approved a plan proposed by the Administrator of Veterans' Affairs, Gen. Omar N. Bradley, under which the Army Institute of Pathology would serve as a central source of pathological knowledge and assistance for the Veterans' Administration. The Institute, later called the Armed Forces Institute of Pathology because it came to include the Navy and the Air Force as well as the Army, still serves the Veterans' Administration, and in recent years it has also been serving the Atomic Energy Commission and the U.S. Public Health Service. It has pathological records and specimens of many thousands of active fighting men who, on their retirement from service, will become veterans. In this way, continuity of information on their pathological history can be maintained, and extended to the Veterans' Administration if they should ever need agency medical care.

The VA Pathology and Allied Sciences Service is also represented on the Interagency Committee on Laboratory Medicine, which includes the Army, Navy, Air Force, and Public Health Service. The Committee exchanges and pools information on all aspects of laboratory medicine, such as reporting of tests, space allocations, laboratory planning and design, and the use of automation and computers.

In its nationwide system, the Service, in order to provide all VA hospitals with the latest clinical laboratory tests available, has developed reference laboratories in the VA hospitals at Boston, Washington, D.C., Atlanta, Dallas, Chicago, Minneapolis, Denver, San Francisco, and Portland. These reference laboratories supplement the work of the regular pathological laboratories which are in all Veterans' Administration hospitals. It is highly probable that VA internists and VA surgeons, in their study of the agency's patients before undertaking treatment or surgery, make more use of laboratory medicine than most physicians elsewhere.

DOMICILIARIES, RESTORATION CENTERS, AND OTHER INPATIENT SERVICES

Within the Veterans' Administration, there is an important group of extended care inpatient nonhospital services. These are domiciliaries, restoration centers, a nursing home care program within the VA itself, and a similar program, under VA auspices, conducted through various community resources.

The following eight former national homes for disabled volunteer soldiers, which became part of the VA in 1930, are now VA domiciliaries: Wood, Wis., founded in 1867; Dayton, Ohio, 1867; Kecoughtan, Va., 1870; Wadsworth, Kans., 1885; Los Angeles, Calif., 1888; Mountain Home, Tenn., 1901; Hot Springs, S. Dak., 1907; Bath, N.Y., 1929.
Former national homes founded at Togus, Maine, 1866; Marion, Ind., 1890; and Danville, Ill., 1898, are now Veterans' Administration hospitals, but not domiciliaries.

Eight other domiciliaries now in the VA system, which are not national homes in origin, were opened at Whipple, Ariz., 1931; Bay Pines, Fla., and Biloxi, Miss., 1933; Martinsburg, W. Va., and Temple, Tex., 1946; White City, Ore., 1949; Bonham, Tex., 1951; and Dublin, Ga., 1959.

Two former Army hospitals at Thomasville, Ga., and Clinton, Iowa, were used as VA domiciliaries from 1948 to 1965. Both facilities were small, Thomasville accommodating only 160 members, Clinton only 113. The present 16 VA domiciliaries accommodate over 14,000 members.

But an interesting development in VA domiciliaries has taken place in recent years, and present indications are that that development will continue. Despite the increase in the veteran population, there has been a decrease in the domiciliary population, from almost 17,000 in 1953 to a little over 14,000 in 1966.

One factor in this decrease has been the general economic prosperity of the 1960's. Most able and willing veterans (and able and willing is what the vast majority of veterans are) have found it possible to obtain employment, some of it with the thousands of veterans who are employers. But there are two internal factors within the VA domiciliary system itself which also account for the decrease:

When an eligible veteran applies for admission to a domiciliary, an effort is made by the VA, without coercion, to learn why he seeks admission. Is his physical health impaired? His mental and emotional health? If so, then perhaps what he needs is VA hospital or clinical care, rather than domiciliary care.

Most men, if given the chance, prefer standing on their own feet to being supported. But there are times when, for physical or psychiatric reasons, they may experience periods of inability to cope with circumstances and need to retire from society into a way of life in which others will take care of them. The VA believes that in the long run it is better medical practice and more humane to help them over such periods whenever possible. Admit such veterans to inpatient hospital or domiciliary care, yes—if that is what seems best for them. But if outpatient care at a VA clinic seems even better, offer them that. Medical attention, psychiatric attention, or the assistance of social workers may well keep them out of hospitals and domiciliaries and help them to remain in society as normal citizens.

Especially among veterans of World War II and the Korean conflict, it has been found that even after they are admitted to a domiciliary many of them can be prepared, given their cooperation, to return to active life. And in this way, too, the domiciliary population has been reduced. A positive philosophy of rehabilitation rather than a passive philosophy of "once in a domiciliary, always in a domiciliary" has been put effectively to work. Every member of a domiciliary staff has not only a custodial function but also a therapeutic one, whether direct or indirect.

As for those veterans in domiciliaries who by reason of their age or other factors cannot reasonably or humanely be expected to reenter society actively, the domiciliary program since World War II has been characterized by two major approaches:
(1) The former semimilitary cleanliness and orderliness of domiciliaries has gradually become more civilian in character. Cleanliness and orderliness, where large numbers of people live together, are essential, and serious infractions of rules and regulations of common sense and decency may necessitate expulsion. Domiciliary discipline, however, is maintained more from a public health standpoint than from an effort to standardize individual behavior.

(2) Part-time work, both indoors and outdoors, is made available to domiciliary members who are capable of it, and large numbers of them take advantage of this opportunity to foster self-respect. An old national homes tradition of interior decoration or landscaping by domiciliary members has been preserved. Although all VA domiciliaries follow a basic administrative procedure, and the same basic rules and regulations, they are not only permitted, they are encouraged, to develop their own local customs. If the members show a creative interest in the grounds, or in the public rooms, hallways, libraries, or chapels, such interest is welcomed. VA domiciliaries are painted, furnished, and decorated practically but cheerfully; diversions and hobbies are promoted and supported; and the emphasis upon home likeness, rather than institutional likeness, is a sincere one. Full consideration is given to individual dignity and privacy.

All VA domiciliaries except the one at White City, Oreg., are units in VA centers, which means that there is a VA hospital adjacent to them. If hospitalization is indicated for White City domiciliary members, they are sent to the nearest VA hospital which is best equipped and staffed to care for their particular illnesses.

A domiciliary is never regarded by the VA as a substitute for a hospital. It does not attempt definitive treatments of acute illnesses; to do so is to deprive veterans of the much more extensive care which is available in VA hospitals.

Not exactly hospitals and not exactly domiciliaries—but institutions unique in character—there are two VA restoration centers. One opened in Chicago in 1961; the other in East Orange, N.J., in 1964. The purpose of these centers is to restore certain types of patients to home living and community living when the normal, matter-of-fact, now-you-are-in, now-you-are-out type of discharge from hospital would be inadequate therapy, and in some cases, poor therapy.

There are illnesses, both physical and mental, which in effect are severe shocks to the human system, and which call for the most specialized and prolonged medical treatment. Unfortunately, recovery from these illnesses can also, in its way, be a new shock. How to face living in the world, or just simply in one's own home, after the amputation of an extremity? Or after a spinal cord injury? Or after a serious mental illness? If the strictly medical treatment has been completed, what about the new attitudes and the new aptitudes which are necessary for a return to society?

These new attitudes and aptitudes are the concern of the specialists at the restoration centers in Chicago and East Orange. Since the program began in 1961 there were 3,334 admissions to the two centers up to the end of June 1966. Of these, 607 were transferred to VA hospitals or domiciliaries or to nursing home care; 1,463 were restored to society and their own private mode of living. The results to date, on the whole, would seem to justify the program as being one of the
most modern methods of total therapy. One of its most helpful by-products has been the practical knowledge which has been acquired for dissemination to VA hospitals and clinics in assisting the restoration to normal living of patients whose cases are not quite as severe as those which are treated in the restoration centers.

Another special type of provision for veterans is nursing home care, both in the Veterans' Administration itself and in community nursing home care facilities.

Public Law 88-450, August 19, 1964, authorized the Veterans' Administration to operate a total of 4,000 nursing-home-care beds. During fiscal year 1965, 1,000 nursing beds were installed, and during fiscal year 1966 a second total of 1,253 beds. Plans call for 1,738 beds to be added in fiscal year 1967, bringing the total to the congressionally stipulated 4,000.

Professional nurses are in charge of each VA nursing home care unit. These nurses are responsible for providing skilled nursing care services, including the preventative and restorative measures needed for long-term patients. Teaching self-care to the patients is of particular importance in this area of nursing.

The purpose of the VA nursing home care program is to enable the agency to move patients out of its hospital beds when they no longer need hospitalization but still need nursing care. Where there is reasonable assurance that their care at Government expense can be terminated within 6 months, they are placed in approved private community nursing care homes. If it appears that they must continue indefinitely as VA beneficiaries, they are placed in VA nursing home care units. Veterans needing nursing home care for service-connected disabilities generally are placed in VA beds unless they request placement in community homes or State soldiers' homes.

Up to the end of June 1966, 2,203 veterans were placed in nursing care units in State soldiers' homes. Where these homes are building new facilities to expand their nursing home care units, the VA meets half the costs of construction.

The community nursing home care program provides for payment at a maximum per diem rate of $10.50 to private nursing homes, which meet prescribed standards, for skilled nursing care furnished to eligible veterans. Generally, such care is not authorized for a period of more than 6 months. The primary purpose of this program is to provide the type of care which is needed and to help the veteran and his family in making the transition from hospital to community by giving them time to marshal their own resources for the veteran's continued care. Between August 1964 and the end of June 1966, over 7,000 patients had been placed in community nursing home care establishments.

Clinics and Related Outpatient Services

The Veterans' Administration was operating 201 clinics at the beginning of 1966.

Clinics—definable as places of medical or dental treatment in which the patients are not bedded—have been a feature of veterans' care since the beginning of the Veterans' Bureau. They may be described, briefly, as serving three major purposes:
They provide a wide range of actual, direct diagnostic and therapeutic services for patients who require medical treatment but not hospitalization.

They conduct evaluation examinations of veterans to determine the extent of their disabilities for compensation or pension purposes.

They provide prehospital and posthospital care, and thus, although an outpatient program, collaborate closely with inpatient programs. This third purpose affords, incidentally but not unimportantly, the double economic advantage of reducing the amount of time in which a hospital bed is occupied by any one patient, and of enabling patients in many cases to be gainfully employed for more days, or even weeks, than would be possible if they were hospitalized for a prolonged period.

During fiscal year 1965, outpatients made 4,800,000 visits to VA clinics and more than 1,200,000 visits to fee basis physicians under arrangements with the agency. If a VA clinic is not within reasonable distance of the place of residence, of a veteran with a service-connected disability, the agency arranged for him to be treated by a private physician. A "visit" to a clinic is defined as the presence of an outpatient on one day, no matter how many members of the staff he may have to see, whether a physician, a therapist, a social worker, or anyone else concerned with his particular case. He may confer with as many as five staff members, but his presence on any one day is counted as one visit.

Examination or treatment in VA clinics is provided for the following eligible persons:

Veterans for their service-connected disabilities;
Veterans to determine the extent of their disabilities to establish a compensation or pension rating;
Veterans to determine their need for hospital or domiciliary care;
Veterans for prehospital and posthospital care;
Veterans for VA insurance purposes;
Veterans in receipt of VA vocational rehabilitation who require treatment to avoid interruption of training;
Veterans who are in receipt of VA aid and attendance, for continued outpatient care of certain chronic non-service-connected disabilities (cardiovascular-renal disease, endocrinopathies, diabetes mellitus, cancer, neuropsychiatric diseases, and tuberculosis) following a year of posthospital care for those disabilities;
Pensioners of nations allied with the United States in World Wars I and II, such services being provided on a reimbursable basis;
Beneficiaries of other Federal agencies, such as the Peace Corps, Department of Defense, etc.;
VA employees who become ill or are injured while in performance of their duties, or who are engaged in certain types of patient care, or prospective VA employees to determine their fitness for duty;
Persons who require aid in an emergency, for humanitarian reasons. If a serious accident occurs near a VA hospital or clinic the victims who are rushed to it will be cared for at once. And during the famous electrical power failure in New York in
1966 the VA hospitals and clinics were declared available for emergency purposes to nonveteran citizens.

Down through the years since the beginning of the Veterans' Bureau, the operation of clinics for veterans has varied so considerably, with respect both to management and to location, that an account of it would be of interest only to students of administration. There have been no serious issues involved, and the one serious problem, location, has been confronted by making clinics available to veterans in as many centers of population as possible, and private medical care for veterans, if necessary, available everywhere. Generally speaking, where private medical care has been necessary, there has been cordial cooperation by State and county medical and dental societies and by private physicians and dentists, with the Veterans' Administration.

Of the present 201 VA clinics, six are independent field stations, 18 are attached to regional offices, 12 are operated as substations under a hospital or larger clinic, 43 are former regional clinics now merged with hospitals, and 122 are attached to hospitals or domiciliaries for service primarily related to inpatient care (admission examinations, prehospital and posthospital care, and employee health).

A major, full-scale VA clinic serving a large metropolitan area is a place of dynamic activity and no small size: it may occupy as many as three or four floors of a building. Patients are entering or leaving all day long, most of them on a schedule prearranged for them, others coming in unexpectedly and in need, first of all, of reception and guidance. Reception and guidance are given them by the Medical Administration Service. There are physicians of all kinds, sometimes representing the whole array of medical specialties; nurses, therapists, psychologists, social workers, volunteers. Such a clinic would be astonishing to anyone who thinks of clinics in general as being places of emergency first aid, or places for the treatment of minor ailments. Practically speaking, such a clinic is almost a complete hospital in which there happen to be no beds (except for a few emergency cases) and many of whose patients are being treated for ailments more serious than some of those for which people go to regular hospitals. The very fact that a clinic's patients live at home rather than in a hospital is often an essential part of their medical treatment, home being a more effective psychological and therapeutic environment for them than a hospital.

Within the range of treatments provided by VA clinics, four are of special interest. Two of these are partly inpatient, partly outpatient programs; two are outpatient programs entirely.

The two programs in which treatment is overlapping, at times inpatient and at times outpatient in character, are audiology and speech pathology, and blind rehabilitation. There are times when patients being treated under these programs have to spend several days and nights in a hospital, other times when they can live at home.

In 1960, VA speech pathology was organizationally brought into alignment with audiology for the simple reason that the ability to hear and the ability to speak are so closely related. Audiology, both within and without the VA, so progressed during the decade between 1945 and 1955 that in the latter year veterans receiving compensation for hearing disability were reexamined. This review helped to establish more accurate hearing levels than had previously been possible.
Additionally, on the foundation of the postwar development in audiological procedures and instruments, the agency established audiology programs in 28 hospitals and clinics serving various population areas, and several contract clinics were retained to serve less populous areas.

With an aging veteran population, there has been an increase in disabling problems of speech as well as hearing. To cope with these problems, there has been an increase in the agency’s clinical, research, and training programs devoted to audiology and speech pathology. Every modern type of effort is being made to reduce the difficulties and lessen the sadness of impaired communication.

In the field of care for the blind, the Veterans’ Bureau, from 1922 to 1925, operated a blind rehabilitation center at Evergreen, a suburban estate near Baltimore, Md. During World War II, the Veterans’ Administration was designated to administer Public Law 309, which provided for the issuance of seeing-eye dogs and electronic and mechanical aids to veterans with impaired or destroyed vision. Through the intervening years, the agency has also provided canes, special typewriters and watches, braille equipment and other aids, and also training programs to stimulate the motivation and improve the new adjustment to life of blinded veterans.

There has been a continuously enlarged blind rehabilitation center at the VA hospital in Hines, Ill., since 1948. It is probably the most elaborate and modern center of its kind in the world and the object of study by scores of American and foreign specialists in the care of the blind. A similar center, to serve the western third of the United States, will begin operation at the VA hospital in Palo Alto, Calif., early in 1967. Plans also include a center for the eastern third of the country to begin operation in 1968 or 1969.

Treating even more patients than those suffering with problems of hearing, speech, or vision, are two completely outpatient programs: mental hygiene clinics and day treatment centers. In one form or another, what might be called, in laymen’s language, mental ill health is the largest single affliction that VA medicine has to cope with. Each of these programs has its own particular responsibility for dealing with this affliction. There is no “iron curtain” of division between them; specialists in one confer with specialists in the other; but the practical working difference between them is that mental hygiene clinics, of which there are 69, concentrate on treatment; whereas day treatment centers, of which there are 34, concentrate on rehabilitation.

The purpose of a mental hygiene clinic is either to cure, if possible, a mental disability, or to arrest it, if possible, so as to keep the patient out of the hospital. VA medicine, with its vast clinical experience and research facilities, is a firm believer in the enlargement of this area. Current tranquilizers and current psychiatric, neurological, and psychological procedures justify hope that the condition of many mentally ill patients can be strikingly improved.

Psychiatrists, psychologists, and social workers on a mental hygiene clinic’s staff advise not only their patients, but also the relatives, friends, or landlords with whom the patients live. How a patient’s companions at home treat him is a positive factor in his improvement or decline. No aspect of a patient’s life in a community is left unconsidered. Normal life in a community, in fact, is the major objective of mental hygiene. The substitution of self-reliance for reliance upon a hospital or a clinic is encouraged.
Day treatment centers, always located nearby mental hygiene clinics, assist those patients whose treatment in a hospital or a clinic has been so successful that they are judged mentally and emotionally almost ready to undertake normal living. The aims of the day center program are: (a) to assist the patient to make a wholesome and satisfactory transition from hospital to normal community existence; (b) to help the patient resume normal activities in community and family living; (c) to prevent regression of the patient with resultant readmission to the hospital; (d) to provide special outpatient treatment methods for patients who are not amenable to or do not require the conventional psychotherapeutic approach; (e) to conduct psychological, sociological, and anthropological studies in the problems of the chronic psychiatric patient in his adjustment to community living; (f) to observe the psychiatric patient in the “neutral atmosphere between hospital and community.”

In this area of outpatient treatment, the major responsibility shifts gradually from the psychiatry, neurology, and psychology service to the physical medicine and rehabilitation service, although the two services never cease to confer and collaborate. Patients in day treatment centers are eased into fraternizing and working with each other, just as they will have to fraternize and work with their fellow citizens when their recovery is judged complete enough to warrant their full return to society.

The day treatment center outpatient service of the Veterans’ Administration has probably been one of the strongest single influences in the practically universal modern tendency to avoid, whenever possible, isolating the mentally ill. Encouraging them and helping them to fraternize, to socialize, to live in normal circumstances, and to work if at all possible, is the therapy which stands the best chance of restoring them to mental health or to a good and sufficient approximation of it.

### Spinal Cord Injury

There are probably no afflictions, not even those of polio, which call for more elaborate medical treatment than those involving injuries to the spinal cord with resultant paraplegia or quadriplegia.

Paraplegia results from injury to the lower part of the spinal cord. It causes paralysis of the legs and the lower part of the body, including the bowel and urinary bladder. Quadriplegia results from injury to the spinal cord in the area of the neck. It causes paralysis not only of the lower part of the body and legs, but of the arms as well. The term “paraplegics” is widely used, and will be used here, to mean patients who suffer from one affliction or the other.

Prior to World War II, there was relatively little action taken in the field of spinal cord injury. The severity of shock following the injury and the subsequent development of infection in the urinary tract defied all therapeutic efforts available to the medical profession at the time. The majority of paraplegics died soon after they were injured; only a handful survived to lead helpless existences on their backs. They had the will to live; often the spark of life in them was more than a spark, it was a flame; but their bodies were by and large completely dependent upon the ministrations of others.

With the advent of World War II there came about improved methods of handling shock, new drugs to combat infection, and many
other therapeutic procedures which, for the first time in history, enhanced the preservation of life for paraplegics.

The many problems which soon appeared with increased survival in spinal cord injury posed a tremendous challenge to the medical profession. This came to the attention of the Veterans' Administration in particular, and with great force, when large numbers of paraplegics were transferred from military hospitals to VA hospitals. Moreover, motorcar accidents and industrial and other accidents to veterans caused an even greater number of civilian casualties with spinal cord injuries. It can therefore be said that the Veterans' Administration has dealt with more paraplegics than any other single healing institution in the country.

Not only the preservation of the lives of paraplegics, but the enhancement of their lives to the fullest extent possible, has become the agency's aim. Paraplegics have almost insurmountable physical and emotional difficulties to overcome, but many of them succeed. Terry McAdam, a veteran who was treated in a veterans' hospital, has written a book, "Very Much Alive: The Story of a Paraplegic," published by Houghton Mifflin in 1955. The book describes Mr. McAdam's case and the cases of a number of his fellow paraplegics. For reasons which the author notes are obvious, he has deliberately obscured the identities of these other patients. He is frank and realistic, but at the same time compassionate, in describing the physical and emotional difficulties that they, along with himself, are forced to cope with. He goes into detail over the motion-by-motion, step-by-step, now hopeless-now hopeful, and unremitting efforts of VA patients, in collaboration with VA physicians and nurses, to adjust themselves to their for-life handicap.

Internists, surgeons, physical medicine and rehabilitation specialists, prosthetic appliance specialists, psychiatrists and psychologists, social workers, practically every professional service in VA medicine is thrown into the contest between the patient's paralysis on the one hand and his will to live on the other; and his will, also, to more than live—his will to become as self-reliant and as productive as scientific ingenuity and human resolution make possible. The Veterans' Administration, borrowing a thought from the famous Dr. Howard A. Rusk, believes that, having added years to the lives of traumatic paraplegics, it must now, above all, add life to their years.

Since 1955, when Mr. McAdam wrote his book, the technique of the VA approach to paraplegia has, of course, developed, and the agency has felt an obligation to make as widely available as possible its knowledge of spinal cord injuries. It sponsors annual conferences of Federal and private physicians who work in this difficult, complex field of therapy, and in 1963 it published an extensive bibliography of American and foreign publications on every phase of the subject. The bibliography, which has gone through two printings, is much in demand by specialists throughout the world, and a supplement is being prepared for publication in 1967.

In October 1965, the Veterans' Administration was instructed by President Johnson to care for about 60 Vietnamese soldiers who were victims of paraplegia suffered in combat against the Communists. The Vietnamese patients were flown to the VA hospital at Castle Point, N.Y., where they were given the complete medical and rehabilitation attention that is given to American veterans. Mean-
while, a team of Vietnamese physicians, nurses, and other personnel were trained in modern methods of caring for paraplegics. Upon completion of their training, the team returned to Vietnam to establish treatment centers for the care of other Vietnamese victims of spinal cord injuries.

Certain disabled American veterans of wartime or peacetime service may be entitled under certain conditions to a grant from the Veterans' Administration for a “wheelchair” home (with ramps connecting the different levels, guide rails, and other devices) especially adapted to their needs.

The veterans must have a service-connected disability due to wartime or peacetime service after April 20, 1898, entitling them to compensation for permanent and total disability due to the loss, or loss of use, of both lower extremities or blindness plus loss or loss of use of one lower extremity. The home may be a new one designed or an existing one modeled, to suit the requirements of such handicapped veterans. The grant, up to a maximum of $10,000, is for not more than 50 percent of the cost of such homes.

The VA, for veterans of World War II and the Korean conflict, also pays an amount not exceeding $1,600 toward the purchase of an automobile, including special appliances, for service-connected loss, or permanent loss of use, of one or both hands or feet or permanent impairment of vision.

D. M. & S. DENTISTRY

No human being is an interchangeable part in the great scheme of nature. Along with resemblances to all other human beings, he has, in health or in illness, his own special, particular characteristics. Therefore, the differences among patients, as well as the resemblances, are matters of concern to VA diagnosis and therapy. What affects a patient’s own unique mouth can affect his own unique body. And what affects his body can affect his mouth. Hence, in VA hospitals and clinics, the close interdependence between medicine and dentistry. Every VA patient for whom the decision is reached that hospitalization is necessary is given a complete examination, and that examination is dental as well as medical.

Suppose that part of the patient’s health problem is, for example, a vitamin deficiency. Patients suffering from such deficiencies require special dental as well as special medical treatment, with the physician and the dentist conferring on which treatment is best in each particular case. Few patients present all the signs and symptoms described for any nutritional deficiency, hence the “classical case” is a rarity and the “atypical case” more common. Where a case is genuinely serious, affecting not only the patient’s mouth but his whole system (which is what generally happens in vitamin deficiencies), the standard VA practice is for physician and dentist to study him as a unique individual and reach agreement on special attention and treatment for his problem. And the likelihood is that they will call the VA dietitian in on the case, too.

