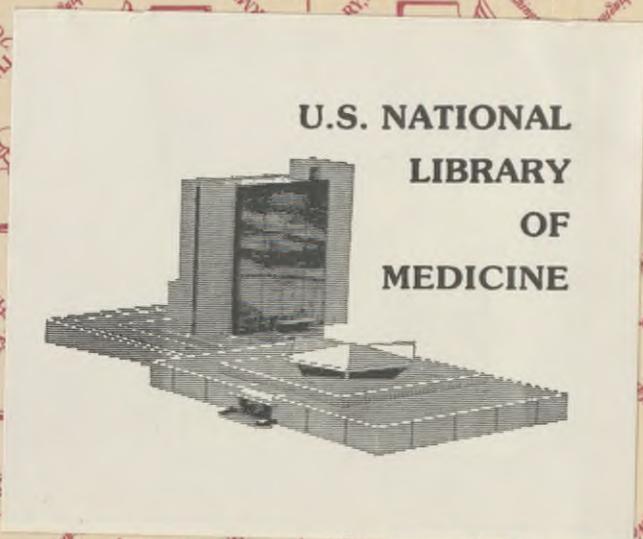
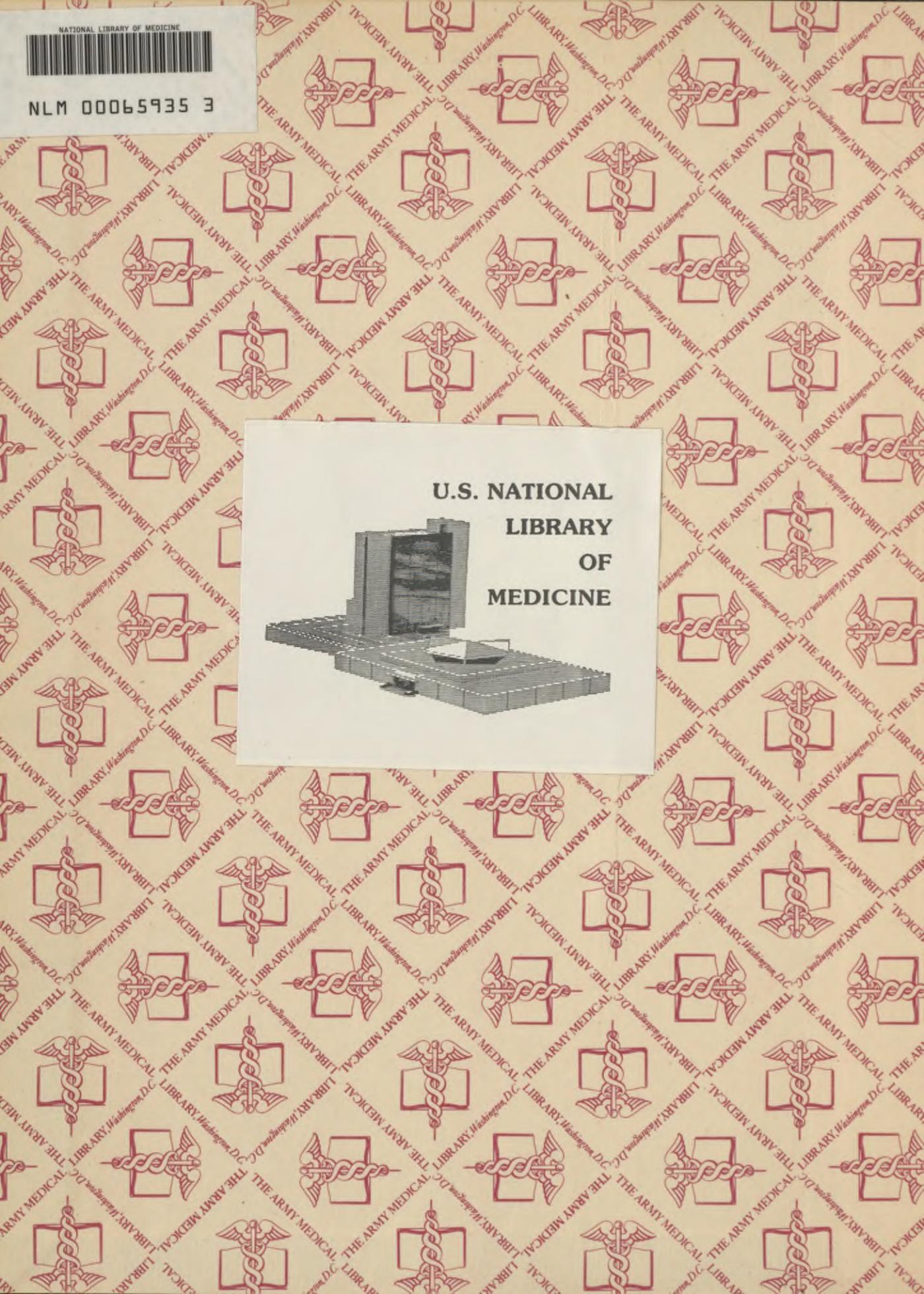




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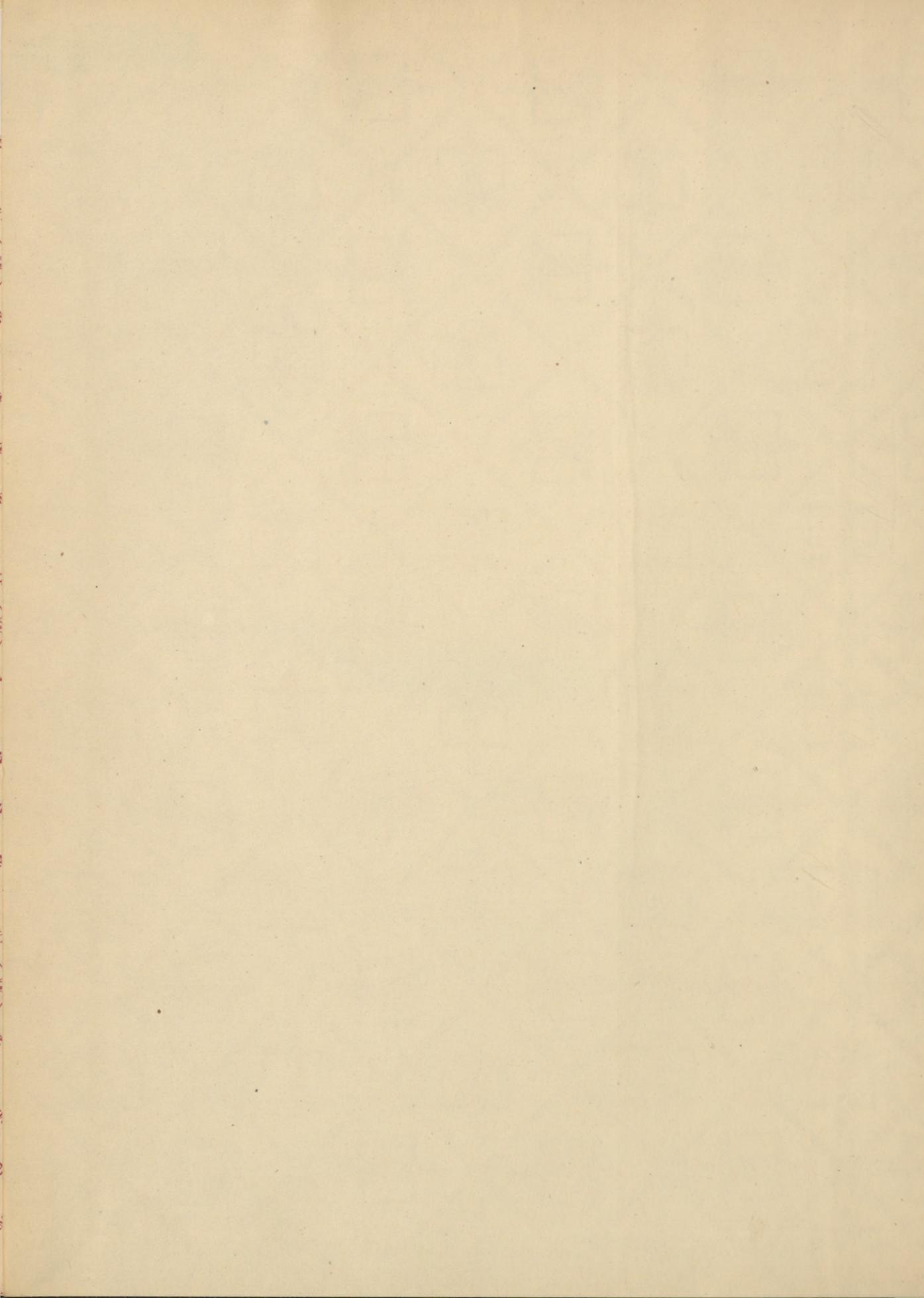
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CHAPTER VIII

NAVY HOSPITALS

Section 1. State of Preparedness on September 1941

The opening of hostilities on 7 December 1941 found the Navy Medical Department better prepared for a sudden situation than at the commencement of any previous period in the history of the United States.

United States Navy Medical Department

Administrative History 1941-45

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CHAPTER VIII

NAVY HOSPITALS

Section 1 State of Preparedness on 7 December 1941

The opening of hostilities on 7 December 1941 found the Navy Medical Department better prepared for a wartime situation than at the commencement of any previous conflict in the history of the United States. The national preparedness program had afforded the Bureau of Medicine and Surgery an opportunity to project its planning and to establish additional installations to meet the expected patient load rise due to increase in the personnel and casualties resulting from possible armed conflict.¹ Despite the fact that a firm basis had been formed, the influx of the recruits resulting from the preparedness program had already resulted in a rapidly mounting patient load. At the time of Pearl Harbor the hospitals were able to cope with the situation, and as a result of the expansion of plans previously made, were able to absorb the shock of the war emergency by using new units coming into commission.

At the beginning of the War there were 18 continental hospitals in commission. These institutions had an authorized bed capacity, on eight-foot centers, of 8,437 and were actually caring for 7,558 patients on the day of the Japanese attack. Of these, some

1. Annual Sanitary Reports for 1939, 1940, 1941.

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1,441 were supernumeraries.² This classification included the dependents of naval personnel, retired officers and men, and patients cared for under arrangement with the Veterans' Administration. This left a total of 6,117 patients from regular naval personnel on active service. At the time of Pearl Harbor, the size of the naval establishment was Navy 325,095; Marine Corps 70,475; Coast Guard 25,002--a total of 420,572 service personnel who were potential patients.³ This gave a ratio of one authorized hospital bed for approximately 50 patients. The above figure does not take into account the hospital potentiality for supernumeraries--which cannot be accurately estimated. The size of the existing patient load in continental hospitals left, in terms of 8-foot centers, only 879 beds available for the wartime casualties, a margin much too low even if there had not been the anticipated expansion of naval personnel.⁴

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2. Unless otherwise indicated, all statistical information on bed capacity and patient load are taken from tabulated forms in the Bureau of Medicine and Surgery. The particular information referred to in this instance is taken from: Memorandum for Chief, Administration Division, F. R. Lang, Chief, Medical Statistics Division, 22 Jan. 1946.
 3. Our Navy At War, Official Report Concerning Combat Operations up to 1 March 1944, Adm. E. J. King, p. 13.
 4. The standard practice is to have beds in United States naval hospitals arranged with an interval of 8 feet between bed centers. This is the optimum condition and the number of beds at this interval at any given hospital is known as its authorized capacity. In actual practice, especially during wartime, this does not pertain and hospitals very frequently carry a patient load considerably in excess of their authorized capacity. The increase is achieved by several regularly employed practices. The beds can be moved to a basis of 6 feet centers which increases the bed capacity more than half. In wards where ambulatory patients are housed, installation of double deck bunks doubles the capacity. Usually a combination of these two are used. In cases of extreme emergency, additional beds are set up in the aisles and quiet rooms. By these devices a hospital could care for more than twice its authorized capacity.

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The continental naval hospitals at the time of the War's beginning were on sites whose geographical locations had been dictated primarily by historical rather than by current or future needs.⁵ Most of the hospital construction undertaken under the preparedness program immediately preceding the outbreak of the War had been placed to give ready service to the rapidly expanding Navy training program. With the exception of Jacksonville, Corpus Christi, and Quantico, added in 1941, all of the naval hospitals had served during World War I and several had service records for five previous wars.⁶ In the location of these hospitals, the first consideration had been their ability to serve the Fleet. As a result, most of the hospitals in existence were placed in positions which were designed to serve a Fleet whose major theatre of activity was in the Atlantic Ocean. The hospitals were located chiefly in such port cities as Boston, Brooklyn, and Philadelphia. These cities had grown in size with the passage of years and frequently the hospitals were found in the midst of a busy industrial or business environment with its resulting noise, smoke and confusion.⁷

On the eastern coast were located the preponderant number of naval hospitals--12 of the 18 then in commission. This condition was the natural result of the fact that during our history most naval

5. Louis H. Roddis, A Short History of Nautical Medicine, pp. 252-300.

6. Ibid.

7. Annual Sanitary Reports, 1945, Cumulative Histories; in particular, note pictures of Brooklyn, Great Lakes, and the plat for Chelsea, given in Appendix K.

activity has been based in this area. The hospitals located in the East included U. S. Naval Hospitals in Portsmouth, New Hampshire; Chelsea, Massachusetts; Newport, Rhode Island; Brooklyn, New York; Philadelphia, Pennsylvania; Portsmouth, Virginia; Washington, District of Columbia; and Charleston, South Carolina. These institutions are all primarily designed to support operating bases, Navy yards, the training program, and Fleet activities. On the West Coast, serving similar types of activities, were the U. S. Naval Hospitals in Bremerton, Washington; Mare Island, California; and San Diego, California. All of these hospitals had been located as permanent installations to serve the peacetime activities of naval operation. With the increased tempo of the preparedness program, the training facilities of the Navy sea and air establishments had taken on new importance. As a result, medical facilities serving the training program were the first to feel the need of expansion. The dispensary at Marine Barracks, Quantico, was replaced by the U. S. Naval Hospital, Quantico, Virginia. At three naval air training centers the facilities were increased. New institutions were designated and established as U. S. Naval Hospital, Corpus Christi, Texas, and U. S. Naval Hospital, Jacksonville, Florida, while a new building was being constructed at Pensacola, Florida. In addition to these four, there were other units exclusively serving training activities of the Navy and Marine Corps. These were the U. S. Naval Hospitals in Great Lakes, Illinois; Parris Island, South Carolina; and Annapolis, Maryland. The patient loads at these hospitals had

increased markedly during this period.⁸

The hospitals in the eastern part of the nation contained a stated bed capacity of 6,121 while the actual patient load was 5,037. This allowed an expansion of only 1,084 beds with the standard eight-foot centers. On the West Coast the stated capacity was 2,316 and the patient load was 2,335, leaving no room for expansion at optimum conditions and already requiring the invoking of emergency procedures.⁹ It can safely be concluded that the morbidity of the expanded peacetime Navy nearly filled the authorized bed capacity of the established naval hospitals, leaving no opportunity for expansion to meet the wartime emergency, especially on the West Coast where such expansion would be most needed.

This difficulty had been recognized by Bullied long before Pearl Harbor and, within the limits imposed by the temper of the country and the funds available at that time, steps had been taken to meet the need. Not only had the three new hospitals been established and significant replacements and additions made as indicated above, but other plans and implementation of plans were underway. The dispensary at Key West was soon superseded by the U. S. Naval Hospital, Key West, Florida, which had been in the planning stage

8. Chapter III in this compilation illustrates this trend in detail. Annual Sanitary Report for 1939, 1940, 1941, 1942; General Files, Naval Hospitals 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 28, 30, 32, 61 give data on each of these institutions.

9. Memorandum for Chief, Administration Division, F. R. Lang, Chief, Medical Statistics Division, 22 Jan. 1946.

since early summer and the site chose by 15 August.¹⁰ The U. S. Naval Hospital, Washington, District of Columbia, was soon transferred to Bethesda to become an integral part of the National Naval Medical Center.¹¹ The construction of the physical plant of this project was rapidly nearing completion and could afford a considerable expansion. The 750-bed permanent U. S. Naval Hospital, Norfolk, Virginia, NOB, was under construction by 15 November 1941.¹² Discussions were also underway looking toward the acquisition of the Norconian Hotel, located some 50 miles east of Los Angeles, for an additional facility on the West Coast.¹³

Difficulties encountered by the Navy in new hospital construction during the period of the national emergency were amply illustrated in the construction of the U. S. Naval Hospital, Long Beach, California. The selection of the site was complicated by the efforts of rival communities to obtain the "prize". The work of the Shore Station Development Board and the district medical officer hampered by the flood of letters, telegrams, and other means designed to influence their decision.¹⁴ The problems of climatic

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10. Annual Sanitary Report for Key West, 1945, Cumulative History; also see General Files, N.H. 11.
 11. Annual Sanitary Report, Bethesda, 1945, Cumulative History; see also Chapter XI of this compilation for specific details.
 12. Annual Sanitary Report for Norfolk, NOB, 1945, Cumulative History; also see General Files, N.H. 49.
 13. Joint Letter to Chief of BuMed, Bureau of Yards and Docks, Commandant 11th Naval District, consideration of Norconian Hotel as convalescent center, Luther Sheldon, 21 Nov. 1941.
 14. See General Correspondence Files, N.H. 56.

conditions, accessibility, transportation, sanitation, and utilities were difficult questions to resolve; when these were further complicated by the factionalisms of contending civic groups, the achievement of an objective result is extremely difficult. In the selection of a particular site it was frequently found that the owner of the property desired was reluctant to sell or had an inflated monetary value placed on the site. Some property owners were actively pressing the advantages of sites they possessed and used many channels to convey this information to those charged with the selection of the location of the proposed hospital. Occasionally, it was necessary to take property by legal action, which was not only time-consuming but engendered a certain amount of local ill will -- a poor atmosphere for the initial phase of public relations.¹⁵ Every one of these problems was illustrated in the selection of the site of the Long Beach hospital. The first concrete was poured for this hospital on the day before the bombs dropped on Pearl Harbor.

The Navy Medical Department had an inadequate hospital plant to meet all the problems of the war which opened on 7 December. However, the problem was recognized, initial additions had already been established, and other units were in the planning stage or actually under construction. Although hospital facilities were not as extensive as the Department would have preferred, steps had been taken to meet the defense program and plans were being made and carried out to meet the eventuality of war.

15. This was even more frequently the case with special hospitals where established institutions were taken over. Note particularly General Correspondence Files, N.H. 47, 56, 71, 80, 170.

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Sections 2, Planning

General Planning Problems

The Medical Department is responsible for the maintenance of the health of the Navy.¹⁶ It is the oft repeated slogan of the Navy Medical Department that its mission is "To keep as many men at as many guns as many days as possible." It is well to consider first the exact position of Navy hospitals in the general pattern of the Department's service.

When any individual in the naval service is sick, wounded, or injured, he is entitled to the benefits of medical attendance and placed under the care of the medical officer of his command. At the dispensary or sick bay he is treated for his sickness or injury. This is his right and he remains under such care until he has recovered.¹⁷

Many dispensaries have beds and nursing service, and are, in effect, small hospitals. In such instances, except for serious cases where additional medical or surgical care is needed, the patient remains in the dispensary.¹⁸ The medical officer makes a daily report to the commandant of all persons who shall be excused from duty. This list is referred to as the binnacle list.¹⁹ The medical officer also reports in writing every morning to the commanding officer the names and condition of the sick.²⁰

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16. Navy Regulations, Article 457.
 17. Navy Regulations, Article 1191.
 18. See Chap. XII in this series.
 19. Navy Regulations, Article 1154, Article 1540.
 20. Navy Regulations, Article 1153.

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If the dispensary or sick bay cannot adequately care for the patient, he is sent to a naval hospital. This may be done on the recommendation of the medical officer, or by a board of medical survey, approved by the commanding officer. A hospital ticket, Form G, is made out and accompanies the patient until his discharge from the hospital.²¹ His health record and all other necessary papers also accompany him.²² The naval hospital cares for all sick and injured patients transferred to it from activities in the contiguous districts, and all other patients from outlying stations in the district, or casualties from overseas which are sent for their care by direction of the district medical officer or by higher authority.

Patients with diseases or injuries which require particularly specialized care and treatment may be transferred again to hospitals which specialize in such care. Convalescent patients are also transferred to convalescent or special hospitals. These topics are more fully dealt with in later sections of this chapter.

Most planning for activities of the Navy Medical Department in general, and U. S. naval hospitals in particular, is based on a number of factors over which the Surgeon General has no direct control. These are as follows:

1. The size of the Navy in terms of personnel. The expectancy is that approximately 1 to 2 percent of the duty personnel will be hospitalized in con-

21. Navy Regulations, Article 142; Manual of the Navy Medical Department, par. 3417.

22. Navy Regulations, Article 1195.

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tinental naval hospitals, and this figure directly influences the planning for the size of the hospital plant needed.²³

2. The location of naval activities, shore training facilities and bases for fleet and air activities strongly influences the location of hospitals.
3. The general theatres of action, which call for hospitals to be built and augmented to care for the resulting casualty load. In the late war the Pacific facilities were most heavily augmented because most naval action was in that theater and the casualty load was channeled through Pacific Coast hospitals.
4. As foreknowledge of military action, which is likely to produce casualties in great number, had been furnished to the Navy Medical Department only a very short time before the action took place, and in some instances only at the time of action. This practice of withholding certain classified information seriously hampered planning for the channeling of casualties. It was not until the spring of 1944 that the Medical Department was able to effect a system whereby this difficulty was mitigated in part.²⁴

23. Federal Board of Hospitalization, Resolution 150, 26 Feb. 1945.

In Nov. 1944 the ratio was 1.58% and in Feb. 1945 it was 1.92%.

24. Vice Adm. R. T McIntire to Capt. T. C. Anderson, Staff CominchPac
25 Apr. 1944.

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Planning as Revealed by Action

The office of the Surgeon General is charged with the problem of providing for all matters of planning affecting the Bureau of Medicine and Surgery. He is the direct representative of the Chief of Naval Operations with regard to medical matters in all things having to do with preparing the naval forces for war.²⁵ The correspondence files of the Bureau of Medicine and Surgery are replete with examples of the work of the Surgeon General in planning for the establishment, expansion and equipping of naval hospitals, as well as the formulation of general plans to meet the problems produced by an expanding Navy and the problems of caring for the thousands of casualties resulting from the War.²⁶

As has been stated in the previous chapter, the Bureau had been laying plans to order its establishment to meet the needs of the defense program and the possibility of a two-ocean war. Particular attention was already being accorded to training activity areas and to building additional facilities on the Pacific Coast.

With the coming of war, immediate action was taken to provide adequate facilities for large numbers of war casualties from Pearl Harbor and from other anticipated operations. The policy of taking over hotels, sanitariums and schools from civilian management

25. Annual Report, Chief BuMed, Fiscal Year 1939.

26. General Files, N.H. Section.

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and converting them into general or special hospitals was immediately inaugurated. Previous to Pearl Harbor, the Bureau had been studying this conversion program and the policy was ready for immediate implementation when the emergency arose.²⁷

Experience proved that this type of facility was well adapted to the special or convalescent type hospital but Corona was the only general hospital so converted. By the end of the War those converted buildings, with many added temporary facilities, accounted for 10,571 patients, or 11 percent of the total patient load of the continental hospitals at that time. It should be particularly noted that the decision to take over these institutions was not a sudden move adopted without consideration previous to the War's beginning.

The administrative organization of the Planning Division of the Bureau of Medicine and Surgery has been discussed in Chapter I of this book under "Organizational History of the Bureau of Medicine and Surgery." Here an endeavor will be made to indicate the results achieved by the Navy Medical Department relative to planning and construction of hospitals rather than to repeat internal organizational structure.

The Design Section of the Division, in cooperation with the Hospital Division of the Bureau of Yards and Docks, has evolved standard plans of both permanent and temporary buildings for various

27. Joint ltr. Chief BuMed and Bu Y&D and Commandant 11th Naval District from Chief BuMed, 21 Nov. 1941, Gen. Correspondence Files, N.H. 47.

hospital uses.²⁸ The Construction Section of the Bureau of Medicine and Surgery closely followed the building of each hospital unit. The wide use of standard plans and the cooperation of the two bureaus in their initiation greatly facilitated the speed with which the several hospitals were built. Standard plans led to considerable savings in the cost of construction by making possible large lot purchases of particular items. Although the plans were uniform, materials for construction could be obtained which were most available in the locality. Thus along the East Coast cinder blocks were frequently used; throughout the eastern and central part of the nation asbestos cement composition siding over wood frame was common, and on the West Coast readily available redwood sheathing was used for most temporary structures.²⁹

The Specifications Section was chiefly concerned with equipment furnished the hospitals, establishing specifications for type and quality. As in the case of the Design Section, this administrative unit is fully discussed as to organization in Chapter I of this book.

Specific Planning Problems

In any consideration of planning for naval hospitals, it is helpful to keep in mind certain official and functional differentiations between hospital types. The continental hospitals under the direction of the Surgeon General are officially classified as a U. S.

28. See Appendix L for example of detailed plan of building.

29. See descriptions of specific hospitals in this chapter.

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Naval Hospital, which is a general hospital, or a U. S. Naval Special Hospital, which is usually a convalescent hospital. In actual fact, certain dispensaries have been functioning as small hospitals, but will not be so considered in this appraisal.

The U. S. Naval Hospitals may specialize in some particular field of medicine or surgery, but they do not lose their fundamental character as general hospitals. A U. S. Naval Hospital may have associated with it, and under its command, an annex for convalescent patients.³⁰ Although in function these annex units are similar to special hospitals, they are not so designated and serve as regular adjuncts to the larger installations. At certain hospitals associated with training activities, the station dispensaries are directly under the hospital command, and for administrative purposes are treated as annexes.³¹ Out-patient clinics and family hospital units are also occasionally physically detached from the main hospital compound, but for administrative purposes are treated as annexes.³²

The U. S. Naval Receiving Hospital, San Francisco, is the only continental hospital so designated. Its purpose is to screen, classify and route properly to continental hospitals patients evacuated from overseas. It was originally designated Fleet Hospital No. 113, but was redesignated as a general hospital. It is more fully described later.

30. Examples are Chelsea (Fenway Annex), Corona (Spadra), Great Lakes (Lawrence and MacIntyre), Mare Island (Napa), Philadelphia (Swarthmore), San Diego (Balboa).

31. See Sanitary Reports for Norfolk and Sampson.

32. See Sanitary Reports for Memphis, Farragut, Quantico.

The scope of the planning activities and the flexibility used in achieving results is perhaps best illustrated in a division of the types of hospitals on a basis of the medium of construction or acquisition. Once the extent of patient load was conjectured the specific planning to meet the problem was channeled in the following manner:

1. Permanent hospitals of permanent construction were the great preponderance of facilities available upon the outbreak of hostilities. Their condition at the War's outbreak has already been chronicled. During the War, a long-range planning program was pursued to guarantee adequate facilities for the post-war period. Within the limitations of material scarcity, new units were constructed and old facilities augmented by permanent structures.³³ It had been estimated that hospital requirements for Navy personnel in the post-war period will be roughly four times that required before the War, and the planning was keyed to meet this end.³⁴ During the emergency and war period, seven new permanent hospitals were completed or in advanced stages of completion.³⁵ Three hospitals were given new and permanent plants--Pensacola, Charleston, and Bethesda (replacing Washington). Two others were in the planning stage or

33. See Physical Plant Section of this chapter.

34. Federal Board of Hospitalization, Resolution 161, 24 Apr. 1945.

35. In order of commissioning they were Quantico, Corona, Key West, NOB Norfolk, Long Beach, Dublin, Houston.

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under construction; Beaufort was scheduled to replace Parris Island and St. Albans to replace Brooklyn. Wartime scarcity of materials delayed these latter replacements. The pattern of permanent hospitals at the end of the War placed 14 units on the East Coast and 5 on the West Coast, with 2 in the mid-continent area. The West Coast facilities were larger and thus the disparity of facilities was not as great as the numbers might seem to indicate. A new unit for the San Francisco area had also been in the planning stage since 1943.³⁶

2. Temporary hospitals were built to meet the needs of the training program and to provide facilities in the shortest possible time for care of war casualties. Their placement and size bore no direct relation to planning for the permanent size and disposition of the naval hospital plant. These hospitals were situated at the training areas they served and at points readily accessible to patients being brought into the West Coast from combat areas.

Such hospitals were all housed in temporary structures

36. Permanent hospitals for the post-war era are, East Coast - Annapolis, Beaufort, Bethesda, Charleston, Chelsea, Dublin, Key West, New York, NOB Norfolk, Pensacola, Philadelphia, Portsmouth, N.H., Quantico, St. Albans; West Coast - Bremerton, Corona, Long Beach, Mare Island, San Diego, San Francisco (in planning state); Mid-continent - Great Lakes, Houston.

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of various standard styles. Most common was the "I" or "finger" style, frequently referred to as the "Bethesda type" and used for war purposes.³⁷

The standard "H"-type building was used almost exclusively for quarters purposes at temporary installations. Soon after the out-break of hostilities, the cost of construction was described as follows:

"The Bureau of Yards and Docks in evaluating permanent and temporary construction for hospital facilities, estimate the permanent bed costs at \$6,000, and in temporary construction the cost per bed is approximately \$4,000."³⁸

With costs of labor and material increasing, it is interesting to note that by careful planning and supervision it was possible to build at a figure considerably under this even later in the War.³⁹

3. There was only one instance of the Navy's taking over a civilian institution for general hospital purposes, a policy followed more extensively by the Army. This hospital was Corona which is a good example of dynamic action in making available additional beds in the shortest period. The former Norconian Hotel, Lake

37. Annual Sanitary Report, 1944, Oakland, Long Beach, etc.

38. Chief of Bureau of Medicine and Surgery to Secretary of the Navy, 7 Feb. 1942.

39. Annual Sanitary Report, Shoemaker, 1945, Cumulative History.

Norconian Club, was acquired by the Navy on 9 December, just two days after Pearl Harbor. The possibility of using this establishment for a convalescent center had been under consideration as early as 21 November 1941. Immediately after the receipt of news of the attack, an arrangement was made with the owner for prompt occupancy. The President assisted in this matter with his active interest and by making immediately available necessary money from the Emergency Fund. The fact that funds for the purchase and remodeling of the building were to be taken from this source enabled immediate action, which would otherwise have been prevented by legal restrictions requiring Congressional approval.⁴⁰ U. S. Naval Hospital, Corona, California, was officially designated and established on 16 December. Delay encountered by the Judge Advocate General's office in clearing the title prevented the receiving of patients until 24 February 1942. The hospital was an innovation which conclusively proved its worth in expanding the naval hospitalization facilities to cope with an urgent need. It inaug-

40. JAG, Memorandum to Vice Adm. Ross T McIntire, 10 Dec. 1941.

urated a pattern of expansion which was to be implemented by the establishment of many convalescent and special hospitals.

4. Civilian hotels, sanitariums or school establishments were converted into special or convalescent annexes to regular hospitals. These annex units were of real assistance in relieving the patient load at regular hospitals. Such forehandedness in planning made it possible for the most advantageous utilization of the regular hospital establishments. Examples of these were Spadra Annex at Corona, Swarthmore Annex at Philadelphia, Balboa Annex at San Diego, and Napa Annex at Mare Island.
5. In the latter part of the war period, the Navy was able to use Army installations which became available when the Army training program decreased as Army personnel were sent overseas. The hospital units at two former Army camps were utilized by the Navy as general hospitals. Fort Eustis, Virginia, became a general hospital which served to absorb the load in the Norfolk area. Corvallis, the former Army Camp Adair, served as an overflow general hospital for the 13th Naval District and the Pacific Coast area.

Cooperation With the Federal Board of Hospitalization
in Planning for Naval Hospitals

The Federal Board of Hospitalization was first established in 1924. It served to coordinate federal hospital construction programs and advise the Bureau of the Budget on this subject. "No project for acquisition of additional beds by new construction, major alterations, or leasing of or contracting for existing facilities, (except to meet temporary seasonal, epidemic, or emergency requirement) shall be undertaken by any Federal Agency until it has been submitted to and reviewed by the Board as to need and location and type of construction."⁴¹

The Board membership is drawn from the agencies chiefly concerned and served to bring a greater unity of action.⁴² With the coming of the War, an emergency existed and for the first 18 months after Pearl Harbor the Board did not function relative to military installations. In May of 1943, the hospital expansion programs of the armed forces were again placed under the Board for purposes of coordination. From this time on, all major expenditures for hospitalization were channeled through the Federal Board of Hospitalization.⁴³

Shortly after this directive it was modified "to permit

41. Budget Circular No. 146, 24 Oct. 1924; Budget Circular No. 281, 26 June 1930; Budget Circular No. 282, 28 July 1930.

42. Chairman appointed by Bureau of Budget, members include Commissioner of Indian Affairs, Director of Bureau of Persons, Surgeon General of War Department, Surgeon General of Navy Department, Surgeon General of the Public Health Department, Chief of the Veterans' Administration.

43. Budget Circular No. 419, 7 May 1943.

the War and Navy Department to acquire limited hospital facilities involving temporary types of construction only and not exceeding 150 beds for any one project.⁴⁴ This modification had two results. First, a number of the smaller dispensary units which might have been designated hospitals remained small hospitals in all but name.⁴⁵ Secondly, it enabled emergency additions of several "I" or "H" wards to be made to existing institutions without clearing through the Federal Board of Hospitalization. The general result was that existing institutions were expanded rather than establishing new naval hospitals.

Coordination of effort through the Board facilitated the integration of the Navy building program with the future needs of the Veterans' Administration. The permanent hospitals at Dublin, Georgia, and Houston, Texas, were so planned as to meet requirements for a veterans' facility if after the end of the War it was thought expedient to use them in whole, or in part, to care for patients under the cognizance of the Veterans' Administration. The taking over of unused Army hospital facilities for general hospital purposes was followed at Corvallis, Oregon, and Fort Eustis, Virginia; for Special Hospitals, Banning, Beaumont, Camp White, Camp Wallace, and Spadra Annex. By being a part of this integrated program, the Navy hospital program was in a position to avail itself of other government hospital facilities more quickly than might have otherwise been the case.

44. President F. D. Roosevelt to Harold Smith, Director of Budget, 10 May 1943.

45. A good example is Miami Hospital, N.H. 84.

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The Results of Planning

Planning is best shown in the results. The statistical tables in Appendix Q give authorized bed capacity and the actual patient load at certain specified periods. During the War, the authorized bed capacity of continental regular hospitals increased from 8,437 to 64,009. This represents an increase of 753 percent. The actual patient load increased from 7,558 to 86,331 which represents an increase of 1,142 percent.⁴⁶

It will be noted that actual patient load is considerably above the authorized bed capacity. This condition became true as early as 1 January 1944 and continued throughout the War. Scarcity of materials for building purposes allowed only the most necessary construction. It was only through skilled planning by the Bureau that they were able to provide for the rapid development of patient load. Hospitals were thus located at ports where fleet units were based, centers of training activities, naval construction bases, and ports of casualty debarkation.⁴⁷

The first year of the War found 9 new hospitals placed in commission, 5 of which were on the West Coast.⁴⁸ At the close of 1942, these new hospitals on the West Coast had an authorized bed capacity of 3,400 and an actual patient load of 2,862. In addition, plans were

46. Memorandum for Chief, Administration Division, 22 Jan. 1946. Statistical information in this section is taken from tables accompanying this memorandum.

47. See Appendix P. Note the series of maps in the Appendix R illustrating hospital distribution.

48. See Appendix C for hospitals commissioned. Those on the West Coast were Corona, San Francisco, Oakland, Seattle, Long Beach.

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executed whereby the bed capacity of the three existing hospitals had been raised 2,234 and their actual patient load had increased 3,781. The total increase of bed capacity on the West Coast was 5,634, and the actual patients under care had gone up to 6,643.⁴⁹

During 1943, hospitals were established at the Farragut, Bainbridge, Sampson and Memphis naval training units to afford an authorized capacity of 4,532. The Marine training activities at New River and Camp Pendleton were served respectively by the New River and Santa Margarita Ranch hospitals, which, with the hospital units at Quantico and Parris Island, provided 3,920 authorized beds and actually cared for 2,578 patients at those Marine activities. Santa Margarita Ranch and Shoemaker hospitals were both on the West Coast. The St. Albans hospital serving the vital New York area was also activated during the year.

During 1944, two more hospitals on the West Coast, San Leandro and Astoria, were placed in commission to help absorb the

49.	<u>New Hospitals</u>	<u>Rated Capacity</u>	<u>Bed Patients</u>
	Corom	1,000	257
	San Francisco	500	561
	Oakland	800	1,385
	Seattle	800	447
	Long Beach	300	212
	TOTALS	<u>3,400</u>	<u>2,862</u>

INCREASE IN ESTABLISHED HOSPITALS

	Bremerton	242	234
	San Diego	1,576	2,369
	Mare Island	<u>416</u>	<u>1,178</u>
	TOTAL	2,234	3,781
	GRAND TOTAL	5,634	6,643

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patient load increase caused by returning casualties, and in 1945 two additional units, Corvallis and San Francisco Receiving Hospital, were added. These four units had a combined capacity of 4,291.

A study of the maps in Appendix R showing the geographical distribution of new installations as the War progressed illustrates the effective results of careful planning throughout the entire war period. A study of the sanitary reports confirms the opinion thus formed, and although hospitals bore a heavy burden of patients, the situation was under control and new units regularly came into commission in time to avert a breakdown of the hospitalization program.

Section 3. Organization of Naval Hospitals

The organization of naval hospitals as it existed at the beginning of the War is outlined in the Manual of the Medical Department. The mission of the naval hospital, as there stated, clarifies much concerning the formal organization:

- (1) Care of the sick and injured naval personnel with the object of their restoration to duty.
- (2) The disposition of those patients who require special treatment not satisfactorily available, or who are unfitted for retention in the naval service.
- (3) Treatment of other persons when authorized by competent authority.
- (4) Cooperation with the military and civil authorities in all sanitary matters.⁵⁰

The general organization of U. S. naval hospitals conforms to the chart included in the Manual of the Medical Department.⁵¹ Be-

50. Manual of the Medical Department, Chapter 12, par. 1603.

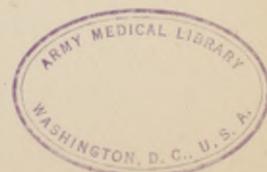
51. Manual of the Medical Department, par. 1605-B. For examples of the charts from the old and revised copies of the Manual, see Appendix E.

cause of the disparity in size of the hospitals and varying classification of patient types, the actual organization may vary somewhat from the model. All of the examples of individual hospital organizational charts included in Appendix E vary in greater or lesser extent. As a general rule, it will be found that the larger the organization the greater the resulting variations from the norm.⁵²

Paramount in all naval organization come the responsibilities of the commanding officer and his direct representatives. The commanding officer communicates directly with the Bureau of Medicine and Surgery upon matters which are of internal or professional interest only. Such matters as may affect military policy or relate to other activities involving major changes shall be communicated through channels to the commandant if the hospital is in a Navy Yard or other group command, or through the commandant of the naval district in which it is located. Upon the commanding officer falls the task of affecting final coordination and the achievement of an efficient organization.⁵³ He is also the official charged with establishing definitive policies and routines. By the nature of his position, he stands as the chief representative of the Navy, as well as of the hospital, in the field of public relations in all matters affecting his command. The commanding officer is assisted by a number of subordinates in these responsibilities--the executive officer, the officer of the day, and the

52. Appendix E includes examples for Annapolis, Jacksonville, Key West, Great Lakes, Long Beach, Mare Island, Memphis, NOB Norfolk, Pensacola, Portsmouth, N.H., St. Albans, Seattle, and Shoemaker.

53. Navy Regulations, Articles 170, 1482, 2038.



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chief master-at-arms. Frequently this section of the organizational scheme includes the security officer and other members of the headquarters staff.

The functional operation of the hospital is divided into two general types of duty, administrative and clinical. All professional activities are grouped under the clinical, and the many other diverse types of activities are assembled under the administrative.

The clinical services employ the greater portion of the hospital personnel and are the center of the hospital system; it is to serve them and to supplement their activities that all other units are created. The individual organizational charts usually list at least eleven service units: surgical, medical, eye, ear, nose and throat, laboratory, urological, neuropsychiatric, X-ray, dental, physical therapy, nursing and out-patient. These groupings are often broken down into other smaller units in the larger hospitals. The out-patient unit may have the dependents separated; the EENT may be separated into the various groups or units of its component parts; physical therapy may have occupational therapy separated, and orthopedic service may be separated from surgery. Other divisions occur when they are deemed expedient. The chiefs of the services are the senior officers attached to these several groups. They are directly responsible for the patients under their care and are representing the commanding officer in all matters of his responsibility under their jurisdiction.⁵⁴

54. Manual of the Medical Department, par. 1663.

Under the heads of each service are heads of departments within those services. After consultation with the chief of their service, they formulate and carry out all administrative rules and duties in their department.

Each ward in the hospital is under the charge of a ward medical officer who is in direct charge of that unit and responsible to his department head. To him fall the tasks of being in constant touch with the patients and overseeing their care. He is also charged with the direction of personnel and the oversight of material.

Junior medical officers and interns not having specific ward assignments are assigned duties by the commanding officer such as watch officer and such other assignments as may supplement their training. Interns are assigned duties furthering their training while in service.

The clinical service in some hospitals, especially smaller hospitals, is often divided into two general groups under the chief of medicine and the chief of surgery. Under the former will be grouped the laboratories, medical wards, neuropsychiatric ward, dental, nursing, and intern training; under the latter will be the operating rooms, surgical wards, EENT, orthopedic, X-ray, physiotherapy, and urological. The specific duties and activities of the various services will be treated in the section relating to activities of the hospitals during the war period, where the account of their work indicates their functional organization.

An observation on the functions and organization of a naval hospital was submitted with the 1945 sanitary report of one of the larger hospitals:

This hospital while following the precepts laid down by higher authority has what is perhaps a unique organization which puts the emphasis not on the Commanding Officer but on the principal function of the hospital--the care of the patient. The patient, therefore, is depicted as the axle of the wheel. The hub is represented by the ward medical officer and his organization made up of nurses and hospital corpsmen. This ward organization furnishes the means of contact between the patient and hospital. This hub, the ward organization, is supported by the hospital facilities representing the spokes of the wheel, and these spokes--each under its designated officer--are to be utilized as required for the benefit of the patient. For example, if the patient's stomach should be resected, General Surgery is utilized; if he needs a blood study, the Laboratory (spoke) does it, and so on for all the hospital activities. These activities, under the proper officer, are coordinated by the officers heading them, the officer of the day, and finally by the Commanding Officer (the tire of the wheel) who appropriately is charged with outside relations, with contact with the outside.⁵⁵

The diagrammatic chart alluded to is found in Appendix E and amply illustrates the points made.

The administrative section of the hospital's organization is so ordered that the routine transaction of hospital business, such as preparation of correspondence, records, reports and returns, and the orderly filing of documents, may be expedited. All hospitals have in some form the following administrative activities: personnel-record office, accounting office, commissary, property office, disbursing office, pharmacy, maintenance department, morale activities, and

55. Annual Sanitary Report, 1945, Long Beach, Calif., Cumulative History.

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training activities. In the larger organizations these are greatly expanded and subdivided as is indicated in their organizational charts. Under administrative activities are frequently grouped such adjuncts to the hospital service as the Red Cross library, athletics, Marine guard, civilian guard, post office, ship's service, brig, chaplain, public relations, and those more recent but signally important activities of the Rehabilitation Board and all of its many ramifications.

Procedure for Establishment of Hospitals

During the War some 31 new U. S. naval hospitals and 15 special or convalescent hospitals were established. Besides these functioning institutions there had been several other projects which had reached the planning stage but were not carried out for various reasons. In addition, 8 annex units were added to existing hospitals.

The procedure for establishment followed in a series of carefully integrated steps which occasionally varied somewhat because of individual situations. The following series of actions are not those followed in any particular instance but are typical of the procedure followed, and all steps were encountered in several individual instances:

1. The general need for the hospital in a given area was determined by the Surgeon General and the Planning Division of the Bureau of Medicine and Surgery. The district medical officer and the inspector of medical department activi-
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ties had in several instances made general or specific recommendations as to needs for expansion in the district or area.⁵⁶

2. The Planning Division made a more exact estimate of the situation suggesting several specific alternatives of location or facilities available. In the early years of the War, this was usually more informal than in the latter period.
3. Subsequent to 7 May 1943, all plans for expansion of hospital facilities were submitted to the Federal Board of Hospitalization for approval.
4. The Shore Station Development Board selected the site for the proposed installation.
5. The Bureau of Yards and Docks, Hospital Division, undertook the construction of the physical plant.
6. The Bureau of Medicine and Surgery appointed, soon after the construction was started, a "prospective medical officer in command" to keep the Bureau informed of progress and offer suggestions.
7. When it became advisable to have other personnel aboard, the Bureau requested the establishment of the hospital. The hospital was established officially by a SecNav "Circular Letter to All Ships and Stations" which was further

56. Manual of the Medical Department, par. 1102 d and h.

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published in the Navy Department Bulletin.

8. Usually accompanying the establishment, but occasionally separate, were the designating and giving of official mailing address.
9. With the establishment and designation, a file number and an accounting number were assigned to the hospital.
10. When a station was established and designated, a paymaster was assigned, this made possible the assembling of a staff in preparation for the commissioning of the institution. The personnel officer and supply officer were also usually assigned at that time.
11. When the date was determined that the institution was in a position to receive patients, a request was made to the Bureau to place the hospital in commission. The Bureau granted the request and on the appointed day the commissioning took place. Sometimes the ceremony was one of considerable dignity and public notice, and in other instances it was only the official recognition of the **activation** of the institution. Theoretically a hospital did not receive patients until it was commissioned, but in several instances emergency conditions arose which placed it in active service before that date. Conversely, a number of hospitals were not able to care of patients until as much as two months after the date of commissioning.⁵⁷

57. The material for the above summary is drawn from the case histories of the hospitals as revealed in their development in General File, N.H.

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Section 4. Physical Plant

In any study of the physical size and features of naval hospital establishments, several fundamental conceptions of their purpose and function must be kept in mind. There are a number of reasonable considerations, which are frequently overlooked, as to why patient loads are larger and individuals stay longer in naval hospital than in comparable civilian institutions. (1) Every person in the Navy needing hospitalization receives it within a hospital and not within his own home as is common for a great number of ailments encountered in civilian life. (2) The Navy patient also receives, as a matter of right, the very best of technical aids, such as X-ray and laboratory services, which are frequently not enjoyed by civilians because of lack of funds to pay for them. Such courses of treatment available at naval hospitals also take additional time. (3) Of necessity they remain in the hospital until they are fit for regular naval duty, while the same patient in a civilian hospital would usually remain in the institution only while a bed patient and then would convalesce at home. (4) A number of naval hospital patients are classed as neuropsychiatric cases and this type of patient is not usually found in civilian general type hospitals. (5) War casualty cases, who come to military hospitals in large numbers and frequently require extended hospitalization, have no counterpart of concentration in civilian institutions. (6) Naval

hospital care for supernumerary patients accounted for 19 percent of the patient load on 7 December and even at the end of the War amounted to 4,612 or 5.4 percent.

Naval hospital establishments have a number of common characteristics in their physical pattern. There is usually a center building or group of connected buildings which house the various administrative offices, operation rooms, X-ray, laboratory, and departmental and divisional office and clinic. The wards and S.O.Q. are also usually an integral, physically connected part of this pattern. In addition, the hospital compound generally includes a number of subsidiary structures usually physically separated from the main unit and from each other. Examples of such units are officers' quarters, nurses' quarters, WAVE quarters, corpsmen quarters, and the auxiliary buildings such as shops, laundry, garages, storehouses, greenhouse, recreation building, and gate houses.

In a group composed largely of permanent buildings, there is a concentration of activities in fewer but larger structures. When temporary structures are used, the buildings are individually smaller, usually being but one story in height and occupying no more ground space than permanent units.

Hospitals contiguous to metropolitan areas are afforded several advantages by such a location. Facilities such as water, sewage disposal, provisioning of fresh vegetables and meat, and fire protection are available and preclude the necessity of constructing such units.

Entertainment for personnel and convalescent patients in such areas is more diverse and readily available.

On the other hand, hospitals located at a distance from large communities have to construct additional facilities such as water tanks and pumps, and install larger storage and refrigeration units, sewage disposal plants, and more completely equipped recreation buildings. In entirely undeveloped areas, housing for civilian employees is frequently required.

An examination of photographs and ground plans of representative hospitals such as San Diego and Houston for permanent structures, and Farragut and Astoria for temporary, will emphasize these generalizations.

The construction program included experimentation in new types of equipment and building material. Every effort was made to cut down noise by acoustical treatment, to use air conditioning in operating rooms, and to eliminate static electricity by insulating operating room floors. Of course wartime scarcity cut down the effectiveness of this program, but in most permanent hospitals very considerable strides in this direction were made.⁵⁸

During the preparedness period and the War, the Navy completed 10 permanent hospital establishments. In order of completion

58. See Sanitary Reports for Pensacola, Charleston, Dublin, Corona, and Key West. "They Told Me About Their Hospitals," Capt. Lucius W. Johnson, (MC), USN, United States Medical Bulletin, Apr. 1940, vol. 38, No. 2.

these were

- Pensacola, Florida
- Quantico, Virginia
- Corona, California
- Charleston, South Carolina
- Bethesda, Maryland
- Key West, Florida
- N.O.B. Norfolk, Virginia
- Long Beach, California
- Dublin, Georgia
- Houston, Texas

The plant at St. Albans was delayed by scarcity of materials during the War, but with its end, work on the permanent structures was again resumed. The Parris Island hospital is to be replaced by a permanent structure in Beaufort. An examination of the physical growth of the several hospitals reveals that during the War almost all existing permanent institutions were augmented by additional permanent buildings which will increase their efficiency and capacity in the post-war period.

During the war period, permanent hospitals were also enlarged by using many temporary buildings to care for the increased load. Almost all permanent hospitals presented a mixed pattern of permanent and temporary structures.

At the close of the War there were 42 general naval hospitals in commission. They ranked from San Diego, the largest with an authorized bed capacity of 10,499, to Quantico with an authorized bed capacity of 270.⁵⁹ During the War the bed capacity for most hospitals

59. See Appendix N.

was greatly increased. The actual beds in use were very frequently in excess of the established capacity on 8-foot centers. At the end of the War, the patient load of 85,845 greatly exceeded the authorized capacity of 64,009.

The U. S. Naval Hospital, Annapolis, Maryland, is associated with the U. S. Naval Academy. The hospital is located on a reservation of approximately 19 acres with an elevation of 45 to 50 feet.⁶⁰ It extended to the Severn River, but war use reduced the section fronting the river.⁶¹ The location has a pleasant vista. The Annapolis hospital is one of the few institutions of its class which did not undergo extensive enlargement following the outbreak of the War.⁶² The main building had been completed in 1907 and at the beginning of hostilities there were 16 auxiliary permanent structures and 4 temporary buildings.⁶³ During the war period one new wing was added and complete renovation of the existing facilities took place.⁶⁴ Its authorized patient load did not change throughout the War, and it ranked forty-first among similar type hospitals at the close of the War.

U. S. Naval Hospital, Astoria, was commissioned late in 1944 to relieve the overcrowding in existing establishments in the Thirteenth Naval District. Being proud of the uniform climate of that region, the sanitary reports note the average temperature does not fall below 42 degrees. It was recorded that an average rainfall of some 61 inches or exceed 57 degrees

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- 60. Annual Sanitary Report, 1943.
 - 61. Annual Sanitary Report, 1942.
 - 62. Annual Sanitary Report, 1945, Cumulative History.
 - 63. Annual Sanitary Report, 1943.
 - 64. Annual Sanitary Report, 1945, Cumulative History.

is experienced and that dense fog is encountered at least ten days each year.⁶⁵ All of the buildings of this installation were of temporary construction of the "I", single-story type with asbestos cement siding. There were 55 buildings in the compound connected by the covered corridors necessary in the climate described.⁶⁶ The hospital ranked thirty-seventh among naval installations at the end of the War.

The large U. S. Naval Training Station, Bainbridge, Maryland, made necessary the hospital at that location. It was placed in commission 4 February 1943. The area of the grounds is 90 acres. During the War it grew to 68 buildings including 30 ward buildings.⁶⁷ The grounds of the hospital were completely cleared while building the new station, and considerable soil erosion resulted. In common with the experience of several such wartime developments, a great deal of labor was rendered necessary to stabilize the soil and prevent blowing dust.⁶⁸ The buildings were of temporary type with an asbestos board exterior. Half of the buildings had flat tops with tarpaper covering which persisted in leaking and required extensive repair and renovation.⁶⁹ Six of the buildings used for administrative and housing purposes were two-storied, of the barracks type. The hospital was nineteenth in size among the naval hospitals of the general type.

The U. S. Naval Hospital, Bremerton, Washington, is situated on the rolling top of a hill approximately 200 feet in elevation over-

65. Annual Sanitary Report, 1944.

66. Ibid.

67. Annual Sanitary Reports, 1943 and 1944.

68. Annual Sanitary Report, 1944.

69. Annual Sanitary Reports, 1943 and 1944.

locking the Puget Sound Navy Yard, of which it is a part, and the Sinclair Inlet. It is one-third mile from the water, located on a reservation of 17 acres.⁷⁰ Neither the hospital nor the grounds have been marred by developments or construction during the war period. "Green lawns and gardens, towering fir trees, and the golf course of the Navy Yard surround the reservation."⁷¹ At the beginning of hostilities, it comprised some 30 brick buildings of old English colonial architecture.⁷² During the War, 5 temporary units were demolished to make way for construction of several new permanent and temporary structures, including a sick officers' quarters, laundry, and Hospital Corps quarters.⁷³ Fivefold expansion in the number of patients caused a very intensive use of the existing facilities. "It can be said that all these things were accomplished in such a way that the hospital was not cut up or cluttered. On the contrary, the hospital presented a calm well-integrated cleanness of line and arrangement which belied the intense activities and testified to the efficient work that characterized the performance of this hospital throughout the war period."⁷⁴ The institution ranked thirty-third among continental hospitals and was an important unit among the West Coast facilities.

U. S. Naval Hospital, Brooklyn, was commissioned in 1832 and has since served the Navy yard at that place. During the war period there was no new construction at the hospital, as it was ex-

70. Annual Sanitary Report, 1942.
 71. Annual Sanitary Report, 1945, Cumulative History.
 72. Annual Sanitary Report, 1944.
 73. Annual Sanitary Report, 1942.
 74. Annual Sanitary Report, 1945, Cumulative History.

pected that the establishment would close at the time of the commissioning of St. Albans, also located in the New York area. However, in February of 1943, when St. Albans was ready to be placed in commission, the patient load in the area had risen to such an extent that it was deemed advisable to continue the Brooklyn hospital.⁷⁵

The Navy yard had planned to use the hospital area for expansion, but this necessary expansion was delayed by the still more urgent need for additional hospital facilities in the area.⁷⁶ The compound contains some 30 buildings of permanent construction. The main buildings were three-story structures closely grouped because of the lack of space. Although no new buildings were constructed, the entire plant was reconditioned and renovated during the war period. Most of this work was accomplished by Navy yard labor which was readily available.⁷⁷

The Brooklyn hospital ranked thirtieth among continental installations.

The U. S. Naval Hospital, Camp LeJeune, North Carolina, served the large Marine training activities in that area. It was originally commissioned as U. S. Naval Hospital, New River, 1 June 1943, but was changed to the present designation on 1 November 1944. The hospital is located a short distance from the camp area and comprises an area of 145 acres. Like several other hospitals in this general region of the South Atlantic and Gulf Coast, the ground is partly sand interspersed with patches of gumbo-like soil. The reservation was well wooded, although the soil of such areas needs to

75. Annual Sanitary Report, 1945, Cumulative History.

76. Annual Sanitary Report, 1943.

77. Annual Sanitary Report, 1944.

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be enriched for grass cover to prevent blowing sand and dust. In the sanitary reports this station relates that the average temperature range is between 63 and 68 degrees, with extremes considerably beyond these figures. The relative humidity averages 73 percent -- a high concentration which is found along the coast increasing southward and westward to Corpus Christi and produces severe patient discomfort in summer. The main group of buildings are permanent brick structures with a number of additional temporary ward and subsidiary structures.⁷⁸ It ranks twenty-third among general hospitals in size.

The U. S. Naval Hospital, Charleston, South Carolina, was the smallest naval hospital. It was created in 1917 to serve the Navy yard at that place. With the coming of the defense program, a new building was authorized and placed in commission on 13 April 1942. The new structure was located in the northwestern section of the Navy yard.⁷⁹ The main building is in the form of a square around a small park, with 12 temporary wards increasing the capacity for war emergency purposes. In addition, there were 8 permanent buildings including the nurses' quarters, sick officers' quarters and recreation building. The corpsmen barracks and the WAVE quarters were of temporary construction.⁸⁰ Part of the area was marsh, and piling was required for construction; the remainder was firmer sand. The buildings are surrounded by abundant shrubbery and woods. Mosquito

78. Annual Sanitary Report, 1944.

79. Ibid.

80. Annual Sanitary Report, 1942.

control and policing were found to be necessary. It started the War with the smallest authorized bed capacity but on V-J Day ranked above 10 other hospitals.

The U. S. Naval Hospital, Chelsea, Massachusetts, is located in proximity to the Charleston Navy Yard. It is located on a "jutting promontory" on a plat of some 81 acres of usable land, with the Mystic and Island End Rivers on either side. At the beginning of the War the hospital area contained a total of 31 buildings of which 13 were permanent. These units were renovated in 1942 by W.P.A. labor.⁸¹ The main structure of the unit is situated on the top of the hill, while the ward buildings and supplementary structures are located on the slopes.⁸² During 1944, a considerable amount of new construction was undertaken and a dependents' unit, WAVE barracks, recreation building, and subsistence building were in various stages of completion, all of permanent construction. In addition, a unit of 5 new ward buildings of frame construction were added on the lower ground at the point. The installation was originally commissioned 7 January 1836, and had served the Navy during four previous wars.⁸³ The hospital was filled to only one-half capacity at the beginning of the War, but as the patient load increased during 1942 and 1943, additional ward buildings were opened. By the close of the War it ranked twelfth among naval hospitals.

The U. S. Naval Hospital, Corona, California, was commissioned 16 December 1941. It is the fourth largest of all naval hospitals

81. Ibid.
82. Annual Sanitary Report, 1943.
83. Historical Data by A. Farenholt, A12/NH102, 1 Nov. 1910.

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and is composed of four major physical units. Unit I is the original Norconian Hotel building, which is located on the brow of a hill.

The construction is of California Spanish style. To the existing unit has been added a large reinforced concrete building, three to five stories in height, located on the side of the hill and connected with the main building by a passageway from the fifth floor. Separate corpsmen and nurse quarters are included in this unit.⁸⁴ Unit

II is of entirely new construction single-story, semi-permanent ward buildings, 30 in number. A long covered passageway connects this unit with Unit I.⁸⁵ Unit III consists of 42 temporary buildings and

is an additional and separate organization for general hospital purposes, although located in the same reservation.⁸⁶ Unit V is frequently referred to as the Spadra Annex. It is situated 22 miles

from Corona.⁸⁷ The buildings were used at one time as the state narcotic hospital. This property had been more recently used by the

Army as a hospital in their desert training program. In all there were 122 buildings, 36 of which were part of the former state narcotic unit and the remainder constructed by the Army. It was used

by the Navy for convalescent patients and for this purpose it proved fairly satisfactory.⁸⁸ Unit II was especially fitted to care for

tuberculosis patients and Unit III for those with rheumatic fever. Corona is the only general hospital which was created by converting

civilian facilities for Navy medical purchase. The convalescent hos-

84. Annual Sanitary Report, 1945, Cumulative History.

85. Annual Sanitary Report, 1944.

86. Ibid.

87. Ibid.

88. Annual Sanitary Report, Historical Supplement, 1944.

pitals, however, were practically all of this type.

The U. S. Naval Hospital, Corpus Christi, Texas, was so located as to serve the naval air station and other activities of that area. The site was chosen in October 1940, and no Navy medical officer was consulted. The site is so located that planes taking off into the prevailing wind fly directly over the hospital at least six months of the year. In common with other coastal areas, loose blowing sand is a constant difficulty, and considerable effort and money have been expended in eliminating this difficulty by planting carpet grass and shrubbery. There were four major hurricanes in the first two and one-half years but no serious damage resulted.⁸⁹ This installation is entirely temporary with wood construction. It started with 23 buildings and a number of additional structures were completed during the war years. The Corpus Christi hospital was placed in commission shortly before the War and ranked thirty-first at the close of the conflict.

The establishment of U. S. Naval Hospital, Corvallis, Oregon, was part of the program to utilize former Army facilities which became available as Army training activities decreased when the men were sent overseas. The Corvallis hospital had been used to serve Camp Adair and was operated in a manner similar to a Navy dispensary. Severe cases had been transferred to other hospitals. It comprises a group of temporary Army barracks, structures grouped con-

89. Annual Sanitary Report, Historical Supplement, 1944.

viently and connected for hospital purposes. Additional equipment needed to be installed to make the establishment suitable for a general Navy hospital. It was commissioned on 3 February 1945 and was the last established of the five hospitals in the Thirteenth Naval District. At the close of the War it ranked ninth among the general hospitals.

U.S. Naval Hospital, Dublin, Georgia, is one of the few permanent structures planned, constructed, and completed during the war period. The plans were drawn in close cooperation with the Veterans' Administration.⁹⁰ It is located in south central Georgia on gently rolling land. The plat includes 240 acres. Representative Carl Vinson, chairman of the House Naval Affairs Committee, rendered valuable assistance in locating a suitable site. Mr. Vinson was familiar with the area as it is located in his Congressional District.⁹¹ The buildings are of brick, and are in keeping with traditional southern colonial architectural style, with pillars adorning the portico of the administration building. The main building unit is arranged in two general wings and is separated into 8 wards. The usual separate units for an establishment not located in a metropolitan area are found here.⁹²

The U. S. Naval Hospital, Farragut, Idaho, is located in the midst of pine forrests on the shores of Idaho's beautiful Lake

90. Federal Board of Hospitalization, Resolution 30, 11 June 1943.
91. General File, N.H. 73.
92. Annual Sanitary Report, 1945, Cumulative History.