To the person who is fortunate enough not to suffer truly serious illnesses during the course of his life, dentistry generally means a cavity filled, a tooth extracted, a denture fitted and inserted, and perhaps a mild case of pyorrhea. If serious, he will find that his dentist is not only a doctor of the teeth but also a doctor of the mouth, and chances are that he will also find that the dentist will recommend
that he take medical as well as dental treatment, because the pus which characterizes pyorrhea may arise from a general body condition rather than an exclusively mouth condition. And in such a case a conscientious mouth doctor recommends that his patient go and see a body doctor as well. Medicine and dentistry share a common foundation in the biologic sciences, and many a good dentist has detected in a patient's mouth symptoms of bodily afflictions which cause him to urge the patient to see his medical doctor as soon as possible.

So insistent is the VA Department of Medicine and Surgery on the interdependence between medicine and dentistry that from time to time it draws special attention to it, the most recent being an article on it which it distributed to its physicians and dentists in July 1965. The article was preceded by this message from Dr. Joseph H. McNinch, at that time the agency's chief medical director:

Dentistry has been an integral part of the VA patient care program for more than 40 years. The oral cavity with its many functions plays a very important part in a patient's physical, mental, and social well-being. Improved health care is being demonstrated daily where the collaborative services of physicians and dentists are known and appreciated by both professions.

I am hopeful that this article on the interdependency of dentistry and medicine will be widely read and further stimulate mutual desire for better understanding and cooperation between the professions within and outside the Veterans' Administration.

The article was written by Dr. Lester W. Burket, dean of the School of Dental Medicine, University of Pennsylvania. Dr. Burket is both a medical doctor and a doctor of dental surgery. His language in the article is the language of one professional man addressing other professional men (the mouth, for example, is the "oral cavity," a tooth socket is an "alveolus," and so forth), but certain facts he points out, even if they cannot be expressed fully in layman's language, are of importance to laymen as well as to professionals. For example:

Between dentists and plastic surgeons who work on repairs to severely damaged faces there must be the closest possible collaboration.

Diabetic patients require regular and frequent oral health care. The intervals for periodic dental examinations and treatments should be shorter than those for the average person, even when the diabetes is well controlled.

Complete denture patients require periodic dental service, contrary to the belief that once a complete denture is provided one's dental problems are over and done with. The denture-supporting tissues, like other tissues of the body, continually change, depending on the individual's chewing habits, general health, and the aging process. Consequently, the dentures must be adjusted or remade to compensate for the tissue changes.

Patients with cardiovascular diseases (those pertaining to the heart and the blood vessels) require close cooperation between the physician and the dentist. Such patients, when they have dental problems, should be examined early, so that the cardiologist and the dentist can determine the proper times and the proper procedures for the treatment.

The oral as well as other health problems of elderly patients will assume increased importance in the immediate future. Poor teeth can affect the diet of the elderly, and poor diet can affect their general health. Too much eating of soft foods, high in
carbohydrate content, can be directly or indirectly responsible for many of the problems of the aging patient. His teeth should be so cared for as to enable him to eat as balanced a diet as his general physical condition permits.

Dozens of other examples could be given of how general health affects oral health, and how oral health affects general health. For one final example: certain medical treatments of the eye, ear, nose, and throat call for special dental treatments of the teeth and the gums. In all these medico-dental interdependencies, the VA patient is the beneficiary of what is probably the most rounded patient care program in the United States.

In the National Homes for Disabled Volunteer Soldiers, there is no record of organized dental treatment for the members prior to 1920, dental emergency treatment up to that time having been provided by local practitioners. But in that year the first full-time dentist was appointed as an “assistant surgeon.” At first, it was contemplated that he would be an itinerant dentist, going about with portable equipment and visiting each of the branches, but this plan was dropped and he was permanently assigned to the Central Branch at Dayton, Ohio. Thus, the first clinic of what was later to become the VA dental service was established in that city, and soon thereafter clinics were opened in all branches of the homes and dentists were assigned to them.

When Congress created the Veterans’ Bureau in 1921, the law specifically mentioned dental as well as medical treatment as a benefit for veterans, and today, in title 38 of the United States Code, the law on veterans’ benefits, there are several specific provisions for dental care. The law also provides that VA dentists, like medical doctors, be graded for salary purposes not upon the positions they hold but upon the professional qualifications they bring to their work.

In the year 1948, during the post-World War II wave of demands upon the VA dental facilities, over 800,000 veterans applied for outpatient dental treatment; 700,000 of these were adjudicated as eligible or service connected, and over 600,000 of these received treatment during that year. By this time, the full-time dentist staff had been increased to approximately 1,000—obviously not sufficient to provide all the hospital and clinical treatment required. However, some 50,000 “home town” dentists participated in the outpatient phase of the program, on a fee basis. These hometown dentists completed 65 percent of the examinations and 92 percent of the treatments, at a cost of over $50 million for that year. This in contrast to the $75,000 for similar outpatient services in 1941, the year the United States entered the war.

When an additional 5 million potentially eligible veterans were added to the VA rolls after the Korean conflict, the agency requested the Congress to review the dental program, with a view either to providing sufficient funds to support the program as it existed or to passing legislation to reduce the scope of the program. On June 16, 1955, Congress elected to amend the basic laws providing for outpatient dental treatment. Not to be technical, legalistic, or detailed about the amendment, it left the number of veterans eligible for outpatient dental treatment a large one, but not nearly as large as it had been immediately after World War II, and the VA dental load, although still heavy, was somewhat lightened.
In general, the present major terms of eligibility for VA dental care are as follows:

If a hospitalized veteran is in need of dental as well as medical care, and especially if his physical condition is affected by his dental condition, he receives essential dental care.

Outpatient dental care is given to veterans for disabilities incurred or aggravated in military service.

Outpatient dental care is also given for certain tightly limited categories of non-service-connected disabilities. For example, if a patient is discharged from a VA hospital, any necessary dental care which was begun in it can be completed at a VA outpatient clinic, or, if a patient has a service-connected medical disability which may be aggravated by a dental condition, a hometown dentist may be authorized to provide the dental treatment required to correct this condition.

Recent pilot studies have shown that approximately one-half of the newly hospitalized VA patients have not been treated by a dentist, Federal or private, for more than 5 years. Oral examination revealed that the average patient required the extraction of more than three infected teeth, in addition to other treatment needs. As a group, these patients' mouths were in a deplorable condition, with adverse effects on their general health.

During fiscal year 1965, special dental X-ray machines picturing the whole mouth at one time were installed at 10 larger VA hospitals having heavy oral examination loads. These machines will facilitate the provision of oral examinations to VA beneficiaries with a significant reduction in costs.

Altogether, during fiscal year 1966, approximately 525,000 hospital patients and domiciliary members were examined by dentists as an integral part of their medical evaluation. These examinations were responsible for the initial detection of 470 oral malignancies. Dental treatment was prescribed for 258,000 and treatment was completed as prescribed for 145,000. Outpatient dental treatment was provided for 54,600 veterans, including 23,000 former hospital patients whose dental treatment was completed in posthospital status.

In March of 1966, there were 654 VA dentists, 56 residents, 56 interns, 61 hygienists, 379 laboratory technicians, and 565 dental assistants—this whole staff headed up by a chief who by law is an Assistant Chief Medical Director in the Department of Medicine and Surgery. The program was affiliated with 43 out of 49 active dental schools throughout the country.

From 1949 to 1959, 218 Veterans' Administration dentists contributed 292 research and other scholarly findings to the dental profession, either as articles in journals of dental literature or as papers, subsequently published, read at regional and national meetings of dentists. All present indications are that by the end of the 1959–69 decade VA research and scholarly contributions to dental literature will be considerably intensified.

MEDICAL RESEARCH AND EDUCATION

At its initial meeting July 22, 23, and 24, 1924, the Medical Council appointed by General Hines submitted as their first recommendation that a policy of research be adopted by the Veterans' Bureau. A
working basis for research should be formulated, opportunities for successful research should be provided, and the results of such research should be rewarded.

Acting on this recommendation, the Bureau established a section on medical research in its medical service. The functions of this section were the study of all available data by which the Bureau's medical care might be measured; the investigation of the character of clinical practice in the diagnostic centers established by the Bureau; the setting up of standards and definitions to effect the improvement of that practice, and the promotion and encouragement of research in the field.

During the fiscal year ending June 30, 1925, the Medical Council arranged with the American College of Surgeons for a survey of every Veterans' Bureau hospital by representatives of the college, so that the Bureau's hospitals might be recognized in accordance with the requirements of that body. Also during the same fiscal year an advisory committee on nursing was established to assist the Medical Council and Medical Director on the subject of nursing, so that the Bureau's medical activities would meet the standards not only of the American Medical Association but also of the other professions associated with medicine. Finally, during that year, the Bureau established a monthly medical journal which contained orders and instructions to the field, new items about the medical service, and articles contributed by employees. This journal, serving a practical purpose and at the same time aimed at promoting a good esprit de corps in a comparatively young organization, was endorsed by the Medical Council.

Additionally, in June 1925, the Bureau established a monthly medical bulletin in which its physicians and other medical employees could publish articles on research, pathology, nursing, psychiatry, occupational therapy, physiotherapy, and other subjects of interest to the medical service.

Many of the research projects of the Veterans' Bureau and the early Veterans' Administration were practical, or what might be called "procedural" in nature. A sincere effort was made to learn, and to keep pace with, medical practices originated outside the Bureau. How to operate a clinic, how to operate a hospital pharmacy, or laboratory, or operating room—these were mainly the kinds of objectives of the early years of Veterans' Bureau and Veterans' Administration medical research. They were limited objectives compared to the objectives of VA research today, but they were pertinent to the needs of the time and they were productive. A basic hospital system had to be developed and refined first, before it could undertake the refinements of more advanced kinds of research.

By no means, however, were all research projects devoted to administrative problems. A cancer research unit was established at the VA Hospital, Hines, Ill., in 1933; a cardiovascular research unit at the VA Hospital, Washington, D.C., in 1936; and a neuropsychiatric research unit at the VA Hospital, Northport, N.Y., 1941.

At the end of World War II the Veterans' Administration, due to its limited staff and limited research resources, was not prepared to meet the postwar demand for increased knowledge and skill in the use of prosthetic and sensory aids. It was making use of the services of the Orthopedic Department of the National Research Council and the
Office of Scientific Research and Development of the Army. No one was satisfied with this dependence on outside services. The veterans' service organizations, representatives of the agency itself, and various Congressmen expressed the belief that the agency should become a leader in the field of medicine which war's ravages had raised to prominence.

This active interest in prosthetic and sensory aids, therefore, was a turning point, and the next turning point followed quickly, in the formation—by Public Law 293 of January 1946, of the VA's modern Department of Medicine and Surgery. Medical research on an intensified scale came to be recognized, and budgeted for, both by the agency and by the Congress. Gradually it was extended to all fields of VA medicine, as well as to prosthetic and sensory aids. It became an essential, rather than an incidental, activity, and it achieved a formal, recognized, major status.

From 1946 to 1954 a large part of the funds available for research were allocated on a contractual basis. It took time to engage the necessary trained personnel and install the proper facilities and laboratories within the VA system. Since 1954, however, most VA research work has been done by VA personnel on VA premises. There have been and will continue to be studies which can be more advantageously or economically undertaken in cooperation with affiliated medical schools, universities, or other research institutions.

Between 1961 and 1966, the VA was granted an average of $31 million a year for medical research—$39,618,000 in 1966. The Congress has been more than generous with the agency's requests for research funds, even to the point of granting more than what had been asked for, to encourage promising projects. In the same period of time, the agency has engaged in an average of about 6,500 projects a year.

The VA's medical research program is very diversified in its nature; emphasis is placed, so far as possible, on projects calculated to bear on the known or anticipated health needs of eligible veteran patients.

A large proportion of patients presently being treated in Veterans' Administration hospitals and clinics are in the age group most affected by chronic diseases, cancer, emphysema, heart disease, stroke, diabetes, rheumatism, mental illness, and so on. Since this circumstance will be magnified as the veteran population continues to become older, VA's research administrators have felt an obligation to intensify the agency's efforts to acquire more extensive knowledge of the causes of these diseases, their successful treatment, the reduction of ensuing disability, and, hopefully, their prevention. Additional emphasis has also been placed on the fundamental processes which relate to the aging process. This involves study of basic biochemical mechanism and genetic factors as they may affect the functions of cells and tissues. Knowledge at a fundamental level of the nature, cause, and biological changes in disease is likely to result in practical effects which lead to better treatment, amelioration, and sometimes cure.

An intensive and extensive mental health research program in the VA is motivated by the fact that fully half of the hospital beds continue to be devoted to psychiatric patients. All of the more prevalent mental disorders are being investigated by the many VA psychologists, biochemists, pharmacologists, biophysicists, and pathologists who
work with the clinicians. The VA is now in its 12th year of investigating problems associated with the use of chemotherapeutic agents in psychiatry. This program has consisted of 12 large-scale cooperative studies evaluating the tranquilizing and antidepressant drugs.

These studies have produced invaluable evidence regarding the effectiveness of the tranquilizing drugs in treating schizophrenia. Its drug evaluation programs made the VA the first large organization to place the revolutionary psychiatric chemotherapy on a solidly scientific basis. Within 10 years after this revolution, the prompt translation of its progressive research findings into clinical usage enabled the VA to treat twice as many psychiatric patients as it had previously—and this was achieved without any increase in hospital beds. It has obviated the need to construct additional psychiatric facilities, which meant substantial Federal tax dollar savings.

The cooperative study technique is also used to considerable advantage in many other fields. It is particularly valuable in the field of drug evaluation. Studies now underway, for example, include: the evaluation of antihypertensive agents; anticoagulants in coronary heart disease and cerebrovascular disease; drugs for reduction of serum cholesterol levels in arteriosclerosis; oral hypoglycemic agents in diabetes mellitus; and amphotericin B in systemic fungus disease.

It should also be mentioned that the VA has a worldwide reputation for the development of this cooperative study approach to research. The first cooperative study within the VA was conceived when the agency was confronted with the staggering problem of providing medical care to the increasing number of tuberculosis patients. Action taken by the Veterans' Administration is set forth in detail under the tuberculosis section of the professional services.

In surgery, VA research covers a broad spectrum of interests. Ninety hospitals are involved in surgical research projects encompassing sixty different areas of investigative concern. The VA is playing a leading role in research in the field of organ transplantation. Interest in this area is keen because of the tremendous benefits a breakthrough would provide for aging patients with disease of the lung, kidney, liver, or heart.

In addition to the several programs mentioned, research is being conducted in pulmonary and infectious diseases, in oral diseases, pathology, physical medicine, and rehabilitation, audiology and speech pathology, radiotopes, psychology, social work, and such basic sciences as biology, chemistry, and anatomy.

For interested professors, practitioners, and students of medicine, all VA medical research projects are a matter of annual public record. The record is published by the Government Printing Office, Washington, D.C., in two forms: the first as a House committee print on "Medical Research in the Veterans' Administration," the second as a House committee print on "Operations of the Veterans' Administration Hospital and Medical Program."

The first House print lists and describes, by disease categories or medical techniques, all research projects of the agency and the names of the physicians or others who are undertaking them. The second print describes the overall activities and summarizes the important statistics of each of the agency's hospitals, and it also lists the research projects which have been approved for them. The first print, devoted to research only, spells out the projects more fully than the second.
Within the agency, a generous-sized bulletin is distributed approximately every 2 weeks in which the nature, progress, conclusions, and the usefulness of a number of its research activities are highlighted for the information and stimulation of its physicians, nurses, technologists, and other paramedical personnel. The bulletin is also distributed to the deans of the medical schools with which the agency is affiliated and to about 50 medical science writers throughout the country.

Intimately related to VA medical research is VA medical education. In addition to the program of affiliation with medical schools which began in 1946, as well as the various training programs in the various specialties of the professional services, opportunities for extra-VA education and training offered by medical centers, universities, colleges, and professional organizations, are made available to VA medical personnel in many categories. During fiscal year 1966, for example, 4,484 extra-VA assignments were made at agency expense in addition to salary; 2,621 of these were made to training under non-Government sponsorship, 1,317 to meetings and conferences of non-VA institutions, and 546 to training offered by other agencies of the Federal Government.

There were also 2,815 assignments to intra-VA details or intra-VA conferences. The extra-VA assignments, in short, were more numerous. The agency does not simply look at itself in a mirror. It looks through a window at the outside world. So looking, it believes, is in the true spirit of research and education.

VA research and education service maintains active liaison with various Federal agencies. It is represented on the Board of Governors of the Science Information Exchange and the Committee on Scientific and Technical Information of the Federal Council for Science and Technology. And it maintains close working relationships with the Bureau of Standards, the Atomic Energy Commission, and the National Research Council.

**PROSTHETIC AND SENSORY AIDS SERVICE**

Provision of aid for amputees, lame, blinded, and other seriously war disabled throughout history has been a deep concern of many rulers, governments, and humane organizations and individuals. Some of the early armorers built remarkable prostheses. A French king granted special privileges to a group of blinded Crusaders. The Napoleonic and Crimean Wars led to development of prostheses in Europe, and the heavy casualties on both sides in the American Civil War led to numerous inventions. During World War I there were active programs on prosthetics development on both sides, and an early version of the reading-aid optophone for the blind was demonstrated in England.

Perhaps the only major development in aids for the disabled during the 1920's and 1930's was the rapid improvement by commercial firms of electrical hearing aids, first as a box to be placed on a desk or table, then reduced in size to permit wearable devices. The already known principles of acoustics, the growing understanding of electronics, and the development of electronics technology for the telephone and radio industries supported the improvements in hearing aids, and a wide commercial market for the devices encouraged highly competitive private industries.
For years prior to 1945, the Veterans' Administration purchased artificial limbs and other prosthetic aids from the lowest bidders in each area who met its specifications, which, in the light of prosthetic knowledge at the time, were rather vague. Government agencies were required, whenever possible, to purchase by competitive bidding. The difficulties in defining terms relating to quality, and in specifying intangible but important considerations like the patients' comfort or his confidence in the fitter, were largely overlooked. As in other routine procurement contracts, the Government would change sources each year as the lowest bidder happened to change.

In addition to this procurement situation, no single VA physician, supply officer, or administrative official had overall responsibility or even a coordinating role in an essentially fragmented program. All concerned with prosthetics, even when dedicated to this unique field, were also involved, usually far more crucially, with numerous other responsibilities.

At the end of World War II, the VA faced a chaotic situation in prosthetic and sensory aids. The problems of the amputees were particularly acute. They were being discharged rapidly and fitted and trained in Army and Navy centers with serviceable but supposedly "temporary" artificial limbs. For "permanent" limbs, they were referred to the VA outpatient clinics, which were crowded, understaffed, and lacking in adequate facilities.

The commercial artificial limbmakers of the country, only a few hundred in number, were handcraftsmen, each proud of his skills, and, in many cases, of his individual invention of a specific prosthetic knee, ankle, or other mechanical feature. The typical shop was a small one and had been swamped during the war years with demands for new limbs from civilian amputees. When veterans with "prescriptions" (in effect, purchase orders), from the VA went to such a shop, they often found that it had a long waiting list. And the newly discharged amputee, only recently assured that he was a hero and perhaps used as a speaker at war bond rallies, was understandably furious when told that he could not have a special artificial limb available to civilians because under the prevailing lowest bid concept it was not the cheapest available to him.

Thus, when veteran amputees demonstrated in the gallery at the Capitol, waving allegedly inadequate artificial limbs at Congressmen, and when newspapers published critical Sunday supplement features, the plight of the amputee became spectacular. Congress became concerned and investigated the situation, and the VA, on November 1, 1945, created a new Prosthetics Appliance Service. To strengthen this service, on December 28, 1945, Congress passed Public Law 268 (79th Cong.) which gave the VA broad authority to provide prosthetic appliances "by purchase, manufacture, contract, or in such other manner as the Administrator may determine to be proper."

On June 19, 1948, the 80th Congress passed Public Law 729 (now sec. 216 of title 38, United States Code) which recognized the need for a continuous program of research and development in the field of prosthetic and sensory aids. This law authorized the appropriation of $1 million a year to support such research, and on August 2, 1962 (Public Law 87–572), the million dollar ceiling was raised so that funds needed in excess of that amount could be requested to support the program.
These two basic laws have made it possible for the VA to assume a leading role in the prosthetics field, and to establish programs which have served as a guide for other Government agencies in the United States, and in many foreign countries.

The new Service rapidly, and sometimes abruptly, initiated a number of new features which have proven effective over many years. Among the early changes were negotiated contracts for buying devices and services from multiple vendors; free choice among those limb facilities under VA contract to provide the prescribed type in a tricent area nearest an individual veteran; a wider choice among limbs and accessories; a highly capable corps of prosthetics specialists, and a unique credit card for repair services. Orthopedic brace shops and plastic artificial eye and cosmetic restoration clinics were established at strategic VA facilities. A wide range of hearing aid models was made available, and selection of the best aid for a veteran through audiology clinics was encouraged. Soon after, a table of prosthetic equipment available for issuance to blinded veterans was developed. A vigorous program of research, development, evaluation, and education has continued for more than 20 years, the first such continuous and integrated program. The results of the research are published twice a year in the VA's Bulletin of Prosthetic Research, which has a national and international circulation of 3,000, over and above the copies circulated within the agency.

On July 1, 1948, prosthetics activities were reorganized as the Prosthetic and Sensory Aids Service, continuing and expanding these activities. Research was strengthened, implementing Public Law 729, 80th Congress, which not only specifically authorized annual appropriations for prosthetics research, assuring continuity, but provided that the results might be made available so that all disabled might benefit. The research program has benefited from the advice of specialized committees of the National Research Council.

There have been numerous innovations in both technical and administrative aspects. Several unusual organizational elements have been used effectively and economically.

Stump socks for amputees and batteries for hearing aid users are purchased in large quantities, sampled and tested for quality control, and mailed to individual veterans by a prosthetic distribution center in Denver. A centralized program for hearing aid repairs has been developed.

Prosthetic treatment centers are being organized to provide full-range capabilities in prosthetics. These centers serve problem cases more effectively and accept referrals from outlying field stations with more limited capabilities. The centers make the best possible use of skilled personnel.

Prosthetics education, in which the VA service has been a pioneer, has taught new principles and techniques developed by the research program. The suction socket, plastic artificial arms, total-contact socket legs, and hydraulic knees, are examples of new mechanisms. The fitting of these appliances is now being done directly following the amputation.

An important trend since World War II has been the movement of limb makers and brace makers from techniques toward increasingly professional status as prosthetists and orthotists. VA policies, educational programs, and new contract formats requiring special education
and certification to supply suction sockets, hydraulic knees, or other new developments in prostheses, have aided this growth. Numerous technical aids for the blind are being issued, and dramatic improvements are only a few years away.

Most veterans with prosthetic disabilities remain eligible for the remainder of their lives; most of them are not confined to hospitals, but are active members of society. Based upon the numbers of veterans who now have minor service-connected disabilities which could reasonably be expected to become serious enough to require prosthetic or related appliances, and upon the average age of veterans today, one can reasonably expect that the present trend of increase in the numbers of active service-connected disabilities will continue for at least another 10 years. In addition, the aging process will undoubtedly lead to increasing numbers of non-service-connected cases. Increased use of posthospital treatment procedures for non-service-connected disabilities now developing will further increase the overall prosthetics caseload.

The taxpayers, like rulers of old, readily recognize their responsibilities to these cases—amputees, blinded, paraplegics, etc. The integrated Veterans' Administration prosthetics program has provided an effective method for meeting these responsibilities, for stimulating improvements, and for helping the much greater numbers of similarly disabled throughout the world. Those veterans of the Vietnam era who will require prostheses or sensory aids face a much more advanced and adequate treatment situation than those disabled veterans of World War II, who waved their artificial limbs in protest.

NURSING SERVICE

Prior to May 1, 1922, the Nursing Service of the Veterans' Bureau provided nursing care to a limited veteran population: veterans with service-connected disabilities, those in vocational training, and those who were eligible for followup care in the clinics of 14 district offices and their suboffices. There was a total of 400 nurses on duty with public health nursing experience.

On May 1, 1922, as the result of an Executive order signed by the President, 46 hospitals of the U.S. Public Health Service were transferred to the jurisdiction of the Veterans' Bureau. This resulted in the transfer to the Veterans' Bureau of 12,069 World War I veterans, and 10,251 hospital personnel, including 1,420 professional nurses. Also, 755 commissioned medical officers in the Public Health Service were detailed to the Veterans' Bureau. All personnel other than physicians were converted to civil service status. Thus, for the first time, a Superintendent of Nurses and an Assistant Superintendent were assigned to the Veterans' Bureau in Washington, D.C.