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Pend Orielle, and adjoins the U. S. Naval Training Center. It is considered one of the most complete hospital units in the Pacific Northwest and is also the most modern and probably the largest in Idaho, Washington, Montana, or southwestern Canada.⁹³ The original plat included 177 acres of virgin timber. The initial construction program called for 44 wards each capable of hospitalizing 46 patients. The compound included the usual subsidiary buildings needed for a hospital establishment located at a considerable distance from any large center of population.⁹⁴ During 1944, 14 additional ward buildings and a civilian unit were located in Farragut village near the main gate. In April of 1945, a unit of the training activity known as Camp Bennion was transferred to the hospital command thus making available an additional 1,600 beds for convalescent patients. At the end of hostilities the Farragut hospital was the third largest naval hospital in the continental United States, and the second largest in the Pacific Coast area.

U. S. Naval Hospital, Fort Eustis, Virginia, was the first Army hospital to be reconverted to naval purposes. Initial plans were made in July and the installation was commissioned 29 August 1944. It was built of regular Army barracks type buildings. This Army hospital was fully equipped and needed only the assembling of staff and personnel so that it could be placed in operation. It was ready to receive patients by 17 September 1944. It is located only

93. Ibid.

94. Ibid.

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27 miles from Norfolk and so was intended to ease the patient load in this area, especially at Portsmouth and Norfolk, NOB. This establishment ranks twenty-first among Navy general hospitals.

The U. S. Naval Hospital, Great Lakes, Chicago, was located on a tract of 91 acres on Lake Michigan, and at the commencement of the War had 45 buildings, a considerable number of which were of old temporary World War I structure. Additional buildings to care for the anticipated load were immediately started. The 1942 sanitary report stated that all vacant land was occupied with buildings and that there was no room for further expansion. During that year the buildings were completely renovated.⁹⁵ Ten sets of officers' quarters and 9 standard "H"-type ward buildings were constructed, several old temporary structures were demolished, and a new dependents' hospital building was constructed.⁹⁶ In January of 1945, the hospital took over two dispensary institutions known as McIntire Dispensary with 1,857 stated capacity and Camp Lawrence. These were responsible for adding 75 acres and 65 buildings. Camp Lawrence was used as a convalescent hospital and McIntire Dispensary became a division of the general hospital. For the use of dependents, some 512 beds were obtained at the Wharton Memorial Hospital in conjunction with Northwestern University. This unit was under the administrative control of the Hospital.⁹⁷ This institution was at first designed to serve the training activities of Great Lakes Training Station and

95. Annual Sanitary Report, 1942

96. Annual Sanitary Report, 1944.

97. Navy Department Conference of District Medical Officers, 11-12 Oct. 1943 (Mimiographed).

associated programs.⁹⁸ It ranks second in the United States and is the only U. S. naval hospital in the entire Ninth Naval District. The Hospital Corps School was established in 1942 on an area adjoining the hospital and remained until June of 1944 when the School was moved to San Diego, thus making additional floor space available to the hospital.

The U. S. Naval Hospital, Houston, Texas, was established 14 July 1945 but was not placed in commission until 1946. It affords a good example of a permanent plant planned carefully to meet future needs. The central block is 7 stories high, with 4 ward blocks of 3 stories and an administration wing of 2 stories. Fourteen permanent ward buildings, similar to the Bethesda "I"-type are connected with the main structure. The separate structures are those common to permanent installations, and usually found with temporary units as well. There are the quarters - three individual sets for officers, bachelor officers' quarters, nurses' quarters; Hospital Corps quarters; cooks' and bakers' quarters, civilian technicians' quarters; power plant; laundry; incinerator; ship's service; garage; storhouses; greenhouse, and gate houses.⁹⁹ As it is in a metropolitan area, water, sewerage, and added fire protection are available and transportation problems are reduced.

The U. S. Naval Hospital, Jacksonville, Florida, is associated with the naval air training activities at that place. It has on

98. Annual Sanitary Report, 1945, Cumulative History.

99. Ibid.

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elevation of about 27 feet and "is within 200 yards of St. Johns River thereby providing a fitting nautical setting."¹⁰⁰ The compound includes about 83 acres and, like installations located in similar coastal areas, contains a varied soil of sand and muck. Planting of coverage vegetation was found necessary to restrain blowing sand.¹⁰¹ The building of this installation has been almost continuous during the entire war period as the hospital expanded its patient load. By 1943, it had doubled its physical size.¹⁰² The buildings are of temporary construction, chiefly of the "H" type. It was originally painted a protective coat of drab gray-green paint, but in 1944 this was covered by a more attractive white or gray.

The U. S. Naval Hospital, Key West, Florida, was originally planned as a 150-bed permanent installation.¹⁰³ When it was commissioned in October of 1942, the prospective patient load had grown and throughout the War its physical growth was continual. It is constructed in an area of about 16 acres and has an elevation of from 3 to 4 feet above high tide. The hazard and annoyance from wind-blown marl dust was abated by planting grass and shrubs.¹⁰⁴ "Most of the work of shoveling and spreading was done by the Hospital Corps", as other labor was not readily available.¹⁰⁵ A severe hurricane during 1944 destroyed much of this landscaping and also demolished the sea wall.¹⁰⁶ The main building is three-story reinforced concrete, with

100. Annual Sanitary Report, Historical Supplement, 1944.

101. Annual Sanitary Report, 1942. Historical Supplement, 1944.

102. Annual Sanitary Reports, 1942, 1943, 1944; Historical Supplement, 1945.

103. Annual Sanitary Report, 1945, Cumulative History.

104. Annual Sanitary Reports, 1942, 1943.

105. Annual Sanitary Report, 1943.

106. Annual Sanitary Report, 1944.

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two "U"-shaped wings two stories in height. Other buildings in the reservation are one or two-story structures, largely of permanent or semi-permanent construction. The hospital serves the NOB, including such units as submarine base, Coast Guard station, two air stations, a convoy center, ship repair depot, and sound school.¹⁰⁷

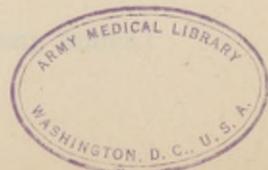
Because of its isolated position, the opening of the highway connecting it with the mainland was of great benefit. Similarly, a fresh water pipeline from the mainland served much better than rainwater collected in cisterns. This hospital was ranked fortieth in authorized bed capacity at the end of the War.

The U. S. Naval Hospital, Long Beach, California, was originally planned as a 300-bed permanent installation, modernistic in design, and of reinforced concrete construction. By the time it was commissioned on 15 December 1942, the need for additional beds was apparent and further expansion was undertaken.¹⁰⁸ This expansion was of temporary construction. By June of 1945 some 3,270 beds were available at the institution. It ranked eighteenth in size among hospitals and third among those of the Eleventh Naval District. It covers 100 acres and "there is an excellent view of the ocean on the south and of the back country to the north."¹⁰⁹ The insert map on the ground plan of this station indicates its relation to Los Angeles, San Pedro, Corona and other naval activities.

107. Annual Sanitary Report, 1943, Historical Supplement.

108. Annual Sanitary Report, 1945, Cumulative History.

109. Annual Sanitary Report, 1943.



The U. S. Naval Hospital, Mare Island, California, is the oldest naval hospital in the West, being established in 1864. The present main building was constructed in 1900 and the plan to raze the old structure and build a new building was prevented only by the outbreak of the War.¹¹⁰ In 1942, the existing buildings were entirely renovated and made suitable for the intensive activity of the next few years.¹¹¹ During the war years, extensive alterations were made in existing structures, and considerable new constructions were undertaken. The replacement of the main unit was not effected but a new permanent and spacious recreation building, bagroom, mess hall, shop and laundry were added.¹¹² These are modernistic reinforced concrete structures of the same general style as the new buildings at Houston and Long Beach.¹¹³ In 1943, the Mare Island Hospital also took a permanent lease on the newly constructed 300-bed unit at Napa State Hospital, which has been designated the Annex. The Annex cared for psychotic patients and relieved the overcrowded main units. This was a further extension of an agreement made in June 1942 by which Napa State Hospital agreed to care for 100 Navy patients. In conjunction with the Annex, two new temporary structures and mess hall were constructed.¹¹⁴ The neuropsychiatric department became so active that extensive shifts were required to care for the heavy patient load. Wards were created in barracks buildings outside the hospital reservation;

110. Annual Sanitary Report, Historical Supplement, 1944.

111. Annual Sanitary Report, 1942.

112. Annual Sanitary Report, 1944.

113. See pictures of these institutions.

114. Resolution 60, Federal Board of Hospitalization; Annual Sanitary Report, 1944.

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the construction of a number of temporary wards and even the erection of an annex of tents was necessary to care for the heavy load of this patient type. Final transfer of patients to the U. S. Public Health Service Hospital, Navy Unit, Fort Worth, Texas, relieved the congestion.¹¹⁵

The Memphis hospital is a wartime temporary hospital serving the adjacent training centers and caring for convalescent patients sent to the hospital because it was located near their home. It is located some 23 miles north of Memphis on land which previous to the War was under cultivation.¹¹⁶ The land is flat and drainage was so poor that construction was seriously hampered in 1942 and 1943 because of heavy rains and the lack of solid roads and walks, which made transportation of material virtually impossible.¹¹⁷ There is no storm sewer available and drainage is by surface ditches where silting requires constant maintenance labor.¹¹⁸ Because of this silting in wet weather and the dust in dry weather, great stress was laid on coverage by lespedeza and Bermuda grass. The completely treeless reservation has been beautified by trees and shrubs. The hospital was commissioned on 17 March 1943 and is a prototype of the temporary asbestos shingle wood construction type structure. The buildings are

115. Annual Sanitary Report, 1942, 1943, and 1944.
116. Annual Sanitary Report, 1944, Historical Supplement.
117. Annual Sanitary Report, 1945, Cumulative History.
118. Annual Sanitary Report, 1943.

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roughly arranged in the form of a cross. One center corridor connects the administration building, subsistence building, and the specialty units of the laboratory operating rooms, X-ray, and physiotherapy wings. The other, and longer, corridor connects all of the wards.¹¹⁹ This conventional design is repeated in other temporary hospitals. The hospital is largest in the Eighth Naval District and twenty-seventh in the United States.

The New Orleans hospital was one of seven continental units authorized by Congress in the spring of 1942 to be built by drawing from an emergency fund of \$800,000,000 appropriated for various urgent naval expansion demands.¹²⁰ "The actual site was chosen because of expediency and is situated in a low area of reclaimed land on the edge of Lake Pontchartrain. The foundations of the wards and other buildings have settled unevenly due to poor ground conditions and the high water table."¹²¹ The reservation is 65.7 acres in extent, and the average elevation is 5.6 feet above the Gulf level. Although underground drains were provided, the runoff was poor because of the flatness of the land.¹²² An Army hospital also serving this general area was located immediately adjacent and constructed at about the same time.¹²³ The administration building is connected with 21 wings, of which all but 2 are used for ward purposes. All wards are arranged so

119. Annual Sanitary Report, 1945, Cumulative History.

120. Memorandum: To R. T McIntire from W. S. Douglass, 26 Aug. 1942; The other hospitals were Bainbridge, Memphis, Norman, Farragut, Santa Margarita Ranch, and Sampson; Public Law 528 - 77th Congress, approved 28 Apr. 1942.

121. R. T McIntire to Leonard Outhwaite, Director Federal Board of Hospitalization, May 1945.

122. Annual Sanitary Report, 1944.

123. See Correspondence File, N.H. 64.

that the administrative end of the building opens into the corridor and the actual bed space is in the opposite end adjoining a solarium. There are 6 separate quarters and service buildings.¹²⁴ The size of the hospital has been increased to this capacity by an extensive building program in 1943-1944. At this time, the space was increased by one-half.¹²⁵ At the end of the War, New Orleans ranked thirty-fourth.

The Newport, Rhode Island, hospital is one of the permanent hospitals commissioned just before World War I. At the beginning of this war, it was a complete unit ready to care for 500 patients under optimum conditions and 1,000 in emergencies.¹²⁶ The size of the reservation was increased by 5.6 acres in 1942 making the total size 32.5 acres.¹²⁷ The grounds overlook Narragansett Bay and the adjacent training station, torpedo stations, and Fort Adanso situated on islands in the bay.¹²⁸ Active construction of temporary wards and quarters buildings was undertaken in 1942 and completed in 1943.¹²⁹ By the end of the War the hospital ranked twenty-fourth in size.

One of the hospital units under construction before Pearl Harbor was the Norfolk, NOB. Construction was commenced on 15 November 1941 and the establishment was commissioned approximately a year later, on 2 November 1942. The facility was originally planned to pro-

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124. Annual Sanitary Report 1945, Cumulative History.
125. Resolution No. 73, Federal Board of Hospitalization, 8 Oct. 1943.
126. Annual Sanitary Report, 1945, Cumulative History.
127. Annual Sanitary Report, 1942.
128. Note: See map on plat.
129. Annual Sanitary Report, 1943.

vide an authorized bed capacity of 750, but during the War 8 wards were added, which raised its capacity to 1,030.¹³⁰ All construction was of permanent reinforced concrete with brick veneer. The wards were "H"-type buildings with the usual sustaining structures for an institution of this type.¹³¹ The reservation, on the site of the old Army base, is 57 acres of flat, sandy land much of which was formerly used as a golf course. Lawns are excellent except where construction has taken place. A 10-acre wooded section affords space for recreational expansion.¹³² A serious drawback to the site was the poor drainage which was finally overcome by storm sewers and extensive filling in of swamp areas. During 1944 a drain was installed to replace the open creek which had carried raw sewage through the midst of the reservation.¹³³ The WAVE barracks and the recreation building were completed in 1944. As is usual with most hospitals, these units were added last, the former upon the arrival of WAVES in force, and the latter as the result of the increased staff and convalescent patient load. The U. S. Naval Hospital, Fort Eustis, Lee Hall, Virginia, which was commissioned in August of 1944 served as an overflow unit for this hospital. Although it was a separate command, it worked closely with NOB Norfolk and Portsmouth in sharing the patient load of that area. The family clinics at Benmoreel and Merrimac Park were transferred from the Fifth Naval District to the command of the hospital on 21 June 1945.

130. Annual Sanitary Report, 1945, Cumulative History.

131. See chart, Appendix L.

132. Annual Sanitary Report, 1943.

133. Annual Sanitary Report, 1944.

Merrimac was decommissioned after the close of the War on 5 October of the same year, while Bermoreel was continued as a family clinic. At the close of the War this hospital ranked twenty-second and had 1,652 patients.

The Norman hospital is found two miles from Norman and 24 miles south of Oklahoma City. It was located at this inland point to serve the large naval air station and other wartime training activities.¹³⁴ It was part of the emergency construction program to build hospital facilities at training centers inaugurated soon after the commencement of the War.¹³⁵ "The reservation occupies 252.8 acres of rolling land, the choice location in the area."¹³⁶ The grounds are well drained, in general, and a creek on the west boundry had been dammed as a source of extra fire protection. The prospective medical officer arriving late in August stated: "The first view of the site was anything but encouraging. There was red, sticky, Oklahoma mud which made transportation in part of the area extremely difficult. There were times when it was impossible to get into the building area in any type of vehicle, including jeeps. Therefore, on those days building just stopped. There were wind and attendant dust storms because the ground was bare, having been denuded by bull-dozers."¹³⁷ Every effort was made to build the hospital as rapidly as possible; therefore pressure was brought to bear and the construction work was

134. Ltr. from Ross T McIntire to Leonard Outhwaite, May 1945, Surgeon General's files.
135. Ltr. from W. S. Douglass to Ross T McIntire, 26 Aug. 1942, Surgeon General's Files; Public Law 528, 77 Cong., approved 28 Apr. 1942.
136. Annual Sanitary Report, 1945, Cumulative History.
137. Annual Sanitary Report, 1943, Historical Supplement.

placed on a twenty-four hour, seven day a week schedule. The acceleration was marked, and commissioning took place on 15 November, some five months after the breaking of ground.¹³⁸ By the beginning of 1945, 55 buildings were in full operation. The construction was of wood with drop siding and held up well during the war period.¹³⁹ Active and continuous attention was accorded the problem of erosion and dust control and the nuisance had been considerably abated by planting.¹⁴⁰ The hospital ranks twenty-ninth among similar installations.

Immediately following Pearl Harbor the need for expanded facilities on the West Coast was undertaken by the Medical Department. The Oakland hospital was established to meet the need in the San Francisco area. The site of the Oak Knoll Golf Club was surveyed in mid-December and the project approved by the Federal Board of Hospitalization on 29 December 1941. The reservation included 320 acres in the foothills section of the city of Oakland overlooking the bay area.¹⁴¹ The greater part of the reservation acreage is of no value for building purposes because of the high hills. The plat plan of construction is different from most of the temporary installations, as the buildings were laid out as would best suit the contour of the land. The buildings were of temporary construction, and divided into two general areas by a creek which courses through the valley, as well as by the configuration of the slopes. As new additions were made

138. Annual Sanitary Report, Historical Supplement, 1943.

139. Annual Sanitary Reports, 1943 and 1944.

140.. Annual Sanitary Report, 1944; Annual Sanitary Report, 1945, Cumulative History.

141. Annual Sanitary Report, 1942.

they climbed higher up the sides of the hills.¹⁴² The installation was originally conceived as a 500-bed hospital but was increased from time to time until by the end of the War it was officially rated as sixth in the country and second in the Twelfth Naval District. For emergency purposes, it could accommodate 5,000 patients.¹⁴³

The naval hospital at Parris Island serves the recruit training activities of that Marine Barracks. At the commencement of hostilities, the hospital command not only covered the small 200-bed establishment but also exercised control over two dispensary units. In October of 1942, these units were separated from the command.¹⁴⁴ "The buildings were all of flimsy construction, susceptible to considerable leaking during driving rains of sub-hurricane and hurricane force."¹⁴⁵ By the end of the War there were 45 buildings, all temporary, and there was no further room for added construction. It was situated on a 17-acre tract directly adjoining the Marine Barracks. The Beaufort River encloses the reservation on two sides.¹⁴⁶ Several ward buildings, as well as the greater part of the hospital grounds, are subject to flooding from tidal waters resulting from hurricanes. The hospital hurricane hill provides for complete evacuation in case of such a catastrophe.¹⁴⁷ The grounds are well kept and present an attractive appearance, especially during the spring, summer and fall seasons.¹⁴⁸

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142. Annual Sanitary Report, 1944.
143. Annual Sanitary Report, 1943; Resolution 25, 21 May 1943.
144. Annual Sanitary Report, 1945, Cumulative History.
145. Annual Sanitary Report, 1944.
146. Annual Sanitary Report, 1945, Cumulative History.
147. Annual Sanitary Report, 1944.
148. Annual Sanitary Report, 1942.

Construction was held to a minimum and only most essential additions were made to the physical plant. However, a new bandstand was donated by the commanding general of the Barracks.¹⁴⁹ Because of the inadequacy of the site and restrictions of space, the Medical Department resolved to construct a new permanent unit in a more suitable location. In the spring of 1945 a definite plan of expansion for a 500-bed hospital was approved, and a 200-acre site was endorsed by the Federal Board of Hospitalization.¹⁵⁰

The Pensacola hospital reservation of 43 acres includes two sections. The old reservation, dating back to 1875, contains the old units which were remodeled and used throughout the duration.¹⁵¹ The new reservation contains the new permanent buildings completed just before the war and has a permanent bed capacity of 350 available for the post-war period naval use.¹⁵² During 1942 and 1943, considerable new construction of temporary "H" and "I" wards and quarters buildings was carried out. The facility is located on top of a 30-foot sand bluff overlooking Pensacola Bay to the south. This installation served the Intermediate Air Training Command units and naval air stations of the area. It was the only permanent hospital in commission at the close of the War in the Eighth Naval District and ranked twenty-eighth among continental hospitals.

The Philadelphia hospital is located within the city of

149. Annual Sanitary Report, Historical Supplement, 1943.

150. Federal Board of Hospitalization, Resolution 162, 22 May 1945.

151. Annual Sanitary Report, 1942.

152. Ltr. from Ross T McIntire to Leonard Outhwaite, May 1945.

Philadelphia on part of the grounds once used for the Sesquicentennial Celebration. It is situated about a mile from the Navy yard. During 1942, some 25 acres were added to the reservation making a total of 49 acres.¹⁵³ The main building is of permanent brick construction of the skyscraper type. It is located in a sunken area 9 feet below the street level, and included 11 units at the outbreak of the War.¹⁵⁴ During 1942, two permanent wings were added to the main building structure.¹⁵⁵ Because of the large patient load from the Navy yard and the units in the port, a great many temporary additions were made. These temporary buildings were of cinder block construction giving the facility a greater appearance of permanence than the more common wood or asbestos shingle type of exterior.¹⁵⁶ The convalescent annex at Swathmore was occupied on January 1943 and served as an overflow facility for the Philadelphia hospital.¹⁵⁷ This hospital is the only general hospital in the Fourth Naval District and ranks eleventh in the United States. In addition, 100 beds were made available at the Naval Home for the care of active duty naval patients.¹⁵⁸

The main building of the Portsmouth, New Hampshire, hospital was built in 1913 and remains the center of the institution's activities. It is a three-story brick building. During the War three "H"-type buildings, one of permanent construction, were added and several smaller outlying buildings were converted into wards for convalescent

153. Annual Sanitary Report, 1945, Cumulative History.

154. *Ibid.*

155. Annual Sanitary Report, 1942.

156. Annual Sanitary Report, 1943.

157. N.H. 70.

158. Navy Department conferences, DistMedOff, 11-12 Oct. 1944.

patients.¹⁵⁹ In 1943, a wing for hospitalization of dependents was opened as well as quarters for nurses and hospital corpsmen. There were some 16 wooden structures serving outlying activities.¹⁶⁰ The basement of the main building was designated as an air-raid shelter and all doors and windows were bombproofed by brick and cement shields. These were removed in 1944.¹⁶¹ The patient load increased markedly during the War, necessitating numerous shifts within existing structures and various additions. Despite this increase in activities the hospital ranked next to last among Navy general hospitals in its patient load and thirty-eighth in authorized bed capacity.

The U. S. Naval Hospital, Portsmouth, Virginia, is the oldest established naval hospital in the United States. Previous to May of 1943, it was known as Norfolk Naval Hospital, Portsmouth, Virginia, but the name was changed to prevent confusion after the hospital was established at the NOB, Norfolk.¹⁶²

The Portsmouth, Virginia, hospital is situated on a tract of 141 acres of which 109 are hard land. The land is very flat and sandy, with an elevation of about 90 feet above the Elizabeth River. It is bounded by that river and a residential section of Portsmouth.¹⁶³ It serves the Norfolk Navy Yard, other Fifth Naval District activities, and fleet units based in the area.¹⁶⁴ At the beginning of the War, it was the second largest hospital and had adequate facilities for peacetime

159. Annual Sanitary Report, 1945, Cumulative History.

160. Annual Sanitary Report, Historical Supplement, 1943.

161. Annual Sanitary Report, 1945, Cumulative History.

162. Annual Sanitary Report, 1945, Cumulative History.

163. Annual Sanitary Report, 1945, Cumulative History; Annual Sanitary Reports, 1943 and 1944.

164. Annual Sanitary Report, 1945, Cumulative History.

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activities. Two new wings had been recently added and its permanent buildings for housing personnel and equipment were adequate. With the coming of wartime conditions, an extensive building program was inaugurated which extended throughout the entire War. Extensive renovation maintained the old structures in excellent condition.¹⁶⁵

Because of the military importance of the area, a passive defense program of sandbag barricades around important units was instituted and not removed until 1944.¹⁶⁶ Except for the long established part of the grounds, the area was bare of trees. In 1944 an arrangement was made with the Navy yard whereby two barracks were placed under the cognizance of the hospital and cases awaiting discharge were quartered there, thus releasing 460 hospital beds previously used for such cases.¹⁶⁷ The hospital was the second largest on the East Coast, being surpassed only by St. Albans. It ranked tenth among all continental hospitals.

The Quantico hospital was one of the three institutions opened just before Pearl Harbor. It is situated at the site of an old Liberty Shipyard of World War I, on an elevated point of land on the west bank of the Potomac River. "The location of the grounds are ideally suited for the purpose, providing a fitting nautical setting and an invigorating but quiet and restful atmosphere."¹⁶⁸ The grounds

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165. Federal Board of Hospitalization, Resolution 14, 17 May 1943; Annual Sanitary Reports for 1942, 1943, and 1944.
166. Annual Sanitary Report, 1944.
167. Annual Sanitary Report, 1944.

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needed considerable landscaping and removal of concrete and debris left from the shipyard establishment.¹⁶⁹ The reservation contains about 60 acres, including 10 acres of swamp land which necessitated energetic malarial draining and policing. During the War an adequate program of landscaping, seeding, filling, and construction of walks and roads was carried out.¹⁷⁰ More than 3,000 trees and shrubs were planted to beautify the compound. In 1943, an increase of one-third in acreage was purchased. Included with the land were 13 dwellings which were promptly converted to officers' quarters. In this regard, the officers of the Quantico hospital were most fortunate as building restrictions commonly allowed only three sets of quarters to be erected.¹⁷¹ The modern main building of the hospital was a three-story colonial style, wing-type building of limestone, granite, and red brick. During the War, buildings to house the increased patient load were continually under construction. This hospital was the smallest of the four units primarily serving Marine Corps training activities and ranked forty-second among all naval hospitals.¹⁷²

The U. S. Naval Receiving Hospital, San Francisco, is different in its physical constitution from the other continental naval hospitals. In the planning stage it was first designated Mobile Hospital No. 13, and its site was determined in the spring of 1944.¹⁷³

168. Annual Sanitary Report, 1945, Cumulative History.
169. Annual Sanitary Report, 1942.
170. Annual Sanitary Reports, 1942, 1943, 1944.
171. Annual Sanitary Report, 1943.
172. Annual Sanitary Reports, 1942, 1943, and 1944.
The other hospitals associated with Marine training camps are, in order to size, Santa Margarita Ranch, Camp LeJeune, and Parris Island.
173. Ltr. from Ross T McIntire to Cominch, CNO, 26 Apr. 1944; Ltr. from CNO to BuMed, 19 Mar. 1944.

This hospital is located at the Amazon Reservoir in south central San Francisco, some distance from the harbor. The reservation had been previously used as a recreation area, and three stadiums are among the 62 buildings in use at the close of the War. The elevation of the ground is some 200 feet, and hills surround it. The buildings are all of the temporary pre-fabricated type, devised for the mobile hospitals. The 47 units which made up the original hospital were assembled in less than 120 days.¹⁷⁴ The facility was placed in commission on 9 December 1944 as Fleet Hospital Number 113. In the middle of February the commanding officer received a letter from the Bureau stating:

If you have not already gotten the word you will be interested to know that the activity under your command as of 8 February 1945 was designated USN Receiving Hospital, San Francisco, California. This was requested by Commander Western Sea Frontier and is O.K. except that we feel that by change in name it will lose its identity and significance as an overseas facility set up in the U. S. to meet a particular need.¹⁷⁵

The hospital acts as a clearing house to segregate and distribute patients coming to the continent from overseas. Originally devised to house 1,000 patients, the hospital was so expanded that it could take 2,262 in emergencies.¹⁷⁶

The San Diego hospital was the largest institution at the beginning of hostilities and during the War continued to hold this

174. Annual Sanitary Report, 1944.

175. Ltr. from Capt. C. L. Andrus, to "Dcs. Gerald" (Capt. Gerald W. Smith) 14 Feb. 1945; SecNav Conf. ltr. Op13-1D psp Serial 0102513, (SC) A42/NH, of 8 Feb. 1945. N.D. Conf., Bul. C45-10 of 15 Feb. 1945.

176. March Quarter Annual Sanitary Report.

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rank.¹⁷⁷ At the beginning of the War the hospital command covered a Hospital Corps school and an out-patient department which together included 56 buildings on a 77-acre compound. By the end of the War it had so expanded that it was divided into six units with a total of 241 buildings on a combined acreage of 247.¹⁷⁸ On 7 December 1941, the hospital had an authorized capacity of 1,424, and on V-J Day 10,499. The permanent group of buildings was regularly referred to as mainside and designated Unit Number 1. This Unit contained 89 buildings of which 47 are temporary structures. In addition, 100 tents were set up with wooden decks and supports.¹⁷⁹ The older buildings are California-Spanish style construction. During the War a number of permanent structures were added to the mainside hospital.¹⁸⁰

Unit 2 is occupied chiefly by the neuropsychiatric department and the medical service and is located on the former San Diego Exposition grounds situated in Balboa Park. It is located only two-tenths of a mile from the main unit. The Exposition buildings were frame with stucco exterior and needed extensive work in remodeling. Subsequent to the exposition they had been used as museum and art galleries and upon being taken over by the Navy in December of 1941, the art objects were removed and stored. This unit contains 33 acres and 25 buildings.¹⁸¹ It was occupied by the Navy without lease and without cost other than upkeep and repairs, merely on the non-objection

177. Medical Statistical Division.

178. Annual Sanitary Report, 1945, Cumulative History.

179. Annual Sanitary Report, 1944.

180. Federal Board of Hospitalization, Resolution 161, U.S.N.H., San Diego, 24 Apr. 1945.

181. Annual Sanitary Report, 1944.

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of the city.¹⁸² Ingenious devices were used in altering the various structures for hospital purposes. One large building contained two natural-habitat, mounted bird groups which could not be removed. The group was left in place, a housing built over them and a nurses' platform was located on top of the housing. Some 380 double-deck beds occupied the floor space and the ward was said to be the largest single medical ward in any hospital in the world.¹⁸³ This unit also contained 239 tents with wooden decks and supports. At the peak of hospital admissions, some of these were used for patients, although they were intended for corpsmen.¹⁸⁴

Unit Number 3 is the plat of 33 acres previously known as Camp Kidd, while it served as a naval training center and later as repair base. In May 1944, the area was turned over to the hospital command for a Hospital Corps school. There were 22 buildings of frame and plaster-covered exterior, dating from the exposition period, and 33 former Army barracks were moved in and converted.¹⁸⁵ In June of 1944 the San Diego U. S. Naval Hospital Corps School, formerly located in Unit 2, was consolidated with the Hospital Corps School from Great Lakes, Illinois.¹⁸⁶

Unit Number 4 was situated in the southwest corner of Balboa and was made up entirely of Army barracks converted into convalescent wards. The Navy took over this ex-Army camp site in October 1944.

182. Annual Sanitary Report, 1945, Cumulative History.
183. Annual Sanitary Report, 1945, Cumulative History.
184. Ibid.; Annual Sanitary Report, 1944.
185. Annual Sanitary Report, 1945, Cumulative History; Annual Sanitary Report, 1944.
186. Annual Sanitary Report, 1945, Cumulative History.