With the popular conception that World War I was the war to end all wars, it was not expected that this service would expand greatly. But events proved otherwise. In 1924, the hospital doors were opened to veterans with non-service-connected disabilities. This gradually increased the number of patients applying for care; thus more medical personnel, including nurses and auxiliary personnel, were required. With the advent of World War II, and the Korean conflict, the Nursing Service grew into a staff of approximately 1,500 professional nurses, 3,300 practical nurses, and 26,000 nursing
assistants. Today, it is the largest service of its kind in the United States, and offers unusual career opportunities to nurses with varied professional interests.

The passage of Public Law 293, 79th Congress, January 3, 1946, raised the status of the Nursing Service immeasurably. Shortly before this, the Civil Service Commission had changed the classification of nurses from subprofessional to professional. While this was a step forward, Public Law 293 removed them from civil service, making them members of the Department of Medicine and Surgery of the Veterans' Administration, along with doctors and dentists. Salaries were made commensurate with their professional qualifications, regardless of duties performed. Many highly qualified nurses were attracted to the new Department. The Veterans' Administration has been a leader among the Federal nursing services in the utilization of the services of men nurses. Currently, 500 men nurses are employed within the hospital system.

From its inception, the Nursing Service has emphasized the importance of nursing education. Within 1 month after the Veterans' Bureau assumed control of the hospitals, nursing conferences were organized in three of the hospitals to review the then modern concepts of nursing in the care of the tuberculous and neuropsychiatric patient. A Veterans' Bureau School of Nursing was established at the VA hospital, Ft. McHenry, Md. This was later abandoned and combined with the Army School of Nursing at Walter Reed Hospital, Washington, D.C. The need to keep abreast of modern trends in medical science was recognized, and many conferences and meetings with educational objectives have been and are still being held. VA nurses have been encouraged to take leave to further their education, and, in some cases where there was direct benefit to the Government, their educational pursuits have been subsidized. Thus, the educational level of the nursing staff has risen steadily. In 1965, within a total of 15,000 nurses, five nurses had doctors' degrees, 610 masters' degrees, 3,329 bachelors' degrees, and 58 associate arts degrees.

The Nursing Service has been most progressive in relation to the proper utilization of its manpower. Extensive study was done of activities in which nursing personnel were engaged. Results of these studies have been most fruitful. Nursing personnel have been relieved of many activities that formerly were the responsibility of other services. For example, housekeeping duties have been assumed by housekeeping service under an executive housekeeper. The serving of meals on the wards is done now by dietetic service. Ward clerks perform clerical functions. A central service unit relieves ward personnel of time-consuming jobs of cleaning, preparing, and sterilizing equipment for future use. The introduction of pneumatic tube systems and other automated mechanical devices has reduced greatly the time nurses and nursing assistants must spend away from the patient. Recovery rooms for patients who have undergone surgery relieve ward nursing personnel from special-care duties until the patient has recovered from the anesthesia. These and many other innovations are designed to free nursing personnel for bedside nursing of patients.

The use of auxiliary nursing personnel—the licensed practical nurse and the nursing assistant—has expanded greatly, and has contributed to improved patient care. In the early days, practical nurses were almost nonexistent in the hospital system. Nursing assistants were
engaged to a large extent in housekeeping and other nonnursing duties. At present, there are 3,300 licensed practical nurses, and about 26,000 well-trained nursing assistants taking an active part in the direct nursing care of veteran patients. The nursing team concept was introduced, with each member—the professional nurse, the licensed practical nurse, and the nursing assistant—playing an important role. This accomplishment has drawn praise from many health and hospital organizations, including the World Health Organization.

One of the outstanding contributions to the health service needs of the Nation has been the opening of the clinical resources of the Veterans' Administration to schools of professional nursing in the community. Over 6,100 students of nursing, from 144 schools of nursing, received clinical experience in 80 VA hospitals during fiscal year 1966. As a result of recent Federal legislation, VA Nursing Service is now participating in the training of health workers to assist professional nurses.

Nursing Service has successfully utilized the services of volunteer workers. During fiscal year 1966, volunteer workers gave 2,023,379 hours in assisting with patient care. Many volunteers like direct contact with patients, and have made a major contribution by performing such duties as reading to them and writing letters for them, by feeding patients, and by escorting them to various parts of the hospital.

The high level of nursing care given the veteran patient has been accomplished by excellent teamwork, and by the leadership, vision, and wisdom of those who have guided this gigantic program. The Veterans' Administration Nursing Service, through its nursing care program and progressive personnel management practices, has made a profound impact on the health of the Nation and on the course of professional nursing.

**Dietetic Service**

The American Dietetic Association defines dietetics as the application of the science of nutrition and the art of feeding people. A knowledge of the nutritional value of food and its relationship to good health, forms the scientific basis of dietetics. The art of dietetics involves assuring that food is as attractive, palatable, and satisfying as it is nutritious.

Early in the 19th century, the practice of dietetics was associated solely with that branch of medicine called diet therapy. By the turn of the century, however, nutritional science had advanced significantly, and ultimately broadened the scope of dietetics to encompass normal and preventative as well as restorative nutrition.

Beginning in 1899, dietitians and home economists met together annually at Lake Placid, N.Y. The first “dietitians conference” convened in October 1917, in Cleveland, Ohio, to determine how dietitians could best serve the hospitals, and the war needs at home and overseas. It was at this conference that dietitians decided to form a permanent organization, which was called the American Dietetic Association. From the 39 charter members who attended the 1917 conference, this organization has grown to approximately 19,000 members in 1966. Veterans' Administration dietitians have been active in that association since shortly after its inception. They have held responsible positions in the national organization and in its
State and local echelons. Further evidence of VA dietitians' professional leadership and interest is found in their contributions to scientific and technical journals and in the adoption of VA dietetic procedures and systems by other government and nongovernment dietary departments.

Less than a year after assuming responsibility for the hospitalization of veterans, the Veterans' Bureau had one superintendent and one assistant superintendent of dietitians in the Washington headquarters, and 37 chief dietitians, 60 assistant dietitians, and 52 dietitians in its hospitals. Today, 1966, approximately 1,000 dietitians staff the Veterans' Administration hospitals, domiciliaries, and clinics. The agency is the largest single employer of dietitians in the country.

The national homes historically were not staffed with professional dietitians. When the VA absorbed the homes in 1930, they were permitted to follow their own "subsistence" procedures until 1950. Accordingly, each home had a commissary sergeant who was responsible to the home's governor, rather than to the chief surgeon, and who supervised a staff of cooks, bakers, stewards, waiters, laborers, and a worker called "operator, ice pit." While the five main divisions of the national homes—subsistence, household, hospital, repairs, and farm—were all separately responsible to the governor, the commissary sergeant undoubtedly had need to consult with the chief surgeon.

In 1950, the VA placed the administration of food service in national homes under the VA dietetic service. Thus, an era of semimilitary "subsistence" procedures came to a halt, and modern concepts of food service operation came into being in the homes.

Dietitians employed by the Veterans' Bureau between 1921 and 1930 met civil service requirements if they had been graduated from a course of at least 2 years of home economics in a recognized college, with the course including at least 1 year in chemistry, 1 year in biology, and 1 year in food preparation, plus classes in quantity cooking nutrition, and dietetics. Civil service requirements for dietitians were raised in 1929 and again in 1935, at which time a candidate for employment as a graduate dietitian in a VA hospital had to complete a full 4-year course in dietetics leading to a bachelor's degree, and also have prior hospital experience or a 1-year student dietitian training course (later designated as dietetic internship).

Following a survey of the duties and responsibilities of VA dietitians by the Civil Service Commission, another advancement in dietetic standards was effected in July 1945, when the status of dietitians was changed from the subprofessional to the professional series. This change was of marked assistance in recruiting some of the best civilian and ex-service dietitians at the close of World War II.

In order to meet the staffing needs of VA hospitals and to cope with the shortage of civilian dietitians created by World War II, a training course for dietetic interns was started in 1943 at the VA hospital, Hines, Ill. Similar courses, developed in accordance with the American Dietetic Association's standards for training, have since been established at other VA hospitals: Bronx, N.Y., and Los Angeles, Calif., in 1945; Memphis, Tenn., in 1947; and Houston, Tex., in 1952. The Memphis internship was discontinued in 1956, with VA training needs in the South being met adequately by the other internship programs.

In 1961, a new dietetic internship—masters' degree program was established at the VA hospital in Cleveland. Coordinated and
sponsored by Western Reserve University, with the VA hospital, the university hospitals, and Mount Sinai Hospital cooperating, the program combines university resources with instruction and experience in these three large teaching hospitals. Successful completion of this program leads to a master's degree. The VA has found that intensified dietetic education like this is imperative because of rapid changes and increasing complexity in food technology, in the science of nutrition, and diet therapy, and in the behavioral sciences.

VA dietetic internships annually provide a significant number of qualified dietitians to meet the nationwide demand for this segment of health services personnel. Approximately one-third of the VA dietetic internship graduates accept initial staff appointments in VA hospitals. About 10 percent of the total number of all qualified dietitians trained annually complete their required internship experience with the VA.

Several VA hospitals that do not have their own dietetic internship programs provide specialized experience for dietetic interns from non-Government hospitals. These dietetic interns affiliate at VA hospitals for part of the training needed to meet professional requirements.

Summer employment in the Veterans' Administration has given many high school and college students a keen insight into hospital dietetics. This brief glimpse has served as an effective means of interesting young people in a dietetics career and of recruiting for the profession.

The goal of VA Dietetic Service has always been and is today the maintenance of good nutrition for the veteran, and the integration of accepted concepts of diet therapy and restorative nutrition with the veteran's total medical treatment. Responsibility for fulfilling this objective extends beyond the veteran's dietary care in a VA hospital to his nutritional needs in the community, be it in a nursing home, halfway house, foster home, a private home, or in a VA outpatient clinic.

Guide material, including nutrition and diet manuals, has been developed in central office and distributed to the field stations as reference material for approved policies and procedures. Using these guidelines from headquarters, and nutrition information from other authoritative sources, each field station develops nutrition education material to meet its own special needs. Dietary modifications required in patient therapy are planned and coordinated with the medical staff at each station.

The most pressing problem with which the Dietetic Service was confronted during the late 1940's was that of the variations and fluctuations in food cost. It appeared that a standard allowance presented the best method of insuring that a patient in any given VA hospital would receive a nutritionally adequate ration, and, at the same time, one comparable in quantity and quality to that provided at any other VA hospital. The term "ration" represents the total amount of food served a patient during a 24-hour period. The Veterans' Administration Dietetic Service served 46 million rations in 1965.

The standard ration pattern adopted in 1950 for use in all VA hospitals has been periodically updated in keeping with the recommended dietary allowances of the National Research Council, and
with changes in the medical treatment of patients. As applied, the pattern assures that each patient will receive a nutritionally adequate diet, respecting the special requirements imposed by his physical condition and by the medical treatment employed.

The standard ration pattern enables all hospitalized veterans from coast to coast to enjoy satisfying and nourishing meals that look, taste good, and even feature favorite regional foods and cooking. As the dietitian plans the hospital menus, she applies the principles of normal nutrition and sound administrative judgment in selecting foods in order to adhere closely to the standard ration pattern and still hold tight reins on the food budget.

An increasingly important facet of the VA dietetic program in recent years is that of research—both metabolic and clinical. Knowledge gained from nutrition research should enhance the care of veteran patients and, at the same time, make important contributions to the science of nutrition in general.

During the 1920's and early 1930's, the structure of many veterans' hospitals was basically horizontal. Consequently, food service was decentralized, with many serving kitchens sending trays to bed patients and dining rooms serving ambulant patients. But, during the depression of the 1930's, many VA hospitals, for economy reasons, began to change from a decentralized to a centralized system of tray service. Moreover, the increase in the number of vertical hospitals, with additional floors replacing additional buildings, confirmed the centralized kitchen arrangement. This called for VA dietitians to work closely with industry in developing suitable tray trucks for transporting food from kitchens to wards. The agency was a pioneer in the practical research involved in the evolution of "hot and cold" tray trucks used in centralized tray service today.

Hospital food is essential not only to the patients' well-being but also to their morale. For this reason, VA Dietetic Service strives constantly to attain food quality and food service that are second to none. Every step of the food service operation in VA hospitals is carefully supervised to assure retention of peak food quality, skilled preparation, and expeditious delivery of meals to all patients.

In 1955, VA dietitians cooperated in developing a mechanized system of subsistence cost accounting, VA wide. This is one of the first applications of automatic data processing in the Department of Medicine and Surgery. In 1961, a dietitian was among the personnel assigned to work on the development of automated procedures for VA hospital operation. One of the first accomplishments was the development of a machine method for use agencywide in calculating the nutritive content of menus. Several related procedures—such as doctors' diet prescriptions, requests for dietary consultations, late meal requests, and other dietary situations which arise in hospitals are included in the automated hospital information system which is presently under development in the Washington, D.C., VA hospital.

But every concern of the Dietetic Service—food service, patient therapy and education, research, training, automation—is directed, along with all services in the Department of Medicine and Surgery, toward the physical, psychological, and total human welfare of that nonautomaton: The individual patient who is under Veterans' Administration medical care.
Drug expenditures by the Veterans' Administration rose from almost $15 million in 1955 to almost $32 million in 1965. This more than doubling of VA's budget for drugs does not mean that the cost of individual drugs doubled. The agency's purchasing procedures kept drug costs down. It reflects, rather, an increased use of drugs in VA therapy, hundreds of new drugs having been developed since World War II by the pharmaceutical industry in collaboration with the medical profession.

Altogether, there are about 50,000 pharmaceutical compounds available either in prepared form or in the form of prescriptions written by individual physicians for individual patients. Especially notable in VA medication since World War II have been the use of antitubercular chemotherapy (streptomycin, etc.) and the use, in psychiatric cases, of antidepressants and tranquilizers.

Of the hundreds of new drugs which have come into use in the present generation, practically all those which might be helpful for VA types of patients have been subjected to careful study by the agency's physicians and pharmacists. It is important to emphasize that drugs are studied not only in their direct effects on ailments but in what are popularly called their side effects.

Special interest has been shown in drugs which counteract certain types of tumors. The VA, in short, quietly but steadily, is playing its part in the many-sided search, both Federal and private, for drugs and procedures to combat cancer.

The Veterans' Administration is the largest civilian purchaser of drugs; among all purchasers, it is second only to the Department of Defense. Together, Defense; the VA; the Department of Health, Education, and Welfare; and other Federal agencies which have need of drugs; have formed IPAD, the Intragovernmental Procurement Advisory Council on Drugs. The purpose of this association is to pool the agencies' findings on the effectiveness, the quality, the packaging, the availability, and the prices of the drugs they purchase. The Council also studies the effectiveness of syringes, needles, and other instruments associated with the administration of drugs.

This pooling of information by Federal agencies, and the open competitive bidding under which they procure their bulk drug needs, have had their favorable effects on the purity, effectiveness, packaging, and the prices of drugs purchased and dispensed by State, municipal, and private hospitals and clinics, and also, indirectly, similar effects on drugs prescribed for private individuals.

In 1955, there were almost 8 million pharmacy actions by VA employees. In 1965, there were almost 15 million such actions. Pharmacy actions are the total of (a) prescriptions, (b) line items (compounds in prepared form), and (c) alcohol and narcotics orders filled.

Eligible outpatients unable to have prescriptions filled at a VA pharmacy may have them filled by their hometown pharmacists, who sends the bills to the VA hospital or clinic of jurisdiction in each particular veteran's case. Over a half million such prescriptions were filled during 1965.

Since 1946 and the foundation of the modern Department of medicine and Surgery, the educational requirements for VA pharmacists have been strictly professional. Applicants must have either the
doctor of pharmacy or the bachelor of science in pharmacy degree, and they must be licensed by the boards of pharmacy of the States in which they intend to practice. Salaries, in consequence, have been made commensurate.

In the Veterans’ Bureau and the pre-World War II Veterans’ Administration, there was a small number of pharmacists who had not taken a full course in a school of pharmacy, but who were licensed by their respective States. In the postwar period a retroactive “grandfather” clause made it possible for them to continue their employment.

The two best known fields of pharmacy are retail pharmacy and hospital pharmacy (there are such other fields as industrial and research). Most schools of pharmacy prepare their graduates mainly in retail pharmacy, although hospital pharmacy is a widening area of the profession. The VA conducts special training courses to enable graduate, licensed pharmacists to adapt themselves to hospital pharmacy. It also conducts internship programs at 10 of its hospitals, and residency programs in cooperation with schools of pharmacy at 11 universities.

A VA pharmacy residency is a 2-year combined course consisting of part-time employment in a hospital or clinic pharmacy, classes at the graduate level, orientation in hospital administration, and pharmaceutical research. It is aimed at satisfying the requirements for the degree of master of science. The VA pharmacy internship is a 1-year training course, in which the candidate is paid a modest but living wage, and there is a financial encouragement to excellence, with those in the upper 25 percent of their class being paid a bonus of almost $600 a year. Upon completion of the course, they receive a certificate of internship.

In pharmacy, men outnumber women by about 19 to 1, but the VA Pharmacy Service believes that women, with their conscientiousness and compassion in matters of the health of others, might well find in pharmacy, and VA pharmacy in particular a rewarding career. At the beginning of 1966 there were 633 VA pharmacists and 193 other pharmacy employees.

VA pharmacists do not simply fill orders made out by physicians and administered by nurses whom they do not see. There is a close, personal working relationship among all the services which make up the agency’s Department of Medicine and Surgery. The Pharmacy Service, for example, is collaborating on a factfinding basis with physicians, nurses, and administrative personnel on the use of automated equipment aimed at saving nursing time through the better control, distribution, and storage of drugs in VA hospitals.

Pharmacy Service is also collaborating with the agency’s Department of Data Management on a pilot model project in which ADP (automatic data processing) equipment is being used to correlate information on the drugs required for patients, the nature of the ailments for which the drugs are intended, and the amount and the costs of the drugs both for individual patients and for groups of patients.

All VA pharmacists with the necessary ability, experience, and interest are given the opportunity to participate in similar experiments and investigations, as well as in seminars, workshops, and refresher courses in hospital pharmacy and pharmacy administration. The pursuit of nothing but the best for the agency’s patients has the
more than incidental side effect of a similar pursuit for its professional employees.

SOCIAL WORK SERVICE

A veteran's best link with his society is himself. By "his society" is meant his family, his neighbors, his friends, and his associates at the place where he works. If for reasons of poor health—physical, mental, or a combination of the two—he is temporarily a "weak link," the Veterans' Administration social worker helps him strengthen the link—strengthen, that is, himself.

Or, to change the comparison somewhat, the social worker helps to build a bridge for the patient between the limiting world of medical care and the public world of productive work and social living from which he has been withdrawn by his illness. Social work, being a realistic, down-to-earth profession and an optimistic one, has demonstrated that in many cases he can be returned to this public world and become again, gradually, his own link, his own bridge.

Those services of VA medicine which social work particularly supplements are psychiatry, neurology, and psychology; physical medicine and rehabilitation—especially in such outpatient programs as mental health clinics, day treatment centers, and foster homes. It also participates in the restoration center program, which is for inpatients who are on the point of becoming outpatients. Whenever a veteran, returning or preparing to return to society, needs assistance in making the transition, a VA social worker either directly helps him or supervises the efforts of the volunteer workers who participate in the VA voluntary service program.

Another area of VA social work is in the agency's domiciliaries. Here there is no longer the assumption, especially toward younger members, that once in a domiciliary always in a domiciliary. VA psychiatrists, psychologists and social workers bend every effort to return veterans of World War II and the Korean conflict who have the necessary aptitude and attitude to a larger life beyond the soldiers' home concept. Even some veterans of World War I are being returned to their home communities. The domiciliary, in short, in as many cases as possible is being more and more considered as a temporary shelter where the veteran can regain strength, regroup his forces, and learn new ways of using his personal resources in returning to the community.

Social work has always been part of veterans' medical care. During World War I the American Red Cross established social work in Army and Navy hospitals and later in the Public Health Service hospitals which cared for veterans before the Veterans' Bureau was established. In 1923 some of the Bureau's regional offices asked the help of social workers in evaluating the adjustment of veterans who had left the hospital with continuing disabilities. A few of the Red Cross workers were used under varying civil service designations. In 1926 the Bureau formally established a social work service to serve in a few regional offices and in a number of hospitals.

As for qualifications during the 1920's, the Bureau's "senior social workers" were expected to have at least 1 year of psychiatric or social work experience in a hospital or clinic, and "junior social workers" were generally college graduates who had had "some" postgraduate training in a school of social work. By modern standards, the educa-
tional qualifications were vague and flexible, but were advanced for those times.

At first, Veterans' Bureau social workers were utilized to obtain comprehensive social histories for the information of psychiatrists. But social work itself gradually developed, and the Veterans' Bureau was enlarged into the Veterans' Administration, and VA physicians, even during the years before World War II were among the leaders in promoting the now widely held concept of the patient as a "whole man" and not simply as a "case."

As a result of this VA medical attitude, VA social workers in addition to continuing their contribution to the diagnostic phase of patient care, began to assist in the curative phase. From playing a part in diagnosis they moved up, under the direction of appropriate medical specialists, to playing a part in therapy. If they learned much about what a patient's problems were in adapting himself to society, they also learned much about what solutions there might be to those problems. No single medico-social institution in the country has had more opportunity than the VA for direct, immediate experience of social situations that call for social work. Other agencies may have a comprehensive statistical knowledge of the problems of social living, but the VA's knowledge is that of nationwide, day-to-day, person-to-person contact.

As it learned new ways to meet old problems, the VA became a pioneer in developing new social treatment methods as it had done in developing new medical treatment methods in conjunction with psychiatrists. It learned ways to adapt group work as well as casework to the needs of patients in hospitals and clinics. It introduced programs of social work for chronically ill veterans in their own homes. In 1951, it instituted a special placement service for improved psychiatric patients and placed 185 veterans in foster homes, a type of outpatient program it was the leader in sponsoring. In fiscal year 1966 it placed almost 9,000 such patients in foster homes, halfway houses, nursing homes, and other places of abode in which the patients, no longer restricted to the special, limited life of a hospital, were given opportunity to return fully to society.

There are 64 schools or departments of social work which are accredited by the Council of Social Work Education. VA is affiliated with all of them and provides field experience for more than 500 students each year. The trend in social work education has in recent years moved from preparation for specialized practice to a broader orientation. A generic preparation for social work is now emphasized, with the fieldwork placement of the social work student in specialized fields of practice, such as corrections, medical, or psychiatric social work. On-the-job supervision and training for a 2-year period following attainment of the professional master's degree in social work is a further requirement for the individual's membership in the Academy of Certified Social Workers.

The Council on Social Work Education and the National Association of Social Workers estimate that for the various State social service agencies with which the Federal Department of Health, Education, and Welfare collaborates, 100,000 more social workers with full professional education will be needed by 1970.

The Veterans' Administration is feeling the pinch of this demand in excess of supply. Like other organizations, it has been seeking ways
of expanding the effectiveness of its professionals in short supply. A recent 2-year study at 10 stations has demonstrated the feasibility of employing social work assistants, with a bachelor's degree. More will be employed at additional stations in the coming year.

A social work assistant performs his or her duties under the guidance of a social worker with a master's degree. Opportunities are provided for assistants who show special ability and interest to enlarge their education, because the social work service believes that only the best possible education, training, and experience are adequate for the current heavy demands made upon it, especially by the increase in the number of veterans and the wide range of their problems, particularly of the older World War I veteran.

Several thousands of aging veterans are in a sort of no man's land category, not ill enough to be hospitalized, but not well enough to work, and many are in need of the kind of expert social service which will help them to maximize their adjustment in their difficult circumstances. Much can be done to make old age not only tolerable but also worthwhile. Social workers are in the vanguard of the search for outlets and satisfactions for the aging.

With the increasing recognition of the importance of the social aspect of medical care, VA social work service has grown. At the beginning of 1966 it had approximately 1,660 social workers and 20 social work assistants. These 1,680 employees (53 percent of them women, and 47 percent men) served close to 415,000 veterans during the year. When it is considered that social work involves dealing not only with the patient but also, very often with members of his family, his employer, and other people who affect his living conditions, it can easily be imagined that Veterans' Administration social workers are a busy lot. And the prospects are that in the years to come their work will not be slackening any.

**CHAPLAIN SERVICE**

The Veterans' Administration provides, through the chaplain service, a program of religious ministry to hospitalized and domiciled veterans which is part of the total care and treatment of patients.

This service for veterans dates back to 1866 when the first National Home for Disabled Volunteer Soldiers was established. In the minutes of one of their earlier meetings (July 12, 1866), the following appears: "The salary of the chaplain shall be that allowed by the law to a chaplain of the Army." ($1,500 per annum, quarters, and forage for one horse.)

Originally, religious services were held in the theaters or amusement halls of the homes. Gradually, chapels were constructed. Usually, this building was one of the finest and most elaborate on the reservation. In most cases, Catholic and Protestant services were held alternately; in others, one building housed two separate chapels. Services for members of the Jewish faith were conducted as the need arose.

In 1922, when the hospitals caring for veterans under the Public Health Service were transferred to the Veterans' Bureau, the necessary religious functions were, in most cases, inadequate. The appointment of chaplains was left to the medical officer in charge of the hospital. Some lived in quarters on the reservation, receiving
$1 a year, plus quarters, subsistence, and laundry. Others, and by far the greatest number, were recruited locally and paid a token amount for Sunday services and emergency calls. Financial remuneration of the chaplain now approximates that of his coworkers.

Religious services were held in the recreation halls at most of the hospitals. It was not until after the Veterans' Administration was formed in 1930 that separate chapels were constructed, and then only in isolated cases. However, with the building program instituted in 1945, all of the new hospitals included either a separate chapel or appropriate space for religious participation in one of the buildings. In the older hospitals which did not have chapels, adequate space was also made available.

During the closing period of World War II, religious organizations representing the predominant groups petitioned the Administrator of Veterans' Affairs to establish the chaplaincy in the VA on a national basis. In a letter dated August 9, 1945, addressed to all facilities, General Hines announced the establishment of a Chaplaincy Service (later renamed Chaplain Service) in the VA, and expressed the reason therefor as follows: "It is felt that the chaplaincy service of the Veterans' Administration should be strengthened and established on a basis that will assure beneficiaries the best possible spiritual guidance, religious services, etc." This letter made the Director of the Chaplaincy Service responsible for the recruitment and placement of chaplains, whether on a full- or part-time basis.

In a letter dated November 28, 1945, General Bradley authorized the placement of full- and part-time chaplains in the VA hospitals.

The office of the Director of the Chaplain Service was first placed under the Assistant Administrator for Personnel. Eventually, it was made an integral part of the Department of Medicine and Surgery.

From its inception, the ministry provided by chaplains evoked a warm response from many sources. The following greetings from the first post-World War II Administrator set the tone for the service as chaplains became fully integrated into the total hospital program and the treatment team:

As June 15, 1946, the first anniversary of the founding of the Chaplain Service approaches, I hope that you will find an ever-increasing measure of satisfaction in the performance of your vital spiritual ministry to the veterans of our country. * * *

Omar N. Bradley,
General, U.S. Army, Administrator.

On the 20th anniversary of the Service, the Administrator, William J. Driver, said in greetings to all Veterans' Administration chaplains:

The founding of this service recognized that an effective therapeutic climate demands that hospitals treat the whole man, and not consider patients as merely a collection of symptoms. The VA Chaplain Service has shown clearly that it occupies a significant place in the "team approach" to meeting the medical needs of sick and disabled veterans. There is no doubt in my mind that many, many veterans owe their recovery to the spiritual support given through the dedicated men of God who compose our Chaplain Service.

The span of decades has seen the remarkable growth from just a few chaplains, employed locally on a fee basis, to the present institutional ministry, soundly based, professionally supervised, and spiritually vibrant. The physical facilities for worship, whether in a separate building or not, now compare favorably with some of our finest small houses of worship in the country.
In addition to a central office staff comprised of 5 chaplains—2 Catholic, 2 Protestant, and 1 Jewish—there are 752 full- and part-time hospital chaplains, representing all major faiths including many Protestant denominations.

By statute, the appointment of the Director of the Chaplain Service is on a rotating basis, with a 2-year tenure of office subject to reappointment for one additional term. This was done on the recommendation of a former Director of Chaplain Service, of the Catholic faith. It was his idea that, on a rotating basis, the three predominant religions would, periodically, have one of their faith as head of the VA religious program.

In 1964, the Veterans' Administration established a school for chaplains at the VA hospital in Jefferson Barracks, Mo. All newly appointed chaplains attend for 6 weeks. This is an intensive program covering the professional and administrative facets of the chaplain's work. The faculty are, in the main, VA employees. The subjects range from the medical service to such aspects as laundry and supplies. The purpose is to acquaint the chaplain with everything in the VA hospital setting which touches the life of the patient.

VA chaplains not only conduct formal religious services on Sunday or the Sabbath. They also "make their daily rounds" of the wards, administering communion to those patients who request it; giving spiritual advice, counsel, and encouragement; helping in the selection of books; serving as go-betweens (and sometimes peacemakers) between patients and their families; and conferring about patients' problems with physicians, nurses, and social workers. Their work calls for knowledge of human nature as well as knowledge of theology, and for sympathy, understanding, humor, and the general capacity for being outgoing and helpful.

In 1959, the Chaplain Service Advisory Committee was established to provide the Director and his staff guidance and advice on the thinking and interests of the religious community. This committee is composed of 10 outstanding clergymen representing the diverse denominations of the country. They meet regularly with the central office staff, visit hospitals, and submit their findings and recommendations.

In summary, it is fair to state that the long-range vision of the Veterans' Administration has resulted in the establishment of an institutional ministry which has become the prototype of what State hospitals are attempting to do. The complete team approach, which includes spiritual ministry, ecumenical in nature, is a vital factor in reducing the patient's hospital stay and hastening his return to the community.

LIBRARY SERVICE

A patient in a Veterans' Administration library once said to a staff librarian: "It depresses me to read about happy people when I am sick. Give me a gloomy book with an unhappy ending. I feel better when I read about someone in a worse situation than mine!"

Most VA patients do not prescribe for themselves the drastic literary taste of that particular patient. Actually, representing as they do a cross section of American society, those of them who read books prefer the variety of reading matter which is available in a good neighborhood-type public library. Therefore, a well-selected variety
characterizes the reading matter made available to VA patients, not only on hospital library shelves but on the shelves of the book-and-
magazine carts which are wheeled to their beds.

Hospital libraries are so important both to medical staffs and to patients that in Malcolm MacEachern's monumental text "Hospital Organization and Management" an entire chapter of 35 pages is devoted to them. It can be imagined how extensive must be the selection, cataloging, and distribution of books and periodicals for the vast VA system of central office, hospitals, domiciliaries, and clinics.

The VA's affiliation with medical schools and postgraduate medical education makes it imperative that the demands of its residents and other physicians for the best and latest in medical literature be met. Many of these physicians are among the most research-minded medical people in the country, and the agency is insistent that they be provided with the proper reference materials they need. At the same time, the whole VA medical system exists for its patients, and these, too, are provided with a balanced sufficiency of reading matter.

Historically, for the chief surgeon of the hospital division of each of the national homes for disabled volunteer soldiers, the board of managers provided a basic set of medical texts. For members of the homes, and patients in their hospitals, the local chaplain usually doubled as librarian; it was to him that, unofficially and informally, the cultural as well as spiritual welfare of a home would fall. The result was that the books provided were often of an edifying rather than informative or entertaining nature, although the selection at the central branch in Dayton seems to have been more liberal in scope.

The Veterans' Bureau established the first officially supported library service in 1923. A document was sent to all hospitals describing the service of the librarian in bringing books to patients in the wards as one of her most important duties. It was noted that the Congress, in appropriating funds for reading materials, clearly indicated its intention of having libraries in the Bureau's hospitals, and it was stated that "the policy of the Bureau is to place this service in the hands of trained and experienced librarians." At the beginning, there were 38 of these.

On the whole, the emphasis during the General Hines administration of the Veterans' Bureau and the Veterans' Administration (1923-45) was patient oriented, rather than staff oriented, and much freedom was permitted to librarians in the individual hospitals. At the end of 1945 there were 161 librarians, 570,000 books for patients, and 47,700 medical books in 97 VA hospitals. At the end of 1965, in 168 hospitals there were 360 librarians, 1,215,000 books for patients, and 671,000 medical and related books. The increase in the number of medical books, proportionately higher than the increase in the number of hospitals, reflected the postwar development of the Department of Medicine and Surgery.

From 1946 to 1953, the Director of Library Service informed each hospital of the amount of funds against which the hospital could order the books and periodicals which it required. But, in 1953, this postwar policy of central control was modified. With the local hospital director receiving a lump sum of money, a primary fund, to run his hospital, he would determine in consultation with his chief librarian the amount of money which would be spent annually on books for
the patient and the staff. The librarian, of course, would previously have consulted with the staff.

The headquarters library in Washington, however, continued to exercise the principal functions for which it exists:
1. To prepare policy and directive material for the system.
2. To prepare qualification standards for VA librarians.
3. To prepare recruitment brochures and library exhibits for use by the system.
4. To conduct or supervise library training courses for the system.
5. To prepare lists of basic and recommended books and periodicals for VA medical and patient libraries.
6. To direct the work of cataloging and classification performed for the system at the VA supply depot in Somerville, N.J. Book pockets and cards are also supplied from this source.
7. To lend to the VA hospitals and clinics books from its own central office library, or books obtained on loan from the Congressional, the National Library of Medicine, and other libraries in the Washington area.

In the medical collection of the central office library there are at present 21,000 books, 9,000 journal volumes, 300 current periodical subscriptions, and 4,000 pamphlets, brochures, and reprints. In the general reference collection—which includes publications on veterans' affairs, histories of the wars in which the United States has engaged, public administration, personnel administration, accounting, insurance, statistics, computers, and automation—there are 20,000 books, 135 current journal subscriptions, and 2,500 pamphlets, brochures, and reprints. Many of these publications are of practical assistance to hospital administrative and supervisory personnel.

Altogether, the central office library processes approximately 10,000 interlibrary loan requests yearly from VA field stations throughout the country. It has also published Medical Care of the Veterans in the United States, 1870-1960, a bibliography, and Traumatic Paraplegia, also a bibliography, which have had wide international circulation (see section in this chapter on spinal cord injuries).

There are two special personnel programs in the VA library system at the present time. The first of these is a work-and-study program which has been in operation since 1859. Applicants for this program must have the bachelor's degree and must be enrolled or accepted for enrollment in a curriculum leading to a master's degree in library science. Sixteen such work-and-study appointments, under the direction of local VA librarians, were in effect in June 1966:

A second program develops VA librarians already on the job. Librarians who participate in it are appointed to training detail in the central office library, to intra-VA station detail, to attendance at VA-sponsored librarian conferences, and to attendance at professional meetings. With these programs, the VA library service contributes not only to its own library needs but also to the whole field of medical, hospital, and institutional library science.

**VOLUNTARY SERVICE (“VAVS”)**

Much of the sympathy which—aroused and guided by the Sanitary Commission—had gone out to soldiers and sailors of the Civil War when the conflict was being waged was transferred to disabled vet-
erans of the conflict when it was over. The story has already been related of how generous contributions of money and property from private citizens helped to start national homes for disabled Civil War veterans at Milwaukee, Dayton, and Los Angeles. And the historical record of all the national homes makes frequent mention of how the Grand Army of the Republic, the Civil War veterans' service organization, and its ladies' auxiliary, the Woman's Relief Corps, took an interest in the personal comfort, welfare, and entertainment of the veterans who lived in them.

The GAR is no longer in existence, but the Woman's Relief Corps, with its membership made up of the children, grandchildren, and great-grandchildren of Civil War veterans, is active in the modern VAVS—the Veterans' Administration Voluntary Service. In a grand American tradition, veterans' service organizations and other patriotic and welfare groups take this personal interest in fighting men during times of war and in veterans during times of peace—"serving those who have served."

At the end of World War II, the VA, with its greatly increased number of patients, saw the need for an enlarged program of community volunteer participation. On April 8, 1946, at the invitation of General Bradley, leaders of veterans' and welfare organizations met in Washington, D.C., with members of the VA's central office staff.

At this meeting, it was agreed that the voluntary organizations and the VA would work together, under a program called the Veterans' Administration Voluntary Service, to coordinate, integrate, and increase volunteer assistance of many kinds to veterans in VA hospitals and domiciliaries. A National Advisory Committee, representing the volunteer organizations, was set up, and for the last 20 years it has worked closely with the small VAVS central staff, developing a significant program of purposeful and effective citizen volunteer participation in the care and treatment of veteran-patients.

The VA Voluntary Service plan is unique in Government operations. No other Government agency has developed such a plan by means of which the private voluntary groups participating in the agency's programs also participate actively in helping to plan those programs.

As a result of the meeting in 1946, there are now—in 1966—42 national organizations working with the VAVS program. A monthly average of over 108,000 volunteers is providing over 8 million hours of service a year to sick and disabled veterans in VA hospitals, domiciliaries, and clinics. These volunteers are regarded as "belonging"—not to the Veterans' Administration, but to their various organizations: the Red Cross, the Veterans of Foreign Wars, the American Legion, the Disabled American Veterans, the Woman's Relief Corps, and all the others. "VAVS" is simply the coordinating crystallizing factor in the whole manifold activity of direct, personal, humane service to veterans.

There are two main groups of in-hospital volunteers: those who serve occasionally, such as two or three times a year for special events, and those who serve regularly, once a week or once every 2 weeks. Of those who serve regularly, the largest single group works under the guidance of VA nurses and with physical rehabilitation therapists in hospital wards. Others work with VA social workers, therapists, recreation specialists, chaplains, and other staff personnel. Volunteers also serve in the community, helping to restore veterans released from
hospitalization back into the normal life of society. Organizationally, volunteers work under the leadership and guidance of the office of the chief of staff.

Volunteers are considered as highly useful assistants to the medical team in the hospitals of the VA, supplementing the efforts of the professional staff. They work for the patients; not for the institution. Volunteers acting on behalf of the VA in an authorized capacity on a specific VA mission are, in effect, considered as unsalaried employees and are therefore regarded as covered by the provisions of the Federal Employees Compensation Act and the Federal Tort Claims Act. This status accorded to volunteers is an evidence of the VA's recognition of the importance of their services.

Within the past few years, VA hospitals have adopted new medical treatment programs and changing concepts of patient care. It has been found that long-term hospitalization in many instances is unnecessary and that patients can be more rapidly and effectively rehabilitated by receiving needed medical care and assistance in their home communities. It has also been found that many patients who are physically weak, but who do not need daily medical attention of a serious nature, are happier in their own homes. Under these concepts of patient care, moreover, more beds are made available for patients who really need them.

In this situation of patients returning to their homes, and hundreds of them, hopefully, returning to productive employment as well, volunteers are proving themselves to be effective assistants to the professional staff. Two examples of effective use of volunteer services, out of hundreds similar in character, are here offered.

The first example, involving an in-the-hospital patient, is from the VA hospital in Salem, Va., which is a psychiatric hospital (the names of the participants have been changed):

With the doctor's approval, we approached one of our volunteers, Mrs. Jones, about being a friendly visitor to Mr. Smith, a 71-year-old World War I veteran, hospitalized continuously since 1919.

Mr. Smith had only recently been referred by the staff physician as a patient who was medically able to leave the hospital. Mrs. Jones was agreeable to bi-weekly visits. On several of these visits, she took Mr. Smith off the hospital grounds to Salem, visiting the mall and the shopping centers, and riding around in Roanoke. Mr. Smith showed a great deal of interest in what was going on about him; he was observant of the homes and countryside and awed with the "new, outside world."

Mrs. Jones, a warm and friendly person who is ever aware of herself as representing the community, continually presented reality to Mr. Smith. This experience gave Mr. Smith his first opportunity in 45 years to get "beyond the walls" of a mental hospital and, undoubtedly, was the main motivating force which made it possible for him to leave the hospital and live in a family care home.

The other example involves an in-the-community patient, a 35-year-old veteran of the Korean conflict who came to the VA hospital at Danville, Ill., with a diagnosis of schizophrenic reaction, paranoid type, and a history of repeated threats of suicide. Following a year of intensive treatment in the hospital a return to society, on a trial basis, was recommended by the staff, and placement in a foster home was chosen by the veteran as an alternative to returning to the home of his parents.

The initial months of his foster home experience were touch and go. Anxiety prone, lacking in confidence, the veteran found difficulty in associating with people. When his first few attempts to obtain
employment were unsuccessful, he balanced on the verge of returning to the hospital. In this situation, the efforts of a volunteer and her husband proved invaluable. They began to drop by the veteran's foster home, had him over to their own home, took him out to dinner, and occasionally accompanied him downtown so that he could adjust himself to being in the midst of people and the life around him. Their influence and support have been definite factors in his remaining out of the hospital. Although he is still (at the time this book goes to press) unemployed, he is making contact with his State vocational rehabilitation service and is attempting to formulate some realistic plans for job training. A man at one time almost hopeless is now becoming hopeful and purposeful.

Note that in these two examples the volunteers did not commit themselves merely to one or two graceful, but comparatively empty, gestures of good will. Their efforts were prolonged, unremitting, and devoted, like the efforts of loyal relatives. "Foster relatives," in fact, would be a good description of volunteers in hospital and post hospital service. In the case of many a veteran, they fill a family sort of need when the veteran's own family is either scattered, or, as can sadly happen, indifferent.

Most of the 8 million hours a year of voluntary service under the Veterans' Administration Voluntary Service program are like the service in the two examples described: they are person to person, they are human, they are necessary, and they are expressive of the best in the American tradition and way of life. As President Truman said, in commending the work of the volunteers on May 21, 1952: "Your work in the Veterans' Administration Voluntary Service program is an inspiring illustration of devoted dedication to your mission on behalf of the hospitalized veterans. It is, in addition, one of the best possible examples of our democracy in action."

THE ADMINISTRATIVE SERVICES

From the early days of the Veterans' Bureau, and continuing on until after World War II in the Veterans' Administration, there was a great deal of centralization in the administration of the hospitals.

The head of the hospital was at first known as medical officer in charge; later changed to manager, and then to the present title of director.

Finances were controlled solely from the central office and if a hospital needed an additional employee it was necessary to submit a full explanation and request for money to the central office. This was so, regardless of the grade or salary of the position desired. After World War II, this system was modernized and, at the present time, the director, within certain guidelines, has control of the expenditure of funds for his station.

The director of a VA hospital may be either a physician or a non-medical man experienced in hospital administration. Prior to the appointment of General Bradley, the VA stations which housed purely hospital activities were headed by a physician. Laymen were used as managers of combined facilities where a hospital and a regional office were under one management. With the advent of the new Administrator, this policy was changed, and in making an appointment, the man best qualified was appointed as head of the hospital
whether a physician or a layman. This policy has been continued by all Administrators and Chief Medical Directors since that time.

The VA now has 99 hospitals headed by physicians and 81 headed by laymen. The two main assistants to the director are the chief of staff, a physician, and the assistant director, a nonmedical man. The chief of staff is responsible for the professional care of patients, together with the ancillary personnel involved in their treatment. This position was formerly named clinical director, and was later changed to director, professional services. The present title was adopted during Dr. Middleton’s term of office.

In 1924, the position of business manager was created by General Hines to take care of the purely administrative activities of the hospitals. In 1935 it was abolished, and the heads of the administrative divisions became responsible to the manager only.

When the Department of Medicine and Surgery was created in 1946, a new position was established to perform similar duties to those of the former business manager. This position was at first called executive officer, and changed shortly to assistant manager, and subsequently to assistant director.

Not all hospitals have the position of chief of staff or assistant director. In 17 of the small hospitals where the director is a physician, he acts as his own chief of staff. In another 17 of the same type, where the director is nonmedical, he absorbs the duties normally performed by the assistant director.

Appointments to the positions of director, chief of staff, and assistant director are made by the Administrator on the recommendation of the Chief Medical Director. For this purpose an appraisal committee, appointed by the Chief Medical Director, reviews the individual records of eligibles and conducts personal interviews when possible. The committee then makes recommendations. In the case of physicians, only one name is submitted, as a rule. For those who come under civil service regulations (nonmedical personnel) it is necessary to submit three names. In either case, an outline of the candidate’s experience, evaluation of performance and potential, as well as mention of special achievements, accompany the recommendation.

When a physician is nominated, the Chief Medical Director, if he agrees, forwards the nomination to the Administrator for approval. In the case of nonmedical nominees, he indicates his preference and sends it to the Administrator for concurrence.

All assistant directors are laymen and are stationed in 143 hospitals and domiciliaries. They are responsible for the activities of the administrative divisions in the hospitals. There follows a brief description of the activities of each of these divisions.

**Personnel**

There are certain positions in the hospitals which are called “centralized” inasmuch as the appointment, promotion, or other change in status, has to be approved by the central office. A professional standards board, consisting solely of physicians, passes on a physician’s case. A nursing standards board passes on appointments or promotions of certain nurses. The professional standards board requires that the following personnel actions be approved by them:

- Initial appointments above the salary of intermediate grade;
- All promotions of doctors and dentists;
Special advancement for performance or achievement;
Noncitizen physicians and dentists who have received a license to practice in the United States.

The nursing standards board has responsibility for actions on the following:
Initial appointments above the salary of intermediate grade;
Appointment of noncitizens;
Promotions recommended for performance on duty.

The director, nursing service, retains the authority to approve the following:
Chief, nursing service.
Assistant chief for education.
Assistant chief, nursing service.
Supervisor of nursing home care.

The assistant director is responsible for the activities of the following divisions within the hospital: Supply, engineering, housekeeping, medical administration, fiscal, personnel. Division chiefs of these services are also considered to be centralized positions, and appointments and transfers are approved in central office. Appointments and transfers of assistant chiefs of the administrative services must have the concurrence of the head of the service in central office.

Other personnel functions involving the Department of Medicine and Surgery are the responsibility of the Assistant Administrator for Personnel.

Every effort is made to have the top echelons in the hospitals, especially the laymen, enhance their education in hospital administration. Of those now on duty as directors, chiefs of staff, and assistant directors (303 in number) 47 have become fellows of the American College of Hospital Administrators—73 are members and 28 are nominees. This number is gradually increasing. In the same group, 26 hold M.A. degrees in hospital administration, and all but one of these are nonmedical personnel.

MEDICAL ADMINISTRATION SERVICE

The activities of this service are primarily concerned with administrative procedures involving the admission, treatment, discharge or transfer of all patients.

These duties were originally performed in part by a clinical clerk. Following World War II, the service was renamed registrar service, and recently has been again changed to medical administration.

The duties have been considerably expanded since the days of the clinical clerk, especially with the introduction of the medical record library staff. (A distinction should be made between this staff and the medical library—the latter is part of the library service, a section of the professional services which provides librarian reference assistance.)

The medical records librarian, however, is responsible for the analysis and classification of patient treatment records, keeping them readily available for the use of the medical staff, including residents.

The interviewing of the applicant for hospitalization is a highly important assignment. Much personal information is solicited and this requires extreme tact on the part of the interviewer. This is conducted in the greatest possible privacy.
Upon admission, proper disposition is made of the patient's valuables, if he so desires. Depending upon the nature of his disability and the probable length of treatment, clothing is either stored or he is allowed to take it to the ward.

The medical administration service staff interviews veterans applying for hospitalization; determines their eligibility, and, if a physical examination reveals the necessity for hospitalization, handles the arrangements to transport the patient to the appropriate ward where a bed is available.

After the veteran patient is admitted to the ward, and treatment has begun, all clinical records are kept on the ward. Upon discharge, either to another institution or to the care of his own private doctor, a summary of his treatment is forwarded by the medical administration service. When treatment is completed, the patient's folder is sent from the ward to the medical record section in the hospital for analysis by a medical record librarian. This information is coded and forwarded to a centralized computer system located at the Data Processing Center, Hines, Ill. This information bank regarding patient treatment is most important to researchers, medical residents, and professional staff, including those located in the VA central office in Washington, D.C. For example, a VA physician in Boston doing research on pulmonary emphysema may desire to have the complete diagnosis and treatment records of a sampling of patients who have been treated in VA hospitals. He can request this information from the center at Hines.

Medical administration service is also charged with the following duties:

Provides clerical and stenographic assistance to all wards and professional services;

Furnishes and arranges for transportation to and from the veteran's home, when required. This factor is also included in outpatient treatment in VA clinics;

Provides messenger service throughout the hospital, mail service, telephone service, pneumatic tube and teletype service.

The medical records librarian staff is a fairly recent addition, having originally been placed in the research service. This staff will undoubtedly play an important part in medical administration service when the automated hospital information system is perfected.

**BUILDING MAINTENANCE SERVICE**

Until 1954, housekeeping or custodial responsibility in VA hospitals was divided among several elements of the staffs, with the nursing service having the major responsibility for the wards and other patient care areas. But in line with a policy of relieving professional medical personnel of nonmedical responsibilities, the establishment of separate housekeeping divisions was approved by the Chief Medical Director in June 1954. These divisions were limited to cleaning and protective care of building interiors.