The unit consists of 28 buildings on 7.8 acres of wooded land. The buildings were all constructed originally for the Army antiaircraft barracks and WACS' barracks and remodeled for adaptation to naval use. All four of these areas require irrigation for trees and other vegetation.

Unit Number 5 consists of 2.5 acres of wooded land with 11 buildings scattered among pine trees. This is used as a baggage and storage center for crew and patients.¹⁸⁷

Unit Number 6 is the convalescent branch of the hospital at Rancho Santa Fe, 30 miles from the main compound. It is the John Burnham estate which is under lease to the Navy. There are 9 buildings, 3 belonging to the owner and 6 converted from 13 Army barracks moved from an adjoining camp site.¹⁸⁸

At the time of the greatest patient load, the beds were set up in each unit as follows:

	Patients	Non-Patients
Unit No. 1	5,354	2,097
Unit No. 2	4,786	1,355
Unit No. 3	949 (Reserved)	2,710
Unit No. 4	671	
Unit No. 5		16
Unit No. 6	254	35
	<hr/> 12,014	<hr/> 6,213

In addition to beds set up, there are 1,669 berths in storage, including 495 single beds, 479 double deck beds, 13 cribs and 3 bassinets.

187. Annual Sanitary Report, 1944 and 1945, Cumulative History.

188. Ibid.

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The San Leandro hospital was built on a 162-acre tract which was part of the original tract of the Oakland hospital. It is located in the southwest section of the city of Oakland in the San Leandro hills. The area is very irregular, being cut up by large deep ravines. The surrounding hills are suitable only for grazing land.¹⁸⁹ The buildings are all temporary of wood frame construction with redwood siding. The 26 wards are single-story and connected by an enclosed corridor. Most of the buildings of thirteen quarters are of two stories. There are eleven detached utility buildings. The hospital was designated and established in August of 1943 but was not commissioned and did not receive patients until more than a year later. It is the smallest in the Twelfth Naval District and twenty-sixth in the United States.

Sampson hospital was established as an adjunct to the Sampson Naval Training Station, Lake Seneca, New York, and was commissioned 27 February 1943.¹⁹⁰ It is located on a tract of 474 acres on Lake Seneca in the Finger Lake region of central New York. The land was previously used for farming. About 200 acres are fairly level and situated on the top of a 150-foot hill which slopes down to the lake. The hospital is built on this plateau and is surrounded by groves of hardwood. During 1943 and 1944 extensive landscaping was carried out. In this beautification project valuable assistance was rendered by the Rochester Garden Club. Construction was commenced in July of

189. Annual Sanitary Report, 1944.

190. Public Law 528, 77 Cong., Approved 28 Apr. 1942.

1942 and by the commissioning date the hospital was ready to function. Most of the buildings are of temporary construction, with the asbestos shingle siding frequently found in similar temporary installations. Only 9 of the smaller utility structures were of permanent construction. Sampson, like Bainbridge and Farragut, was a large general naval training center in a non-congested area. The hospital was designed primarily to serve such activities. Sampson was between the other two in size and ranked fourteenth in the general hospital field.

The suggestion that the new dispensary unit at Treasure Island be designated the San Francisco Naval Hospital was made by the district medical officer in December of 1941. The unit was so designated 20 January 1942 and was commissioned on 4 April. The construction was not far enough advanced, however, to afford admittance to patients and they were not received until the 15th of July, more than three months after commissioning.¹⁹¹ It was originally designed as a 500-bed hospital, but by the close of hostilities it was rated as a 572-bed institution and ranked thirty-fifth among naval general hospitals.¹⁹² The hospital is located on reclaimed land used originally for the San Francisco World Fair. It comprises an area of about three and one-half average city blocks. The soil is sandy and vegetation has been maintained only after considerable effort on the part of the hospital maintenance force. At the end of the War, the area was

191. Annual Sanitary Report, 1945, Cumulative History; Gen. Files, N.H. 48.

192. Annual Sanitary Report, 1945, Cumulative History.

closely packed with temporary hospital and auxiliary structures.¹⁹³

In September of 1942, at the time of the dedication of Camp Pendleton, the Surgeon General personally chose the site for the Santa Margarita Ranch naval hospital. Construction started the next month and it was commissioned in September of the following year. At the time of commissioning, the compound contained 54 buildings. It is located between Los Angeles and San Diego about 12 miles from Ocean-side.¹⁹⁴ The hospital buildings are grouped in an area of 94 acres on the top of a large, fairly level knoll.¹⁹⁵ All buildings are of temporary wood frame construction and are one story in height, with the exception of the administration and quarters buildings. The administration and subsistence buildings are flanked on either side by two double sets of ward buildings. Covered passageways connect all wards. The entire hospital reservation covers 230 acres at an average elevation of 103 feet. Erosion has been prevented by extensive planting of grass, trees, and shrubs. The climatic and geographical conditions of this hospital site afford a natural and delightful area for the treatment of the sick and injured. The hospital fronts on a lake made by the Santa Margarita River. At the close of the War it ranked twentieth in size.

The Seattle hospital was part of the expansion program inaugurated immediately after Pearl Harbor. An estimate of the situation in the Puget Sound area was made and it was determined that the

193. Annual Sanitary Reports, 1943 and 1944.

194. Annual Sanitary Report, 1943, Cumulative History, 1945.

195. Annual Sanitary Report, 1944.

use of civilian establishments, as had been successfully accomplished at Corona, was not feasible in this locality.¹⁹⁶ The hospital reservation consists of an approximately square plot of land leased from the state at \$1,200 per year. It is located about 10 miles from the Thirteenth Naval District Headquarters in downtown Seattle. The plot contains 165 acres of rolling ground, about half of which is covered by second-growth pine and fir. Construction work bared considerable land which became a drainage problem in wet weather and a serious dust annoyance in dry weather. Top soil was spread and extensive cover planted.¹⁹⁷ The brush and fallen logs which constituted a serious fire hazard were removed. The hospital was originally planned as a 1,000-bed institution. Within six months after its commissioning on 22 August 1942, an expansion program calling for 500 additional beds was inaugurated. The buildings are one-story frame construction, with California redwood siding and paper roofs. The original plan called for administration and utility structures flanked on two sides by ward blocks. The expansion program doubled the size of one block and extended it behind the service units. A fire was sustained by one of the wards in May of 1944. Great difficulty was experienced with the sewage disposal unit, because some of the original equipment was set up and connected in the reverse of its established function.¹⁹⁸ The hospital was the third largest in the Thirteenth

196. General Files, N.H. 46.
 197. Annual Sanitary Reports, 1942 and 1943.
 198. Annual Sanitary Report, 1945, Cumulative History.

Naval District and seventeenth in the country.

The Shoemaker hospital is located 30 miles southeast of Oakland in the Livermore Valley. "It is not now known exactly why or how this site was selected but it is thought the principal reason was that an enormous tract of flat land was needed and this was the nearest available tract of suitable size to the city of Oakland.¹⁹⁹ The Navy took over 1,000 acres of land which was roughly divided into three units, Shoemaker hospital being Unit III with 250 acres of land. The land is flat and level, of black adobe soil that bakes dry and cracks widely in summer. In winter the rainy season promotes a lush growth of grass and weeds, but scarcity of water in the dry season prohibits irrigation with the resultant browning of vegetation. The elevation is about 350 feet.²⁰⁰ Initial construction of the hospital was begun in the spring of 1943 and the hospital was commissioned on 1 October of that year. Expansion of the physical plant has been almost continual since that time. On V-J Day, the compound included 106 buildings of which 63 were wards.²⁰¹ The buildings are single story frame "I"-type. The original group for 1,000 beds was constructed of first class materials such as hardwood floors, while subsequent units were built of poor grade, non-strategic materials.²⁰² This hospital is the largest in the Twelfth Naval District and fifth in the country. Shoemaker hospital supplies adequate figures for individual study of the cost of such temporary installations.

199. Annual Sanitary Report, 1945, Cumulative History.

200. Annual Sanitary Report, 1945, Cumulative History.

201. Federal Board of Hospitalization, Resolution 26, 25 June 1943.

202. Bureau of M&S ltr. 12 May 1943; Annual Sanitary Report, 1943.

Cost of land	\$ 30,220.00
Improvements & service utilities	727,104.00
Building value	5,001,307.91
Cost of Equipment	<u>1,197,010.49</u>
TOTAL COST	\$6,955,642.40

The fact that cost per authorized bed of \$2,830.69 is below the estimated expense for this purpose indicates that great care was exercised.²⁰³

The St. Albans hospital was placed in commission 15 February 1943. The plans were laid early in 1942 to build a hospital in the New York area to supplant the installation at the Brooklyn Navy Yard which was poorly situated for hospital purposes and not in a position to expand. At that time it was planned to use the Brooklyn hospital buildings for housing crews of vessels undergoing overhaul, after the hospital had been transferred.²⁰⁴ The site of the St. Albans Golf Club was selected and construction was undertaken in the spring of 1942. The reservation includes 117.2 acres on Long Island about 27 miles from the center of New York. The site is gently rolling with an elevation averaging 25 feet above sea level. The sub-soil drainage is good and the sandy loam soil supports a satisfactory turf.²⁰⁵ The foundation of the permanent building was completed, and some structural steel was already on the site when, on 15 October 1942, the work on the permanent structure was halted upon the recommendation of the War Production Board. During 1945, the con-

203. Annual Sanitary Report, 1945, Cumulative History.

204. General Files, N.H. 59.

205. Annual Sanitary Report, 1943.

struction of the permanent structure was resumed. The permanent hospital is to furnish 1,000 beds for the postwar period.²⁰⁶ The construction of temporary buildings was carried on throughout the War and the hospital comprised 77 regular wing units connected by a main corridor more than a mile in length. These structures were of wood frame, asbestos shingle siding, with oak floors. Interspersed among the wings were 2 subsistence buildings, a library, occupational therapy unit, chapel, auditorium, and administration buildings. There were two-story quarters buildings for nurses, WAVES, and corpsmen, and three single units for officers. At one side of the reservation, a group of permanent brick utility buildings was constructed. These include laundry, greenhouse, garage, carpenter shop, machine and paint shop, firehouse, incinerator, steam heating plant and gate house.²⁰⁷ This hospital is the largest on the East Coast and ranks seventh among all continental hospitals.

Section 5. Activities of Naval Hospitals

The routine operations of the U. S. Naval Hospital during the war period were carried out within an organizational framework similar to that existing before the War. Since the organization and functions of hospitals before the War have been treated in a previous section, this account will merely give a general description of various problems that arose in consequence of the stresses of war.

206. Federal Board of Hospitalization, Resolution 161, 26 Feb. 1945.

207. Annual Sanitary Reports, 1943 and 1944.

Three special aspects of naval hospitals -- rehabilitation, specialization, and transfer of patients -- are treated in separate sections.

Expansion of the size and number of naval hospitals was the most obvious consequence of the War. Another factor of importance was expressed by the medical officer in command of the Seattle Hospital: "Rapid as this expansion has been, however, it is overshadowed in significance by the multiplication of organized departments within the hospital and the intense development of the manifold activities contributing to the medical care."²⁰⁸

Supervision of medical care of patients was accomplished within the clinical branch of the hospital organization. This clinical branch was divided into medical and surgical services.²⁰⁹ During both the pre-war and war periods, the medical service cared for the larger number of patients, although the number and proportion of surgical cases naturally rose with the arrival of battle casualties from overseas. At the head of the two principal services were the Chief of Medicine and the Chief of Surgery. The chiefs maintained supervision of the respective departments through the senior medical officers who had charge of the several departments. In many hospitals, periodic conferences were useful not only for the dissemination of professional information but also for the administrative coordination of the departmental activities.²¹⁰

208. Historical Supplement to Annual Sanitary Report from U. S. Naval Hospital, Pensacola, Florida, 1944.
209. See Appendix E for charts of the general organization of hospitals; attention is also called to Section 3 of this chapter.
210. Annual Sanitary Report from U. S. Naval Hospital, Pensacola, Florida, 1943.

A major problem in the hospitals was the necessity of making numerous subdivisions of departments in order to separate types of disease and injuries and types of personnel. The needs were often so unstable that a division made at a certain date would be unsuited for the number of types of patients received at a later date. Thus some departments, sections within departments, or wards would be overcrowded while other special divisions would have an excess capacity. Multifarious subdivisions and segregations were recognized as indispensable and desirable, but the everchanging patient load often made the accomplishment of such divisions on an efficient basis virtually an administrative impossibility. ²¹¹

Little attention was given in the annual sanitary and historical reports to that section of the hospital concerned with general medicine. Overcrowding was indicated in a number of reports, especially from Medical Department facilities near training stations or places which received patients with tropical diseases who had been evacuated from areas of the South Pacific. ²¹²

The Navy was fortunate in having no general epidemic of contagious disease during the War. Nearly all the hospitals reported large numbers of catarrhal fever cases, especially during the winter months; but there was no repetition of the influenza epidemic of the

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211. Annual Sanitary Report from U. S. Naval Hospital, Quantico, Virginia, 1943; Annual Sanitary Reports from U. S. Naval Hospital, Bainbridge, Maryland, and U. S. Naval Hospital, Chelsea, Massachusetts, 1944.
212. Annual Sanitary Reports from U. S. Naval Hospital, Pensacola, Florida, 1944; from U. S. Naval Hospital, Norman, Oklahoma, 1943; and from U. S. Naval Hospital, Long Beach, California 1943 and 1944.

first World War. A serious disorder which originated usually in the United States was rheumatic fever, of which there was a rather large incidence in the Pacific Northwest, especially at Farragut, Idaho. To meet the problem at Farragut, the afflicted were transferred to a more favorable climate; in time a program of prevention succeeded in reducing the incidence of the disease.²¹³ The small ratio of cases of contagious diseases to the total strength of the Navy was a very considerable testimonial to the efficacy of the preventive medicine and sanitary control program conducted by the Navy Medical Department.

Error in diagnosis, encountered particularly by the general medicine branch, was an administrative as well as medical problem. Lack of laboratory facilities in the early part of the War, lack of time as the War progressed, and perhaps the introduction of inexperienced personnel were factors involved in this situation. The rate of changes of diagnosis declined in the closing part of the War.²¹⁴

A somewhat similar problem was the large number of patients at naval hospitals who were found unfit for service because of conditions that existed prior to induction. Some of these cases represented recurrences of previous ailments, but many were conditions which might have been discovered if the time and facilities for exam-

213. Annual Sanitary Reports from U. S. Naval Hospital, Farragut, Idaho, 1943 and 1944; Federal Board of Hospitalization, Resolution 62, 24 Sept. 1943.

214. Annual Sanitary Reports from U. S. Naval Hospital, Newport, Rhode Island, 1943 and 1944.

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ination had been greater or the examiners more skilled.²¹⁵

The neuropsychiatric department expanded rapidly in the average naval hospital. Few sanitary or historical reports failed to comment upon the extensive and speedy growth of this department. From an administrative standpoint, the allocation of space to this department was a difficult problem. Although the patients were not usually confined to bed and many could be assigned to double-deck bunks, special arrangements had to be made for certain types of cases. Locked wards and special rooms for violent or agitated patients had to be made available. The difficulties of providing facilities and quarters for the more serious type of cases were increased because of the slow turnover of patients; admissions tended to accumulate faster than dispositions could be made. The special hospitals were able to take only a small proportion of the cases in the regular neuropsychiatric wards of the naval hospitals, and they offered little relief for the overburdened departments of neuropsychiatry. The transfer of psychotic patients also took much administrative care and time of personnel.²¹⁶

During the early period of the War, many reports noted that the greatest number of patients with neuropsychiatric diagnoses were recruits. Some of these men, according to the reports, had not been properly screened at the induction and reception stations; others

215. Annual Sanitary Reports from U. S. Naval Hospital, Parris Island, S. C., 1943; and from U. S. Naval Hospital, Mare Island, 1944.
216. Annual Sanitary Reports from U. S. Naval Hospital, Mare Island, 1944; Parris Island, 1944; Philadelphia, 1944; and Federal Board of Hospitalization, Resolution 30, 11 June 1943.

were unable to adjust satisfactorily to military routine. Although the volume of recruits had begun to level off by 1944, the rate of admissions for neuropsychiatric patients continued to rise. The reports for 1944 noted several trends in the types of patients admitted: They were usually (1) older men, (2) men with longer service, and (3) men of the regular Navy. The number of psychoses also showed some increase. These changes were accounted for partly by the fact that men from the older age groups were being drafted; partly by the fact that more men with disorders precipitated by fatigue, boredom, and combat experiences were arriving in the United States for treatment and disposition.²¹⁷

Neuropsychiatric patients usually occupied from one-fourth to as high as two-thirds of the beds in hospitals. Although exact and complete statistics are not available, the percentage of patients returned to duty ran as high as 40 percent in some hospitals. A comment made in the annual sanitary report for 1944 from the Long Beach hospital is of interest because of its interpretation of one obstacle to returning combat fatigue cases to duty:

It has been further observed at this activity that there are many factors which militate against the return to duty of a case of combat fatigue. Among these we have learned that the exposure of the individual to the current civilian attitude in this particular sector has been destructive to those elements in his personality which constitute his morale and sense of duty.

It is interesting to note that during the latter half of 1944, the majority of our admissions were from new construction and replacement centers and consisted of individuals who had returned from combat areas approximately six

217. Annual Sanitary Reports from U. S. Naval Hospital, Seattle, Washington, 1944; San Leandro, California, 1944.

months prior to their admission to the sick list and who were filled with the imminence of return to combat duty. The history on these individuals indicated that there had been definite combat fatigue reaction prior to their initial return to the mainland which had assumed latent and dormant form during their stay within the continental limits and been relighted during their assignments.²¹⁸

In the early years of the War all reports indicated a marked increase in surgery, both because of the larger patient load and as a result of battle casualties. The number of wards increased and the organizational subdivisions multiplied. General surgery was the most common division. Appendectomies, tonsillectomies, and hernia operations were the most frequent. Patients assigned to general surgery were usually not long in convalescence and the turnover in these wards was rather rapid. The parts of the surgery departments designated for orthopedic surgery, genito-urinary surgery, and neurological surgery were all expanded and became active units in most hospitals. Because of the nature of surgical procedures, patients remained longer in this department than in others, and ward space was comparatively large for the number of persons treated in a given period. During the latter part of 1944 eastern hospitals began receiving sizable contingents of overseas casualties; a high proportion of these were surgical patients and the activity of this service consequently increased.²¹⁹

218. Annual Sanitary Report from U. S. Naval Hospital, Long Beach, California, 1944.

219. Annual Sanitary Report from Camp LeJeune, 1944.

The EENT (eye, ear, nose, and throat) department was divided into several parts in the larger hospitals; in the smaller hospitals, however, it was sometimes operated as an undivided unit. In this hospital speciality, the good fortune which the Naval Reserve commonly had in securing the services of distinguished and reputable specialists from civilian life was especially noticeable. A plethora of reports offered testimony of the high level of performance maintained in this department of the hospitals.

The Navy had an established policy of caring for dependents whenever the service could be instituted. This was further implemented by a law passed in 1943.²²⁰ The method of care varied from hospital to hospital. Where possible, a dependent unit was provided. Some of these units, such as the one at San Diego, were large; others, such as that at Key West, were small. Arrangements for the hospitalization of dependents in civilian city hospitals were commonplace.²²¹ An historical report from the naval hospital at Jacksonville described what may be considered a representative dependents' unit:

The most recent addition to the Jacksonville Naval Hospital has been a modern and attractive Dependents Unit. This one story building is located several hundred yards south of the main building. It is constructed in three (3) sections arranged for housing obstetrical, surgical and medical patients. The rooms are commodious and well equipped and many of them open on glass enclosed porches allowing the beds to be wheeled out into the sunshine. The operating and delivery rooms are modern and supplied with the latest medical and surgical equipment. The general appearance and atmosphere of the building both within and without

220. Public Law 51, 78 Congress, 10 May 1943.

221. Annual Sanitary Report from U. S. Naval Hospital, Philadelphia, Pennsylvania, 1943.

is homelike and quiet. The division is staffed by 30 nurses and 40 waves. It represents an ideal unit for the care of eligible dependents of Naval personnel. Ambulant patients are cared for in the Out-Patient Department which occupies one of the wings of the main hospital. In view of the distance of the hospital from Jacksonville or nearby towns, transportation of dependents when necessary has been authorized.²²²

At hospitals located in isolated areas where few or no civilian medical doctors or hospital facilities were available, the dependents units were of special importance; a review of the reports indicates that their work had a salutary effect upon the morale of Navy personnel.²²³

Many services essential to the operation of the Navy hospitals were only related to the care of the sick and injured in an indirect and supportive way.²²⁴ Such services as water supply, sewage disposal, and garbage disposal had, long before World War II, become established and regulated by a rather standardized set of customs and regulations. They were, during the War, provided without much difficulty and to the general satisfaction of officials in charge of the hospitals. More directly related to clinical care and therapy in general was medical supply. Here, too, the Medical Department profited from a system which had long been established; and despite the rapidly increasing demands placed upon the supply depots, most of the hospitals reported that supplies were adequate. Some equipment was slow in procurement because of wartime shortages.

222. Historical Supplement to Annual Sanitary Report from U. S. Naval Hospital, Jacksonville, Florida, 1944.

223. Annual Sanitary Reports from U. S. Naval Hospital, Farragut, Idaho, 1944; from Key West, 1943.

224. The place of these services in the internal organizational structure of naval hospitals can be seen by consulting the charts in Appendix E.

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Annual sanitary reports during the War were often cryptic in their discussion of the food situation at hospitals, and the historical reports generally ignored the subject. Little or no food poisoning occurred at the hospitals, and the few cases that were reported were not serious. The procurement of food for a balanced and interesting diet was extremely difficult during the War because of food shortages. Some hospitals, favorably located, had foods which were scarce in other parts of the country. In the Eleventh Naval District hospitals were able to make joint purchases with the Army. This cooperation raised quality and lowered cost.²²⁵ At other hospitals the "Fleet Service" organization of the supply department was used to advantage. In hospitals not located in conjunction with naval activities, the contract system was generally used.²²⁶ The most frequent complaint about food at the hospitals was aimed at the lack of variety and the use of scrap meals.²²⁷

During the first three years of the War the number of persons on duty status increased more than three fold. In 1942, the average strength of personnel in U. S. Naval Hospitals was 9,586; in 1943 it rose to 21,131, and in 1944 to 30,809. The greatest ratio of increase was noted in nurse personnel on hospital staffs; this group increased from an average of 1,423 in 1942 to an average of 5,046 in 1944, or an increase of 254 percent. The number of enlisted men increased from

225. Annual Sanitary Report from U. S. Naval Hospital, San Diego, California, 1943.
226. Annual Sanitary Report from U. S. Naval Hospital, Chelsea, 1944.
227. Annual Sanitary Report from U. S. Naval Hospital, Newport, Rhode Island, 1943.

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6,892 in 1942 to 23,339 in 1944, or a rise of 240 percent. The increase in the number of medical officers was somewhat less--from an average of 1,270 in 1942 to 3,373 in 1944, or a rise of 165 percent.²²⁸

The rate of increase in hospital staff personnel was considerably less than the rate of increase in the number of patients during this same period.²²⁹

The annual sanitary and historical reports abound with comments upon the rapid turnover of personnel. The military necessity for such a turnover was recognized as unavoidable, but the effect on the hospitals was none the less deleterious and an acute administrative problem at certain times during the War. In view of the disadvantages of rapid turnover and the necessity of employing untrained or inexperienced personnel, the quality of the work performed was considered highly satisfactory.

Hospital corpsmen were often referred to as being of a "high type" and the performance of their duties was frequently commented upon favorably in the sanitary and historical reports. In the early years of the War enough trained men for the higher ratings were not always available, but by the close of the conflict this difficulty was no longer mentioned. Where the hospitals were inspected, favorable comments were frequently made relative to the high morale of the men.

The advent of WAVES in hospitals was greeted with almost unanimous acclaim by medical officers in command. A report from San

228. See Appendix B.

229. See Appendix Q.

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Diego stated: "The Waves were truly life savers and the highest credit goes to all members of the Womens Reserve."²³⁰ The medical officer in command of the Seattle hospital was "so gratified with the Wave program" that he held "the conviction that Waves would be an asset to the Navy in peace as well as in war."²³¹ A report from Parris Island stated that the general concensus was that WAVES had satisfactorily replaced male corpsmen.²³² There were, of course, some medical officers whose opinions of the WAVES was somewhat more qualified. For example, the Corpus Christi hospital reported that the WAVES did good work but that they did not have physical strength equal to that of the men.²³³

No personnel problem was more difficult than that of procuring and holding the required number of qualified civilian workers in the hospitals. The wages paid to civilian employees in no way compared to the compensation which was current in industrial activities. As many hospitals were located in the outer suburbs of metropolitan areas, or in areas far from communities, both transportation and housing were serious problems. As a result, frequently only very inefficient help was obtainable. Absenteeism and tardiness tended to lessen hospital efficiency. The draft continually removed trained civilians and made necessary the training of new personnel. Morale of the civilians in the lower wage scale brackets was not good

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- 230. Annual Sanitary Report from U. S. Naval Hospital, San Diego, 1944.
 - 231. Annual Sanitary Report from U. S. Naval Hospital, Seattle, Washington, 1944.
 - 232. Annual Sanitary Report from U. S. Naval Hospital, Parris Island, South Carolina, 1944.
 - 233. Annual Sanitary Report from U. S. Naval Hospital, Corpus Christi, Texas, 1943.

in some places. Servicemen's wives were employed and did excellent work, but because they usually resigned when their husbands were transferred, the turnover was great. The turnover of civilian help, and the retraining and replacement resulting, was a major problem in the clerical and commissary branches. The scarcity of properly trained civilian help necessitated the use of corpsmen and WAVES in work which took them from duties for which they were trained.²³⁴

Training activities at hospitals were synchronized with the routine of the institutions. Because of the constant replacement of men sent to other stations, the training program for the new men was often not completed. Advancements in ratings were not only to the advantage of the men but the added skills and techniques were of great worth to the most efficient administration of the hospital. It was sometimes difficult to determine whether the training division was a functioning hospital unit, or a training school; yet the work was so organized that both interests were adequately served. Part of the teaching was done by medical officers and nurses.²³⁵

The training of officers was a constant problem for the hospitals. The intern system was well established and few comments were registered concerning its functioning. With the influx of thousands of doctors into the Navy, a very real problem of indoctrination was presented. As the turnover of officers was very fast, training and

234. Annual Sanitary Reports, 1943, from the hospitals at St. Albans, Philadelphia, San Francisco, Parris Island; Annual Sanitary Reports, 1944, from the hospitals at Oakland, San Leandra, Portsmouth, Pensacola.

235. Annual Sanitary Reports, 1943, from the hospitals at Norfolk, Brooklyn, San Francisco; Annual Sanitary Reports, 1944, from the hospitals at Parris Island and San Diego,

indoctrination in Navy methods were of a cursory nature. The demand for medical officers in the ever-increasing fleet drew them from the hospitals as soon as possible.²³⁶ Whenever possible, an effort was made to teach all medical officers, irrespective of their specialties, to perform routine surgical procedures. This training was considered of primary value to medical officers who would eventually serve on the fighting fronts. At some hospitals officers back from overseas were re-indoctrinated, especially in records and surveys.²³⁷ Many medical officers assigned to duty in the Pacific area and awaiting transportation in San Francisco were given lectures and demonstrations in practical surgical emergencies by hospitals of the area.²³⁸

Senior medical officers at all naval hospitals received valuable clinical instruction and demonstrations by competent senior medical officers. Because of the great number and variety of cases cared for, there was ample clinical subject material. Such postgraduate instruction was most beneficial to the officers concerned.²³⁹

Hospitals which conducted the Cadet Nursing program reported strongly in its favor. Even while in training the Cadet Nurses proved to be valuable assistants, sharing the ever increasing burden of patient population.²⁴⁰

A routine but important sanitary problem at the hospitals was the control of vermin. In temporary buildings of flimsy construc-

236. Annual Sanitary Report, 1944, from U.S. Naval Hospital, Norman, Oklahoma.
 237. Annual Sanitary Report, 1944, from U. S. Naval Hospital, Great Lakes, Illinois.
 238. Annual Sanitary Report from U.S. Naval Hospital, San Francisco, 1944.
 239. Annual Sanitary Report from U.S. Naval Hospital, Philadelphia, 1944.
 240. Annual Sanitary Report from U.S. Naval Hospital, Oakland, 1944.

tion, entirely effective control was extremely difficult. In the several places of the hospitals where food was served or stored, special precautions against the propagation of vermin had to be taken. The introduction of DDT in 1944 was a very real help in solving this problem, especially in the eradication of roaches, flies and mosquitoes. Both the spray and the powder were found to be effective. Rats and mice were trapped and sodium fluoride was used under expert supervision. The use of sodium fluoride, as poison, was deterred by its being misplaced or used as a means of suicide.²⁴²

A work in all hospitals which consumed much time for both medical staff and patients was the preparation of medical surveys. The meeting of boards, and the long periods of waiting for action from Washington created consternation in hospital administration as well as dissatisfaction on the part of individuals awaiting action. One medical officer in command pointedly noted: "It is becoming increasingly evident that more patients must be surveyed here and not passed on to other hospitals with the vague hope of future full or limited duty for these patients."²⁴³

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241. Annual Sanitary Report from U. S. Naval Hospital, San Francisco, 1944.
242. Annual Sanitary Report from U. S. Naval Hospital, Memphis, 1944.
243. Annual Sanitary Report from U. S. Naval Hospital, Long Beach, 1944.

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Section 6 - Transfer of Patients

The advisability of transferring casualty patients to hospitals near their home naval district had long been recognized by the Bureau, but there were certain difficulties of a technical nature preventing the full achievement of the policy until some time after Pearl Harbor.

The usual and accepted policy was that of assigning patients to hospitals near the port of debarkation. However, patients, if they desired, might request transfer to hospitals near their homes at their own expense or were granted up to 60 days' convalescent leave, with permission to report to a naval hospital near their home, which amounted to the same fundamental procedure.²⁴⁴ Unfortunately the number of patients desiring transfer was great, and although the vast majority of requests for transfer were granted, it took from five to six weeks for approval to be returned from the Bureau.²⁴⁵ This policy was made necessary because of regulations by the Bureau of Personnel and the Bureau of Supplies and Accounts which did not allow payment of such transportation except in individual and unusual circumstances. This policy was severely criticized by Congress and by veteran organizations.²⁴⁶

In the fall of 1944, the Bureau of Medicine and Surgery requested permission to authorize transportation of patients at government expense. The request was accepted by BuPers and the following

244. BuPers Cir: Ltr. No. 196-43; BuPers Ltr. Pers 630-RFT(1), 26 Apr. 1943.

245. Memorandum: Rear Adm. Daniel Hunt, Com 12 NavDist to N. B. Adams, 13 Oct. 1944.

246. Rear Adm. L. Sheldon, Acting Chief of Bureau, to Comdr. Marine Corps via BuPers, 14 Sept. 1944.

general policy was adopted covering the transfer of patients:

1. This policy applied to all patients disabled overseas.
2. Patients were to receive transportation at government expense if it was expected that hospitalization would exceed 30 days.
3. "For medical and psychological reasons, such transfers are not to be considered as for the convenience of the officer or man, but as a means to assist in recovery, adjustment, and final disposition."
4. Patients were to be given convalescent leave under two systems, neither granting leave of more than 30 days:
 - (a) Return to same hospital--travel at own expense.
 - (b) Be sent to hospital near home at government expense and report back there.
5. Transfer only at request of medical officer in command of the hospital where the man was a patient, and subject to the prior approval of the Bureau. This gave assurance of available beds at the destination and that adequate facilities for treatment were at hand for the particular disease or injury of the patient.²⁴⁷

247. BulMed to MedOfCom, NavHosps, NavConvalHosps (Continental limits) by R. T McIntire, conference 12 Oct. 1944.

On 11-12 October, a discussion meeting dealing with hospitalization problems was held by the district medical officers and Bureau representatives. The problem was fully examined and many of the difficulties concerned with the inauguration of this rapidly increasing program were reconciled. A mutual understanding of the problems involved enabled a better coordination of effort on the part of both the district medical officers and the Bureau representatives acting on this problem.