Since 1954, the housekeeping service has been enlarged to include not only the cleaning but the sanitation and protective care of interiors; interior decoration; and the operation of the living quarters of those physicians, nurses, and other personnel who live on VA premises.
As for interior decoration, a hospital by its nature is primarily functional, but it need not be severe in appearance, or forbidding in atmosphere. Color schemes, furnishings, floorings, and draperies—all of which can have psychological effects—should be as pleasing as possible for the patients, their visitors, and the members of the staff. A studied rather than a haphazard effort is undertaken to make VA hospital wards, corridors, offices, chapels, libraries, and other areas attractive. Expert decorators staff an interior decoration division in the Washington office of housekeeping service. This service—a postwar departure from the prewar spartan approach to VA decoration—feeds the entire VA system with decorating ideas and plans which are adaptable to individual hospitals, domiciliaries, and clinics.

ENGINEERING SERVICE

Until the reorganization of the Veterans' Administration in 1953, following the recommendations of the management consultant firm of Booz, Allen & Hamilton, what is now the engineering service was under the jurisdiction of the Assistant Administrator for Construction, Supply, and Real Estate.

In consonance with the philosophy that the Department of Medicine and Surgery be responsible for a complete hospital service, it was obvious that engineering was a vital part of the operation. As the name implies, this service is responsible for engineering activities in all hospitals, containing in excess of 8,000 buildings with about 119 million square feet of floor area, and covering approximately 25,000 acres of land. These services must cover such diversified items as powerplants, roads, walks, grounds, sewage, water and electrical systems, refrigeration and air-conditioning plants, innumerable items of specialized equipment, laundries, safety and fire protection, transportation and communication systems, radio and television facilities.

The physical plant for which the engineering service must insure adequate maintenance and operation has a current replacement value of around $375 million. Maintenance and operation of this plant involves an annual expenditure of $125 to $130 million—about 10 to 20 percent of the total medical care appropriation—and employs more than 11,000 people, ranging in skills from laborers to professional engineers.

These responsibilities are carried out by a central office engineering service which provides overall direction to the program, and by an engineering division at each field station. Each field station division is headed by an engineer officer; the majority of these are classified as professional engineers. Engineering personnel are most important members of the treatment team: if the heating system breaks down, electricity goes off, or there is improper wiring—these, and many other phases of the engineering service—have a direct bearing on the comfort and well-being of the patients.

SUPPLY SERVICE

The annual supply expenditures for the Veterans' Administration, including payments to public utilities for water, gas, and electricity, approximate $170 million a year, and supply employees total more than 3,200.
The supply service has the following responsibilities to all VA departments:

- Purchase, storage, and distribution of all equipment and supplies for all the agency's activities;
- Accountability for all VA property, other than real estate, and for auditing of property accounts;
- Operation and management of supply depots;
- Contracts, leases, and agreements with all contractors (except construction contractors) with whom the agency conducts business.

VA supply depots are located at Somerville, N.J., Hines, Ill., and Wilmington, Calif. The storage facilities at these depots make possible the bulk purchase of hundreds of items at favorable prices.

There are 165 supply divisions (small, local depots) located mainly in VA hospitals. These furnish supplies to 257 VA installations throughout the United States, the Republic of the Philippines, and the Commonwealth of Puerto Rico.

The supply service, through the VA depots and national VA contracts, also furnishes supplies to hospitals of the Department of Health, Education, and Welfare, and provides support and counsel of various kinds to other Federal agencies.

To specifications and quantities ordered by the pharmacy service, supply procures and distributes drugs, biologicals, and chemicals. It purchases and stocks nonperishable foods for the dietetic service, and arranges with National, State, and local sources for about 45 million pounds of meat, fish, poultry, and eggs a year; 85 million pounds of milk and milk products; 6 million pounds of butter and other fats; 80 million pounds of vegetables and fruits; 19 million pounds of bread and cereal products; and 16 million pounds of such miscellaneous foods as condiments, coffee, and tea.

For Thanksgiving Day in VA hospitals and domiciliaries, it purchases about 125,000 pounds of turkey.

Except for real estate and construction materials, supply service purchases everything the Veterans' Administration needs—from rubber bands and paper clips to the linear accelerators and betatrons used in the radiology service.

BUDGET SERVICE—DEPARTMENT OF MEDICINE AND SURGERY

With the establishment of the Department of Medicine and Surgery in 1946, a budget division was organized as part of the Department's program analysis staff. The budget division served in liaison capacity to agency staff officials on financial management matters affecting the Department. In 1954, major decentralization of financial management responsibilities to departments resulted in the dissolution of the budget division and establishment of a budget service in the newly formed office of the Comptroller, Department of Medicine and Surgery. Concurrently an annual budget program system of operation was adopted by the Department, which gave field station heads broad authority and direct responsibility to manage their activities and accomplish their medical mission within a specified annual dollar allocation.

The annual dollar amounts or budgets allocated to field stations have been and continue to be predicated on budget estimates developed at the field station, as adjusted by Central Office and Bureau of the
Budget review, and action of the Congress. Increased demands for medical treatment and care of eligible beneficiaries, along with advances in treatment techniques, higher salaries, and the increased cost of supplies, have resulted in steady growth in annual appropriations required for the operation of Veterans' Administration medical programs. For example, $502,556,000 was obligated in fiscal year 1947 for all agency medical programs, compared to $1,323 million appropriated and available for obligation in fiscal year 1967.

In 1947, the hospitals were caring for an average of 85,415 patients per day, whereas this number is expected to reach 107,292 per day in fiscal year 1967. Likewise, the average daily cost per patient, of all types, rose from $10.33 per day in fiscal year 1947 to an estimated $26.90 in fiscal year 1967.

In comparing the cost of medical care in VA hospitals with those of the community hospitals, one must consider that the overall expense includes the services of the doctors and other special personnel. However, medical costs are mounting, either within or outside hospitals in any category, and the Congress has continually appropriated sufficient funds for the continuance of the highest type of medical care in VA hospitals.

VETERANS' CANTEEN SERVICE

The veterans' canteen service was established in 1946 as an independent instrumentality within the Veterans' Administration. The legal provisions for it are chapter 75 of title 38, United States Code—the collection of laws on veterans' benefits.

The canteen service was given an original allotment of $4,965,000. The $965,000 proved to be inadequate to support the service, and the $4 million was eventually returned to the U.S. Treasury. With an annual gross of $60 million, the service pays all its expenses (including the salaries of its officials and employees), reimburses the Veterans' Administration for floor space and utilities, and maintains a reserve for contingencies.

To carry out the intention of Congress, an organization was established within the Department of Medicine and Surgery, consisting of the veterans' canteen service, in the central office, Washington, D.C., canteen service field offices at five locations throughout the country, and canteens at VA hospitals and domiciliaries. The employees at the hospital level are not classified civil service employees, but are eligible for the standard civil service fringe benefits, such as retirement, etc.

The primary purpose of the canteen service is to make available to hospitalized veterans and to members of VA domiciliaries reasonably priced merchandise and services essential to their comfort and well-being. Its secondary purpose is to provide food services for employees of the Veterans' Administration.

VA canteens include retail stores, cafeterias, snackbars, vending machines, barbershops, and other service activities. They sell tobacco products, candies, toiletries, haberdashery, magazines and books, and such sundry items as writing paper, postcards, photographic film, and inexpensive snapshot cameras.

Among the many services the program provides are: scheduled visits of ward carts to the bedsides of nonambulatory patients; a program of self-selection of clothing by patients. If the patient...
is without funds of his own, necessary clothing is paid for by the
Government funds.

HOSPITAL CONSTRUCTION

The selection of a site for a new hospital is the joint responsibility
of the Department of Medicine and Surgery and the office of the
Assistant Administrator for Construction. Generally, these sites are
near a medical school for close affiliation between the Veterans' Ad-
ministration and the medical school.

The master plan for the hospital is developed by the Department
of Medicine and Surgery. This is a comprehensive listing of all the
facilities contained in the building, together with the area require-
ments for each service, room by room.

After full coordination with the interested VA offices, the master
plan is forwarded through the Administrator to the Bureau of the
Budget for Presidential approval. Upon approval of that office, the
preliminary design is undertaken by the Assistant Administrator for
Construction, on the functional aspects, with participation by the
Department of Medicine and Surgery.

The Office of Construction then advertises and awards a contract
for the development of the working drawings and specifications to a
private architectural-engineering firm. Reviews are made period-
ically during this development. Upon completion of this phase, the
Office of Construction advertises again for a general contractor and
awards the construction project to the low bidder. During the entire
construction phase, a representative of the Assistant Administrator
for Construction—a superintendent of construction—is on duty at
the site.

VA hospitals include many features and facilities not generally
found or included in the typical community hospital. Some of these
are—

More extensive, multipurpose recreational facilities, including
 provision for motion pictures, radio control studio, patient ac-
tivity rooms, et cetera. In hospitals which include a large num-
ber of neuropsychiatric bed facilities, a therapeutic pool and
exercise areas, along with a separate theater, bowling alleys and
billiards, are provided. These facilities are necessary because of
the longer period of hospitalization for these patients.

Library services.

Chaplain services.

Congregate dining room facilities for ambulant patients.

Extensive physical medicine and rehabilitation facilities, in-
cluding physical therapy, corrective therapy, occupational ther-
apy, and manual arts, educational, and industrial therapy.

Canteen service, which provides a complete cafeteria, along
with a retail store for patients and staff.

Large storage areas for medical and subsistence supplies, which
are carried on a 90-day stock level.

In section 101 of the Servicemen's Readjustment Act of 1944 (GI
bill) there was provided authorization of $500 million for hospital
construction. Following the enactment of this bill, Administrator
Hines and his staff, in collaboration with the Federal Board of Hos-
pitalization, submitted to the President a program covering the
hospital needs up to and including June 30, 1947. This plan not
only included new construction but additional and modernization of
existing hospitals. It was approved by the President on September 12, 1944, and General Hines was authorized to submit a construction program totaling 14,100 beds for the fiscal year ending June 30, 1946. This was expected to provide for 18 new hospitals and expansion of 12 others.

An appropriation for hospital construction of $84,500,000 was enacted into law—Public Law 49, 79th Congress, May 3, 1945. Thereafter, the authorization under the GI bill of $500 million was divided into yearly appropriations for construction of new hospitals under General Bradley and General Gray. With adequate funds available, the spaciousness and architecture of these hospitals changed considerably; there are shown five examples of the type of hospital planned at that time.

In addition, a picture of the new Washington, D.C., Veterans' Administration Hospital is included. The old hospital had been on the list of replacement hospitals required longer than any hospital in the service, having been acquired when the Public Health Service hospitals were transferred to the Veterans' Bureau in 1922. There is also a picture of the dedication of this new hospital, held in April 1945, at which Vice President Hubert H. Humphrey was the principal speaker.

Veterans Administration Hospital (Research), Chicago, Illinois, 1953.
Veterans Administration Hospital, New York, N.Y., 1954.

Veterans Administration Hospital, Big Spring, Texas, 1950.
Veterans Administration Hospital, Salt Lake City, Utah, 1952.

Veterans Administration Hospital, Washington, D.C., 1965.
Mt. Alto Veterans Administration Hospital, Washington, D.C. Acquired by the Veterans Bureau in 1922. Closed in 1965 when new VA Hospital in Washington, D.C. was opened.

The Honorable Hubert H. Humphrey, Vice-President of the United States, on the occasion of the Washington, D.C. Veterans Administration Hospital Dedication, April 28, 1965.
CHAPTER XII. OTHER FACTORS IN VETERANS CARE

CONGRESS AND THE AMERICAN VETERAN

Legislation relating to veterans has played an important role in the activity of every Congress since the founding of the Nation. Both the Senate and the House have always felt a special responsibility for those who served their country.

Suggestions for needed legislation may originate with members of Congress themselves, from the Veterans' Administration, the various service organizations, or from interested private citizens. The latter two enlist the interest of a Senator or a Congressman to introduce a bill for whatever benefit or change in the basic law they believe warranted.

When such bills are presented, they are referred to the appropriate standing committee of either the Senate or the House. A standing committee is appointed or elected at the beginning of each session in accordance with the Legislative Reorganization Act of 1946, as indicated hereafter. It is given jurisdiction for consideration of proposed legislation within its scope of responsibility, such as the present House Veterans' Affairs Committee. One exception is the handling of appropriations for all Government departments, which is within the purview of the Appropriations Committees of both the Senate and the House. Agency estimates of financial requirements are first submitted to the Bureau of the Budget and, as approved by them, they are included in the President's annual budget message. Supplemental appropriations are submitted to the President, after coordination with the Bureau of the Budget, for transmittal to the Appropriations Committee of the House.

Other than these appropriation bills, the majority of legislation, especially if it involves veterans, is first considered by the House Veterans' Affairs Committee, which decides whether or not hearings will be held. Prior to this, the recommendation of the agency concerned is requested, as well as that of the Bureau of the Budget, to determine whether it is in line with the programs of the President.

On the Senate side, matters pertaining to veterans affairs, other than appropriations, are considered either by the Committee on Finance or the Committee on Labor and Public Welfare.

The jurisdiction of the Finance Committee includes: (1) veterans' measures generally, (2) pensions of all the wars of the United States, either general or special, (3) life insurance issued by the Government on account of services in the Armed Forces, and (4) compensation and pension of veterans.

The Committee on Labor and Public Welfare is charged with consideration of: (1) vocational rehabilitation and education of veterans, (2) veterans' hospitals, medical care and treatment of veterans, (3) soldiers and sailors civil relief, and (4) readjustment of servicemen to civil life.

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After Committee action and passage by one House of the Congress, the proposed legislation is referred to the appropriate committee in the other House. If there is favorable action by both Houses, the bill is then presented to the President for signature into law. If there is disagreement, conferees are appointed to resolve the differences of both houses.

Other Senate and House committees which have jurisdiction over certain matters affecting all departments and agencies of the executive branch of the Government may also be interested in all or particular phases of the programs and operations of the Veterans' Administration.

With but one committee on the House side devoting its entire time to veterans' affairs, it is only natural that there is a very close liaison between their members and staff and the Veterans' Administration. This relationship and close cooperation has facilitated the enactment of much legislation most beneficial to our veterans. The same spirit pervades in the contact with the Senate committees.

To insure prompt service to Members of Congress, the VA maintains congressional liaison offices in both the offices of the Senate and the House. Their functions are to render rapid services to Members of Congress on every phase of veterans' affairs.

The House Veterans' Affairs Committee has an imposing list of forebears. The First Congress relied mainly on the Committee of the Whole House for developing general principles of veteran legislation and referred them to numerous select committees to perfect the details.

Inasmuch as pension was the only benefit provided veterans at that time, the first standing committee to consider pension legislation was called the Committee on Claims, created November 13, 1794. It shares with the Committee on Elections the distinction of being the oldest standing committee of the House.

From then on for the next 130 years, one House committee would be formed, then abolished and succeeded by another, with jurisdiction and name changed. However, all had the same primary purpose—veterans' affairs.

Following World War I, a great many bills providing benefits for veterans were passed by the Congress. At the insistence of the leaders who had participated in World War I, and supported by friends both in and out of Congress, the Committee on World War Veterans' Legislation was created at the beginning of the 68th Congress, on January 18, 1924. This committee, however, did not have jurisdiction over all veterans' legislation. The Committee on Pensions considered proposals relating to pensions for veterans of the Spanish-American War, the Philippine Insurrection, and the Boxer Rebellion. The Committee on Invalid Pensions had jurisdiction over pensions of veterans of all the wars of the United States other than those assigned the Committee on Pensions.

Thus, while the Committee on World War Veterans' Legislation passed upon the requirements of the Veterans' Bureau, the Committee on Military Affairs, in both the House and the Senate, had jurisdiction over the legislation affecting the National Home for Disabled Volunteer Soldiers. The requirements of the Pension Bureau (except Civil War pensions) were handled by the Committee on Pensions in both the House and Senate. Civil War pensions were within the jurisdiction of the Committee on Invalid Pensions of the House and the Committee on Pensions of the Senate.
Even with the consolidation in 1930 of the Veterans' Bureau, the National Home for Disabled Volunteer Soldiers, and the Pension Bureau, with only minor changes in committee jurisdiction this situation remained the same until the onset of World War II.

A conflict arose as to the jurisdiction of benefits between the House Committee on Invalid Pensions and the Committee on World War Veterans' Legislation. On January 6, 1943, House Resolution No. 29, 78th Congress, first session, was introduced by Hon. John E. Rankin, then chairman of the Committee on World War Veterans' Legislation. This granted jurisdiction to his committee of all compensation, allowances, and pensions for veterans of World Wars I and II, and all legislation affecting them, other than civil service, public lands, and adjusted compensation. This resolution was agreed to on January 24, 1944.

Public Law 601, the Legislative Reorganization Act, passed August 2, 1946, made material changes in the rules of the House and the Senate. This law made material changes in the titles and jurisdiction of standing committees of both the House and the Senate.

In the Senate, the Committee on Finance was given jurisdiction over proposed legislation concerning VA affairs for Senate consideration, as follows: "veteran measures generally; pensions of all wars of the United States, general and special; life insurance issued by the Government on account of service in the Armed Forces; compensation of veterans." Senator Russell B. Long is chairman of this committee.

The Senate Committee on Labor and Public Welfare is charged with the consideration of the following proposed legislation presented to the Senate: (1) vocational rehabilitation and education of veterans, (2) veterans hospitals, medical care and treatment of veterans; (3) soldiers and sailors civil relief; and (4) readjustment of servicemen to civil life. Senator Lister Hill is chairman of this committee.

In the House of Representatives, the Committee on Veterans' Affairs was created with the following jurisdictions: (1) veterans' measures generally; (2) compensation, vocational rehabilitation, and education of veterans; (3) life insurance issued by the Government on account of service in the Armed Forces; (4) pensions of all the wars of the United States, general and special; (5) soldiers' and sailors' relief; (6) veterans hospitals, medical care and treatment of veterans; and (7) readjustment of servicemen to civil life.

The appropriations for the Veterans' Administration continue to be handled by the committees or subcommittees on appropriations in both Houses.

The Legislative Reorganization Act also empowered the Comptroller General to make analyses of the expenditures of each agency to determine whether public funds have been economically and efficiently administered and expended, with reports of their findings submitted to both Houses of Congress.

Each of the congressional standing committees has permanent professional and clerical staffs. It is the good fortune of the VA that staffs to the committees considering veterans' affairs are thoroughly familiar with the operation and policies of the VA and the needs of the veterans. The chairman, many members and the staff of the Committee on Veterans' Affairs, are especially qualified in this respect inasmuch as their jurisdiction covers the entire gamut of veterans' benefits and they have had long experience in dealing with the problems
of the ex-serviceman. They, as well as the entire committee, have accomplished much in improving the medical care of the American veteran. To them, the VA staff is indeed grateful for their perception and cooperation in solving the problems of an organization of approximately 160,000 employees serving over 21 million veterans.
Senator Russell B. Long

Russell B. Long was born November 3, 1918, in Shreveport, La., the son of Huey P. and Rose (McConnell) Long. His father was Governor of Louisiana, as well as U.S. Senator. He graduated from Louisiana State University in 1941 with a B.A. degree, and the next year received the bachelor of laws degree. He then enlisted in the U.S. Navy as an apprentice seaman for World War II duty. After training at the midshipmen's school at Columbia University, he was commissioned an ensign and entered the amphibious service of the Navy. He was given command of a landing craft which took part in the invasions of north Africa, Sicily, Anzio, and southern France. His record in these campaigns brought him four battle stars. He was discharged from the Navy in November 1945 with the rank of lieutenant.

He then returned to Louisiana and opened a law office in Baton Rouge. When his uncle, Earl Long, became Governor of Louisiana, he appointed his nephew as executive counsel. In this capacity he assisted in establishing a program which included an old-age pension system, free school lunches, higher salaries for teachers, a veterans' bonus, and capital improvements for the State.

He had served only 2 months as executive counsel when Senator Overton of Louisiana died, leaving 2 years of his term unfilled. Since Long had not yet attained the legal age of 30 required of a Senator, his uncle made an interim appointment to the post. Upon reaching the required age, he was elected for the balance of the interim appointment of 2 years, and to the Senate, following the November election of 1948, making him the youngest U.S. Senator.

Among Senator Long's accomplishments were the authorship of the pay reclassification bill for Federal employees, passed in September 1949, which included a number of incentive proposals designed to inspire workers to economy measures.

He was returned to the Senate following the 1950 elections for a full term. Among his committee assignments was an appointment to the Armed Services Committee and, later, to the Committee on Finance, the chairman of which was Senator Harry F. Byrd, Sr. Upon his death in 1966, Senator Long, the ranking member, became chairman. Being a veteran himself, he has been most sympathetic, as have the members of the committee, to the financial needs of the veteran, and has supported legislation to liberalize pension and compensation for them.
Senator Lister Hill
THE SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

Senator Lister Hill

Senator Lister Hill has a long and distinguished record as a representative of the Senate.

He was born at Montgomery, Ala., on December 29, 1894, the son of Dr. Luther L. Hill, a noted surgeon, and Lily (Lyons) Hill.

He received his B.A. degree from the University of Alabama in 1914 and an LL.B. in 1915. He also took special courses in law at the University of Michigan and at Columbia University, where he received a second law degree.

He returned to Montgomery and began the practice of law. He became president of the board of education at age 22 and continued in that position for 5 years.

He enlisted in the U.S. Army on August 7, 1917, and served until January 1919, being discharged as a first lieutenant.

Senator Hill has long maintained a deep interest in military and medical affairs. These interests have made him an extremely valuable chairman of the Committee on Labor and Public Welfare, especially in considering legislation involving the medical care of the veteran. He was chairman of the House Military Affairs Committee.

Among the many honorary fellowships and awards he has received are several from medical associations.

He was elected to the House of Representatives, 68th Congress, on August 14, 1923, and served through the 76th Congress. In 1937, he was elected to the Senate, where he is still serving.

He is a member of the Appropriations Committee of the Senate, and chairman of the Appropriations Subcommittee that handles health and medical research funds. He is also chairman of the Senate Labor and Public Welfare Committee. He is keenly interested in the medical program of the VA and in medical research, receiving the Albert Lasker Award in 1959.

Senator Hill was one of the authors of the GI bill of rights for World War II and Korean conflict veterans.
Congressman Royal C. Johnson
Royal Cleaves Johnson

Upon creation of the House Committee on World War Veterans' Legislation, Congressman Royal C. Johnson of South Dakota was appointed chairman. He served in this capacity from 1924 until 1931.

He was born in Cherokee, Iowa, October 3, 1882, the son of Eli and Philena (Everett) Johnson.

When 5 months old, he and his family moved to Highmore, S. Dak. After graduation from the University of South Dakota, with a degree in law, he practiced in Highmore, S. Dak. He served as deputy State's attorney, 1906-09, State's attorney, 1909-10, and attorney general of South Dakota from 1911 to 1915. He was elected to the 64th Congress and to the eight succeeding Congresses—March 4, 1915, to March 3, 1933.

During World War I he tendered his resignation, which was not entertained, whereupon he absented himself from the House and enlisted in the Army on January 5, 1918, as a private. He advanced to sergeant, second lieutenant, first lieutenant, and was discharged December 20, 1918. He was wounded at Mont Faucon, in the Meuse-Argonne attack on September 27, 1918. The Distinguished Service Cross was awarded him by the U.S. Government and the Croix de Guerre with gold star by the Republic of France.

He returned to Congress in 1919 and remained there until 1933, after which he practiced law in Washington until his death August 2, 1939. In his memory, Congress in 1945 authorized naming the VA hospital in Sioux Falls, S. Dak., the Royal C. Johnson Veterans' Memorial Hospital. In that same year, Congress authorized that the VA hospital at Montrose, N.Y., be named in memory of President Franklin D. Roosevelt, to be known as the Franklin Delano Roosevelt Hospital. These are the only two VA hospitals named as memorials to individuals.

*Chairman, House Committee on World War Veterans' Legislation, 1924-31.
John Elliott Rankin was born in Boland, Miss., March 20, 1882. He graduated in law from the University of Mississippi in 1910 and was admitted to the bar the same year. He practiced law in West Point, Miss., and Tupelo, Miss., becoming prosecuting attorney of Lee County, Miss. He was also engaged as a lecturer and newspaper writer. He served in the U.S. Army during World War I.

He was elected to the 67th Congress and the 15 succeeding Congresses, serving continuously from March 4, 1921, to Jan. 3, 1953. Upon assuming chairmanship of the Committee on World War Veterans' Legislation, he was known as an ardent advocate of proposals for the betterment of veterans' care and welfare.

Many knotty problems were laid before this committee and during his chairmanship there occurred many of the most critical situations in the history of veterans' benefits: the depression, the bonus march, the Economy Act, the onset of World War II and formation of plans for returning veterans, the unfavorable publicity on medical care, with the resulting investigation and the reorganization of the Veterans' Administration under General Bradley and General Hawley.

Regardless of political affiliations, he was most forthright in his views as to what was best for the veteran. He assailed the Presidential veto of the bonus bill. He attacked the Economy Act and was instrumental in its repeal. It was said of him that many a Republican gave more support to a Democratic administration than he did.

He was successful in securing legislation providing pensions for widows, children, and dependent parents of veterans dying from non-service-connected disabilities. He sponsored the bill providing for a flag to drape the casket of honorably discharged veterans.

Congressman Rankin's most valuable contribution to the veteran was the passage of the so-called GI bill. It had its origin in January 1944 in identical bills introduced in both the Senate and the House. The Senate, after amending it slightly, approved it. The House Committee on World War Veterans' Legislation, however, did not report it to the House until early in May 1944. The following month, it was approved by that body with a House vote of 372 to 0. The delay in the committee was primarily due to Congressman Rankin's opposition to the provision for unemployment benefits ("52-20 club"). It believed it would make idleness more attractive than jobs. Another cause of delay was Rankin's addition to the bill calling for furnishing of artificial limbs and funds to be used for training in their use. Additionally, he objected to the proposed limitation of $500 million for new hospital construction. He said, "We may need more." It was changed to authorize such appropriations as may be necessary.

In 1947, he relinquished the chairmanship for 2 years, but was re-appointed in the 81st and 82d Congresses.

He then returned to Tupelo and resumed his law practice. He was also interested in real estate and farming.

For 18 years he was the champion of veterans' benefits. A rather small man, white-haired and wiry, words of all sorts came easy to him. Vigorous, apparently tireless in his efforts to improve the lot of the veteran, he earned a prominent spot in the history of the care of those who served. He died November 26, 1960.

Chairman, House Committee on World War Veterans' Legislation 1931-46, and chairman, House Committee on Veterans' Affairs 1940-52.
When she first took her place in the 69th Congress, veteran lawmakers predicted her congressional career would be brief. First, she was serving out the unexpired term of her deceased husband, John Jacob Rogers, one of the most popular members of the Massachusetts delegation. Second, she had to live down the fact that few women had made their mark in a male-dominated Congress.
Her fellow legislators received a surprise when the smartly dressed, agile, sharp-eyed lady from Massachusetts suddenly began to display a talent for bobbing up aggressively and speaking her mind. While there have been other women in the Congress both able and energetic, few have been as effective and none revealed such initiative in dealing with issues of national and even international importance.

Mrs. Rogers was no novice in the field of public service. She had to her credit many years of service devoted to war veterans' welfare. She had an extraordinary grasp of their needs and problems.

In her early life, she had lived in her native town of Saco, Maine, a mill town. She became thoroughly acquainted with the textile industry and, later, she worked tirelessly for tariff laws helpful to the millowners as well as for legislation beneficial to the millhands and their families.

She received her education at the Rogers Hall School in Lowell, Mass., and Madame Julian's School in Paris. She married John Jacob Rogers in 1907. He was elected to the 63rd Congress and served from March 4, 1913, until his death in 1925, with the exception of a period of military service in 1918.

At the outbreak of World War I, Mrs. Rogers volunteered for civilian service overseas and was sent to France in 1917, where she engaged in work for the YMCA and the American Red Cross. Later, as a Red Cross worker she served at U.S. Army Walter Reed Hospital, Washington, D.C., from 1918 to 1922.

Her service on behalf of the disabled veteran became so well known that President Harding asked her to be his personal representative in charge of assistance to them. She was successively named by President Coolidge and President Hoover to the same post. She visited many veterans' hospitals during this time and gained valuable insight into the care of the ex-serviceman. Upon entering Congress, it was only natural that her talents could be best used as a member of the Committee on World War Veterans' Legislation—later the Committee on Veterans' Affairs—where she served for 36 years, twice during that time as chairman of the committee.

Mrs. Rogers, through her work with veterans, became very popular with ex-servicemen's organizations and continued until her death to be respected by them. In later years, when she attended their meetings or dinners, she usually preceded her talk by saying, "The Old Gray Mare; She Ain't What She Used To Be." This grew to be her theme song, and was played in her presence whenever possible.

She was the first woman Member of Congress whose name has been attached to a major piece of legislation. She introduced bills providing pensions for widows of veterans and for the establishment of the Women's Army Civilian Corps.

A beloved lady, a real friend of the veteran, died in 1960 and will long be missed by all who had the privilege of knowing her.

Note—Mrs. Rogers was succeeded by F. Bradford Morse of Massachusetts, who left his position as Deputy Administrator of Veterans' Affairs to run for that seat.
Olin Earle Teague, Chairman, House Committee on Veterans' Affairs, 1965 to date.

Olin E. Teague was born April 6, 1910, the son of James M. and Ida (Sturgeon) Teague, at Woodard, Okla. He graduated from the Texas Agricultural and Mechanical College at College Station, Tex., in 1932. After completion of his studies he was employed in the U.S. post office at College Station, from 1932 to 1940, resigning as superintendent of the post office.
He volunteered for duty with the U.S. Army in October 1940 and was commissioned a first lieutenant. Previously, he had served for 3 years as an enlisted man in the National Guard. During World War II he saw action as commander of the 1st Battalion, 314th Infantry, 79th Division. He was in combat for 6 months and wounded several times. During the attack on the Siegfried line in southern Germany, he suffered shrapnel wounds that necessitated removal of a portion of his left ankle. He was discharged with the rank of colonel at Walter Reed Hospital in September 1946.

He holds 11 decorations, among which are the Silver Star with two clusters, the Purple Heart with two clusters, the Army Commendation Ribbon, and the Croix de Guerre with palm.

Upon leaving Walter Reed Hospital he was elected in September 1946 to the Congress to fill a vacancy created by the resignation of Luther A. Johnson. Soon after taking his seat in the Congress, in the 1948 elections he was chosen Representative to the 80th Congress. He has continuously been re-elected since that date.

In 1947, as a member of the subcommittee of the House Foreign Affairs Committee, he toured the frontier regions of Greece with other members of the group. During the fighting between the Greek Army and guerrilla forces, he was cut off for several days from the Government-held region and was under fire.

Since taking his seat in the House of Representatives, he has served as a member of the House Veterans' Affairs Committee, and was elected chairman in 1955, which office he has held to date.

His record is replete with the authorship of much beneficial legislation on behalf of the veteran, especially those disabled.

Assignments other than chairman of the Committee on Veterans' Affairs are: He is a second ranking majority member of the Committee on Science and Aeronautics, chairman of the Subcommittee on Manned Space Flight, and of the Subcommittee of the Legislative Committee on Oversight.

He is especially interested in the U.S. relationship with the Philippine Republic, and is a member of a panel of a joint commission appointed to study problems involving benefits to Philippine veterans of World War II. He also served with the American-Philippine Assembly, a group of distinguished American financiers, attorneys, and other high ranking Government officials, who met in the Philippines in February 1966 with their Philippine counterparts.

He has been a member of the West Point Board of Visitors for 11 years, being a continuing member longer than any other member. He has served two consecutive terms as president of the Texas State Society, one of the largest State societies in Washington.

He holds a number of distinguished service awards, in addition to those received from the military, including decorations from practically all of the ex-servicemen's organizations, his alma mater, and CARE.

He is a stocky, gray-haired gentleman, with a very pleasant personality and extremely adept in remembering those whom he has previously met casually, and able to call them by name.

Chairman Teague headed the select committee investigating abuses under the World War II GI bill of rights, which led to the enactment of a new bill with an entirely different administrative approach for the Korean conflict veterans. This was Public Law 82-550. He also served as a member of a select committee which led to the enactment of the Servicemen's
and Veterans' Survivor Benefits Act, Public Law 84-881. In addition to his other congressional activities, he was a member of the Committee on the District of Columbia for a considerable period of his congressional service.

He has also sponsored an increase in the number of nursing home type beds in VA, bringing it to a total of 4,000. There are many other benefits which have had prompt action due to the energetic interest of "Tiger" Teague.

MEDICAL CARE FOR U.S. VETERANS RESIDING OUTSIDE THE CONTINENTAL LIMITS OF THE UNITED STATES

HAWAII AND ALASKA

The Veterans' Administration does not have hospitals in either of these States, but utilizes to a great extent the existing Federal hospitals located in each, and, to a lesser degree, contract hospitals. In the Federal hospitals, the eligibility requirements are the same as in other VA hospitals. However, contract hospitals may be utilized for service-connected cases only.

Prior to attaining statehood, both Hawaii and Alaska could use contract hospitals for indigent non-service-connected veterans, as well as for those suffering from service-connected disabilities.

In Hawaii, the U.S. Army Tripler Hospital, Honolulu, is the facility most used. In Alaska, several Federal hospitals are used, with the Elmendorf Air Base Hospital being used most frequently.

PUERTO RICO

The VA, in 1946, took over the San Patricio Hospital in San Juan, P.R., on a revocable permit from the U.S. Navy. It is part of the VA hospital system, but contains only 200 beds. It became necessary, therefore, to use a number of contract hospitals—approximately 18 in 1966.

Differing from the VA hospitals located in the States, the indigent non-service-connected veteran may be hospitalized in a contract hospital. A new hospital is now being erected which will contain 720 beds, and this will undoubtedly eliminate the use of contract hospitals.

Outpatient services for the service-connected veterans are available in Alaska through the regional office at Juneau. Fee-basis physicians are used entirely for this service.

In Hawaii, a clinic is located in the regional office at Honolulu for this purpose.

In Puerto Rico, the outpatient clinic is located in the VA hospital.

FOREIGN COUNTRIES

At the present time, there are 4,547 veterans residing in other parts of the world who are being paid compensation for their service-connected disabilities and therefore are potential hospital or clinic patients. They are located as follows:
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<tr>
<th>Region</th>
<th>Number of Veterans</th>
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<tbody>
<tr>
<td>Europe</td>
<td>1,780</td>
</tr>
<tr>
<td>Australia</td>
<td>250</td>
</tr>
<tr>
<td>Africa</td>
<td>60</td>
</tr>
<tr>
<td>Central America</td>
<td>95</td>
</tr>
<tr>
<td>Asia</td>
<td>278</td>
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<tr>
<td>West Indies</td>
<td>67</td>
</tr>
<tr>
<td>North America</td>
<td>1,303</td>
</tr>
<tr>
<td>Other countries</td>
<td>549</td>
</tr>
<tr>
<td>South America</td>
<td>165</td>
</tr>
</tbody>
</table>

1 60 percent reside in Italy and Greece.
2 Other than United States.

In addition to the above, 26,360 veterans and dependents living abroad are drawing pension or dependents' benefits. This group is not entitled to hospital care at Government expense. If hospitalization is indicated, an application is made to the U.S. Embassy in the country of the veteran's residence and, with the exception of the countries of western Europe, request for eligibility is submitted to the Washington, D.C., regional office, where there is established a unit to handle foreign and insular affairs.

In the countries of Western Europe, where the majority of service-connected veterans maintain their residences, the request for eligibility is sent to Rome, Italy, where an office to handle veterans' affairs for this area has been established.

If eligible, and hospitalization is required, the veteran is authorized to receive treatment in a local hospital at the expense of the Veterans' Administration.

**The Philippines**

As early as the fiscal year 1923, the Veterans' Bureau established an office in Manila to provide service to U.S. war veterans residing in the Commonwealth of the Philippines. It was later made a regional office and continues as such to the present. There were comparatively few World War I veterans in that part of the world at the time, as little or no action of the First World War occurred in the Southwest Pacific. In World War II, the reverse was true. After the Japanese surrender, the activities of the Manila regional office increased greatly.

During the Second World War, the military forces of the Commonwealth of the Philippines fought alongside the U.S. Army, together with certain guerrilla organizations recognized by U.S. officers.

A third group were the Philippine scouts, who enlisted directly in the U.S. Army between 1898 and 1945.

Upon discharge, the Philippine regular forces, as well as the recognized guerrillas, became known as the Commonwealth Army Veterans (CAV).

The Philippine Scouts, of course, after discharge were considered to be U.S. veterans, as well as those American ex-servicemen who took up permanent residence in the Philippines.

The Commonwealth was made an independent nation July 4, 1946, becoming the Republic of the Philippines. Therefore, only the CAV's discharged before that date were deemed entitled to certain veterans' benefits (compensation, hospitalization, outpatient treatment) granted by the United States.

Following the surrender by the Japanese Government and the end of World War II, and the closing of military hospitals, the only medical care available for those disabled in line of duty was in contract hospitals scattered throughout the islands. Most of these facilities were very provincial, inadequate, and unsatisfactory.
This situation was of the gravest concern to the Veterans' Administration, as well as to the House Veterans' Affairs Committee. The Honorable Edith Nourse Rogers, a member of that committee, was deeply sympathetic to the plight of the Philippine war veterans. To alleviate this situation, she introduced a bill for their relief which was signed by President Truman July 1, 1948. It became Public Law 865, 80th Congress.

This act authorized the President of the United States to provide aid to the Republic of the Philippines in the form of grants-in-aid, not to exceed $22,500,000, for the construction and equipping of necessary hospital facilities for the exclusive use of disabled Philippine World War II veterans. Provision was also made in this act for reimbursement by the U.S. Government to the Philippine Republic for moneys expended for contract hospitalization for eligible disabled veterans, pending the construction of the new hospital.

In 1951, plans for the new hospital were completed and sent to Washington for review. They were approved and bids were issued for the construction of the hospital. The low bid was approximately $15 million. This was considered by the Washington authorities to be excessive. The Philippine Government was requested to revise its plans with a view to eliminating certain ancillary facilities to reduce the cost, and thus bring it within the amount set aside for construction.

The project was again advertised and the low bid came within the appropriated amount, $9,400,000. Contracts were then awarded for construction and the necessary equipment and supplies purchased.

Work on the hospital started in September 1953. Completed and dedicated as the Veterans' memorial hospital on November 20, 1955, it contains 720 beds. The organization of the hospital was patterned after the Veterans' Administration hospitals in the United States, including the appointment of a deans committee.

To render any advice required in the initial operation of the hospital, a representative of the Chief Medical Director of the VA was sent to

Veterans Memorial Hospital, Manila, P.I.
Dr. R. C. Cook, former Deputy Chief Medical Director, spent 2 years in this assignment, and was followed by Dr. Frank B. Brewer, formerly Assistant Chief Medical Director, for the next 2 years, after which this assistance was no longer deemed necessary.

The original bill provided for grants-in-aid for the operation of the hospital as well as for the care of those in contract facilities, and was for a period of 5 years, July 1954 to June 30, 1958.

The first yearly grant was for $3 million and then it was gradually reduced to $1,500,000 per annum for the fiscal year ending June 30, 1958.

Public Law 461, 85th Congress, dated June 18, 1958, continued these grants-in-aid another 5 years at $2 million annually. In 1963 the grants were again renewed for 5 years at $500,000 annually.

The original authorization of the President was to provide funds for the care of eligible Philippine veterans with service-connected disabilities as determined by the Veterans' Administration. Beginning with 1958, the admission requirements were broadened—first, to include U.S. veterans residing in the Philippines and Philippine scouts, who can receive hospital care on a bed-available basis—regardless of service connection. Funds for this purpose were furnished separately by the VA on a reimbursable basis. The next year, the Philippine Government authorized the hospitalization of indigent CAV’s and guerrillas, regardless of service connection, and for their immediate dependents. This is at the expense of the Philippine Government.

Nonindigent veterans and civilians can also be admitted on a pay basis, subject to the availability of accommodations and without prejudice to the beneficiaries of the United States and the Philippine hospital program. The latter group are admitted only in a very few exceptional cases, or on recommendation of the U.S. Government.

Outpatient treatment is available for service-connected veterans at the regional office clinic and at the hospital.

In recent years the Philippine Government has experienced difficulty in maintaining the hospital, and for some time it has been operating at a substantially less than full capacity. The maintenance of the physical facilities and equipment has steadily declined, due to lack of funds. Considerable rehabilitation in this respect is necessary if the hospital is to continue in operation.

This matter is now receiving consideration by the Administrator, as well as the House Veterans' Affairs Committee. It is anticipated that additional funds will be made available in order to modernize the hospital, to promote research, and broaden the eligibility to include veterans in the Philippines not now entitled to hospitalization at either the expense of the Philippine Government or the United States.

This proposal, if approved—and it undoubtedly will be—insures the future care of the Philippine veterans and places the physical plant of the Veterans' Memorial Hospital on a modern basis similar to those Veterans' hospitals in the United States.

Thus, a grateful U.S. Government extends its hand across the sea to help a new nation take care of its veterans, who so valiantly fought for our common cause in World War II.

In retrospect

The history of the medical service of the Veterans' Bureau and the Veterans' Administration (later the Department of Medicine and
Surgery), is replete with records of frustration and endeavors to raise the standards of medical care.

When all of the physicians were converted to civil service status their salaries were pitifully low. Very few young doctors would enter the medical service for $3,200 per annum—a governmental career for a professional man, at that time, was not too highly regarded.

Like all civil service employees, the medical personnel were subject to the classification act which set the salary for jobs according to the responsibilities of the employee. Clinical directors, and medical officers in charge, were in higher grades than the doctors who were actually taking care of patients. Therefore, to secure advancement a physician usually had to give up his clinical work and take over administrative duties. Many felt that the years spent in studying medicine should not be evaluated on the same level with duties involving being an overlord of paperwork.

Retirement prospects were not encouraging. As a matter of fact, prior to August 1920 there was no retirement system in the civil service. The first benefit (1920) for retirement provided that $720 per annum was the maximum anyone could receive. On July 1, 1930, this was increased to $1,200 a year. It was not until January 24, 1942, that the present retirement system was inaugurated, based on age, length of service, and salary received, with no maximum stipulated. Many of the hospitals were situated in isolated locations, where there were poor school facilities for those with children, and limited social activities. Most VA hospitals had only seven sets of quarters for the staff, and housing in nearby communities was usually substandard. (In this respect, the National Soldiers' Homes provided many more housekeeping quarters than the hospitals of the Veterans' Bureau. On the other hand, the prospects for interesting and challenging professional work were limited, being confined mostly to infirmary type cases.)

There was little opportunity for educational advancement, although in later years more and more funds became available for postgraduate education.

The doctors were somewhat isolated from their colleagues in the community. The local medical societies required members to hold licensure to practice in the particular State. Being a hospital system national in scope, naturally, physicians were recruited from all States and sent where they were needed. Transfers between stations and States were frequent. Therefore, one could not expect a doctor to secure a new license in every State to which he was sent. It was not until years later that arrangements were made with the American Medical Association whereby service memberships were granted to those doctors serving in the Federal Government, regardless of where they were stationed.

Although all these factors were on the minus side, there were benefits on the affirmative. There was a continuing effort to create a medical corps which would give status and monetary advantages. Promotions were made from within the ranks. A young man had opportunities for advancement; and there is a wealth of clinical material among the vast number of patients, which would interest any doctor worthy of the title.

But, above all, the hard core of devoted doctors—including the medical directors—held together those who put service above self,
and patients were cared for during those dark and discouraging years regardless of circumstances. True, there were many things to be criticized, most of which were beyond control, and many charges were true, but by far the largest share were unfounded.

With World War II ended, and with the creation of the Department of Medicine and Surgery, a new day dawned. Many of the long-term VA doctors joined enthusiastically in the reorganization and were placed in very responsible assignments. Most of them are now retired, but they can look back with satisfaction and pride on the accomplishment of their most difficult tasks under extremely adverse circumstances.

What could have been done to avoid such a near breakdown in medical care? If the Medical Corps bill had been made law in the early days, with appropriate salaries and fringe benefits, many doctors would have remained in the Veterans' Bureau. If the Administrator had accepted the idea of affiliation with medical schools and had established residency training programs, the medicine practiced in the VA would then equal that of the most progressive hospitals in the United States. If the status of the medical director had been raised so that he would be responsible to the Administrator only, and not through a third party, the prestige of the service would have been enhanced.

However, that is all in the past. The future will profit by these mistakes, and "medical care second to none" will continue to reach new heights.

A LOOK INTO THE FUTURE

The preceding detailed story of the origins and development of the care of the American veteran has been terminated in this book at the retirement of Dr. William S. Middleton as Chief Medical Director in February 1963, and the resignation of Administrator John S. Gleason, Jr., in January 1965.

Recent legislation has introduced added benefits and expanded greatly the numbers of veterans who are entitled to one benefit or another. The Veterans' Readjustment Benefits Act of 1966 produced a new GI bill. Actually, it authorized for those who served on active duty since January 31, 1955, a number of the same benefits that were provided for those with wartime service during the Korean conflict.

Those whose service followed the end of the Korean conflict could now get hospitalization for non-service-connected disabilities; education, home and farm loans, etc. The bill did not, however, give them disability compensation at wartime rates under all circumstances. They were denied disability pensions for themselves and death pensions for their widows and children under the same conditions afforded war veterans and their widows and children. Likewise, they were not entitled to the $250 burial allowance benefit nor could they get the $1,600 allowance for a special automobile awarded similarly disabled veterans who served during a war period.

On September 7, 1966, Administrator Driver, speaking on Senate bill 3580, strongly advocated to the Senate Committee on Finance that these certain benefits denied those with service since January 31, 1955, be granted those whose military service began August 5, 1964. Thus a new category of war veteran would be created officially, and
probably would be known as those with service during the "Vietnam era."

The most favorable augury for the future care and interest in veterans came with the unprecedented message of President Johnson to Congress on January 31, 1967.

Emphasizing that the Nation had not forgotten the veterans of past wars and that Americans have never had more cause to be proud than of today's Armed Forces, the President proposed a Vietnam Conflict Servicemen and Veterans Act and outlined six major legislative objectives for consideration by the Congress. They were:

First, to remove the inequities in the treatment of veterans of the present conflict in Vietnam.

Second, to enlarge the opportunities for educationally disadvantaged veterans.

Third, to expand educational allowances under the GI bill.

Fourth, to increase the amount of servicemen's group life insurance.

Fifth, to increase the pensions now received by 1.4 million disabled veterans, widows, and dependents.

Sixth, to make certain that no veteran's pension will be reduced as a result of increases in Federal retirement benefits, such as social security.

The President also recommended that the following benefits be extended to veterans who have served on or after August 5, 1964 (the date of the Tonkin Gulf incident):

1. I recommend that the following benefits be extended to veterans who have served on or after August 5, 1964:
   - Disability compensation at full wartime rate for all veterans.
   - Disability pensions for veterans and death pensions for widows and children.
   - Special medical care benefits, including medicines and drugs for severely disabled veterans on the pension rolls.
   - $1,000 toward the purchase of an automobile by veterans with special disabilities.

The President also recommended:

a. Legislation to provide full GI bill payments to educationally disadvantaged veterans so that they can complete high school without losing eligibility for college benefits.

b. An increase in the monthly assistance allowances and in payments for the second and additional children of veterans attending school.

c. An increase in the amount of available serviceman's group life insurance to a minimum of $12,000 and a maximum of $30,000.

d. A 5.4-percent increase in the present pension system for veterans, widows, and dependents.

e. Protection against reduction of pensions due to increases in Federal retirement benefits, such as social security.

As a final step in strengthening veterans' program President Johnson directed Administrator Driver in consultation with leading veterans groups, to conduct a comprehensive study of the pension, compensation, and benefits system for veterans, their families, and their survivors and to recommend by January 1968 proposals to assure that the tax dollars for veterans' benefits are wisely used and that the Government is meeting its full share of responsibility to "all those to whom we owe so much."
After thorough preparatory study, Administrator Driver selected an 11-man committee to be headed by Robert M. McCurdy of Pasadena, Calif., long active in veterans' affairs and for more than 20 years chairman of the American Legion's National Rehabilitation Commission.

Members of the committee include—
- Andy Borg, Superior, Wis., former national commander in chief, Veterans of Foreign Wars.
- Claude Callegary, Baltimore, Md., former national commander, Disabled American Veterans, Baltimore, Md.
- Melvin T. Dixon, State service officer, Florida Department of Veterans' Affairs, St. Petersburg, Fla.
- Ralph E. Hall, Washington, D.C., national executive director, AMVETS.
- Herbert M. Houston, Chattanooga, Tenn., past national commander, Veterans of World War I.
- L. Eldon James, Hampton, Va., past national commander, American Legion.
- William N. Rice, Denver, Colo., director, Colorado Department of Veterans Affairs.
- Pete Wheeler, Atlanta, Ga., State director, department of veterans service.
- Ted C. Connell, of Killeen, Tex., past commander in chief of the Veterans of Foreign Wars, is director of field operations for the Commission.