In October of 1944, the transfer of patients was further expedited by eliminating the necessity of action by a Board of Medical Survey before transfer. The Bureau acted as the dispatching service, receiving requests and granting clearance if beds were available at the desired hospital.

To insure adequate preparation for reception of patients, the facility forwarding patients notified the receiving activity of the scheduled time of arrival, number of stretcher cases, number of cases requiring special attention, and all other information considered relative to the best interests of the patient.²⁴⁸

The policy of transfer of patients was not only of medical and psychological value from the point of view of the patient, but it also provided considerable relief at a more rapid rate for the greatly overcrowded hospitals on the West Coast. The patient load of these hospitals was dangerously near the point of maximum expansion.

248. Ibid., conference 11-12 Oct. 1944.

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In December the work of transfer was still further expedited by allowing the commanding officer to issue the orders for travel and the disbursing officer to pay the expenses without further approval by BuPers, provided that the transfer had been cleared with BuMed to be certain that facilities were available. Copies of orders were then forwarded to BuPers. This change also included travel by air.²⁴⁹

In order to reduce the heavy patient loads in hospitals, to provide beds for overseas evacuees, and to eliminate all unnecessary transfers, it was decided to have certain dispensaries retain classes of patients heretofore generally transferred to hospitals. The well trained medical officers assigned to dispensaries equipped with adequate facilities would also thus be afforded an opportunity to apply their skill and experience. The cases to be retained were those which might require only short periods of hospitalization, and general surgical procedures could be carried out there.²⁵⁰

The transfer of patients in the overcrowded Pacific Coast area was particularly facilitated by allowing the district medical officers of Districts 11, 12, and 13 the authority to transfer patients to hospitals within any of these three districts without reference to the Bureau. This was effected by clearing patients through the Inspector, Pacific Coast. Transfer to eastern hospitals would still be made through the Hospital Division of the Bureau.

249. BuPer Cir. Ltr. No. 367 to All Ships and Stations, 11 Dec. 1944.

250. BuMed to All District Medical Officers, 11 Dec. 1944.

In February of 1945, the entire program was summarized and reevaluated in a joint letter by BuMed, BuPers and Marine Corps. The points have largely been outlined above, but a few new factors were stressed. The mode of travel was made a matter of local decision. Although in most cases a Board of Medical Survey is not necessary, it is required in the case of psychotic patients, and upon such a survey the commanding officer may take final action on transfer to another naval hospital or to the U. S. Public Health Service Hospital, Fort Worth, Texas. Copies of the report and orders are sent to the Bureau for record purposes.

Transfer to non-naval hospitals must be sanctioned by BuMed, BuPers, or the Marine Corps. This is the procedure to be followed in admitting patients to Army and Navy hospitals at Hot Springs, Arkansas, and the Georgia Warm Springs Foundation. When BuMed receives requests for transfer such requests are approved or modified according to the availability of beds, and notice is sent to the receiving facility. The transferring activity informs the receiving activity well in advance of the scheduled time of arrival, the number of ambulatory, convalescent, and stretcher cases, and the number of cases requiring special handling.²⁵¹

In March of 1945, the same general policy was adopted in regard to forwarding patients requiring special treatment to hospitals which afforded such treatment. This expedited the movement of patients

251. Joint Letter--BuMed, MarCorps, BuPers to All Ships and Stations, 21 Feb. 1945.

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by allowing transfer to be made with as little paper work and a few exchanges of communication as possible with proper regard to adequate facilities for their receipt.²⁵²

Starting about 1 May 1945, all hospitals on the West Coast were requested to send daily reports of vacant beds to the Inspector, Medical Department Activities, West Coast. These reports, sent by telegram or teletype, enabled the inspector to better route patients coming into the country from overseas. Transfers between naval hospitals and naval convalescent hospitals were from that time forth to be made through the inspector and not through the Bureau. Requests for transfer by air were, in addition, to be cleared through the district commandant. The commandant continued, as formerly, to transfer patients within the district upon the advice of the district medical officer.²⁵³

Transfer of patients involves transportation, and transportation in war time is a major problem. The dispatching of patients by air was difficult chiefly because of the lack of space. Rail transportation was frequently uncertain as to time of arrival. This was a particular trial to the receiving facility. The train commander was supposed to notify the receiving facility of delays, but occasionally this was not done promptly. The number of hospital attendants and ambulances needed for stretcher cases was a serious problem, for the

252. Bulled to MedOfCom, NavHosps, 20 Mar. 1945.

253. Commander Western Sea Frontier's Direction N9-WSF-CL, Serial 3591, 26 Apr. 1945.

drafts of patients were frequently large.²⁵⁴

The hospital trains had to be especially serviced with food and even a special heating problem arose when they were delayed in some railroad yards.²⁵⁵

The transfer of patients to hospitals near their homes greatly raised their morale. It aided also in their chance of recovery by placing them in hospitals specializing in their own particular infirmity. This policy was necessary in order to distribute the great load of patients accumulating on the West Coast. On all points it proved a success, even though it involved principles and procedures in variance with established custom.

The problem of receiving overseas patients for distribution to hospitals in this country was centralized chiefly in two ports of debarkation--New York for the East Coast and San Francisco for the West Coast. The Inspector, Medical Department Activities, Pacific Coast, acted as to the routing of the evacuees. Patients to be hospitalized in the 11th or 13th Naval Districts were dispatched to those hospitals by air, train or bus. This policy of centralization, though no doubt expedient in a number of respects, was strongly criticized. "The port authorities, as I see it, seem to handle casualties as they do freight, and it does not seem expedient to them to disembark patients in San Diego."²⁵⁶

254. Memorandum, W.J.C. Agnew, from G. C. Thomas, 14 May 1945.

255. From MedOfCom, Hospital Train to Chief, Bureau Supplies and Accounts, 30 May 1945.

256. From Rear Adm. G. C. Thomas, (MC), USN, (Ret.), to Vice Adm. R. T McIntire, 13 Mar. 1944.

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Section 7 Specialization in Hospitals

Malignancy

Prior to the War, all malignant patients were sent to the U. S. Naval Hospital, Brooklyn. For special treatment, patients were transferred to Memorial Hospital, New York. A contract between the Navy and that hospital provided for treatment and hospitalization during treatment for short periods, usually about 10 days. As the government had a deposit of radium at the hospital, no charge for its use was made--an arrangement which made the hospital most convenient for the Navy.²⁵⁷

During the War, new techniques introduced in the treatment of cancer required a longer period of care at the Memorial Hospital and in 1943 a new agreement was made to cover this necessity. The staff of Memorial was most cooperative and their extensive consultant work for the Navy, without any compensation whatever, was most helpful. One of the advantages for the patient was his psychological reaction upon being given diagnostic and medical treatment at a world renowned center for such treatment. Actually much of the work was accomplished at the Brooklyn Naval Hospital and a number of the medical officers at that institution had formerly been staff members at Memorial Hospital. With these reserve officer specialists available, the Brooklyn Hospital was able to enlarge its field of

257. Manual of the Medical Department, paragraph 2176; Memorandum to Capt. Owen, (MC), USN, from Mr. W. S. Douglass, Chief Clerk, 30 Oct. 1941.

activity. During the War, considerable equipment designed for the treatment of malignancy was installed at Brooklyn.²⁵⁸

The problem on the eastern seaboard was further alleviated during the War by cooperation with Rockefeller Institute of Medical Research in New York, which cooperated with research on unusual cases.²⁵⁹ The establishment of the National Naval Medical Center, Bethesda, provided additional beds and trained staff for this type of disease. Bethesda was commissioned in February of 1942 and was continually increasing its facilities.²⁶⁰

On the West Coast, San Diego was officially classified as a center for treatment, although in reality it only served as a concentration center for shipment to Brooklyn.²⁶¹ The long trip from the West Coast to Brooklyn was considered to be particularly depressing to patients traveling away from friends and family for treatment. Even before the War, serious consideration was given to establishing a similar center on the Pacific Coast. Both the Los Angeles Tumor Institute and the Swedish Hospital at Seattle were under consideration.²⁶² Because of pressing general hospitalization needs, this project was not implemented until the spring of 1943 when Corona was designated as a cancer center and a contract was arranged with the

258. Capt. G. E. Robertson, (MC), USN, to Rear Adm. D. G. Sutton, (MC), USN, 8 Dec. 1943.
259. Annual Sanitary Report, Brooklyn, 1943, 1944.
260. Chief BuMed to MedOfinCom, Brooklyn, 26 Mar. 1942.
261. Manual of the Navy Medical Department, paragraph 2177.
262. Dr. Albert D. Suiland, Los Angeles Tumor Institute, to Surgeon General, 10 July 1941; DistMedOf 13th NavDist to Capt. Luther Sheldon, Jr., (MC), USN, 3 Oct. 1941.

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Los Angeles Tumor Institute. In July, Long Beach was designated to act as the hospital serving patients under treatment as it was nearer the Institute than Corona. Army patients were also serviced under the same contract. From the date of establishment of the cancer center, all patients in the 11th, 12th and 13th Naval Districts were cared for without necessity of transfer across the continent.²⁶³

Because of the increase in the size of the naval service, the patients afflicted by this particular type of illness increased more than 200 percent during the first year of the War and remained a serious problem for the duration. The adequate provisions taken by the Medical Department prior to the War, and the flexibility of modifying that program to meet the increased demand, enabled the Department to meet the need.²⁶⁴

Psychotic Cases

As was the case with the care of patients with malignant diseases, there was an established pattern functioning at the beginning of the War for handling psychotic cases. After Pearl Harbor, the excessive growth of the Navy necessitated great expansion of facilities, but little change in general organizational procedures took place.

Individuals giving evidence of being psychotic cases were transferred from their regular duty station to naval hospitals. All

263. Chief BuMed to MOinCom Corona, 28 Feb. 1943; MedOfinCom, Corona, to Chief BuMed, 19 Mar. 1943; Chief BuMed to MOinCom, Corona, 1 Apr. 1943; Chief BuMed to DMO, 11th, 12th, 13th NavDist, 8 July 1943.

264. To BuMed from MOinCom, Brooklyn, 26 Nov. 1943; Chief BuMed to MOinCom NavHosps, NavConvalHosps, 20 Mar. 1945.

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hospitals had wards especially set aside for this type of patient, who was confined and segregated from other patients. At the hospital they were treated by members of the staff specializing in mental diseases and were given a period of treatment to determine the nature and extent of their problem. Patients who were to require a long period of treatment and observation were transferred to Washington, D. C., or Mare Island, California.²⁶⁵ Patients who appeared to require permanent care or a longer period of observation were transferred to St. Elizabeth's Hospital, District of Columbia, upon recommendation of a board of medical survey. This facility is especially equipped and organized to care for and treat psychotics. It receives patients from the armed services and certain veteran cases.²⁶⁶

The increased patient load of psychotics was absorbed in several ways. One of the most important was the large number retained at regular naval hospitals, particularly those observed during initial training activities. Sanitary reports from all hospitals during the war years reflect the great increase in patient load made up of psychotics and the corresponding growth of physical plant and staff for their care.

hospital organization in growth.

The establishment of the National Naval Medical Center offered greatly increased facilities over the Washington naval hospital which it replaced. Mare Island not only expanded on its own compound with

265. Manual of the Medical Department, paragraph 2154.

266. Manual of the Medical Department, paragraph 2155.

temporary facilities, but through the agreement with the Napa State Hospital, discussed in the section on Physical Plant, was enabled to give excellent care to a greatly increased number.²⁶⁷

Previous to the War, in cases of emergency, the Navy was a party to an arrangement whereby the facilities of the Public Health Service Hospitals were made available, and the Bureau was billed for the hospitalization charge.²⁶⁸ During the War, a U. S. Navy Unit was established at the U. S. Public Health Service Hospital, Fort Worth, Texas. The Unit served as the administrative control and by the end of 1944 had 11 doctors and 138 corpsmen on its staff. In addition, there were 136 positions filled by Public Health personnel. During the year 1943, the Unit admitted 1,156 patients and during 1944, 2,041. The rate of increase continued the same into 1945.

Air transport of psychotic patients was found to be greatly superior to rail. It saved time of nursing care and the handling of smaller drafts was more satisfactory. This service initiated in February of 1944.²⁶⁹ A special type of car which could be treated as a locked ward was used for rail transfer of groups to Fort Worth, or wherever needed. It was referred to as the "prison car."²⁷⁰ Starting with the summer of 1944, Navy patients were transferred to Veterans' Administration facilities near their homes or those of relatives upon the request of these relatives. They were always patients who were

267. Mare Island, Sanitary Reports, 1942, 1943, 1944.
268. Manual of the Medical Department, paragraph 2172.
269. Annual Sanitary Report, U. S. Navy Unit, U. S. Public Health Service Hospital, Fort Worth, Texas, 1944.
270. Capt. J. P. Owens, (MC), USN, to Capt. C. L. Andrus, (MC), USN, 22 Dec. 1944.

considered to be in need of extended hospitalization.²⁷¹

The three major administrative changes were extensive use of non-naval facilities, the transporting of patients by air whenever possible, and the policy of transferring patients to facilities near relatives.²⁷²

Poliomyelitis

The Navy specialized program for the treatment of poliomyelitis grew from a policy of close cooperation with the Warm Springs Foundation. This service on the part of the Foundation was made available to the Navy prior to Pearl Harbor.²⁷³ For the first year and a half of the War, the problem was not pressing as there were fortunately very few cases of this disease. The Foundation set aside 5 beds for the use of the Navy and this proved ample. In fact, from November 1942 to March 1943 there were no admissions at all.²⁷⁴

After October of 1943, the load increased rapidly and by the end of 1944 the Navy was using the 40 beds which were then assigned to Navy personnel. This increase of available beds was made possible by expansion of the Foundation's facilities, and by their generous allocation of beds for Navy use. About one-third of the hospital's capacity was being utilized by the Navy. From time to time it was

271. BuMed Ltr., 4 Apr. 1944; Annual Sanitary Report, U. S. Public Health Service Hospital, Fort Worth, Texas, 1944.

272. State Hospital, Napa; Public Health Service Hospital, Fort Worth; St. Elizabeth's Hospital, D. C.; Veterans' Administration.

273. Chief BuMed to MedOfinCom, Washington, 30 Oct. 1941.

274. Surgeon General to Mr. Basil O'Conner--Chairman, Executive Committee, Warm Springs Foundation, 15 Dec. 1942.

necessary to delay transfer of patients because of the overcrowding of the hospital.²⁷⁵

With the considerable group of Navy patients at the hospital, certain problems resulted which made it advisable to establish a Navy unit at the facility. The Navy patients had no military supervision and broke hospital rules relative to use of intoxicating beverages on the compound and leaving on unauthorized liberty. This disregard of hospital regulations on the part of Navy personnel brought unfavorable comments from other patients as well as from the staff.²⁷⁶ The Surgeon General immediately suggested the establishment of the naval unit, a move which was appreciated by the Foundation and also served to relieve the staff of that institution of some of their work with naval patients. The unit was established on 20 March 1945. Some difficulty was experienced in finding quarters because of wartime crowding, but its work was soon integrated with that of the Foundation. The relations throughout the War were of a friendly and mutually cooperative nature.²⁷⁷

From the time of the commissioning of U. S. Naval Hospital, Corona, poliomyelitis patients on the West Coast were sent to this facility for care pending transfer to Warm Springs.²⁷⁸ In January of

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275. Dr. C. E. Irwin, Chief Surgeon, Warm Springs Foundation, to BuMed, 14 Dec. 1943; Memo from Dr. C. E. Irwin to BuMed, 11 Dec. 1944.
276. Dr. C. E. Irwin, Chief Surgeon, Warm Springs Foundation, to Vice Adm. Ross T McIntire, (MC), USN, 19 Feb. 1945.
277. Surgeon General to Dr. C. E. Irwin, 3 Mar. 1945; Dr. C. E. Irwin to Surgeon General, 7 Mar. 1945; Ross T McIntire to Mr. Basil O'Conner, 26 Mar. 1945; SecNav ltr, 45-272, 20 Mar. 1945.
278. ~~Capt.~~ Luther Sheldon, Jr., (MC), USN, to Capt. H. L. Jensen, (MC), USN, 15 Dec. 1942.

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1944, the Bureau made a resurvey of the facilities at Corona for the care of these patients. Facilities for treatment were adequate and with the transfer of trained personnel it was possible to designate this hospital, on 15 February 1944, as a center for special treatment of poliomyelitis for the West Coast.²⁷⁹

With the two units operating, the care of patients with this disease was adequate. The benefit of the cooperative use of certain facilities was again demonstrated as was the efficient use of especially qualified reserve medical officers.

Amputation Cases

In this field of specialization the U. S. Naval Hospitals at Mare Island and Philadelphia achieved outstanding success and made many important contributions to the advancement of the science and art of equipping amputees with serviceable limbs. Great advances were also made in the training of patients in the correct and normal usage of these artificial limbs. The program grew from the grave necessities of the war situation and was greatly aided by civilian assistance and a number of reserve officers particularly interested in the problem.

The U. S. Naval Hospital, Mare Island, was established and designated as a center for amputation cases and the furnishing of artificial limbs.²⁸⁰ The program was the outgrowth of the needs incurred

279. MedOfinCom, Corona, to Chief BuMed, 12 Jan. 1944; Chief BuMed to MedOfinCom, NavHosp, NavConvalHosp 11th, 12th, 13th NavDist., 15 Feb. 1944.

280. Inspector Naval Medical Dept. Activities, Pacific Coast, ComOf NavHosp, 11th, 12th, 13th NavDist, P4-3/NH15, 13 Aug. 1943.

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immediately after Pearl Harbor when the hospital had no facilities to do the work. The local San Francisco manufacturers of limbs were of little help and were reluctant to include a pylon, the training and shaping device, in their bids for contracts to make limbs. Furthermore, patients were forced to take numerous trips for fittings. "The matter of braces such as walking calipers, etc., was impossible. The patients were not physically able to go to San Francisco for their braces and again the dealers were reluctant to come to the hospital."²⁸¹

Mr. Matthew Lawrence had formerly been the bracemaker for the orthopedic surgeon of this hospital. During the early months of the War, he brought his own tools and materials to the hospital each Saturday. Under his direction the Navy developed an articulated pylon which greatly assisted patients in learning to walk. Under his direction also, experiments were made with plastics, with the active cooperation of the Bakelite Corporation.

In December of 1942, one of the shops in the Navy yard gave \$800.00 to the hospital for use in establishing a brace shop. This gesture aroused great enthusiasm and a sum of several thousand dollars was contributed. By March the brace shop was making all the splints, walking calipers, braces and pylons used by the orthopedic department. One ambulatory patient worked full time, and Mr. Lawrence came two days per week, without pay. With the designation of the hos-

281. Historical Supplement, Mare Island, 1943.

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pital as amputation center, the name of the shop was changed to Artificial Limb Department. Mr. Lawrence was placed on civil service at full time, and ten enlisted men were employed at the work.²⁸² The hospital could now handle up to 150 amputation patients.²⁸³ This expansion was made possible by money from the welfare fund and other gifts.

Of particular importance in the success of this project was the close cooperation among patient, doctor, and bracemaker. Under the direction of Lieutenant Commander Toffelmier, (MC), USNR, the orthopedic surgeon, a plastic leg was designed and manufactured at a cost of only \$30.25. This was far under current prices and was considered by the Bureau to be superior. Patient and public reaction to the Navy's work was also very favorable, as the leg was lighter and more easily made than others obtainable.²⁸⁴

In December of 1943, the transfer of patients to this center was greatly facilitated by an order allowing the transfer of amputation cases upon the recommendation of the commanding officer of hospitals in the 11th, 12th, and 13th Naval Districts without the necessity of a board of survey.²⁸⁵ The U. S. Naval Hospital, Philadelphia, was designated to receive amputation cases from the remaining continental naval districts, 29 March 1944, and after May patients

282. Historical Supplement, Mare Island, 1943.

283. Telegram, NavHosp, Mare Island, to BuMed, 25 Sept. 1943.

284. Memorandum for Capt. John Harper, (MC), USN, from C. L. Andrus 22 Oct. 1943; Historical Supplement, 1943.

285. BuPers to Com 11 and Com 12, 4 Dec. 1943.

were transferred to this center from the East Coast districts without surveys.²⁸⁶

During 1944, the cooperation on the part of artificial limb manufacturers was much better, and the artificial limb departments specialized in the manufacture of plastic lower limbs and more frequently turned to commercial concerns which held patents on joints and similar necessary parts for the more extensive production of complete arms and legs.²⁸⁷

By 1945, the centers for amputation cases at Mare Island and Philadelphia had large, smoothly operating artificial limb departments, which received very favorable recognition from the Committee on Prosthetic Limbs of the National Research Council. The medical procedures, in which the Navy had always excelled, were being further developed and instructions were sent to advance units with suggestions for procedures which would facilitate the later rehabilitation of the patient.²⁸⁸ The Medical Department also contributed to a number of conferences in coordinating the work of the armed services and in mutual exchange of experience. In the summer of 1945, Great Lakes was notified of plans to make it an amputation center and at the close of the War operations were under way.²⁸⁹

The rehabilitation service at these centers was of great

286. BuMed ltr. 44-365, P4-3/NH(082), 29 Mar. 1944; Chief BuPers to Com 1-9 NavDist, Potomac River Naval Command and Severn River Naval Command, 4 May 1944.

287. Chief BuMed to MOinCom, Philadelphia, 29 June 1944; MOinCom, Mare Island, to Chief BuMed, 17 Aug. 1944.

288. MOinCom, Philadelphia, to Chief BuMed, 18 June 1945.

289. Great Lakes, Cumulative Report, 1945.

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significance. Particular attention was given to teaching the patient how to use the limb properly. A booklet entitled Plotting Your Course was the result of experience in this work, and films on the subject were available. Of special importance was the assistance rendered by individuals who had lost a limb and who by speech and example did much to raise the morale of patients. Those patients who were well on the way for release were an ever-present testimonial of possible achievement. The Red Cross sent private citizens and representatives who had artificial limbs, yet were living normal and successful lives to the hospitals to service as examples of achievement. This did much to raise the morale of patients.²⁹⁰

Patients were transferred to the centers as soon after amputation as it was practicable for them to travel. They were sent to the center nearest their homes. They stayed until they were healed and a permanent limb had been fitted to the satisfaction of both the patient and the hospitals staff.²⁹¹

One of the common routines of life is the driving of a car. Amputees were afforded an opportunity to learn this art through the cooperation of manufacturers in lending properly equipped cars to the hospitals. Assurance was also given that cars properly equipped would be available after patients had been discharged.²⁹²

290. Vice Adm. Ross T McIntire to Robert E. Bondy, American Red Cross, 21 June 1945.

291. Chief BuMed to MOinCom, NavHosps, NavConvalHosps, 20 Mar. 1945; Chief BuMed to Hon. Harry L. Towe, 6 Nov. 1945.

292. S. E. Skinner, Gen. Mgr. Oldsmobile Corp. to Vice Adm. Ross T McIntire, 17 Sept. 1945; John S. Bugas, Gen. Mgr. Ford Motor Corp. to Vice Adm. Ross T McIntire, 23 Aug. 1945.

In addition to the limb furnished by the Navy, the amputee was assured a second prosthesis by the Veterans' Bureau, so in case one was broken a spare would be available for the emergency.²⁹³

The program of establishing the brace center at Mare Island, which initiated this particular policy, was the result of individuals' doing work beyond their line of duty. The civilian bracemaker, the orthopedic surgeon, a reserve officer, and the eight other reserve officers associated with them in this work went far beyond the requirement of regulations. The cooperation of the commanding officer enabled them to create a new and vital service for the Navy which by the end of the War was one of the items viewed with satisfaction by the Department. Early in 1943, when the project was brought to the attention of the Surgeon General, it received his ready and continued assistance. Its spread to Philadelphia and Great Lakes reflects this interest.

Deafness

The U. S. Naval Hospital, Philadelphia, was designated as a reception center in July of 1944 for all cases of deafness in the Navy and Marine Corps. Patients were transferred to the facility as soon as it was determined, by standard procedures, that such deafness existed. The immediate transfer was followed so that corrective measures might be taken and rehabilitation begun at once. Because of the obvious danger to hearing involved, travel by air was not allowed

293. Chief Bullod to MedOffCom, NavHosp, Philadelphia, Pa., 5 Nov. 1945.

for such cases.²⁹⁴ Patients were brought before a board of medical survey, which recommended their transfer to Philadelphia when it was considered expedient.

Preparation for the inauguration of the program was undertaken in April, and a survey of naval hospitals was made to determine the extent of the problem. Even during this formative period, patients were transferred to Philadelphia and work was started on the program.²⁹⁵

During the late spring and early summer, a number of nationally recognized specialists in lip reading and the rehabilitation of the hard of hearing were brought to Philadelphia and were frequently given commissions. Individuals already in the service, with special training in the field, were also transferred to this center.²⁹⁶

Patients were not taught the sign language, but are all furnished an opportunity to acquire proficiency in lip reading and are given speech correction to overcome faulty methods of speech. It should be remembered that these patients came into the service with normal phonation and their problems of speech are not the same as in cases where deafness came early in life. The Navy furnished aids in all cases where they would be of service. The contracts for these appliances were made with local dealers, who furnished an especially molded earpiece and other necessary equipment. This method was found

294. Chief BuMed to MedOfCom, NavHosps, NavConvalHosps, 20 Mar. 1945; Chief BuMed to MedOfCom, NavHosps, NavConvalHosps, 5 July 1944.

295. Rear Adm. L. Sheldon, Jr., (MC), USN, Acting Chief of Bureau, to Capt. J. W. Miller, (MC), USN, MOinC Philadelphia, 14 Apr. 1944; Chief BuMed to MedOfCom, NavHosps, NavConvalHosps, Senior MO, Major Shore Stations, 2 May 1944.

296. To Chief BuPers from Chief BuMed, 19 May 1944; MOinC, NavHosp, Philadelphia, to Chief BuMed, 19 May 1945.

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to be particularly advantageous during the early period of expansion.²⁹⁷

Early in 1945, there was considerable unavoidable overcrowding at Philadelphia. A 500-bed expansion was obtained, which relieved this condition. Expansion of the program by establishing a unit on the West Coast was under consideration at the close of the War. More careful classification of cases sent to the center also helped in solving the problem.²⁹⁸

The patients were practically all ambulatory and in good physical condition. They needed physical training, occupational therapy and recreation in conjunction with improvement of their mental outlook and hastening recovery. The shock experienced by deaf patients is similar to that which all who suffer sudden and unexpected handicaps experience. Part of the problem of adjustment on the acquiring of skills is psychological as well as physical.²⁹⁹ However, the Philadelphia hospital had very limited recreation facilities and very inadequate occupational therapy equipment. For these reasons, serious consideration was given to moving the center to U. S. N. Special Hospital, Asbury Park, where such facilities were ample. It was felt that the care there could be as adequate as at Philadelphia because "the personnel who care for these patients are usually Hospital Corps officers, WAVES especially trained to give lip reading instructions, etc., and very few

297. MedOfinCom, Philadelphia, to Chief BuMed, 28 Feb. 1945.

298. MedOfinCom, NavHosp, Philadelphia to Chief BuMed, 21 Mar. 1945.

299. To Lt. (jg) Ben E. Hoffmeyer, D(S), USNR, USS BOYD (DD544), from Capt. Howard H. Montgomery, (MC), USN.

doctors whose principal function is administrative." This group of specialists and patients could be moved without inconvenience to the Philadelphia hospital.³⁰⁰ Because of other administrative complications, however, this move was not made.

In the first ten months of operation, this unit treated 1,456 patients. Some 488 were discharged from the hospital, 848 to civilian life. At that time 1,141 hearing aids had already been delivered.

At first some 45 patients could be completely and carefully examined each week; later when an addition was furnished, over 60 admissions per week were examined.³⁰¹ The aural rehabilitation program of the Navy resulted from the advisability of concentrating patients in one locality for rehabilitation. Because of physical limitations of space and equipment, the full rehabilitation program of physical training, occupational therapy, and educational therapy, and educational service could not be accomplished. However, the program directly relating to hearing aids, lip reading, and remedy of speech defects was adequate. The program was almost entirely the work of specialists brought into the Navy for the purpose and made specialist officers of the Hospital Corps and WAVES. Every report indicates they did a satisfactory piece of work.

300. Memorandum: Commo. C. L. Andrus, (MC), USN, to Professional Division, 29 Apr. 1945.

301. MOinC, NavHosp, Philadelphia, to Chief of BuMed, 28 May 1945.

Blindness

The problem of handling blindness in the Navy is similar to that of deafness. It is the result of accidents, casualties in battle and other causes. Eighteen percent of patients admitted blind were in that condition as the result of drinking methyl alcohol. In addition, an average of one other died for each blinded.³⁰² The medical service at all hospitals is competent to handle all clinical problems and specialization of treatment is largely a rehabilitation problem.

Until the end of 1943, the number of blind patients was not large enough to justify extensive and specialized facilities. At that time an agreement was made with the Army whereby patients could be transferred to Letterman General Hospital or Valley Forge where they received both medical treatment and social adjustment. At the end of this time, the naval patient was returned to the naval hospital.³⁰³ The patients were transferred to Philadelphia for regulation care and transferred to the Army facility only for certain specialized treatments. By May of 1944, the Army facilities were so overcrowded that some Navy patients were being held at Philadelphia who would ordinarily be transferred.