It is presently estimated that by 1970 there will be approximately 27 million living veterans, including those of the "Vietnam era."

Congress has authorized 4,000 beds for veterans requiring nursing home type of care either in existing VA hospitals or on a contract basis under certain circumstances. With the increasing age of veterans, this program will undoubtedly reach tremendous proportions.

The study of automation as related to medicine is constantly forging ahead and no one can accurately foresee the ultimate accomplishments in the advancement of medical care and diagnosis. The predictions are most encouraging.

The amount of funds available to the Veterans' Administration for research and education is steadily increasing year by year. While, as yet, no earth-shaking discovery has been made, such as a breakthrough in the cure of cancer or other ravaging diseases, it will undoubtedly come eventually.

With the emphasis on training of younger college graduates, through intern programs, etc., the VA is building up a strong, well-qualified reserve force to replace the older staff employees as they leave or retire. The VA offers an exceptional opportunity for those qualified and desiring a career in paramedical activities such as pharmacy, social work, laboratory, X-ray and prosthetic appliance technicians, dietitians, medical illustrators, occupational and physical therapists, librarians, chaplains.

The residency training in our hospitals is becoming increasingly attractive to your medical interns. Thus, the VA will more and more
contribute to the medical education of the country as a whole, even though only a fraction of the graduate residents remain in Federal service.

Legislation has been recommended which would extend the involvement of the Veterans' Administration in the whole range of health services, including expansion of the educational programs and sharing of personnel and equipment. If favorably acted upon, it would enable the Department of Medicine and Surgery to arrange with the community hospitals and medical schools by contract for the sharing of highly skilled and professional talent, as well as sharing diagnostic and therapeutic equipment which is very expensive. This undoubtedly will lead to a trend toward the consolidation of health resources throughout the Nation, thus insuring a higher quality of medical services to all citizens.

Certain imponderables which face the agency at this time are—

How far and how long will this conflict in Vietnam extend, and how many of the military will eventually be participating, thus further increasing the number of war veterans?

What effect will medicare have on hospitalization and treatment of the veteran population?

(Under date of February 15, 1966, the House Veterans' Affairs Committee sent a letter and questionnaire to a group of 10,000 veterans. They called attention to the recent enactment of Public Law 89-97 which provides medicare for those individuals covered by the social security system. The veteran was asked to check his preference as to whether he would prefer to be taken care of under the medicare plan in a community hospital, or receive treatment from the Veterans' Administration. Five thousand, nine hundred and forty-two questionnaires were returned, almost all from veterans of World War I. A total of 3,888 veterans—or 65.5 percent of the answers received—indicated a preference for VA hospitalization.) Reference: House Committee Print No. 177, 89th Congress, second session, April 21, 1966, "Impact of Medicare on Veterans' Administration Medical System," Government Printing Office, Washington.

Sufficient time has not elapsed to draw conclusions as to the effect the medicare bill will have on the patient load in VA hospitals. Patients with service-connected disabilities will be admitted as here-tofore, but those applicants having only disabilities not traceable to military service and admitted on a basis of financial need will consider their medicare benefits as part of their ability to pay hospital costs.

In the brief time that the new law has been in effect, some VA hospital directors have detected what they believe to be a drop of 5 percent in the use of beds. Other directors are not so sure and it is evident that a great period of time will be required before any definite trend in VA hospital patients load can be projected with certainty.

THE AUTOMATED HOSPITAL INFORMATION SYSTEM

The reams of paperwork connected with providing medical care and treatment for veterans have always been the bane of doctors, nurses, and other professionals in the Veterans' Administration.

During the Whittier administration, a "crash" program was undertaken to automate just about all the paperwork activities of the Insurance and Veterans Benefits Departments.
Medical administrators began casting anxious eyes at the VA's computer operation and its potential. Maybe here was the solution to the headaches brought on by those mountains of paperwork.

There was constant criticism and complaining about the amount of time doctors and nurses were spending on paperwork—time that could be better spent with the patient.

Finally, in 1964 it was decided that a pilot study was in order. This was undertaken at the Washington, D.C., VA hospital. This study was the prelude to an ambitious plan for a prototype automated hospital information system. It is not expected that the full development of such a system will be realized before sometime in 1968.

At that time, assuming the system is found to be technically and economically feasible, VA intends to develop a nationwide automated hospital information system network.

When the system is perfected, it is hoped that all necessary information concerning a patient from his admission to his discharge will be recorded electronically.

Installed in all wards and service areas (dietetic, pharmacy, X-ray, laboratory, etc.) will be two-way communication terminals, connected with the system.

Henceforth, when a veteran applies for admission to a VA hospital, it would be hoped that automation systems could be queried for such instant information as: his legal eligibility, previous hospitalization, diagnosis at that time, treatment record, etc.

Armed with this information, the admitting physician would then give the veteran an examination to determine if he now needs hospitalization. If this examination proves the need, the system would be referred to once more.

"Where is there a suitable bed?" it would be asked.

Presumably the system would answer up with the exact location. Electronically, that ward would be advised to make ready for a specific type patient. Simultaneously, the required services such as dietary, pharmacy, chaplaincy, library, etc., would also be alerted as to what would be expected of them. From that moment on an intercommunications system would provide the flow of necessary instructions as to prescriptions, dietetic needs, etc.

Regional data processing centers are planned to assemble all this information and service the information needs of designated VA medical installations within specific geographical areas.

At the present time, VA is exploring the rapid conversion of laboratory autoanalyzer signals to digital data for computer processing in the hope of speeding up the actual report of findings.

Regardless of what the future brings, it will find the Veterans' Administration based on a sound structure, able to meet all exigencies or changes. Great strides forward have been made since 1930, when the organization came into being as one focal point in the entire picture for those who served. It is now manned with younger men, with vision and aptitude to meet whatever challenge presents itself.

The agency has in its time made mistakes, but they have been speedily corrected. As the fourth largest agency of the Government, consisting of approximately 170,000 employees, and spending for the veterans over $6 billion a year, the Veterans' Administration is a credit to the populace of this, our United States, in caring for those "who shall have borne the battle."
The story of accomplishments and advances made in the future will be left to other compilers of VA history.

It is safe to say that the mission of medical care of eligible veterans will extend for years to come. The present situation will unquestionably result in swelling the ranks of veterans. As has been related, a grateful Government will never see these men and women who helped defend their country suffer, either physically or financially. Thus, the Veterans’ Administration will continue to dispense veterans’ benefits according to the will of the Congress. This lot will undoubtedly fall upon the shoulders of a third generation of VA employees.
### APPENDIX A.—Chronology of legislative attempts to establish a permanent Medical Service (Medical Corps) in the Veterans' Bureau, later the Veterans' Administration

<table>
<thead>
<tr>
<th>Bill No.</th>
<th>Introduction</th>
<th>Disposition by Congress</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.R. 12308, 60th Cong., 2d sess.</td>
<td>Feb. 16, 1925 (Hon. Royal C. Johnson)</td>
<td>Continued various amendments to World War Veterans' Act. Sec. 10 of bill provided for a Medical Corps in the Veterans' Bureau. This section was in the bill as it passed the House Feb. 28, 1925, but was dropped from the bill in the Senate.</td>
</tr>
<tr>
<td>H.R. 4474, 60th Cong., 1st sess.</td>
<td>Dec. 8, 1925 (Hon. Royal C. Johnson)</td>
<td>Contained various amendments to the World War Veterans' Act. Sec. 2 would have created a U.S. Veterans' Bureau Medical Service. In hearings on bill General Haas referred to prior favorable reports and especially H.R. 10534 above. H.R. 4474 not reported by committee.</td>
</tr>
<tr>
<td>H.R. 10240, 60th Cong., 1st sess.</td>
<td>Mar. 11, 1926 (Hon. Royal C. Johnson)</td>
<td>Would have amended World War Veterans' Act and provided for a permanent Veterans' Bureau Medical Service. Reported by Committees on World War Veterans' Legislation Mar. 11, 1926. Veterans' Bureau favorable to this provision in principle. After hearings, H.R. 12175 was introduced which dropped the provision for a Medical Service and replaced H.R. 10240. H.R. 12175 became act of July 2, 1926.</td>
</tr>
<tr>
<td>S. 2310, 60th Cong., 1st sess.</td>
<td>Jan. 9, 1926 (Senator David A. Reed)</td>
<td>Contained provision for Medical Service as H.R. 10240, above. Similar report given by Veterans' Bureau. Bill not reported by committee.</td>
</tr>
<tr>
<td>H.R. 6006, 71st Cong., 2d sess.</td>
<td>Dec. 6, 1929 (Hon. Royal C. Johnson)</td>
<td>Also would have established in Veterans' Bureau a commissioned Medical Service. Hearings by Committees on World War Veterans' Legislation Mar. 4, 1930. Not reported by committee.</td>
</tr>
<tr>
<td>S. 6020, 71st Cong., 3d sess.</td>
<td>Jan. 26, 1931 (Senator David A. Reed)</td>
<td>Would have set up permanent Medical Service in the Veterans' Administration. VA recommended delay because of consolidation act of July 2, 1930. Bill not reported by the Committee on Finance.</td>
</tr>
<tr>
<td>S. 1667, 72d Cong., 1st Sess.</td>
<td>Dec. 14, 1931 (Senator David A. Reed)</td>
<td>Would have established a permanent Medical Service in the Veterans' Administration. Report of VA recommended delay because of pending legislation on all classes of employees bill not reported by Committee on Finance.</td>
</tr>
<tr>
<td>H.R. 9104, 74th Cong., 1st sess.</td>
<td>Aug. 12, 1935 (Hon. John E. Rankin)</td>
<td>Would have established a permanent Medical Service in the VA. Not reported by the committee.</td>
</tr>
<tr>
<td>H.R. 2826, 78th Cong., 1st sess.</td>
<td>May 27, 1943 (Hon. Edith Nourse Rogers)</td>
<td>Would have instituted a permanent Medical Service in the VA. Agency report unfavorable. Mentioned assistance in meeting recruitment problem by Civil Service, Bureau of the Budget, and service departments. Also mentioned injustice in adopting medical alone as bill. Bill not reported by the committee.</td>
</tr>
</tbody>
</table>
APPENDIX A.—Chronology of legislative attempts to establish a permanent Medical Service (Medical Corps) in the Veterans’ Bureau, later the Veterans’ Administration—Continued

<table>
<thead>
<tr>
<th>Bill No.</th>
<th>Introduction</th>
<th>Disposition by Congress</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.R. 3623, 78th Cong., 1st sess.</td>
<td>Nov. 6, 1943 (Hon. Edith Nurse Rogers).</td>
<td>Would have established a permanent Medical Corps. VA report adverse, similar to report H.R. 2820. The committee did not report the bill.</td>
</tr>
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</table>
### APPENDIX B—History of construction and acquisition of VA hospitals and domiciliaries

<table>
<thead>
<tr>
<th>Location of hospital or domiciliary</th>
<th>Present type</th>
<th>Opening or reopening date</th>
<th>Method of acquisition</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque, N. Mex.</td>
<td>General</td>
<td>Apr. 16, 1951</td>
<td>Constructed by VA</td>
<td>Opened at TB hospital. Closed by VB on May 1, 1928</td>
</tr>
<tr>
<td>Do</td>
<td>do</td>
<td>Aug. 22, 1952</td>
<td>Constructed by VA on donated site</td>
<td></td>
</tr>
<tr>
<td>Alexandria, La.</td>
<td>General</td>
<td>Apr. 7, 1919</td>
<td>Base hospital at Camp Beauregard transferred from War Department to U.S. Public Health Service in 1919, then to VB on Apr. 29, 1922, by Executive Order 3669. New hospital constructed by VB on donated site.</td>
<td></td>
</tr>
<tr>
<td>Do</td>
<td>General</td>
<td>Dec. 2, 1929</td>
<td>Hospital transferred from Navy Department to U.S. Public Health Service in 1921, then to the VB on Apr. 29, 1922, by Executive Order 3669.</td>
<td>Closed temporarily in May 1927 due to flood conditions. Reopened in June 1927. Closed by VB Dec. 6, 1929.</td>
</tr>
<tr>
<td>Algiers, La.</td>
<td>General</td>
<td>Sept. 24, 1921</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altoona, Pa.</td>
<td>General</td>
<td>Oct. 12, 1953</td>
<td>Constructed by VA</td>
<td></td>
</tr>
<tr>
<td>Amarillo, Tex.</td>
<td>General</td>
<td>Oct. 10, 1925</td>
<td>Constructed by VA on donated site</td>
<td></td>
</tr>
<tr>
<td>Aspinwall, Pa.</td>
<td>General</td>
<td>Oct. 21, 1920</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atlanta, Ga.</td>
<td>General</td>
<td>Feb. 1, 1920</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do</td>
<td>General</td>
<td>Dec. 2, 1929</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of hospital or domiciliary</td>
<td>Present type</td>
<td>Opening or reopening date</td>
<td>Method of acquisition</td>
<td>Remarks</td>
</tr>
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</tr>
<tr>
<td>Augusta, Ga.</td>
<td>General</td>
<td>July 8, 1951</td>
<td>Oliver General, acquired from Army</td>
<td>Identified as Forest Hills division of VA hospital, Augusta, Ga. Forest Hills division was declared a general hospital Oct. 22, 1965, and is to be counted a separate hospital. Closed July 1, 1942. Opened as annex to Augusta (for females only).</td>
</tr>
<tr>
<td>Do.</td>
<td></td>
<td>Feb. 1, 1933</td>
<td>The former Allen's Invalid Home, Milledgeville, Ga., leased by VA.</td>
<td></td>
</tr>
<tr>
<td>Augusta, Maine</td>
<td></td>
<td>July 1, 1920</td>
<td>The Army hospital at Fort McHenry Military Reservation transferred from War Department to U.S. Public Health Service, then to VA on Apr. 29, 1922, by Executive Order 5969. Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Baltimore, Md.</td>
<td></td>
<td></td>
<td></td>
<td>See Togus, Maine.</td>
</tr>
<tr>
<td>Do.</td>
<td>Tuberculosis</td>
<td>Oct. 28, 1932</td>
<td>Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Batavia, N.Y.</td>
<td>General</td>
<td>May 3, 1944 and Jan. 1, 1951</td>
<td>Constructed by VA on site donated by the city of Batavia.</td>
<td></td>
</tr>
<tr>
<td>Bath, N.Y.</td>
<td>General and domiciliary</td>
<td>1878</td>
<td>Operation of former New York State Home taken over by the National Home for Disabled Volunteer Soldiers on May 1, 1899. Transferred to VA on July 21, 1936, by Executive Order 5386. New construction added. See Fort Custer.</td>
<td></td>
</tr>
<tr>
<td>Battle Creek, Mich.</td>
<td>Psychiatric</td>
<td></td>
<td></td>
<td>Name change to Battle Creek from Fort Custer Jan. 19, 1933. Formerly known as St. Peterburg. Name changed to Bay Pines on July 1, 1934. See Castle Point, N.Y.</td>
</tr>
<tr>
<td>Bay Pines, Fla.</td>
<td>General and domiciliary</td>
<td>Mar. 16, 1933</td>
<td>Constructed by VA on purchased site.</td>
<td></td>
</tr>
<tr>
<td>Beacon, N.Y.</td>
<td>General</td>
<td>Mar. 1, 1951</td>
<td>Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Beckley, W. Va.</td>
<td>Psychiatric</td>
<td>July 17, 1950</td>
<td>Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Bedford, Mass.</td>
<td>General</td>
<td>Aug. 10, 1933</td>
<td>Constructed by VA on donated and purchased sites.</td>
<td></td>
</tr>
<tr>
<td>Big Springs, Tex.</td>
<td>General</td>
<td>Dec. 6, 1919</td>
<td>Kenilworth Inn leased by U.S. Public Health Service. Transferred to VB on Apr. 29, 1922, by Executive Order 3690. Name changed to Bay Pines on July 1, 1934. See Castle Point, N.Y.</td>
<td></td>
</tr>
<tr>
<td>Biloxi, Miss.</td>
<td>General and domiciliary</td>
<td>Mar. 16, 1953</td>
<td>Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Bonham, Tex.</td>
<td>General and domiciliary</td>
<td>Nov. 1, 1951</td>
<td>Constructed by VA.</td>
<td></td>
</tr>
</tbody>
</table>
Boston, Mass. .................................................. July 1, 1919
Do ................................................................. July 10, 1932
Brockville, Ohio ............................................... July 10, 1932
Do ................................................................. Nov. 1, 1940
Brockton, Mass ............................................... Sept. 5, 1941
Brockton, Mass ............................................... Oct. 6, 1953
Brockton, Mass ............................................... Apr. 17, 1923
Brooklyn, N.Y ................................................ Dec. 7, 1946
Buffalo, N.Y .................................................. Feb. 9, 1950
Butler, Pa ...................................................... Jan. 16, 1950
Camp Custer, Mich ............................................ Sept. 20, 1946
Camp Kearney, Calif .......................................... Jan. 2, 1921
Camp White, Ore. .............................................. Feb. 9, 1933
Canandaigua, N.Y ............................................. Sep. 3, 1949
Castle Point, N.Y ............................................. Sept. 15, 1924
Charleston, S.C .............................................. June 7, 1936
Cheyenne, Wyo ................................................ May 4, 1934
Chicago, Ill ..................................................... June 3, 1919

Lease of Parker Hill property transferred from War Department to U.S. Public Health Service, then to VA on Apr. 29, 1922, by Executive Order 3669.

Purchased by Treasury Department for U.S. Public Health Service and remodeled. Transferred to VA on Apr. 29, 1922, by Executive Order 3669. New construction added.

Sheephead Bay Hospital (Manhattan Beach) transferred from U.S. Public Health Service to VA.

Conducted by VA. New hospital (Fort Hamilton) constructed by VA on site donated from War Department.

Deshon General Hospital transferred from War Department to VA. Additional site and buildings purchased.

Leased site and Government-owned buildings of Camp Kearney base hospital transferred from War Department to U.S. Public Health Service, then to VA on Apr. 29, 1922, by Executive Order 3669.

Lawson General Hospital transferred from War Department to VA.

Purchased by Treasury Department for U.S. Public Health Service and remodeled. Transferred to VA on Apr. 29, 1922, by Executive Order 3669.

The Cooper Monotah Hotel initially leased by War Department for hospital purposes was transferred to U.S. Public Health Service in 1919.

Private hospital leased by U.S. Public Health Service for NP cases in 1921. Both units were transferred to VA on Apr. 29, 1922, by Executive Order 3669.

Preceding entries gives only dates of transfers of units respectively.


Open as G.M. & S. hospital. Closed by VA on Dec. 1, 1922.


Open as NP hospital. Converted to G.M. & S.

Converted from NP to TB hospital July 1, 1951. Redesignated from TB to G.M. & S.

See White City, Ore.

See Fort Custer, Mich.

Open as TB hospital. Closed by VA on Mar. 18, 1926.


Chicago NP hospital opened on July 15, 1921. Operated as separate unit until Dec. 17, 1921, when consolidated with the G.M. & S. hospital and operated as annex thereto. G.M. & S. unit closed by VA on June 30, 1923. NP unit on Feb. 29, 1924.
<table>
<thead>
<tr>
<th>Location of hospital or domiciliary</th>
<th>Present type</th>
<th>Opening or reopening date</th>
<th>Method of acquisition</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago, Ill. (West Side)</td>
<td>do</td>
<td>Dec. 7, 1933</td>
<td>do</td>
<td></td>
</tr>
<tr>
<td>Chicago, Ill. (research)</td>
<td>Psychiatric</td>
<td>Nov. 15, 1921, and June 1, 1924</td>
<td>Sites for both hospitals transferred from War Department. Original hospital constructed by Treasury Department for U.S. Public Health Service. Transferred to VA Apr. 29, 1922, by Executive Order 3669. New hospital constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Cleveland, Ohio</td>
<td>General</td>
<td>June 17, 1948</td>
<td>Irel General Hospital transferred from War Department to VA.</td>
<td></td>
</tr>
<tr>
<td>Corpus Christi, Tex</td>
<td>Psychiatric</td>
<td>Nov. 11, 1930</td>
<td>Constructed by VA on purchased site.</td>
<td></td>
</tr>
<tr>
<td>Colfax, Iowa</td>
<td>General</td>
<td>July 5, 1921</td>
<td>Colfax Springs Hotel leased by U.S. Public Health Service. Transferred to VA Apr. 29, 1922, by Executive Order 3669.</td>
<td></td>
</tr>
<tr>
<td>Coral Gables, Fla.</td>
<td>do</td>
<td>Nov. 15, 1921</td>
<td>Pratt General Hospital transferred from War Department to VA.</td>
<td></td>
</tr>
<tr>
<td>Dayton, Ohio</td>
<td>General</td>
<td>Apr. 15, 1939</td>
<td>Constructed by VA on donated site.</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Type</td>
<td>Date</td>
<td>Remarks</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Denver, Colo.</td>
<td>General</td>
<td>Aug 27, 1951</td>
<td>Constructed by VA</td>
<td></td>
</tr>
<tr>
<td>Des Moines, Iowa</td>
<td>.do.</td>
<td>Apr 2, 1934</td>
<td>Constructed by VA on donated site</td>
<td></td>
</tr>
<tr>
<td>Downey, Ill.</td>
<td>Psychiatric</td>
<td>Mar 1, 1926</td>
<td>Army post transferred to Navy in 1900, to Public Health Service Mar. 1, 1922, and to VA April 29, 1922, by Executive Order 3669. New construction added.</td>
<td></td>
</tr>
<tr>
<td>Dublin, Ga.</td>
<td>General and</td>
<td>July 1, 1948</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Dwight, Ill.</td>
<td>domiciliary.</td>
<td>July 1, 1959</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>East Orange, N.J.</td>
<td>General</td>
<td>Sept 30, 1922</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Excelsior Springs, Mo.</td>
<td>.do.</td>
<td>Nov 11, 1924</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Fargo, N. Dak.</td>
<td>General</td>
<td>June 3, 1929</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Fayetteville, Ark</td>
<td>.do.</td>
<td>Apr 2, 1934</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Fayetteville, N.C.</td>
<td>.do.</td>
<td>Nov 22, 1940</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Federal Park, Md</td>
<td></td>
<td>June 15, 1920</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Fort Benjamin Harris, Ind.</td>
<td>General</td>
<td>June 6, 1921</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Fort Harrison, Mont.</td>
<td>General</td>
<td>Mar 17, 1941</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Fort Howard, Md</td>
<td>.do.</td>
<td>Oct 21, 1946</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
<tr>
<td>Fort Lyon, Colo.</td>
<td>Psychiatric</td>
<td>Mar 1, 1922</td>
<td>Former home of E. L. Morse purchased by VA and remodeled.</td>
<td></td>
</tr>
</tbody>
</table>


Formerly known as Las Animas. Opened as TB hospital. Name changed to Fort Lyon Oct. 1, 1934. Converted to NP Dec 8, 1923.
APPENDIX B.—History of construction and acquisition of VA hospitals and domiciliaries—Continued

<table>
<thead>
<tr>
<th>Location of hospital or domiciliary</th>
<th>Present type</th>
<th>Opening or reopening date</th>
<th>Method of acquisition</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fort Meade, S. Dak.</td>
<td>Psychiatric</td>
<td>May 15, 1945</td>
<td>Site and buildings transferred from War Department to VA. Buildings remodeled, new construction added.</td>
<td>See Baltimore, Md.</td>
</tr>
<tr>
<td>Fort Snelling, Minn.</td>
<td>General</td>
<td>Mar. 5, 1947</td>
<td>Site and buildings transferred from War Department to VA.</td>
<td>Operated as annex to Minneapolis.</td>
</tr>
<tr>
<td>Fort Thomas, Ky.</td>
<td>General</td>
<td>Feb. 15, 1921</td>
<td>Original hospital was former Altamont Hotel which was leased and remodeled by U.S. Public Health Service. Transferred to VA Apr. 29, 1922, by Executive Order 3659. Fort Thomas Station Hospital transferred from War Department to VA in 1947.</td>
<td>Fort Thomas Station Hospital began operation by VA Sept. 2, 1947. Hospital closed Jan. 1, 1956. On Jan. 1, 1956, station to operate as a nursing bed care section of VA hospital, Cincinnati, Ohio.</td>
</tr>
<tr>
<td>Fort Wayne, Ind.</td>
<td>General</td>
<td>May 15, 1950</td>
<td>Constructed by VA.</td>
<td>See Staten Island.</td>
</tr>
<tr>
<td>Framingham, Mass.</td>
<td></td>
<td>Oct. 27, 1950</td>
<td>Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Fresno, Calif.</td>
<td>General</td>
<td>Mar. 27, 1950</td>
<td>Constructed by VA on site donated by the city of Grand Junction.</td>
<td></td>
</tr>
<tr>
<td>Grand Junction, Colo.</td>
<td>do</td>
<td>May 16, 1949</td>
<td>Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Grand Island, Nebr.</td>
<td>do</td>
<td>Sept. 5, 1950</td>
<td>Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Greenville, S.C.</td>
<td></td>
<td>Apr. 3, 1919</td>
<td>Site and buildings at Camp Sevier transferred from War Department to U.S. Public Health Service in 1919, then to VA Apr. 29, 1922, by Executive Order 3659.</td>
<td>Opened as TB hospital. Closed May 12, 1924.</td>
</tr>
<tr>
<td>Hampton, Va.</td>
<td></td>
<td></td>
<td></td>
<td>See Fort Harrison, Mont.</td>
</tr>
<tr>
<td>Helena, Mont.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Function</td>
<td>Date</td>
<td>Event Description</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Hines, Ill.</td>
<td>General</td>
<td>Aug. 8, 1921</td>
<td>While under construction, hotel purchased by Treasury Department for U.S. Public Health Service and converted to hospital. Part of construction cost contributed by Ed Hines, Sr., with understanding the hospital be named for his son, Ed Hines, Jr., a World War I casualty. Transferred to VA Apr. 29, 1922, by Executive Order 3569. Alterations made and new construction added. Gaynus. General Hospital transferred from War Department to VA Mar. 27, 1946.</td>
<td></td>
</tr>
<tr>
<td>Huntington, W. Va.</td>
<td>Tuberculosis</td>
<td>Jan. 4, 1932</td>
<td>Constructed by VA on purchased site.</td>
<td></td>
</tr>
<tr>
<td>Indianapolis, Ind. (Cold Springs Rd.)</td>
<td>General</td>
<td>Jan. 4, 1932</td>
<td>Constructed by VA on donated site.</td>
<td></td>
</tr>
<tr>
<td>Indianapolis, Ind. (10th Ave.)</td>
<td>General</td>
<td>Feb. 7, 1922</td>
<td>Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Iron Mountain, Mich.</td>
<td>do</td>
<td>Mar. 5, 1932</td>
<td>Received from VA.</td>
<td></td>
</tr>
<tr>
<td>Jackson, Miss.</td>
<td>General</td>
<td>Jan. 28, 1946</td>
<td>Foster General Hospital transferred from War Department to VA. Constructed by VA.</td>
<td></td>
</tr>
<tr>
<td>Johnson City, Tenn.</td>
<td>General</td>
<td>Jan. 5, 1921</td>
<td>Wesley Hospital leased by U.S. Public Health Service. Transferred to VA Apr. 29, 1922, by Executive Order 3569. Because of unsuitable location and need for larger facilities was returned to owners July 1, 1926. Christian Hospital leased by VA.</td>
<td></td>
</tr>
<tr>
<td>Kansas City, Mo.</td>
<td>General</td>
<td>Jan. 5, 1921</td>
<td>Wesley Hospital leased by U.S. Public Health Service. Transferred to VA Apr. 29, 1922, by Executive Order 3569. Because of unsuitable location and need for larger facilities was returned to owners July 1, 1926. Christian Hospital leased by VA.</td>
<td></td>
</tr>
</tbody>
</table>

Formerly known as Maywood. Treasury Department order Oct. 24, 1921, designated the hospital as Ed Hines, Jr. Name changed to Hines in September 1933.