In the summer of 1944, the rehabilitation program and social adjustment procedures were inaugurated at Philadelphia, and coordinated

302. MedOfinCom, Philadelphia, to Chief BuMed, 24 Jan. 1945.

303. Commandant 12th NavDist MedOfinCom, NavHosp, 12th Dist, 13 Jan. 1944.

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work with the Veterans' Administration was further implemented. It was at this time that the Office of Rehabilitation was established in the Bureau.³⁰⁴ The supervisor for the blind of the Veterans' Administration was most helpful in assisting the Navy in placing in operation a smoothly functioning program. The cooperation between the Navy and the Veterans' Administration proved advantageous.³⁰⁵

With this consolidation of activities, the transfer to Army facilities was no longer necessary. Immediate transfer to Philadelphia from other hospitals was made so that the social adjustment program could begin at once for each patient.³⁰⁶

Patients were sent to the New York Institute for the Education of the Blind for a period of two weeks' training, at the close of their basic training. Such training was a psychological help, as well as assisting patients to learn vocational aptitudes.³⁰⁷

Interested civilians made possible the gift of a portable typewriter to each blind veteran upon his release, if he had learned to use the machine.³⁰⁸

Rheumatic Fever

Two hospitals were designated as special centers for the care of rheumatic fever. U. S. Naval Hospital, Corona, was officially designated 3 March 1944 and U. S. Naval Hospital, Dublin, received

304. Ltr. from Surgeon General to Administrator of Veterans' Affairs, 23 Oct. 1944.

305. Surgeon General to Administrator of Veterans' Affairs, 22 June 1944.

306. Chief BuMed to MedOfinCom, NavHosp, NavConvalHosp, SMO Shore Stations.
307. MedOfinCom, Philadelphia, to Chief BuMed, 5 Aug. 1944; Chief BuMed to MedOfinCom, Philadelphia, 18 Aug. 1944.

308. Chief BuMed to MOinCom, Philadelphia, 29 Jan. 1945.

the same designation at the time of commissioning on 22 January 1945.³⁰⁹ These particular sites were selected in two sections of the country within areas where there was a low incidence of streptococcus infections. Great care was used in selecting doctors and staff well trained in this particular field.

The program was inaugurated unofficially during the summer of 1943, when U. S. Naval Hospital, Farragut, was faced with the problem of caring for more than 1,000 rheumatic fever patients.³¹⁰ In the northern part of the country the incidence of readmission was high, so patients were sent to the dry warm climate of Corona.³¹¹ For this large number, special trains were used. The entire Navy suffered a considerable rise in cases of this type, and effective steps were taken to lower the rate.³¹² In September a conference was held by a group of scientists at the Bureau and a program of control was devised. By October the Streptococcal Control Program was underway under trained personnel and an epidemiology unit was established at Farragut. These controls soon resulted in a very considerable reduction of the incidence of the disease.³¹³

In December of 1943, a careful survey of facilities available was made. The selection of Corona and Dublin for the specialization amply demonstrated the foresight of the recommendation of the survey.³¹⁴

309. To MedOfinCon, NavHosp, NavConvalHosps, SMO Shore Stations from Chief BuMed, 3 Mar. 1944; From SecNav to Hon. W. Lee O'Daniel, 11 Jan. 1945.

310. Chief BuMed to Chief BuPers, 8 July 1943.

311. MOinC, USNavHosp, Farragut, to Chief BuMed, 18 June 1943.

312. Surgeon General to Dr. Thomas D. Dublin, Long Island College of Medicine, 18 Dec. 1943.

313. Surgeon General to Hon. Harold C. Hagen, 23 Feb. 1944.

314. Memo for Condr. Carter from Lt. Condr. Alvin F. Coburn, 30 Dec. 1943.

A program for rapid transportation by air was inaugurated with excellent cooperation with NATS. Patients in continental hospitals were moved to Corona and taken to Dublin as soon as the presence of the disease was established. The patients transported by air were given a high priority to ensure their speedy removal.³¹⁵ A very careful procedure for care of patients was brought into being and soon proved most effective. All patients beyond continental limits were returned by air.³¹⁶ Patients were either released from the Navy on recovery or assigned to duty in areas of low streptococcal incidence. Because of this policy, the Navy experienced little recurrence.³¹⁷ Before return to duty or release, the patients were given a long period of care and study. If recurrence did develop, the patient was discharged from service upon recovery.³¹⁸

Tuberculosis

Specialization for care of this disease came when the building at Corona for tubercular patients was completed in the summer of 1943. The hospital was officially designated as a unit to receive tuberculosis patients on 29 July 1943.³¹⁹ It has been the policy of the Bureau to locate patients in warm, dry areas. Corona has an excellent climate for care of tubercular patients and its establishment was a logical outgrowth of this policy.³²⁰ As the care of tuberculosis

315. MedOfinCom, NavHosp, Jacksonville, 20 Apr. 1944.

316. ALNAV 47, 44-271, 6 Mar. 1944.

317. Chief BuMed to Chief BuPers, 4 Apr. 1944.

318. Surgeon General to Hon. Robert Wagner, 2 Nov. 1945.

319. Chief BuMed to NavHosp, NavConvalHosp, 29 July 1943.

320. Annual Sanitary Report, Corona, 1943.

patients requires the maximum space between beds, it was necessary to start construction to double the bed capacity to meet increased patient load. The original 240 beds were increased to a total of 500 in January of 1945.³²¹

In March of 1945, the facilities at U. S. Naval Hospital, Sampson, became available because of the lessening of the training program at the training station located there. As a result, this facility was designated to care for tubercular patients in the Eastern United States. By the close of the War, the unit had a staff of 9 tuberculosis specialists and nearly 1,000 patients and grew from 1 to 12 wards.

Surgery was performed on approximately 25 percent of the tubercular patients. At Sampson, delay in the arrival of equipment postponed some of this vital work.³²²

The medical procedures used were standard. Concentration of staff and patients for more adequate care was the purpose of establishing these units. Patients were transferred to Sampson as soon as practicable for treatment, care, and disposition.³²³

Neurosurgery and Plastic Surgery

As the names indicate, these two specialties were primarily surgical problems rather than administrative. At the close of the War,

321. Federal Board of Hospitalization, Resolution 74, 8 Oct. 1943; Annual Sanitary Report, Cumulative History, Corona, 1945.

322. Annual Sanitary Report, Cumulative History, Sampson, 1945; Annual Sanitary Report, Cumulative History, Corona, 1945.

323. Chief BuMed to MOinC, NavHosp, NavConvalHosps, 20 Mar. 1945.

five hospitals had been designated as specialty units for both of these treatments. The hospitals were St. Albans, Bethesda, Oakland, San Diego, and Great Lakes. The medical and surgical progress, as indicated by the annual sanitary reports and cumulative historical reports, was most gratifying.

From an administrative point of view it involved the expansion of the respective surgery departments and full utilization of the rehabilitation program for the convalescing patients.

Conclusion

The specialization program in hospitals of the Medical Department proved adequate to the needs of the situation. In the care and treatment of psychotics, malignancy, and poliomyelitis patients, the pattern was well established prior to the War. The use of facilities outside the Department proved to be of great worth in time of emergency. Blindness and hearing procedures were developed largely. Rehabilitation and social adjustment were synchronized with medical treatment for the care of the blind and deaf. Again the assistance of outside organizations was utilized, and specialists employed or commissioned to implement the Navy program.

Probably the most signal success from the point of leadership in the field was the work of the amputation centers. The work of these centers was largely that of rehabilitation, building on the excellent surgical products of naval hospitalization. Here the enthusiastic cooperation of civilians, reserve officers, and patients created not only

a program of rehabilitation which excited most favorable comment, but produced prostheses which were advanced in design and conception of use.

The specialized unit treatment of rheumatic fever, tuberculosis, neurosurgery and plastic surgery was merely recognition of the growth in size of well established clinical routines. The bringing together of patients and staff in a limited number of units resulted in a selection of the best fitted medical personnel. Climatic conditions were also taken into consideration.

Section 8 Rehabilitation

Rehabilitation as defined by the naval Medical Department has comprised all activities and services which might be required to supplement the ordinary or usual therapeutic procedures in order to achieve maximum adjustment of the individual patient, either for further military service or for return to civil life, with the least possible handicap from his disability.³²⁴

The organization of this program has been graphically illustrated in the chart in Appendix I. The commanding officer's emphasis has been of great importance, for he has set the tempo for the work in his hospital. The rehabilitation officer has been the commanding officer's advisor and, as such, responsible to him for the system's orderly development and smooth functioning. For purposes of coordination,

324. .Capt. Howard H. Montgomery, (MC), USN, "Rehabilitation" in Hospital Corps Quarterly, vol. 18, No. 3, Mar. 1945. Hereafter cited as "Rehabilitation."

the Rehabilitation Board has been established with the rehabilitation officer as chairman and with representatives of the various services as members. Under its supervision have been two general services-- Rehabilitation and Contributory Activities. The Rehabilitation Service has included physical therapy, physical training, occupational therapy, educational services, and civil readjustment. The Contributory Activities Service encompassed welfare and recreation, the chaplain, Red Cross, maintenance and local supporting efforts.

The rehabilitation program as it existed 15 August 1945 was a war time formal organization developed to meet the needs of the medical department. However, the ends it pointed towards have always been the aims of the department; a difference of intensity rather than intent has been the only real change. Before the War the number of patients in any one hospital had been relatively small; most admissions had been for acute conditions of short duration, and therefore the convalescent period had been at a minimum. Only a small number of men requiring adjustment for return to civil life, had been discharged from the services. For those few who had had longer convalescences the ordinary facilities of the hospital had supplied ample employment. When the weather had been suitable, "outside detail" which had been assigned to patients served adequately to prepare them for return to full duty status.

The advent of war magnified the problem beyond solution by already existing measures. The number of patients in hospitals had

increased in direct proportion to the increase in the size of Navy Casualties from combat operations were brought back to continental hospitals. As a result, the size and number of hospitals multiplied, while the pressing problem became twofold--to return to duty as expeditiously as possible any man so able and to take care that any man discharged for medical reasons had been prepared for a proper readjustment to civilian life.³²⁵

Many hospitals inaugurated activities which later were readily incorporated into the formal rehabilitation program. The Red Cross and other community groups provided means for projects later designated as occupational therapy. The chaplain and welfare and recreation services did much to furnish entertainment and diversion. By 1943 individual hospitals had inaugurated rather extensive activities. Red Cross activities at Seattle foreshadowed the type of program later developed by an elaborate system of counseling and preparing the patient for civilian life; a similar project was in operation at Philadelphia. At St. Albans, a demonstration scheme approved by the Navy Department and planned with Arma Corporation (manufacturers of electrical equipment under Navy contracts) was initiated in November 1943. A number of sub-assembly operations of the plant brought into the hospital afforded the patients constructive occupational therapy work which was an excellent morale builder, because it contributed directly to the war effort.

325. "Rehabilitation."

The development of the U. S. Naval Convalescent Hospital during 1942-43 was the initial effort to meet the war-emphasized need for special attention. Here an attempt was made to segregate convalescents into special institutions where special work in physical therapy and the previously mentioned contributory activities could be handled. This program has been more extensively dealt with in Chapter IX on Special Hospitals.

By late fall of 1943 it was clear that the services already under way needed to be coordinated in a uniform plan for all hospitals and increased in scope and extent. Consequently the Surgeon General assigned three medical officers the task of studying the matter and making recommendations. These officers reviewed reports of what had been done in this country and abroad and submitted a report which has been the basis for subsequent developments.³²⁶

On 12 April 1944, a BuMed letter was sent to all medical officers in command of naval hospitals announcing the establishment of an Office of Rehabilitation in the Bureau of Medicine and Surgery as a coordinating agency for educational procedures, occupational therapy in its broad meaning, physical fitness, welfare and recreation, counseling, prevocational training, and assistance for those who would be invalidated from the service.

A rehabilitation program was set up in each hospital as soon as possible. The program was gauged by the patient population of each

326. "Rehabilitation."

327. Chief BuMed to MedOfCom, NavHosps, NavConvHosps, Comdts. N.D., and Inspector MedDept Activities, P4-4/P3-2, 12 Apr. 1944.

hospital and developed in each hospital along lines recommended by the ward medical officers. By these officers, patients were classified into groups based on their physical ability to participate in the activities of the program. The prescribed groups were

- Group 5 -- no activity.
- Group 4 -- confined to bed.
- Group 3 -- confined to ward.
- Group 2 -- ambulant, but with stated restrictions on physical activity.
- Group 1 -- ambulant - no limitations on physical activity.

Physical Therapy

Physical therapy has comprised the use of physical forces, passive or active, on the body. The passive type has consisted of treatments which did not require any effort from the patient and included external heat, ultraviolet radiations, diathermy, low voltage electric currents, hydrotherapy, and massage. The active type has included various kinds of exercises in which cooperation and participation by the patient were necessary. Specific treatments for specific cases have been prescribed by a special medical officer or by the ward medical officer. Although all treatment has been under the supervision of a medical officer or a qualified physical therapist (an officer of the Hospital Corps, the Nurse Corps, or an officer designated as a specialist in the field), the actual administration has been carried on by "qualified assistants."

The basic principle of physical therapy has been to promoting the greatest possible return to normal function. When this has been

impossible, substitute or auxiliary movements have been taught. The U. S. Naval Hospital, Norfolk, reported that the department there was concerned primarily with the restoration of local function in the preparation of the patient for his participation in the general rehabilitation program.³²⁸

The U. S. Naval Hospital, Newport, stated its department was operating at near capacity with an average of 3,500 treatments per month. Patients have been referred back to the prescribing medical officer regularly so that he could check whether the desired results were being obtained or whether a change of treatment should be made to speed recovery.³²⁹ Physical therapy has achieved its purpose when local function has been aided or restored. It has been a valuable supplement to the medical officer's work.

Physical Training

Physical training was instituted in naval hospitals in order to send men back to the service physically fit for arduous duty. The program has been under the charge of the athletic officer, who has been assisted by personnel trained at the Naval Training Center, Sampson, N. Y. Their indoctrination has included an intensive review course in physical education, study of the organization and operation of a naval hospital, and emphasis on the fact that no type of exercise procedure not approved by the medical officer was to be undertaken.

328. Rehabilitation at the U.S. Naval Hospital, Philadelphia, has been thoroughly covered in the Supplement to the U. S. Naval Medical Bulletin, March 1946. It is of general interest.

329. "Reports from Naval Hospitals."

Physical training has been designed to promote general good health and ameliorate disabilities. Intensity of the exercise has varied with the patient's group classification, but it was begun with bed patients. U. S. Naval Hospital, Sampson, N. Y., developed a Gym-o-Bile, a cart with trays for carrying exercising equipment to bed patients. A sample tray contained a spring chest expander, sandbags, tennis and handballs, assistive ropes, spring hand grips, marbles, dynamometer, and bed book arm and leg exerciser. The selection was varied with the type of ward scheduled for exercises.³³⁰

Reclassification or regrouping of patients as well as increasing intensity of exercises has been a necessary part of the program. It has been expedient to use existing facilities, to take advantage of climatic conditions, to provide regular periods in the patient's daily schedule for physical training, and to allot a definite amount of ward time for its use. Special remedial and corrective exercises prescribed by the physician have been added to the regular schedule for both groups and individuals.

The U. S. Naval Hospital, Memphis, worked out a plan whereby the athletic specialist accompanied the ward medical officer on sick call. Particular attention was directed to group organization within wards in order to combat mental and physical inertia and even deterioration. Particularly significant has been the achievement with neuropsychiatric patients who were found to prefer team games. The program has aided in restoring their confidence in their physical

330. Ibid.

skill, giving an outlet to their hostility, and overcoming shortness of breath, lack of muscle tone, and chronic fatigue.³³¹

The U. S. Naval Hospital, Newport, voiced the fact that neuropsychiatric patients were unwilling to participate when the program began. This was combatted by the obvious enjoyment of some of the group. One of the athletic specialists developed an exerciser made of strips of rubber from inner tubes fitted with wooden handles. The result was a spring exerciser without springs which could be used by attachment to the bed or by both hands.³³²

In a survey of five naval hospitals, it was discovered that when specialists dressed up the exercises beyond the mere routine calisthenics stage, enthusiastic enjoyment was evident. The patients, themselves, testified that after a few days of such a regime they felt better, ate better, and found that time passed more quickly.³³³

Occupational Therapy

Although occupational therapy had been a part of naval hospitals during World War I, it had been discarded after demobilization. Therefore, a fresh start had to be made when it was decided to add it to the hospital program during World War II. Hospitals had to be rebuilt and remodeled; trained workers had to be found. Trained occupational therapists commissioned in the Women's Reserve formed the nucleus

331. "Reports from Naval Hospitals".

332. Ibid.

333. W. Kenneth Patton, Ens., (HC), USN, and Victor Ullman, PhM3/c, USNR, "First-hand View of Rehabilitation" in Hospital Corps Quarterly, vol. 18, No. 3, March 1945. Hereafter cited as "First-hand View of Rehabilitation". The hospitals visited were Sampson, Chelsea, Brooklyn, St. Albans, and Philadelphia.

of the group which was expanded by the addition of "qualified assistants, occupational therapy". These were Hospital Corps personnel qualified by training to conduct the activities of the program under supervision. The real emphasis in this field has been its employment for functional restoration and practical skill as differentiated from diversional use of time and projects of artistic significance. Its value has been judged from the benefit to the patient rather than from an artistic finished product.³³⁴

Occupational therapy has been useful in specific conditions in orthopedics, surgery, neuropsychiatrics, and psychomatics. It has aided return of function, has relieved tension, afforded an outlet for energy, and has increased self-confidence. Like other components of the rehabilitation program, this has been under the direction of a medical officer. Additional cooperation with the educational services officer to direct vocational efforts and with the Red Cross arts and skills program has proved wise.

A survey of naval hospitals discovered that occupational therapy has been so popular that it has been difficult to control available facilities so that the greatest number could benefit from them. Equipment was assembled to carry the program to the bed patient and the ambulatory ward patients.

The occupational therapy department of U. S. Naval Hospital, Chelsea, has offered leather work, carpentering, painting, plastics, and repair of electrical equipment. By cooperation with the Navy Yard, the patients have worked on cleaning and rebuilding motors for the

334. "First-hand View of Rehabilitation."

salvage department. The officer in charge of the department has obtained equipment for foot and leg exercises by getting six old style sewing machines with foot pedals and attaching saws to them.³³⁵

The U. S. Naval Hospital, St. Albans, has had one of the best departments, housed in a bright, cheerful wing and divided into three parts. ~~Arms~~ work has been taken to the wards in individual boxes, while long tables have been set up so that an entire group could operate a chain belt system of producing small electrical parts. The other services offered have been carpentering and arts and crafts.³³⁶

The U. S. Naval Hospital, Newport, has viewed occupational therapy as a treatment assisting with or hastening the patient's recovery either for further military service or for return to civilian life with the least possible handicap from his disability. If the patient has been clever at some manual skill or has had a desire to try some manual skill, that interest has been utilized wherever possible. However, the reason why the patient has been sent for occupational therapy has remained the major concern. The work chosen has had to exercise the disabled limb or portion of the body.³³⁷

The U. S. Naval Hospital, Norfolk, has included in this department bookbinding, metal crafts, pottery, weaving, woodworking, gardening, dramatics, music, sports, shorthand, typing, and radio.

335. "Reports from Naval Hospitals".

336. Ibid.

337. Ibid.

The work has been designed to increase muscle strength and joint motion, improve general bodily health, and to supply nearly normal activity through avocational projects and prevocational training.³³⁸

The U. S. Naval Hospital, Great Lakes, has regarded occupational therapy as of major psychological value. The idea of compulsion has faded as the patient has become interested. Finally, the problem was to restrain the patient from overworking.³³⁹ The true value of occupational therapy has lain in the enforced exercised given a specific part of the body. Yet its use in terms of both diversion and vocational training could never be ignored.

Educational Services

Educational Services has become an established part of hospital life and an essential feature of the rehabilitation program during 1944. The work has been directed to educational and vocational counseling and education and training. It has made available to the patient the wide range of courses sponsored by the U. S. Armed Forces Institute, correspondence courses, and rate training manuals. Educational Services has offered war orientation courses, has used training aids and devices to stimulate interest in naval duties, and has made arrangements for patients to attend nearby schools with suitable courses. Another important phase has been helping patients who were to be discharged obtain practical experience in lines of work they aimed to follow in civilian life.

338. Ibid.

339. Ibid.

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The U. S. Naval Hospital, Chelsea, has endeavored to give every patient individual attention not only in counseling but also in tutoring. As a result, staff assistants have been recruited from the patient ranks. Several high school diplomas and even a degree in pharmacy have been secured by means of organized study programs. Resources of the colleges and counseling services in the area have been utilized to implement the service.³⁴⁰

The USNH, Great Lakes, has provided educational opportunities in various ways to meet the patient need. Self teaching materials have been made available for the bed patient; small classes have been organized in the wards; movies have been shown in the wards; regular classroom schedules have been maintained for ambulatory patients. Classes have varied in size from 3 to 15 students.³⁴¹

The USNH, Mare Island, has viewed rehabilitation as a real challenge and made as its goal sending the patient out better equipped than before. Therefore, vocational counseling under the Educational Services officer has been made the core of the second phase of rehabilitation there. The first step has been to find a vocational interest or possibility; the second has been to select the way to reach that goal. A local junior college, the high school, and the Navy apprentice school have cooperated in achieving these aims.³⁴² The work of educational services in restoring confidence, building morale, and pointing out new fields has been a tremendous factor in the rehabilitation process.

340. "Reports from Naval Hospitals."

341. Ibid.

342. Ibid.

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This phase of the program has been applied to the man who has been scheduled for survey and release to civilian life. Civil readjustments responsibility has been to insure for each dischargee an exit interview which will be thorough enough to send him out with the knowledge necessary to complete his service record as well as with a sense of personal satisfaction about readjustment. The Medical Department has assumed the responsibility of seeing that all patients discharged from the service from naval hospitals receive the full benefit of the program. Hospital Corps officers have been specially trained to assist in this work. It has been estimated that a full hour of the civil readjustment officer's time must be allowed for each dischargee. He has had to maintain close cooperation with the Veterans' Administration representative, the Selective Service and Civil Service representatives, and representatives from various veterans' organizations. Experience has shown a practical method stemming from a group lecture or lectures, the presenting of the pamphlet, Your Rights and Benefits, and culminating in the personal interview to answer individual questions.

Civil readjustment has met its responsibilities when the dischargee has left with a feeling of satisfaction in connection with his naval service and confidence in his future civilian life. These, then, have been the actual rehabilitation services as planned for all naval hospitals. They have been complemented by other activities in the

hospital framework, whose duties or services have added to the broad aims of the program.

Contributory Activities

Welfare and recreation has had as distinct a place in the naval as in the civilian hospital. The will to recover, albeit somewhat intangible, has been important to the patient's progress. Hospital hours even with physical and occupational therapy, physical training, and educational services have loomed abnormally long. Then, too, in the case of these patients, the convalescent period, which in civilian life has been spent at home, has had to be spent in the naval hospital.

The major recreation problem has been to fit the programs to the needs and tastes of the men. The most helpful point has been securing patient participation both in planning and in doing.

The Red Cross has been a valuable prop to the morale of patients who have had personal or family problems. This program, handled by trained personnel, has been available to men who have asked for it. The Red Cross also has assisted in recreation, has worked close to occupational therapy with arts and skills, and has aided discharges in preparation of claims for pensions and other benefits.³⁴³

The chaplain has made a definite contribution to rehabilitation in relieving spiritual unrest, which has often impeded recovery.

343. The status of personnel of the American Red Cross in naval activities is stated in U. S. Navy Regulations, Articles 1470-1478. An excellent exposition of their services has been presented in "The Red Cross Rehabilitation," in Supplement to United States Naval Medical Bulletin, March 1946."

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Some patients have wished talks with clergyment of their own faith; others have had help with their personal problems, and still others have appreciated contact with chaplains who have been overseas and so have an idea of combat areas. The chaplain has also generally spoken to groups about to be discharged on the matter of adjustment from regulated military life to unregulated civilian life.

The maintenance department has had a variety of tasks necessary for the upkeep of the hospital which have also offered therapeutic value. Outside detail has been appropriate for patients whose period of hospitalization would be brief. The entire program here has had to be planned with an analysis of physical requirements for a given task and its integration with the patient's classification.

These activities and programs, although not the main stream of the rehabilitation program, have made a real contribution to it. Apart from definite medical procedures, they have highly influenced morale and have administered to personal needs and problems.

It has been virtually impossible to overemphasize the importance of the Rehabilitation Program to the naval service and to the nation. The Surgeon General of the United States Navy offered the following statement of the problem:

".....every member of the Medical Department has as his primary objective the physical well being of the men of the Fleet.

There is another obligation that is just as important and that is saving lives of the men who fight the guns of the Fleet and those who fight on the beaches

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of the far-flung islands of the world, the U. S. Marines. Our life saving record in this war is one that the whole nation can well be thankful for and proud of, but what of the men who are disabled from the blows they have received in this frightful war. What of their future in years to come?

The Medical Department of the Navy, then, has a third task which is even more important than the other two, for upon its ability to solve the variety of problems of rehabilitation depends the future of hundreds of thousands of the youth of our nation. So we have set our eyes on the path ahead. The path that will lead the injured back to a state of health whereby they will be useful citizens again in their communities...."344

344. Vice Adm. Ross T McIntire, Preface to The Rehabilitation Program of the Medical Department of the United States Navy.

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SUPERVISION AND CONTROL OF CONTINENTAL MEDICAL ACTIVITIES
AND NAVY HOSPITALS

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Long Beach
Annapolis
Bremerton
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CHAPTER IX

SPECIAL HOSPITALS

The institutions which were designated U. S. Navy Special Hospitals at the time of the close of the war are a new departure in naval hospitalization. These hospitals were originally designated U. S. Naval Convalescent Hospitals, but by June 1945 their range of functions had become so wide that it was deemed advisable to change the title to U. S. Naval Special Hospital.¹ They were first considered in pre-war planning just before Pearl Harbor. The plan as conceived at that time, and later placed in effect, was to take over civilian institutions such as hotels, sanitariums, and schools for emergency hospitalization. The Norconian Hotel was under consideration as a convalescent center in November. The correspondence, after the hotel was taken for hospital purposes, frequently refers to this installation as U. S. Naval Convalescent Hospital No. 1. However, this title never became official, and it developed as a general hospital with special emphasis on the treatment of convalescent patients.²

During 1942 and the early part of 1943, the general hospitals were in a fairly good position to care for patients, as the building program was able to keep the stated bed capacity above the patient load.³

1. SecNav Serial 313313 to All Ships and Stations, 29 June 1945.
2. Joint Letter, Chief of BuMed, Chief of Bureau of Yards and Docks, to Com. 11th Naval District, 21 Nov. 1941; General Files, Correspondence, N. H., 47.
3. See Appendix 'F'.

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With the need for augmented facilities in the spring of 1943 the establishment of convalescent hospitals was initiated. By the end of July 1943, there were six units established. These units had a stated bed capacity of 3,548 on 1 July. The patient load at that time in these hospitals stood at 1,195.

In general, the patients sent to these hospitals were those who required little treatment other than rest, salubrious climate and diet, psychotherapy, or physiotherapy before being returned to duty, or being discharged.

Organization of Special Hospitals

In organization, these hospitals had a basic similarity to the regular naval hospital. The respective activity of the various units was quite different, however. The hospitals were organized into administrative and clinical divisions, and within the clinical division were the two general services of medical and surgical. The work of both medical and surgical services was largely confined to examination of patients and supervision of progress of convalescence. Surgery usually included the services of X-ray, physiotherapy, and operating room, while the medical service supervised the laboratory, the taking of BMR (basal metabolic rate), and electrocardiography.

As the chief function of the hospital was to facilitate convalescence, the training and morale-building activities normally under the administration branch were integrated more closely with

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the two services of medicine and surgery than would be found in general hospitals. Under morale-building activities the rehabilitation program, civil readjustment, welfare and recreation, library, Red Cross and chaplain's office were usually grouped. Under training activities are the physical training and educational services, both of which work in close cooperation with the regular medical service. In a small facility like Harriman, the organization was relatively informal, while at a larger establishment such as Sun Valley, Asbury Park, or Banning, the organization was, of necessity, more formal and carefully subdivided.⁴

The special hospitals will be dealt with differently from the general hospitals, which were analyzed topically as a group. The special hospitals, being quite different from each other, will each be discussed as a separate entity. The physical characteristics which made the site suitable, the buildings and additions made by the Navy, the particular group of patients served, and the treatments afforded will be noted.

The hospitals will be treated in the order of their commissioning.

SPECIAL HOSPITALS IN ORDER OF COMMISSIONING

1. Harriman, N.Y.	16 November	1942
2. Santa Cruz, Calif.	8 March	1943
3. Asheville, N. C.	24 May	1943
4. Yosemite, Calif.	25 June	1943
5. Sun Valley, Idaho	1 July	1943
6. Glenwood Springs, Colo.	5 July	1943

4. See charts for Sun Valley, Arrowhead, and Asheville.

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7. Arrowhead Springs, Calif.	23 May	1944
8. Sea Gate, Brooklyn, N. Y.	30 August	1944
9. Springfield, Mass.	8 September	1944
10. Banning, Calif.	2 October	1944
11. Beaumont, Calif.	2 October	1944
12. Asbury Park, N. Y.	10 April	1945
13. Palm Beach, Fla.	21 May	1945
14. Camp White, Ore.	31 August	1945
15. Camp Wallace, Tex.	5 September	1945

U. S. Naval Special Hospital, Harriman, New York

The Harriman Hospital was the first convalescent hospital and has remained the smallest in size (80-bed authorized capacity) and patient load. The hospital takes only male officers who are completely ambulatory. No neuropsychiatric cases are taken, only general medical and surgical convalescent cases. Recuperation is thorough rest and careful dietary supervision under very pleasant and informal surroundings.

The installation is housed in the spacious home of Ararat Harriman who offered the property to the Navy on 6 August 1942. The project was approved by the Secretary of the Navy on 5 September, and it was placed in commission on 16 November 1942.⁵ The building was not ready to receive patients until 10 February when the first patients transferred from the Brooklyn Hospital.

The hospital is located 57 miles from New York on the summit of one of the several elevations of the Bear Mountain Range in the Catskills. A beautiful vista can be seen from the grounds which are 1,500 feet above sea level. The installation is quiet and remote from bustling civilization, as typified by the presence of a large herd of deer which heightened the rustic scenery.

5. Historical Supplement to the Annual Sanitary Report, 1940.

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Rear Adm. C. M. Oman, (MC), USN, (Ret.), was in command of the hospital during its three years of activation and fostered the development of an atmosphere of dignified and leisurely calm, quite suitable for this type of institution.⁶

Santa Cruz, U. S. N. Special Hospital

This hospital is located at Santa Cruz, California, by Monterey Bay, about 75 miles south of Oakland. The building was constructed in 1912 as the Casa Del Ray, a beach hotel. The properties of this hospital are leased by the government, and alterations were made under the direction of the Twelfth Naval District Public Works Officer in February of 1943.

The principal distinctive feature in the organization of this hospital is the contract with the Troyer Brothers, Hotel Managers, who had operated the establishment prior to the government's taking the property for the operation of the establishment. The annual contract provides for the furnishing and preparing of all food and the upkeep of the building and premises. "The operation of the Civilian Manager's Contract has proven to be a most satisfactory and economical method of operation."⁷

The hospital was commissioned on 8 March 1943 and received both officer and enlisted patients for care. Its stated bed capacity was 660 when first commissioned and increased at the end of the War

6. General Files, N. H. 70.

7. Historical Supplement to Annual Sanitary Report of 1943.

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to 886. It ranked fifth among special hospitals in size. Care was given to general and surgical convalescents and to neuropsychiatric patients who had completed hospitalization and were awaiting discharge from the naval service. At the close of the War, only enlisted men were cared for at this establishment.⁸ In the early months of operation, the patient turnover was as high as 60 per cent each month, but with the continuance of the War the length of convalescence increased.⁹ At the close of hostilities the hospital had 891 patients, the second largest patient load of the special hospitals.

Asheville, North Carolina, U.S.N. Special Hospital

In October and November of 1942 there was a survey made of hotels in the Fifth Naval District to select facilities for a naval convalescent hospital. The institution selected was Kennelworth Park Hotel (Appalachian Hall) in Asheville, North Carolina. The court gave possession to the government on 26 January, but actual possession was not obtained until 15 February. On 21 February 1943, the hotel Grove Park Inn was designated as an annex for reception of patients and housing of staff pending the completion of alterations on the main structure. The first 52 patients arrived 23 February 1943 and by 6 March, 125 patients were aboard. This number decreased until the opening of the main unit when there were only 4 remaining. The installation was formally established on 26 March and commissioned 24 May. It began receiving

8. Ross T McIntire to MedOfCom, NavHosp, NavConvalesp, 20 Mar. 1945.

9. Historical Supplement to the Annual Sanitary Report, 1943; General Files, N. H., 70.

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a limited number of patients on the 28th.¹⁰

The site on which the hospital is situated consists of 13 acres in the Kenilworth Park section of the city of Asheville, North Carolina. The property is well adapted for the special purpose for which it was used. The buildings are on a flat area of an elevated ridge between two valleys and afford a splendid view of the surrounding country and mountains. Since it is in a sparsely settled section, it is quiet and secluded, yet only two miles from the center of Asheville. The grounds are well landscaped, the work being done by the Navy. The hotel had served as a sanitarium and health resort hotel prior to use by the Navy.¹¹

"Prior to the commissioning of the hospital, the administration gave especial study to the evaluation of the special functioning of a convalescent hospital which in itself was something new in naval hospital experience. A basic policy was adopted at that time built around: (a) the special physical characteristics of the property....., and (b) the idea of convalescence per se."¹²

The local situation provided for patients physical surroundings entirely different from the usual naval environment. This difference was capitalized. The hotel or club idea was made prominent. The patient entering this hospital receives the benefit of a complete change in his naval routine in much the same way that

10. General Files, N. H., Historical Supplement to Annual Sanitary Report, 1943, Asheville.

11. Annual Sanitary Report, 1943.

12. Annual Sanitary Report, 1945, Cumulative History.

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a person in civil life is benefited by a vacation that takes him away from his usual business or routine. This change in the physical environment has been paralleled by a policy of non-regimentation or coddling of patients in providing a program, without undue emphasis on guidance, that encourages the patients to engage in useful or occupational work in which they show an interest or to take up sports and games, serious study, literary pursuits, reading, etc.

In this way, work and play are combined into a form of occupational therapy instrumental to rehabilitation without the patient's being aware of it.¹³

The relations of this institution with the people of Asheville were marked by many pleasant events. The local paper praised the hospital and its work as follows: "In such surroundings, hundreds of convalescent seamen and officers of the Navy are finding their way back to health and further service to the nation. In a sense, medical treatment is only incidental to this restoration. Rest and recreation in a homelike atmosphere under wise, competent and understanding administration are therapies which understandably have worked miracles."¹⁴

The main building is of wood and stucco in the English country-house style of architecture. It is five stories in height in the form of a "T".

13. Ibid.

14. Asheville Citizen, issue of 27 May, as quoted in Historical Supplement to Annual Sanitary Report of Asheville Convalescent Hospital, 1944.

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There was no special medical department, and one medical officer took care of all patients. The facilities were adequate for treatment of convalescent patients. The work of the surgical department consists principally of providing postoperative treatment and convalescent care for orthopedic cases. Dressings and casts are applied and removed and physiotherapy is prescribed and supervised. In cases of communicable diseases, or emergency operative treatment, the patients were transferred to the nearby Moore General Army Hospital.¹⁵

As the War progressed in 1945 a larger proportion of the patients were orthopedic cases requiring more individual treatment, and this type amounted to 60 percent of the patient load as compared with only 24 percent in 1943. Although the altitude is fairly high, the climate is too damp for care of respiratory or joint cases. Also, in winter there is much smoke in the air.

The rehabilitation program, which was provided with ample physiotherapy and mecanotherapy equipment and excellent direction, was perhaps the core of the work of the facility. This was integrated with the active program of welfare and recreation and educational and physical training departments.¹⁶

At the close of the War, this hospital accepted officers, enlisted men, and WAVES, being one of only two convalescent hos-

15. Annual Sanitary Reports, 1943 and 1944.

16. Annual Sanitary Report, 1945, Cumulative Report.

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pitals having facilities for care of W-V's. The installation ranked tenth in size and patient load at the close of hostilities.¹⁷

The hospital was fortunate to have the same commanding officer during its entire period of service. This gave a continuity to its program. The commanding officer was Capt. W. A. Angwin, who, as District Medical Officer of the 6th Naval District, had been instrumental in choosing the site.

Yosemite

U. S. Naval Hospital, Yosemite National Park, California, was the only National Park facility deemed suitable for use by the Navy, although the locations at Yellowstone, Grand Canyon and Glacier National Parks were inspected with this purpose in view.¹⁸

The prospect of using this property was considered in the spring of 1943, and the activity was commissioned 25 June 1943.¹⁹

The hospital reservation comprises 37 acres located in the upper part of Yosemite Valley. "Scenically, the setting is magnificent. To the west were the meadows, pines, and oaks of the valley. Sheer granite cliffs tower some 4,000 feet above the valley floor on all sides. In front was Glacier Point with its famous fire fall. Above was the world-famed Half Dome. Below were the Yosemite Falls and massive El Capitan."²⁰

17. BuMed to MedOfCom, NavHosp, NavConvalHosp., 20 Mar. 1945.

18. Report of Inspection Trip by Rear Adm. L. Sheldon, Jr., (MC), USN, 15 Oct. 1943.

19. Federal Board of Hospitalization, Resolution No. 13, 3 May 1943.

20. Annual Sanitary Report, 1943; Annual Sanitary Report, 1945, Cumulative History.

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The Ahwahae Hotel and grounds were leased from the Yosemite Park and Curry Company. The lease was not finally agreed upon during the War. The main building is a reinforced concrete and native granite building, six stories in height, and of exceptionally fire-proof qualities. In general, the hotel was readily adaptable to conversion into a hospital, especially one of the convalescent type. Hotel bedroom and dining room furniture was reclaimed for naval use, and the linen and chinaware were purchased.²¹

The hospital was first intended for use only by neuropsychiatric patients. The experience of its first summer of operation illustrated that it was unsuitable for this purpose. It is so shut in by high mountains that many patients suffered from claustrophobia. The patients were also unhappy because they were so isolated and there were so few diversions. After September the policy was changed and no more neuropsychiatric patients were sent to Yosemite.²²

During 1943 and the early part of 1944, little if any recreational equipment was available. Skating was readily available and late in the season tobogganing was afforded, but many patients were not in a condition to utilize these sports. Furthermore, the hospital was isolated and liberty passes were of little or no value. "As a natural result, the attitude of the patients was bad. They resented being sent to the valley with its lack of recreational or

21. Annual Sanitary Report, 1943; Annual Sanitary Report, 1945, Cumulative History.

22. Report of Inspection Trip by Read Adm. Luther Sheldon, Jr., (MC), USN, 15 Oct. 1943; Annual Sanitary Report, 1945. Cumulative History.

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other facilities after being in the combat areas of Alaska and the South Pacific for months. They resented having to wait months for medical discharges. They felt that they had done their part in the War, had become casualties and were entitled to be sent home instead of being isolated in the High Sierras. The Hospital Welfare Fund was low and repeated efforts to obtain additional money from other naval activities for bowling alleys, pool tables, etc. were unavailing."²³

During this period, the people of the San Joaquin Valley did much to provide recreational activity and equipment. They brought hostesses and orchestras for dances and furnished equipment for a hobby shop--a forerunner of the rehabilitation program. The nearest town of any size was Merced, 81 miles away, and San Francisco, 211 miles away, which made liberty impossible.

Until 1945 a large percentage of the patients sent to this hospital were awaiting leave. This was because of the length of time necessary for survey and receipt of medical discharge. The San Francisco Bay hospitals, in order to make urgently needed beds available, sent patients to Yosemite who were "waiting for action in Washington". The lengthy delays naturally disturbed the patients and the lack of recreation was a detriment. Morale was low "and the good name of the hospital invariably suffered". At this time emergency leave was possible; the men could not see their families,

23. Annual Sanitary Report, 1945, Cumulative History.

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and there were no accommodations for families or friends to visit them.²⁴

During 1944, the delay in surveys was lessened when commanding officers were allowed to pass on cases. This greatly helped the morale of the patients. The program for rehabilitation was also placed in effect and provided equipment and activity for the patients. During 1945, patients needing treatment were sent to this hospital and it became more truly a convalescent establishment instead of largely a waiting point for discharge or reassignment.²⁵

At the end of the War, the hospital accepted general medical and surgical convalescents and neuropsychiatric patients who had completed hospitalization and were awaiting discharge from the naval service. The hospital was sixth in size and fourth in actual patient load with 709 aboard.

Sun Valley

The Sun Valley Special Hospital was second in stated bed capacity among the special hospitals at the close of the War, but was first in actual patient load. It accepted general medical and surgical convalescent patients who had received essential definitive treatment but whose necessary hospitalization was not completed. It was especially equipped to administer physiotherapy to orthopedic convalescents. Neuropsychiatric cases, except psychosis, epilepsy,

24. Annual Sanitary Report, 1945, Cumulative History.

25. Ibid.

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constitutional psychopaths and mental deficient were accepted. This hospital, with Asheville, was the only institution of its kind which accepted all members of the naval service, officers, enlisted men, and WAVES.²⁶

Negotiations for leasing of the property were initiated in the spring of 1943. The Union Pacific Railroad Company owns Sun Valley resort and has an investment therein of more than \$4,000,000. The area includes 3,529 acres of which about 80 are in the immediate hospital area. The resort is in the south central part of Idaho in the heart of the Sawtooth Mountains. The hospital was commissioned on 1 July 1943, but patients were not received until August.

Sun Valley Lodge was used as the main hospital building. It is a reinforced concrete fireproof building of a double "Y" shape. The concrete was poured in native sawed lumber form and treated so that it appears as wood. The building is four stories in height. The bed capacity when the building was taken over by the Navy was about 1,400, of which 1,035 were considered available for patients, that being its stated capacity. The other beds were used for the staff. The maximum complement of staff and patients was reached shortly before V-J Day when 1,603 naval personnel were aboard.

The greatest problem at this hospital, as at Yosemite,

26. BuMed to MedOfCom, NavHosp, NavConvalHosp., 20 Mar. 1945.

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was its isolation. Transportation was poor for liberty parties, and special trips of 85 miles to Twin Falls and 785 miles to Boise were made by arrangement with local transportation. However, Sun Valley was fortunate in having a wealth of recreational facilities already on hand, and this greatly mitigated the loneliness of the situation.

Two glass-enclosed, heated, yearlong swimming pools were available. Three of the six ski lifts were kept in operation for Navy personnel and in season advantage was taken of the excellent skiing in the very fine powder snow of the area. Ice skating in winter was amply provided for, although the artificial rink was discontinued. Fishing, hunting, soft ball diamond, a golf course, tennis, badminton, and archery courts were all available. Indoor recreation was also ample. A 500-seat theatre with excellent equipment and first-run pictures obtained from Salt Lake City provided entertainment. Bowling alleys, air conditioned and soundproof with 6 regulation alleys, were on hand as were pool tables, ping pong tables, and ample equipment.²⁷

The hospital is organized for care of convalescents and the medical and surgical departments are organized for such service. The major work of the hospital is rehabilitation.²⁸

The average monthly turnover of patients indicates the type of convalescence.

27. Annual Sanitary Report, 1943, 1944; Annual Sanitary Report, 1945, Cumulative History.

28. See Appendix I.

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Admitted from other hospitals	247	
Discharged from service	143	
Transferred to limited duty	26	
Transferred for further treatment	21	
Transferred to full duty	17	29

During the operation of this facility, more and more patients who required definitive treatment, especially orthopedic surgery, were received from West Coast hospitals. Facilities for their care were expanded and the surgical department increased in relative importance.

The inauguration of the integrated rehabilitation program in 1944 brought together and strengthened the various phases of this work. Quonset huts for storage of athletic gear and for gymnasium and game room purposes were erected. A building for expanded educational services was also provided. With the recreational advantages already on hand, the rehabilitation program started under favorable auspices and maintained a high state of efficiency.³⁰

Glenwood Springs

The Glenwood Springs hospital is located at an elevation of 5,783 feet in the city of that name in west central Colorado. It is situated in a deep valley by the Colorado River where the bend of the canyon shelters the town from winds that sweep over the continental divide. The climate is mild, rarely is there a day without sunshine. The area is a resort center with several

29. Annual Sanitary Report, 1945, Cumulative History.

30. Annual Sanitary Report, 1944; Annual Sanitary Report, 1945, Cumulative History.

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hotels and a number of tourist cabin parks.

The chief reason for the hospital building, and, in fact, the town, is the hot springs of that area. The largest of these is located in connection with the hospital and serves the largest outdoor hot mineral water swimming pool in the world.³¹

This hospital was formerly the Colorado Hotel which was leased by the Navy. The building was constructed in 1893 of native red sandstone and brick. It has a slate roof, and is six stories in height. The first floors were completely renovated by the Navy and made usable for hospital purposes, and a new heating system was installed.³² During 1943-1944 there were extended negotiations concerning the purchase of the property, but this was finally abandoned.³³ However, the Navy installed a sprinkler system for fire protection, and several small auxiliary buildings were erected, including Quonset huts and buildings from the former Army Camp Hale.³⁴

The hospital is principally utilized for the care of ambulatory arthritic, orthopedic, nerve injury, and combat fatigue cases. The majority of the patients were brought in by rail from the Bay Area of the West Coast, although, increasingly, naval hospitals throughout the United States sent acute and chronic

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31. Annual Sanitary Report, 1943, Historical Supplement.
 32. Annual Sanitary Report, 1945, Cumulative History.
 33. Annual Sanitary Report, 1944, Historical Supplement.
 34. Memorandum--Covering Inspection Trip of Rear Adm. E. L. Woods, Inspector Medical Department Activities, Pacific Coast, 25-3/ND (113), 18-29 Oct. 1943.

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arthritis cases. The most effective part of the program has been that devoted to rehabilitation of nerve and joint cases. Almost as effective were the results in true combat fatigue cases, which comprised about one-third of the patient load. A 41-foot portion of the 750-foot swimming pool was covered and made into a modern physical therapy section, replacing the old bath and steam house; this section serves as a therapeutic tank and the temperature is maintained at a higher level. The old vacuum system of the hospital was reversed to force jets of air into the bottom of the pool, and high pressure jets of water were used to make it a large Hubbard Therapeutic Tank.³⁵

The rehabilitation program centers about the pool and the recreation it affords. As the patients are 98 percent ambulatory, a medical officer, athletic officer, and welfare and recreation officer are on duty there. Athletic teams, in competition with college and service teams, represent the activity in basketball and soft ball. Fishing, hunting, golfing, horseback riding, and mountain hiking, in season, are well patronized. Ice skating and skiing are enjoyed by a smaller number. Swimming in the warm water pool is mandatory for all patients, and is not only popular but of great value. Because the valley is sheltered, with little wind, this activity is carried on even when the temperature is below freezing.³⁶ The general health of the personnel was excellent,

35. Annual Sanitary Report, 1945, Cumulative History.

36. Annual Sanitary Report, 1943; Annual Sanitary Report, 1945, Cumulative History.

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there seldom being more than two on the sick list.³⁷

This activity was placed in commission on 5 July 1943 after having been under consideration by the Navy since January. The first patients arrived on the 11th of the month. It serves only ambulatory male officers and enlisted men. Milder forms of neuropsychiatric patients are accepted in addition to the arthritic and orthopedic convalescents. The hospital ranked seventh in size and was eighth in patient load at the end of the War.³⁸

Arrowhead Springs

U. S. Naval Hospital, Arrowhead Springs, San Bernardino, California, was recommended for immediate acquisition by the Bureau in December of 1943, and was approved by the Federal Board of Hospitalization on 20 January. It was designated and established on 27 March, commissioned on 23 May, and the following day received 499 patients (299 from Corona, 100 from San Diego, and 100 from Long Beach).³⁹ The hospital is located 6 miles north of San Bernardino at the base of Arrowhead Mountain. It is almost directly east of Los Angeles.

The Arrowhead Springs Hotel was the six-story, 39-room, fireproof structure taken over by the Navy to serve as the main unit of the hospital. On the grounds then were also 90 cottages, a

37. Annual Sanitary Report, 1943.

38. See Appendix O; Annual Sanitary Report, 1945, Cumulative History.

39. General Files N.H. 80; Federal Bureau of Hospitalization, Resolution 82, 20 Jan. 1944.

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laundry, garage, and employees' quarters. The area of the grounds was 1,700 acres, located in the foothills of the San Bernardino mountains. "The hotel was well-known as a resort for those who wanted to relax in a warm dry climate.⁴⁰ In June of 1945, construction was commenced on five temporary buildings to house the various units of the rehabilitation program.

One of the most dramatic episodes in the history of this hospital was the serious tinder and brush fire which threatened it on 26 August 1944. Because of the forehanded plans of the commanding officer and the excellent work of the hospital fire department, corpsmen, and patients with cooperation from the surrounding fire departments, the fire was kept away from hospital property.⁴¹

The organization of this hospital is similar to that of other special hospitals.⁴² It cares for all types of officer and enlisted men patients, except mental and tuberculosis cases. "The only requirement being that they are male and ambulatory." As is common in most convalescent hospitals, a large number were orthopedic cases. During the period of activation of this installation up to 1 November 1944, it cared for 5,789 patients. Of these 5,142 were discharged in the following manner:

Surveyed to civilian life	721
Surveyed to limited duty	716

40. Federal Board of Hospitalization, Resolution 82, 20 Jan. 1944; Annual Sanitary Report, 1945, Cumulative History.

41. Annual Sanitary Report, 1944, Historical Supplement.

42. See Appendix P.

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Discharged to full duty 2,866
Transferred to other hospitals 836 43

The problem of housing both officers and enlisted men is illustrated in the provisions made by this facility:

<u>ROOMS</u>		<u>NO. OF PATIENTS</u>
6	for single occupancy, Admirals and Senior Captains. These can go in bungalows 4, 5, and 6--each bungalow having 2 bedrooms, each with private bath and a sitting room.	6
10	for dual occupancy (Jr. Cpts & Comdrs.)	20
25	for triple occupancy (Lt. Comdrs. or Sr. Lts.)	75
50	for quadruple occupancy in double bunks, (Lts. to Ensigns)	200
<u>91</u>		<u>301</u>

There are a total of 139 rooms in the hospital
 - 4 rooms in terrace are used for office space, OD room, etc.,
 leaving 135 rooms available for patients
 - 85 rooms for officer patients, as above
 leaving 50 rooms for enlisted personnel patients
 at average of x 6 per room
300 enlisted patients

Total capacity, 300 officers and 300 enlisted patients. ⁴⁴

The rehabilitation program of this hospital was considered to be its most effective portion of the medical program. This was a well-rounded program with study, work, and pleasure combined. A

43. Annual Sanitary Report, 1945, Cumulative History.

44. Capt. J. A. Biello, (MC), USN, (Ret.), C.O. of Arrowhead, to Chief BuMed, 29 Sept. 1944, Enc. A.

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curatorium was built and massages, sun baths, physical therapy, Neuheim baths, and steam baths were afforded; the swimming pool also furnished relaxation as well as medicinal advantages.

The education program at this facility was of particular worth because of the proximity of the San Bernardino High School and Junior College. These institutions graciously cooperated in allowing patients to attend regular classes or special review classes. All patients who were unable to pass a 7th grade test were required to attend a class at the hospital under instruction from teachers of the local system. Many credits for high school and college work were obtained and all were benefited.⁴⁵

Sea Gate, Brooklyn

The U. S. Naval Special Hospital, Sea Gate, Brooklyn, New York, was planned during the spring, occupied 11 July, and commissioned on 30 August 1944. The hospital grounds are one acre in extent, lying between West 28th and West 29th Streets adjacent to the Boardwalk at Coney Island. The land about the hospital is sandy with no shrubs, trees or grass, and the elevation is from sea level to a few feet above. The location is a part of the metropolitan New York area.⁴⁶

The activity occupies the building of the former Half Moon Hotel, a 14-story building of reinforced concrete, brick, fireproof

45. Annual Sanitary Report, 1945, Cumulative History.

46. Annual Sanitary Report, 1945, Cumulative History; Annual Sanitary Report, 1944; Federal Hospital Board Resolution 100, 19 Apr. 1944.

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The building contains 294 rooms and 5 public spaces which were converted into offices, lounges, mess halls, chapel, and recreation space. The wards are actually floors with separate rooms of about 14 x 16 feet. Each deck quarters about 110 patients. The building is well constructed and affords maximum heat, light and ventilation. These quarters are comfortable both winter and summer.⁴⁷

The building is serviced in all public places by a private contracting firm which also supplies the food. The total cost of food and building service averaged only \$1.1214 per man per day, a considerable saving to the government. Some 65 civilians were employed by the contract for this work. The hospital laundry was done under contract by the Federal Prisons Industries rather than by installing equipment and using staff members.⁴⁸

The hospital is designated for male patients only, both officers and enlisted men. It serves general medical and surgical convalescents and neuropsychiatric cases who are awaiting discharge. Therefore, both the medical department and the surgical department are limited to treatment of non-operative procedures.⁴⁹ Much of the laboratory work is done at U. S. Naval Hospital, Brooklyn, New York.

The rehabilitation program differed from that noted in connection with other special hospitals in two particular phases. The first was the use of printing as one of the occupational therapy

47. Annual Sanitary Report, 1944.

48. Annual Sanitary Report, 1944.

49. Bufiled to MedOfCom, NavHosps, NavConvalHosps, 20 Mar. 1945.

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activities. In February of 1945 the hospital was given a printing press by the Red Cross and soon thereafter the Linotype Post No. 1202 of the American Legion gave a typesetting machine. The second unusual feature was the work program by the Arma Corporation. This was similar to the program already underway at St. Albans whereby patients made parts which were vital to machines and munitions in the war effort. Both of these were productive work projects and therefore frequently an uplift to morale. When a patient leaves this or any other special hospital, he has enjoyed the maximum benefits of hospitalization and has been tended by all the physical and educational benefits of the rehabilitation program.⁵⁰

Sea Gate presented a situation quite different from that of any special hospital heretofore established, except possibly that at Santa Cruz, in that it was an integrated part of a metropolitan area. Therefore, entertainment was no special problem for this hospital. The problems of transportation, sewage, water, and fire protection were cared for in whole or in part by existing facilities. This hospital was the eighth largest in size but in actual patient load was sixth in size at the close of the War.⁵¹

This hospital was especially established to serve the U. S. Naval Hospitals, Brooklyn, and St. Albans. As New York was the port of debarkation for the European Theater of Operations as well as an

50. Annual Sanitary Report, 1945, Cumulative History.

51. Appendix O.

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active training and service center, these hospitals were continually crowded and Sea Gate enabled many additional beds to be made available.

Springfield

The U. S. Naval Special Hospital, Springfield, Massachusetts, was placed in commission on 8 September 1944. The availability of the installation was brought to the attention of the Bureau by International Young Men's Christian Association College in the spring. Previously, the college grounds and buildings had been used by a training detachment of the Army Air Corps.⁵²

The college grounds are located within the city limits about two miles from the center of the city of Springfield, in southwestern Massachusetts. The buildings leased by the Navy are on high ground that slopes down to artificial Lake Massasoit. There are 149 acres in several parcels. On one section is located the hospital building, previously used as a college dormitory, which is a four-story brick structure. There are no wards in the building, but rooms accommodate from 2 to 5 patients under the best conditions, and space for offices is also available. The administration building provides for offices on the first floor and nurses' and WAVES' quarters on the second. The commissary is an old brick building in good state of repair, with adequate facilities for messing. These three

52. Annual Sanitary Report, 1945, Cumulative History; Federal Board of Hospitalization, Resolution 113, 26 June 1944.

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buildings are connected by enclosed, heated, underblock passageways.

The Hospital Corps quarters, gymnasium, library, and garage all are used for hospital purposes.⁵³

Under the terms of the lease the Navy pays a monthly rental and retains the college's maintenance employees to provide heat, light, upkeep, and commissary for the patients and hospital staff. Food was provided by the Supply Officer, Boston, from the nearby Army Westover Airfield, and locally. All maintenance items not obtainable through the regular naval facilities were secured through the services of the college contractor. "Relations and dealings between the naval special hospital and the International Young Men's Christian Association authorities have been eminently satisfactory. The latter have always been motivated by high patriotic, unselfish, and helpful considerations."⁵⁴

A large proportion of the patients, about 60 percent, have been orthopedic cases. This type requires a considerable amount of medical attention. The physical training facilities available at this institution have been particularly beneficial. Thirty percent of the patients have been medical or mild neuroses and the "fatigues" brought back from combat areas. The disposition of the patients was 57 percent discharged to duty, 30 percent discharged to other hospitals, and 13 percent discharged by medical survey.

53. Annual Sanitary Report, 1945, Cumulative History.

54. Ibid.

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The plant of the hospital is especially designed to facilitate a rehabilitation program. The athletic training plant is exceptional, for the college specialized in physical training. An adequate occupational therapy department was added. "The proximity of the hospital to the highly friendly and patriotic city of Springfield, whose officials and welfare organizations and citizens outdid themselves in offering hospitality and aid to the patients, demonstrated that the selection of this site for a convalescent hospital was a wise one."⁵⁵

The hospital accepted male enlisted men only. At the close of hostilities it ranked ninth in size and in patient load.

Banning

The U. S. Naval Hospital₁, Banning, California, was first planned in May and commissioned 2 October 1944. It received only enlisted men who were preparing for discharge. This installation was also designated as a specialized unit for asthmatic cases which developed after the patient entered the naval service.

The grounds and buildings were taken over from the Army, which had used it as the 297 Headquarters Army Field Hospital to care for the desert training program. The plot was 115 acres in extent and located in the foothills of the San Gorgonio Mountains in San Gorgonio Pass. The setting is excellent, as it affords a

55. Annual Sanitary Report, 1945, Cumulative History.

56. Federal Board of Hospitalization, Resolution 105, 29 May 1944; BuMed to MedOfCom, NavHosp, NavConvalHosps, 20 Mar. 1945.

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view of the San Jacinto Range as well, and these two ranges provide protection from the north and south. The plot is three miles from the city of Banning at an altitude of 2,400 feet. The air has a low humidity and California sunshine prevails. Los Angeles is 90 miles to the west. The temperatures are usually over 100° on summer days, but the nights are cool. In winter there is heavy rainfall and the temperature is relatively cool.

The compound includes 92 buildings hastily constructed and temporary in character. None of the buildings was insulated or lined, and the pine floors had wide cracks. Fuel oil stoves provided heat in winter and "old hot water heaters insulated with cardboard served a shower room and head in each building." Much work was done by the Navy to bring the physical plant up to Navy standards. The floors were covered, new gas space heaters installed, and the buildings reconditioned and insulated. A Quonset hut was erected as a recreation building.

Because of the situation of the hospital, a great many arthritis, rheumatic fever, bronchial, pulmonary and orthopedic cases were cared for. Allergy cases were also given special treatment here. The high altitude, equitable climate, and low pollen and mold count made the hospital an ideal site for a controlled study of asthmatics. Some 496 patients of this type were treated. Of these, 486 were admitted with a diagnosis of asthma. Of this number, 75 percent were evacuated from overseas duty.

Many patients were admitted who were suffering from

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combat fatigue and, at the beginning, some with mild psychoses. It is interesting to note that many patients returning from overseas, transferred here as psychotic, later had their diagnosis changed to 'No Disease'. A number were surveyed out of the service with that diagnosis. Toward the end of the War many desired to leave the service and were willing to accept the diagnosis of psychoses. Each was separately interviewed by the Commanding Officer. Practically all were found to be exaggerating certain subjective symptoms. When it was explained to them thoroughly that they were normal and if they received a psychosis diagnosis it might reflect on their families and themselves, as well as having an effect on their future, their mental attitude changed to one of self-confidence and optimism. Those who were not returned to duty were surveyed as with 'No Disease'. The latter because they had been in actual combat and it seemed beneficial to them to be returned to civilian status as merely unfit for service.⁵⁷

Beaumont

The U. S. Naval Hospital, Beaumont, California, was established at the same time as Banning, 2 October 1944. It is located four miles north of Beaumont in the Cherry Valley, a sparsely populated area between the San Jacinto and San Geronimo Mountains. The valley is irrigated and supports orchards and grain, a striking contrast with the waste lands of the surrounding mountains. The reservation consists of a 100-acre plot completely barren of trees and shrubs, and with very little grass. The clay soil presents an erosion problem during the rainy season, and claims were filed against the Navy because of damage done to orchards due to surface wash.⁵⁸

57. Annual Sanitary Report, 1945, Cumulative History.

58. Annual Sanitary Report, 1944.

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The average temperature is 58 degrees with readings well over 100 degrees during much of the summer. The seasons are those typical of southern California, a wet season in winter and spring and a dry season in summer and fall. During the dry season there is considerable dust in the air.

The compound contained 90 buildings of which 34 were wards and the remainder administrative and auxiliary structures and quarters. They were "Army huttments", wooden frame buildings with single faced bulkheads, wooden floors without covering, and unsealed. The roofs leaked occasionally, and patients had to walk a long way to mess.⁵⁹

"The general hygienic condition of the areas surrounding the hospital are excellent, with the exception that because of the proximity of stock barns and other similar breeding places there is an excessive number of flies, especially during the hot months." The recreation facilities were meager, movies being shown each evening. Liberty parties went to Riverside and Los Angeles.

The hospital received as patients only enlisted men who were general medical and surgical convalescents, and neuropsychiatric patients who were awaiting discharge.⁶⁰

At the close of the War, it was fourth in size and ranked eleventh in patient load.

59. Federal Board of Hospitalization, Resolution 105, 29 May 1944; General Correspondence Files, N.H. 87.
60. R. T McIntire to MedOfCom, NavHosp, NavConvalHosp, 20 Mar. 1945.

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Asbury Park

The Asbury Park Special Hospital was the largest of the special hospitals of this type. The institution was housed in a group of buildings formerly used as a receiving ship for the British Royal Navy and known as "H.M.S. Asbury", and later as the U. S. Naval Pre-midshipmen's School. It was considered for hospital purposes in January of 1945 and commissioned on 10 April.⁶¹

The group contains Berkeley-Carteret Hotel, which is the main building, a fireproof structure of five floors with a capacity of 1,500 patients. The building has four floors used as wards, each having 320 beds, and the administrative offices, library, chapel, storerooms, patients' recreation rooms, and arts and skills unit.