Gaynus began operation as annex to Hines in March 1946. See Parkview, Pa.


See Mountain Home, Tenn.

Opened as O.M. & S. hospital. Closed by VA June 20, 1933.

Formerly known as Hampton. Name changed to Kecoughtan Mar. 1, 1936.
<table>
<thead>
<tr>
<th>Location of hospital or domiciliary</th>
<th>Present type</th>
<th>Opening or reopening date</th>
<th>Method of acquisition</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lake City, Fla.</td>
<td>General</td>
<td>Dec. 6, 1920</td>
<td>Constructed by VA on purchased site.</td>
<td>See Lake City, Fla.</td>
</tr>
<tr>
<td>Las Vegas, Colo.</td>
<td>General</td>
<td>Jan. 21, 1947</td>
<td>Site and buildings at Camp Lawrence transferred from Navy Department to VA.</td>
<td>See Las Vegas, Colo.</td>
</tr>
<tr>
<td>Lawrence, Ill.</td>
<td>General</td>
<td>Dec. 16, 1930</td>
<td>Constructed by VA on purchased site.</td>
<td>See Lawrence, Ill.</td>
</tr>
<tr>
<td>Location</td>
<td>Type</td>
<td>Date</td>
<td>Event Description</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<td></td>
</tr>
<tr>
<td>Manchester, N.H.</td>
<td>Psychiatric</td>
<td>June 28, 1950</td>
<td>Operated as home for NP members until July 1, 1931, then converted to NP hospital (without domiciliary unit).</td>
<td></td>
</tr>
<tr>
<td>Minneapolis, Minn.</td>
<td>General</td>
<td>Feb. 8, 1921</td>
<td>Originally named Peekskill, N.Y. Operated as annex to Oteen until Feb 15, 1947, then established as separate unit and name changed to Swannanoa.</td>
<td></td>
</tr>
<tr>
<td>Minot, N. Dak.</td>
<td>do</td>
<td>July 5, 1950</td>
<td>Formerly known as Johnson City. Name changed to Mountain Home Mar. 1, 1925.</td>
<td></td>
</tr>
<tr>
<td>Mobile, Ala.</td>
<td>do</td>
<td>Aug. 1, 1921</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montgomery, Ala.</td>
<td>General</td>
<td>Nov. 1, 1940</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montrose, N. Y.</td>
<td>Psychiatric</td>
<td>May 15, 1950</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moore Annex, Swannanoa, N.C.</td>
<td>do</td>
<td>Nov. 15, 1946</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mountain Home, Tenn.</td>
<td>General and domiciliary</td>
<td>1903</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murfreesboro, Tenn.</td>
<td>Psychiatric</td>
<td>Feb. 4, 1940</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX B.—History of construction and acquisition of VA hospitals and domiciliaries—Continued

<table>
<thead>
<tr>
<th>Location of hospital or domiciliary</th>
<th>Present type</th>
<th>Opening or reopening date</th>
<th>Method of acquisition</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muskogee, Okla.</td>
<td>General</td>
<td>June 14, 1923</td>
<td>Original hospital leased by VB from Oklahoma June 14, 1923, and purchased Mar. 6, 1925. Muskogee Municipal Hospital purchased by VB Oct. 13, 1926. New construction added. Thayer General Hospital transferred from War Department to VA. Constructed by VA.</td>
<td>Closed May 1, 1943. G.M. &amp; S. hospital during period of VA operation. See Wilmington, Del. See West Haven, Conn.</td>
</tr>
<tr>
<td>Nashville, Tenn.</td>
<td>General</td>
<td>Mar. 4, 1946</td>
<td>Belvidere Mental Infirmary leased for short period by U.S. Public Health Service. LaGrande Hospital transferred from the War Department to VA in April 1946.</td>
<td>See Wilmington, Del.</td>
</tr>
<tr>
<td>Do.</td>
<td>General</td>
<td>May 1, 1963</td>
<td>Belvidere Mental Infirmary leased for short period by U.S. Public Health Service. LaGrande Hospital transferred from the War Department to VA in April 1946.</td>
<td>See Wilmington, Del.</td>
</tr>
<tr>
<td>New Castle, Del.</td>
<td>General</td>
<td>Aug. 6, 1946</td>
<td>Belvidere Mental Infirmary leased for short period by U.S. Public Health Service. LaGrande Hospital transferred from the War Department to VA in April 1946.</td>
<td>See Wilmington, Del.</td>
</tr>
<tr>
<td>New Haven, Conn.</td>
<td>General</td>
<td>May 19, 1933</td>
<td>Belvidere Mental Infirmary leased for short period by U.S. Public Health Service. LaGrande Hospital transferred from the War Department to VA in April 1946.</td>
<td>See Wilmington, Del.</td>
</tr>
<tr>
<td>North Little Rock, Ark.</td>
<td>Psychiatric</td>
<td>Sept. 9, 1952</td>
<td>Constructed by VA.</td>
<td>Opened as G.M. &amp; S. hospital. Closed by VB May 24, 1922. Also known as LaGrande Hospital during construction period or VA operation.</td>
</tr>
<tr>
<td>North Little Rock, Ark.</td>
<td>Psychiatric</td>
<td>Aug. 16, 1919</td>
<td>Leased transferred from War Department to U.S. Public Health Service.</td>
<td>Opened as G.M. &amp; S. hospital. Closed by VB May 24, 1922. Also known as LaGrande Hospital during construction period or VA operation.</td>
</tr>
<tr>
<td>Oaklnd, Calif.</td>
<td>Psychiatric</td>
<td>Apr. 21, 1924</td>
<td>Transfer from War Department to U.S. Public Health Service, then to VB Apr. 29, 1922, by Executive Order 5959. Constructed by VA on donated site.</td>
<td>Opened as G.M. &amp; S. hospital. Closed by VB May 24, 1922. Also known as LaGrande Hospital during construction period or VA operation.</td>
</tr>
<tr>
<td>Do.</td>
<td>General</td>
<td>Apr. 16, 1928</td>
<td>Closed Aug. 16, 1928.</td>
<td>Opened as G.M. &amp; S. hospital. Closed by VB May 24, 1922. Also known as LaGrande Hospital during construction period or VA operation.</td>
</tr>
<tr>
<td>Do.</td>
<td>General</td>
<td>Aug. 1, 1946</td>
<td>Oakland Army Regional Hospital transferred from War Department to VA.</td>
<td>Opened as G.M. &amp; S. hospital. Closed by VB May 24, 1922. Also known as LaGrande Hospital during construction period or VA operation.</td>
</tr>
<tr>
<td>Do.</td>
<td>General</td>
<td>July 15, 1946</td>
<td>Will Rogers ADF Station Hospital transferred from War Department to VA.</td>
<td>Opened as G.M. &amp; S. hospital. Closed by VB May 24, 1922. Also known as LaGrande Hospital during construction period or VA operation.</td>
</tr>
<tr>
<td>Location</td>
<td>Type</td>
<td>Date(s)</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Omaha, Neb</td>
<td>do</td>
<td>Feb. 1, 1951</td>
<td>Army hospital transferred from War Department to U.S. Public Health Service and alterations made. Transferred to VB Apr. 29, 1922, by Executive Order 3669. New construction added.</td>
<td></td>
</tr>
<tr>
<td>Oteen, N.C</td>
<td>do</td>
<td>Oct. 15, 1920</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outwood, Ky</td>
<td>do</td>
<td>Feb. 22, 1922</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palo Alto, Calif</td>
<td>Psychiatric</td>
<td>Apr. 1, 1919</td>
<td>Dibble General Hospital transferred from War Department to U.S. Public Health Service and alterations made. Transferred to VB Apr. 29, 1922, by Executive Order 3669. Additional construction on purchased site.</td>
<td></td>
</tr>
<tr>
<td>Do</td>
<td>General</td>
<td>July 8, 1960</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parkview, Pa</td>
<td>General</td>
<td>Sept. 1, 1919</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perryville, Md</td>
<td>Psychiatric</td>
<td>Sept. 20, 1919</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perry Point, Md</td>
<td>Psychiatric</td>
<td>Feb. 18, 1920</td>
<td>Site and buildings transferred from War Department to U.S. Public Health Service. Alterations made and new construction added. Transferred to VB Apr. 29, 1922, by Executive Order 3669. New construction added.</td>
<td></td>
</tr>
<tr>
<td>Philadelphia, Pa</td>
<td>General</td>
<td>Jan. 2, 1923</td>
<td>Papago Park Prisoner of War Camp transferred from War Department to VA.</td>
<td></td>
</tr>
<tr>
<td>Do</td>
<td>General</td>
<td>June 18, 1946</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do</td>
<td>General</td>
<td>Aug. 18, 1951</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do</td>
<td>General</td>
<td>Sept. 19, 1954</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do</td>
<td>Psychiatric</td>
<td>Nov. 25, 1953</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poplar Bluff, Mo</td>
<td>General</td>
<td>Jan. 8, 1951</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portland, Ore</td>
<td>General</td>
<td>Nov. 1, 1921, and Dec. 19, 1928.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescott, Ariz</td>
<td>General and domiciliary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providence, R.I.</td>
<td>General</td>
<td>June 6, 1949</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of hospital or domiciliary</td>
<td>Present type</td>
<td>Opening or reopening date</td>
<td>Method of acquisition</td>
<td>Remarks</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------</td>
<td>--------------------------</td>
<td>-----------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Richmond, Va.</td>
<td>do</td>
<td>Apr. 1, 1946</td>
<td>Army General Hospital transferred from War Department to VA.</td>
<td>New home opened Sept. 18, 1933, and old buildings converted to attendants' quarters.</td>
</tr>
<tr>
<td>St. Louis, Mo.</td>
<td></td>
<td>July 1, 1925</td>
<td>Constructed by VA.</td>
<td>See Bay Pines, Fla.</td>
</tr>
<tr>
<td>Sampson, N.Y.</td>
<td></td>
<td>Dec. 15, 1946</td>
<td>Site and buildings transferred from Navy Department to VA.</td>
<td>Site permanently transferred to VA Apr. 26, 1938. Acquired from Navy Department on revocable use permit.</td>
</tr>
<tr>
<td>Location</td>
<td>Type</td>
<td>Date</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
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<td>-----------------------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Sawtelle, Calif.</td>
<td>General</td>
<td>May 15, 1951</td>
<td>Constructed by V.A.</td>
<td></td>
</tr>
<tr>
<td>Sepulveda, Calif.</td>
<td>Psychiatric</td>
<td>Apr. 11, 1955</td>
<td>Site and buildings at Fort Mackenzie transferred from War Department to V.A. New construction added.</td>
<td></td>
</tr>
<tr>
<td>Sheridan, Wyo.</td>
<td>do</td>
<td>May 12, 1922</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shreveport, La.</td>
<td>General</td>
<td>Oct. 16, 1950</td>
<td>Constructed by V.A.</td>
<td></td>
</tr>
<tr>
<td>Sioux Falls, S. Dak.</td>
<td>do</td>
<td>July 19, 1949</td>
<td>Site and buildings purchased by V.A. New construction added.</td>
<td></td>
</tr>
<tr>
<td>Somerset Hills, N.J.</td>
<td>General</td>
<td>Nov. 1, 1950</td>
<td>Constructed by V.A.</td>
<td></td>
</tr>
<tr>
<td>Spokane, Wash.</td>
<td>do</td>
<td>Feb. 16, 1947</td>
<td>Site and buildings purchased by V.A. New construction added.</td>
<td></td>
</tr>
<tr>
<td>Sunnycroft, N.Y.</td>
<td></td>
<td>Aug. 15, 1924</td>
<td>Constructed by V.B on donated site.</td>
<td></td>
</tr>
<tr>
<td>Swannanoa, N.C.</td>
<td></td>
<td>Nov. 15, 1946</td>
<td>Moore General Hospital transferred from War Department to V.A.</td>
<td></td>
</tr>
<tr>
<td>Syracuse, N.Y.</td>
<td>General</td>
<td>June 10, 1953</td>
<td>Constructed by V.A.</td>
<td></td>
</tr>
<tr>
<td>Temple, Tex.</td>
<td>General and domiciliary.</td>
<td>June 13, 1946</td>
<td>McCloskey General Hospital transferred from War Department to V.A.</td>
<td></td>
</tr>
</tbody>
</table>


See Los Angeles, Calif.

Formerly known as Fort Mackenzie. Name changed to Sheridan on Oct. 1, 1924.

See Lyons, N.J.

Closed Aug. 29, 1952. TB hospital during period of V.A. operation.


### APPENDIX B. — History of construction and acquisition of VA hospitals and domiciliaries—Continued

<table>
<thead>
<tr>
<th>Location of hospital or domiciliary</th>
<th>Present type</th>
<th>Opening or reopening date</th>
<th>Method of acquisition</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuskegee, Ala.</td>
<td>do</td>
<td>June 15, 1923</td>
<td>Constructed by VB on site donated by Tuskegee Institute.</td>
<td>Opened as TB–NP hospital. Converted to G.M. &amp; S. Aug. 6, 1924. Domiciliary unit opened Feb. 9, 1933, but discontinued May 15, 1934, and hospital converted to NP.</td>
</tr>
<tr>
<td>Tupper Lake, N.Y.</td>
<td>Psychiatric</td>
<td>Aug. 1, 1946</td>
<td>Barnes General Hospital transferred from War Department to VA.</td>
<td>Operated as an annex to Portland until Oct. 24, 1947, when it was established as a separate unit.</td>
</tr>
<tr>
<td>Vancouver, Wash.</td>
<td>General</td>
<td>Aug. 2, 1946</td>
<td>Site and buildings transferred from War Department to VA.</td>
<td>Operated as an annex to Tuskees.</td>
</tr>
<tr>
<td>Van Nuys, Calif.</td>
<td>Psychiatric</td>
<td>Mar. 6, 1932</td>
<td>Site and buildings transferred from War Department to VA.</td>
<td>Formerly known as Leavenworth. Name was changed to Wadsworth on Mar. 1, 1936. Domiciliary unit was closed on Apr. 30, 1943, and hospital was converted to NF. Domiciliary unit was reopened on Jan. 7, 1947, at which time the hospital unit was converted to G.M. &amp; S. TB hospital from 1922–59. Redesignated from TB to G.M. &amp; S. hospital July 20, 1959.</td>
</tr>
<tr>
<td>Vaughn, Ill.</td>
<td>General and domiciliary</td>
<td>1884</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waco, Tex.</td>
<td>Psychiatric</td>
<td>May 10, 1922</td>
<td>Site and buildings transferred from War Department to U.S. Public Health Service. Alterations made and new construction added.</td>
<td></td>
</tr>
<tr>
<td>Wadsworth, Kans.</td>
<td>General</td>
<td>May 10, 1922</td>
<td>Site and buildings transferred from War Department to U.S. Public Health Service. Alterations made and new construction added.</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Date of Event</td>
<td>Event Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Haven, Conn.</td>
<td>Sept. 12, 1919</td>
<td>Lease of Allenton Hospital transferred from War Department to U.S. Public Health Service. Transferred to VB Apr. 22, 1922, by Executive Order 3669.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do, West Los Angeles, Calif.</td>
<td>Apr. 8, 1953</td>
<td>Boston City Hospital, leased by the War Department for convalescent patients, transferred to U.S. Public Health Service in 1918. Transferred to VB Apr. 29, 1922, by Executive Order 3669. Constructed by VA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do, West Roxbury, Mass.</td>
<td>Jan. 20, 1944</td>
<td>Hospital returned to control of Boston, buildings razed and site designated as park. Site of old hospital purchased in 1943 by VA for construction of new hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White River Junction, Vt.</td>
<td>Oct. 17, 1938</td>
<td>Site and buildings transferred from War Department to VA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilkes-Barre, Pa.</td>
<td>Nov. 16, 1928</td>
<td>Constructed by VA on purchased site.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilmington, Del.</td>
<td>Aug. 6, 1946</td>
<td>New Castle Airfield acquired by VA from War Department on revocable use permit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do</td>
<td>May 23, 1965</td>
<td>Replacement of old hospital.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Washington, D.C. (Mount Alto) was opened as a hospital and later became the National School of Domestic Arts and Sciences. It was leased to the Treasury Department and then purchased by the U.S. Public Health Service. New construction was added in 1922, and the hospital was transferred to the VA. The name was changed to Wood in 1949.

Washington, D.C. was previously known as New Castle. The name was changed to Wood.

Waukesha, Wis. was formerly known as Milwaukee Soldiers Home. It was acquired by the VA on leased property and then purchased outright. New construction was added in 1922. The hospital was renamed Waukesha.

West Haven, Conn. was formerly known as White City. The hospital was leased to the VA and later purchased by the U.S. Public Health Service. New construction was added in 1922. The hospital was transferred to the VA.

West Los Angeles, Calif. was formerly known as Los Angeles City Hospital. It was leased to the VA and later purchased by the Treasury Department. The hospital was transferred to the VA.

West Roxbury, Mass. was formerly known as White City. The hospital was leased to the VA and later purchased by the U.S. Public Health Service. New construction was added in 1922. The hospital was transferred to the VA.

Whipple, Ariz. was formerly known as Prescott. The hospital was opened as a TB hospital and later became a VA hospital. It was renamed Whipple.

White City, Oreg. was formerly known as New Haven. The hospital was opened as a VA hospital and later became a domiciliary unit. It was renamed White City.

White River Junction, Vt. was formerly known as New Castle. The hospital was opened as a VA hospital and later became a domiciliary unit. It was renamed White River Junction.

Wilkes-Barre, Pa. was formerly known as New Haven. The hospital was opened as a VA hospital and later became a domiciliary unit. It was renamed Wilkes-Barre.

Wilmington, Del. was formerly known as New Castle. The hospital was opened as a VA hospital and later became a domiciliary unit. It was renamed Wilmington.

Wood, Wis. was formerly known as Milwaukee Soldiers Home. The hospital was originally at Milwaukee and later moved to Wood. It was leased to the VA, then purchased outright. New construction was added. The name was changed to Wood.

The table above provides a chronological overview of various events related to the opening, transfer, and renaming of VA hospitals and domiciliaries from 1919 to 1965. Each location and associated events are detailed with specific dates and descriptions of changes in name, ownership, and construction.
APPENDIX C.—Bibliography, With Explanatory Notes

Because the principal sources of the materials for the present volume may serve as a guide and a timesaver to possible future researchers and writers, the following notes are here offered:

The first obvious source has been the extensive collection of annual reports of the National Home for Disabled Volunteer Soldiers, the Bureau of War Risk Insurance, the Veterans' Bureau, and the Veterans' Administration. These reports are available in the medical and general reference library of the Veterans' Administration Central Office. Miscellaneous historical material on the Bureau of Pensions and the Bureau of War Risk Insurance is available in the National Archives. Additionally, each of those present-day VA domiciliaries whose origins were in the national homes has its own file of locally collected historical information.

The records room of the legislative reference and research staff of the General Counsel's Office of the VA is a rich source of historical material on the agency. Along with almost every piece of legislation passed in behalf of veterans since World War I, there is a file which includes hearings on the legislation; correspondence connected with the hearings; important newspaper editorials and speeches on the subject of the legislation; interoffice and intergovernmental memoranda; and other related material. Some of these files are well indexed and run several hundred pages in length.

Probably the most detailed sources of information have been the administrative files of the VA Administrators, Medical Directors, Chief Medical Directors, and Directors of the Department of Veterans' Benefits. Files from 1945 to the present are kept in the central office. Files preceding 1945 are kept in a depot in Shirlington, Va. All these files are maintained by the Central Office Records Management Division of Administrative Services.

There is an abundance of miscellaneous VA historical material, in the form of unpublished documents, in the files of the various subdivisions of the Department of Medicine and Surgery and the Department of Veterans' Benefits, and also a cabinet reserved for such material in the medical and general reference library. Certain speeches of VA Administrators are also available in this library, as well as in the records' room of the legislative reference and research staff. Some of these speeches contain important explanations of VA policy and interesting descriptions of VA activities, often in styles which are more colorful and more forceful than the necessarily impersonal language of annual reports.

The collection of laws on veterans' benefits, title 38 of the United States Code, is available in two editions. One, in one volume, is published by the Government Printing Office, Washington, D.C. The other, in two volumes, annotated for lawyers, is published jointly by West Publishing Co., St. Paul, Minn., and Edward Thompson Co., Brooklyn, N.Y. In the back of the GPO edition, there is a 40-page historical summary of veterans' benefits, in outline form. At the beginning of the West-Thompson edition, there is a 38-page "brief history" in narrative form. The GPO summary does not include medical benefits, although these, of course, are spelled out in the main text of the edition. The highlights of title 38, with summaries of new legislation when necessary, are published annually in a fact sheet of between 40 and 50 pages, produced by the VA Information Service.

The "Medical Bulletin" was published almost every month by the Veterans' Bureau and the Veterans' Administration from 1925 to 1944. Its principal purpose was to publish articles by the agency's doctors on medical research, but it also contained articles of general interest, in layman's language, about activities and personalities in veterans' hospitals and clinics.

For guidance to those responsible for this volume, a series of papers on various phases of veterans' legislation were prepared by Mr. Guy E. Birdsall, who retired in 1960, as General Counsel of the Veterans' Administration.