The former Monterey Hotel is used as quarters for men and women enlisted personnel, the general mess, Ship's service, and other service facilities. The Convention Hall building is the center of recreation activities such as movies, concerts, shows and dances. It also serves for physical training and remedial gymnasium activities, and the educational services with shops, and work and study spaces. During the summer months, the open air pool and beach are used for recreational purposes, and the solarium has sundecks and recreation rooms.⁶²

This hospital is similar to Sea Gate in that it is adjacent to a metropolitan area where many ambulatory patients can easily go

61. Federal Board of Hospitalization, Resolution 148, 29 Jan. 1945.
62. Annual Sanitary Report, 1944.

for recreational purposes in contrast with most hospitals of this type which are far removed from crowded areas.

The hospital contained 551 patients at the close of the War and ranked seventh among this type of facility.

Palm Beach

The last special hospital to be established before V-J Day was Palm Beach, which was commissioned on 21 May 1945. The Palm Beach Biltmore Hotel was previously used by the U. S. Coast Guard as a SPAR training station for a period of 18 months prior to use by the Navy.⁶³

The building was a 10-story reinforced concrete structure in which the floors had never been finished, and carpeting was used over heavy padding. For hospital purposes this was unsatisfactory, and the carpets were removed from the ward floors and filler cement poured. "In spite of labor troubles and delay in procurement of materials, all conversion plans were rapidly consummated."

Fully 95 percent of the patients were victims of rheumatic fever and few were considered fit for return to full duty status, especially after the first few months of operation of the hospital.

As at other special hospitals, the rehabilitation program was the most important work of the institution. "The mild climate, abundance of sunshine, and availability of surf bathing in warm salt

63. Federal Board of Hospitalization, Resolution 152, 23 Feb. 1945.

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water afforded a most beneficial environment for the convalescent treatment of rheumatic fever cases. Many of the patients who had come to this hospital as pale, anemic, underweight youths with flabby musculature, were transformed in a few weeks to well-tanned sturdy looking lads, with a new light in their eyes, and a look of confidence in their countenances."⁶⁴

The community cooperation with the hospital was very fine. The various civic clubs and servicemen's organizations and many social organizations arranged picnics, deep-sea fishing, sightseeing trips, boat rides, and many individual "family-style" dinners. The patients were also accepted by the high school and junior college for enrollment in regular classes, and special classes were established for their convenience.

Although this hospital was initiated late in the War, it served to lighten the load on general hospitals at a very crucial period.

An early experiment with special hospitals also took place in Palm Beach. Soon after Pearl Harbor, Mrs. Amy Guest offered her palatial home, Villa Artemis, to the Navy. The matter was delayed until 2 November 1942, when the Bureau recommended that the home be designated and established as the U. S. Naval Convalescent Hospital, Palm Beach, Florida. There is no record of such official action. However, the hospital did receive a limited number of

64. Annual Sanitary Report, 1944.

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officer patients. Mrs. Guest, who had had World War I experience in hospital work, assisted with the rehabilitation activities. The hospital was closed 24 July 1943.⁶⁵

Camp White

As early as September 1944, the Navy started negotiations with the Army leading to the commissioning of Camp White as a U. S. naval special hospital on 31 August 1945. A number of factors caused this long delay, including some question over the advisability of granting "Station Hospital" treatment to Army personnel in the area, involving the problem of divided command.⁶⁶

Camp Wallace

This was the second Army hospital transferred to the Navy following the close of the War. Negotiations started in April of 1944 and the institution was placed in commission on 5 September 1945. The unit had a stated capacity of 465 beds. It is expected that this hospital will be decommissioned at the time Houston is commissioned so that the latter may start with a sizable patient load.⁶⁷

65. Chief BuMed to Chief BuPers, 20 Feb. 1943. Chief BuMed to ComOf, Sampson, N. H., 10 June 1943.

66. Federal Board of Hospitalization, Resolution 169, 2 June 1945; General Files, N.H. 91.

67. Federal Board of Hospitalization, Resolution 103, 19 Apr. 1944; General Files, N.H. 85.

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Conclusion

A consideration of the several special hospitals leads to the conclusion that such a system can be of very considerable value at a time when regular general hospital facilities are being over-taxed by excessive patient loads as they are during periods of active combat in major wars.

It would be advisable for the Bureau to have prepared plans for the conversion of existing facilities, such as hotels, schools and sanitoriums for use in a period of emergency. Preparatory planning would no doubt eliminate many of the errors in selection of site and method of operation caused by the press of necessity during a war. The true function of such institutions must always be kept in mind. They are for completely ambulatory patients, and so only a comparatively small amount of floor space need be used for clinical facilities, while most of the available floors would be used for double deck beds. A rehabilitation program would be the chief activity, and equipment for a well-rounded program of physical and educational facilities should be provided. The selection of site should be made in the light of experiences narrated in the account of the special hospitals during the recent War.

The ambulatory patients in these hospitals desire ample recreation which is provided only at great expense in beautiful but isolated areas. Quiet and healthful surroundings in proximity to a large metropolitan area solve this problem with least expense to the government and greatest convenience to

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the patient.

The organizational framework of special hospitals should be carefully considered in the light of their function rather than by the president of the general hospital. A study of the existing charts of these hospitals in Appendix F will indicate the trend of recognizing the special function.

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APPENDIX A

Duty Status of Personnel of U. S. Naval Hospitals
for Years 1942, 1943 and 1944

Source: Annual Sanitary Reports for each hospital.

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FOR THE YEAR 1943

	<u>Totals</u>	<u>Officers</u>	<u>Enlisted</u> <u>Men</u>	<u>Nurses</u>	<u>Rank</u>
Annapolis, Md.	255	32	189	34	32
Bainbridge, Md.	490	49	363	78	22
Bremerton, Wash.	385	55	280	50	25
Brooklyn, N. Y.	872	101	595	176	9
Charleston, S. C.	340	47	221	72	28
Chelsea, Mass.	862	92	602	168	11
Corona, Calif.	795	93	585	117	13
Corpus Christi, Tex.	560	50	454	56	18
Farragut, Idaho	872	72	648	152	10
Great Lakes, Ill.	1,853	128	1,436	289	3
Jacksonville, Fla.	578	63	416	99	17
Key West, Fla.	217	34	160	23	33
Long Beach, Calif.	915	85	656	174	8
Mare Island, Calif.	998	91	728	179	7
Memphis, Tenn.	359	49	261	49	26
Newport, R. I.	516	68	370	78	21
New River, N. C.	387	52	245	90	24
Norfolk, Va.	835	73	629	133	12
Norman, Okla.	348	48	253	47	27
Oakland, Calif.	2,103	149	1,662	292	2
Oceanside, Calif.	560	59	405	96	19
Parris Island, S. C.	291	39	216	36	29
Pensacola, Fla.	453	51	335	67	23
Philadelphia, Pa.	1,117	160	669	288	6
Portsmouth, N. H.	261	26	205	30	31
Portsmouth, Va.	1,392	137	893	362	5
Quantico, Va.	278	36	218	24	30
Sampson, N. Y.	735	60	478	197	14
San Diego, Calif.	2,740	66	2,297	377	1
San Francisco (T.I.), Calif.	517	65	386	66	20
Seattle, Washington	709	83	490	136	15
Shoemaker, Calif.	795	68	620	107	16
St. Albans, N. Y.	1,426	131	1,075	220	4
TOTALS	25,814	2,412	19,040	4,362	

Source: Annual Sanitary Reports For Each Hospital

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APPENDIX A

DUTY STATUS OF PERSONNEL OF U. S. NAVAL HOSPITALS
FOR THE YEAR 1942

	<u>Totals</u>	<u>Officers</u>	<u>Enlisted</u>	<u>Nurses</u>	<u>Rank</u>
			<u>Men</u>		
Annapolis, Md.	213	28	162	23	20
Bremerton, Wash.	390	40	308	42	13
Brooklyn, N. Y.	875	90	622	163	5
Charleston, S. C.	280	33	213	34	18
Chelsea, Mass.	553	82	372	99	8
Corona, Calif.	288	39	205	44	17
Corpus Christi, Tex.	433	51	348	34	10
Great Lakes, Ill.	1451	101	1094	256	2
Jacksonville, Fla.	390	50	253	87	12
Key West, Fla.	173	23	137	13	21
Mare Island, Calif.	833	101	571	161	6
Newport, R. I.	474	62	331	81	9
Oakland, Calif.	653	95	468	90	7
Parris Island, S. C.	313	39	242	32	15
Pensacola, Fla.	407	40	326	41	11
Philadelphia, Pa.	908	135	610	163	4
Portsmouth, N. H.	341	24	296	21	14
Portsmouth, Va.	1121	134	837	150	3
Quantico, Va.	165	29	121	15	22
San Diego, Calif.	1747	200	1270	277	1
San Francisco (T.I.), Calif.	239	40	159	40	19
Seattle, Washington	311	45	210	56	16
TOTALS	12558	1481	9155	1922	

Source: Annual Sanitary Reports For Each Hospital

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APPENDIX A (Cont'd.)

DUTY STATUS OF PERSONNEL OF U. S. NAVAL HOSPITALS
FOR THE YEAR 1944

	<u>Totals</u>	<u>Officers</u>	<u>Enlisted</u> <u>Men</u>	<u>Nurses</u>	<u>Rank</u>
Annapolis, Md.	212	21	164	27	36
Astoria, Oregon	297	46	210	41	33
Bainbridge, Md.	1,585	63	1,426	96	5
Bremerton, Wash.	517	51	405	61	23
Brooklyn, N. Y.	778	107	507	164	17
Charleston, S. C.	420	57	295	68	30
Chelsea, Mass.	1,052	106	754	192	11
Corona, Calif.	1,727	118	1,402	207	4
Corpus Christi, Tex.	536	56	397	83	22
Farragut, Idaho	1,042	76	783	183	12
Great Lakes, Ill.	1,494	123	1,085	286	8
Jacksonville, Fla.	590	69	385	136	20
Key West, Fla.	280	34	218	28	34
Long Beach, Calif.	968	102	714	152	14
Mare Island, Calif.	970	99	702	169	13
Memphis, Tenn.	451	50	352	49	27
New Orleans, La.	449	63	313	73	28
Newport, R. I.	493	65	334	94	24
New River, N. C.	541	54	397	90	21
Norfolk, Va.	735	72	533	130	19
Norman, Okla.	457	57	335	65	25
Oakland, Calif.	2,130	194	1,571	365	2
Oceanside, Calif.	740	71	576	93	18
Parris Island, S. C.	343	39	266	38	31
Pensacola, Fla.	448	53	286	109	29
Philadelphia, Pa.	1,513	192	937	384	6
Portsmouth, N. H.	267	32	205	30	35
Portsmouth, Va.	1,513	138	1,030	345	7
Quantico, Va.	330	37	268	25	32
Sampson, N. Y.	928	74	640	214	15
San Diego, Calif.	3,201	336	2,498	457	1
San Francisco (T.I.), Calif.	455	57	330	68	26
San Leandro, Calif.	787	72	605	110	16
Seattle, Washington	1,104	128	870	106	10
Shoemaker, Calif.	1,116	100	869	147	9
St. Albans, N. Y.	1,880	183	1,409	288	3
TOTALS	32,349	3,195	23,981	5,173	

Source: Annual Sanitary Reports For Each Hospital

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APPENDIX B

Average Strength of Personnel of U. S. Naval Hospitals
for Years 1942, 1943 and 1944

Source: Annual Sanitary Reports for each hospital.

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APPENDIX B

AVERAGE STRENGTH OF PERSONNEL OF U. S. NAVAL HOSPITALS
FOR THE YEAR 1942

	<u>Total</u>	<u>Officers</u>	<u>Enlisted</u> <u>Men</u>	<u>Nurses</u>	<u>Rank</u>
Annapolis, Md.	167.0	23.0	125.0	19.0	20
Bremerton, Wash.	411.0	45.2	326.6	39.2	6
Brooklyn, N. Y.	545.1	80.5	356.0	108.6	5
Charleston, S. C.	197.5	29.3	143.0	25.2	17
Chelsea, Mass.	408.0	66.0	249.0	93.0	7
Corona, Calif.	243.0	30.0	178.0	35.0	16
Corpus Christi, Tex.	342.1	44.3	267.8	30.0	11
Great Lakes, Ill.	890.0	90.0	675.0	125.0	1
Jacksonville, Fla.	260.5	42.0	169.0	49.5	15
Key West, Fla.	126.0	23.0	91.0	12.0	22
Mare Island, Calif.	770.0	88.0	565.0	117.0	3
Newport, R. I.	366.2	50.8	264.9	50.5	8
Oakland, Calif.	354.3	48.3	254.1	51.9	10
Parris Island, S. C.	304.0	73.2	208.8	22.0	13
Pensacola, Fla.	359.7	42.0	292.4	25.3	9
Philadelphia, Pa.	663.2	108.1	428.9	126.2	4
Portsmouth, N. H.	134.7	18.5	100.1	16.1	21
Portsmouth, Va.	862.0	113.0	621.0	128.0	2
Quantico, Va.	175.0	25.0	135.0	15.0	19
San Diego, Calif.	1514.0	160.0	1101.0	253.0	14
San Francisco (T.I.), Calif.	185.0	31.0	132.8	21.2	18
Seattle, Washington	307.5	39.5	207.5	60.5	12
TOTALS	<u>9585.8</u>	<u>1270.7</u>	<u>6891.9</u>	<u>1423.2</u>	

Source: Annual Sanitary Reports for each hospital.

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APPENDIX B (Cont'd.)

AVERAGE STRENGTH OF PERSONNEL OF U. S. NAVAL HOSPITALS
FOR THE YEAR 1943

	<u>Total</u>	<u>Officers</u>	<u>Enlisted</u> <u>Men</u>	<u>Nurses</u>	<u>Rank</u>
Annapolis, Md.	219.0	30.0	161.0	28.0	32
Bainbridge, Md.	681.3	46.1	556.6	78.6	12
Bremerton, Wash.	401.4	45.5	302.9	53.0	24
Brooklyn, N. Y.	775.9	107.6	459.8	208.5	10
Charleston, S. C.	279.0	36.5	188.3	54.2	28
Chelsea, Mass.	680.0	86.0	420.0	174.0	13
Corona, Calif.	595.0	67.0	439.0	89.0	15
Corpus Christi, Tex.	465.3	53.1	364.8	47.4	19
Farragut, Idaho	791.5	58.6	575.4	157.5	8
Great Lakes, Ill.	1424.0	132.0	1009.0	283.0	2
Jacksonville, Fla.	459.2	57.6	309.0	92.6	20
Key West, Fla.	194.0	29.0	143.0	22.0	33
Long Beach, Calif.	478.0	55.0	358.0	65.0	18
Mare Island, Calif.	871.2	107.5	591.0	172.7	7
Memphis, Tenn.	312.0	42.0	229.0	41.0	27
Newport, R. I.	591.5	68.6	434.3	88.6	14
New River, N. C.	391.0	44.0	267.0	80.0	25
Norfolk, Va.	753.2	87.5	549.7	116.0	11
Norman, Okla.	367.0	36.0	289.0	42.0	26
Oakland, Calif.	1221.0	119.0	891.0	211.0	3
Oceanside, Calif.	448.0	41.0	341.0	66.0	21
Parris Island, S. C.	269.0	37.6	196.3	35.1	29
Pensacola, Fla.	403.0	50.0	298.0	55.0	23
Philadelphia, Pa.	997.2	165.3	576.8	255.1	5
Portsmouth, N. H.	246.5	12.2	209.5	24.8	30
Portsmouth, Va.	1177.0	131.0	842.0	204.0	4
Quantico, Va.	243.0	32.0	188.0	23.0	31
Sampson, N. Y.	786.7	63.9	547.6	175.2	9
San Diego, Calif.	2173.0	233.0	1596.0	344.0	1
San Francisco (T.I.), Calif.	437.0	58.0	325.0	54.0	22
Seattle, Washington	577.0	71.8	389.1	116.1	16
Shoemaker, Calif.	507.0	57.0	383.0	67.0	17
St. Albans, N. Y.	916.0	87.0	646.0	183.0	6
TOTALS	21130.9	2348.4	15076.1	3706.4	

Source: Annual Sanitary Reports for each hospital.

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DECLASSIFICATION BOARDAPPENDIX B (Cont'd.)AVERAGE STRENGTH OF PERSONNEL OF U. S. NAVAL HOSPITAL
FOR THE YEAR 1944

	<u>Total</u>	<u>Officers</u>	<u>Enlisted Men</u>	<u>Nurses</u>	<u>Rank</u>
Annapolis, Md.	230.0	25.0	173.0	32.0	35
Astoria, Oreg.	259.8	36.4	184.7	38.7	36
Bainbridge, Md.	683.95	59.25	531.7	93.0	8
Bremerton, Wash.	501.5	47.3	383.3	70.9	27
Brooklyn, N. Y.	648.5	93.3	406.5	148.7	19
Charleston, S. C.	424.0	48.0	309.0	67.0	30
Chelsea, Mass.	833.0	91.0	544.0	198.0	14
Corona, Calif.	1492.0	100.0	1208.0	184.0	5
Corpus Christi, Tex.	529.9	53.4	399.8	76.7	25
Farragut, Idaho	983.5	75.4	813.0	95.1	12
Great Lakes, Ill.	1513.0	124.0	1069.0	320.0	4
Jacksonville, Fla.	529.2	62.4	359.0	107.8	26
Key West, Fla.	280.0	29.0	223.0	28.0	33
Long Beach, Calif.	1016.0	90.0	777.0	149.0	10
Mare Island, Calif.	1006.3	82.5	735.2	188.6	11
Memphis, Tenn.	471.0	49.0	372.0	50.0	29
New Orleans, La.	576.0	51.0	450.0	75.0	20
Newport, R. I.	539.6	65.8	376.9	96.9	23
New River, N. C.	539.0	56.0	393.0	90.0	24
Norfolk, Va.	804.9	76.1	595.6	133.2	15
Norman, Okla.	454.0	52.0	347.0	55.0	22
Oakland, Calif.	2033.0	168.0	1552.0	303.0	2
Oceanside, Calif.	705.0	64.0	539.0	102.0	18
Parris Island, S. C.	292.8	36.0	219.5	37.3	32
Pensacola, Fla.	489.0	53.0	333.0	103.0	28
Philadelphia, Pa.	1329.3	164.0	837.3	328.0	7
Portsmouth, N. H.	274.2	23.8	220.1	30.3	34
Portsmouth, Va.	1490.5	123.3	1007.1	360.1	6
Quantico, Va.	330.0	32.0	272.0	26.0	31
Sampson, N. Y.	734.4	69.5	449.3	215.6	17
San Diego, Calif.	3294.0	280.0	2578.0	436.0	1
San Francisco (T.I.), Calif.	512.0	61.0	380.0	71.0	21
San Leandro, Calif.	792.8	65.6	610.8	116.4	16
Seattle, Washington	973.7	94.7	735.0	144.0	13
Shoemaker, Calif.	1071.0	84.0	810.0	177.0	9
St. Albans, N. Y.	1649.0	154.0	1196.0	299.0	3
TOTALS	36431.4	3373.0	23339.8	5046.3	

Source: Annual Sanitary Reports for each hospital.

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APPENDIX C

Hospitals in Commission

1. 7 December 1941
2. 16 December 1941
3. 1 January 1942 to 1 January 1943
4. 1 January 1943 to 1 January 1944
5. 1 January 1944 to 1 January 1945
6. 1 January 1945 to 1 January 1946
7. To be commissioned in 1946

Source: General Correspondence Files, M&S
Annual Sanitary Reports for hospitals
Cumulative Histories for hospitals

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APPENDIX C

HOSPITALS IN COMMISSION

7 December 1941

ANNAPOLIS, MD.
BREMERTON, WASHINGTON
BROOKLYN, N. Y.
CHARLESTON, S. C.
CHELSEA, MASS.
CORPUS CHRISTI, TEX.
GREAT LAKES, ILL.
JACKSONVILLE, FLA.
MARE ISLAND, CALIF.
NEWPORT, R. I.
PARRIS ISLAND, S. C.
PENSACOLA, FLA.
PHILADELPHIA, PA.
PORTSMOUTH, N. H.
PORTSMOUTH, VA. (Norfolk)
QUANTICO, VA.
SAN DIEGO, CALIF.
WASHINGTON, D. C.

16 December, 1941

Corona, Calif.

Source: General Correspondence Files, M&S.

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HOSPITALS COMMISSIONED

1 January 1942 to 1 January, 1943

- Bethesda, Md. 5 Feb. 1942
- San Francisco, Calif. (Treasure Island) 4 Apr. 1942
- Oakland, Calif. 1 Jul. 1942
- Seattle, Wash. 22 Aug. 1942
- Key West, Fla. 19 Oct. 1942
- Norfolk, (NOB), Va. 2 Nov. 1942
- Norman, Okla. 15 Nov. 1942
- Long Beach, Calif. 15 Dec. 1942

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1 January, 1943 to 1 January, 1944

- Farragut, Idaho 15 Jan. 1943
- Bainbridge, Md. 4 Feb. 1943
- St. Albans, N. Y. 15 Feb. 1943
- Sampson, N. Y. 27 Feb. 1943
- Memphis, Tenn. 1 Mar. 1943
- New Orleans, La. 1 May 1943
- New River, N. C. 1 May 1943
- Oceanside, Calif. 3 Sept. 1943
- Shoemaker, Calif. 1 Oct. 1943

1 January 1944 to 1 January 1945

- San Leandro, Calif. 15 Aug. 1944
- Fort Eustis, Va. 29 Aug. 1944
- Astoria, Oregon 17 Oct. 1944

Source: General Correspondence Files, M&S

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HOSPITALS COMMISSIONED (Cont'd.)

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1 January 1945 to 1 January 1946

Dublin, Ga.

22 Jan. 1945

Corvallis, Ore.

3 Feb. 1945

To be Commissioned in 1946

Houston, Tex.

1 Mar. 1946

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Source: General Correspondence Files, M&S

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APPENDIX D

Hospital Capacity and Load -- 1941

1. East Coast
2. West Coast

Source: Medical Statistical Division

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HOSPITAL CAPACITY & PATIENT LOAD OF EAST & WEST COAST HOSPITALS--1941

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E A S T C O A S T

<u>Hospitals</u>	<u>Beds Authorized</u>	<u>Patient Load</u>
Annapolis, Md.	192	83
Brooklyn, N. Y.	580	589
Charleston, S. C.	117	124
Chelsea, Mass.	335	495
Corpus Christi, Tex.	420	206
Great Lakes, Ill.	501	350
Jacksonville, Fla.	400	209
Newport, R. I.	465	245
Norfolk, Va.	1,298	1,199
Parris Island, S. C.	209	215
Pensacola, Fla.	386	227
Philadelphia, Pa.	663	643
Portsmouth, N. H.	190	124
Quantico, Va.	131	118
Washington, D. C.	234	210
TOTALS	<u>6,121</u>	<u>5,037</u>

W E S T C O A S T

Mare Island, Calif.	584	676
Puget Sound, Wash.	308	299
San Diego, Calif.	1,424	1,360
TOTALS	<u>2,316</u>	<u>2,335</u>

Source: Medical Statistical Division

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APPENDIX E

Organizational Charts, U. S. N. Hospitals

1. Annapolis, Maryland
2. Great Lakes, Illinois
3. Jacksonville, Florida
4. Key West, Florida
5. Long Beach, California
6. Mare Island, California
7. Memphis, Tennessee
8. Newport, Rhode Island
9. Norfolk, Virginia
10. Pensacola, Florida
11. Portsmouth, New Hampshire
12. St. Albans, New York
13. Seattle, Washington

Source: Annual Sanitary Reports
Cumulative Histories for each
hospital

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APPENDIX F

Organizational Charts, Special Hospitals



1. Arrowhead Springs, California
2. Asbury Park, New Jersey
3. Asheville, North Carolina
4. Sun Valley, Idaho

Source: Annual Sanitary Reports and Cumulative
Histories for each hospital

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APPENDIX G

Organizational Charts, Districts and Groups

1. Bureau of Medicine and Surgery
2. General Organizational Charts (4),
District Medical Officer,
First Naval District
3. Group Commands
 - a. NOB, Newport, Rhode Island
 - b. U. S. Naval Training and
Distribution Center,
Shoemaker, California

Source: Manual of Organization Charts, Navy Dep't.,
Report of District Medical Officer,
First Naval District, 1945.

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APPENDIX H

Organizational Charts--Medical Service
and Surgical Service

1. Medical Department Organization--Long Beach and San Diego
2. Surgical Department Organization--Long Beach

Source: Long Beach and San Diego Annual Sanitary Reports

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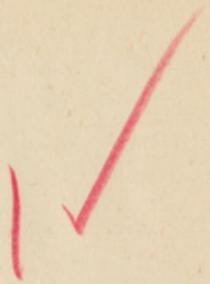
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APPENDIX I

Organizational Charts--Rehabilitation

- 
1. BUMED Charts
 - a. Rehabilitation Service and Status in Hospital Organization
 - b. Organization of the Rehabilitation Program
 - c. Rehabilitation Program as it applies to the usual patient
 - d. Flow Chart for Processing Discharge
 2. Rehabilitation Charts
 - a. Chelsea, Massachusetts
 - b. St. Albans, New York
 - c. Seattle, Washington
 3. Diagram of Method Used in Scheduling Patients for Rehabilitation Services, Seattle, Washington

Source: BUMED Charts, Sanitary Reports for Individual Hospitals Named

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APPENDIX J

Organizational Charts--Dependents
U. S. Naval Hospital, San Diego, California

1. World, Oregon
2. Chicago, Illinois
3. Chicago, Illinois
4. Chicago, Illinois
5. Long Beach, California
6. Berkeley, California
7. Newport, Rhode Island
8. Portsmouth, New Hampshire
9. San Diego, California
10. San Diego, California
11. San Diego, California
12. U. S. Naval Hospital, San Diego, California
13. San Diego, California
14. U. S. Naval Hospital, San Diego, California
15. San Diego, California

Source: Sanitary Report, U. S. Naval Hospital,
San Diego, California

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APPENDIX K

Hospital Plot Plan

1. Astoria, Oregon
2. Chelsea, Massachusetts
3. Corona, California
4. Farragut, Idaho
5. Long Beach, California
6. Memphis, Tennessee
7. Newport, Rhode Island
8. Portsmouth, New Hampshire
9. San Diego, California
10. Santa Margarita Ranch, Oceanside, California
11. Shoemaker, California
12. U. S. N. Receiving Hospital,
San Francisco, California

Source: Annual Sanitary Reports for each hospital

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APPENDIX L

Floor Plan--"H" and "I"-Type Buildings

Source: Navy Department, Bureau of Yards and Docks

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APPENDIX M

1. U. S. Naval Hospitals -- commissioned, established, approved by Federal Board, decommissioned
2. U. S. Naval Special Hospitals (Convalescent)-- commissioned, established, approved by Federal Board, decommissioned
3. Annex Units to General Hospital Serving as Special Hospital Type Facilities

Source: Annual Sanitary Reports, Cumulative Histories, General Correspondence Files

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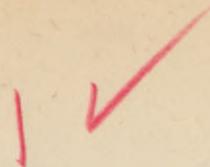
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APPENDIX M 1947

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CONVALESCENT HOSPITALS



HOSPITAL	FEDERAL BOARD APPROVAL	DESIGNATED & ESTABLISHED	COMMISSIONED	DECOMMISSIONED
Arrowhead Springs, Calif. (San Bernardino)			23 May 1944	15 Apr 1946
Asbury Park, N. J.	29 Jan. 1945	31 Mar. 1945	10 Apr. 1945	1 Apr. 1946
Asheville, N. C.		26 Mar. 1943	24 May 1943	10 Apr. 1946
Banning, Calif.	29 May 1944	15 June 1944	2 Oct. 1944	31 Dec. 1945
Beaumont, Calif.	29 May 1944	15 June 1944	2 Oct. 1944	15 Oct. 1945
Camp Wallace, Tex. (Galveston)		5 Sept. 1945	5 Sept. 1945	
Camp White, Oregon (Medford)	2 June 1944	8 Aug. 1945	31 Aug. 1945	
Glenwood Springs, Colo.		6 Mar. 1943	5 July 1942	1 Apr. 1946
Harriman, N. Y.		5 Sept. 1945	16 Nov. 1942	1 Nov. 1945
Palm Beach, Fla.	23 Feb. 1945	10 May 1945	21 May 1945	20 Feb. 1946
Santa Cruz, Calif.			8 Mar. 1943	1 Apr. 1946
Sea Gate, N. Y. (Brooklyn)	14 Apr. 1944	16 July 1944	30 Aug. 1944	
Springfield, Mass.	26 June 1944	8 Sept. 1944	8 Sept. 1944	1 Mar. 1946
Sun Valley, Idaho		1 June 1943	1 July 1945	1 Dec. 1945
Yosemite National Park, Calif.	3 May 1945	17 May 1943	25 June 1943	15 Dec. 1945

ANNEX UNITS TO GENERAL HOSPITALS
SERVING AS SPECIAL HOSPITAL TYPE FACILITIES

- | | |
|----------------------------------|---------------------------------|
| 1. Balboa Annex (San Diego) | 5. Lawrence Annex (Great Lakes) |
| 2. Benmoreel Annex (Norfolk NOB) | 6. McIntyre Annex (Great Lakes) |
| 3. Callaghan Annex (Sampson) | 7. Napa Annex (Mare Island) |
| 4. Camp Bennion Annex (Farragut) | 8. Rancho Santa Fe (San Diego) |

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APPENDIX M (Cont'd.)

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DECLASSIFICATION BOARD

HOSPITAL	FEDERAL BOARD APPROVAL	DESIGNATED & ESTABLISHED	COMMISSIONED
Annapolis, Md.			1846
Astoria, Oregon	11 June 1943 (19 June)	7 Oct. 1943	17 Oct. 1944
Bainbridge, Md.		27 Sept. 1942	4 Feb. 1942
Beaufort, S. C.	22 May 1945 (To replace Parris Island)		
Bethesda, Md. (Washington, D. C.)			5 Feb. 1942
Bremerton, Wash. (Puget Sound)			26 Jan. 1903 1 Jan. 1912
Brooklyn, N. Y.			1811, 1838
Camp LeJeune (New River, N. C.)	1 Nov. 1944	20 Jan. 1942 (designation changed to Camp LeJeune)	1 May 1943
Charleston, S. C.			13 July 1917 13 Apr. 1942
Chelsea, Mass.			7 Jan. 1836
Corona, Calif.		16 Dec. 1941	16 Dec. 1941
Corpus Christi, Tex.		1 July 1941	1 July 1941
Corvallis, Oregon	17 Nov. 1944	27 Dec. 1944	3 Feb. 1945
Dublin, Ga.	14 May 1943		22 Jan. 1945
Farragut, Idaho		27 Sept. 1943	15 Jan. 1945
Fort Eustis, Va.	27 July 1944	29 Aug. 1944 Decommissioned	13 Sept. 1944 1 Feb. 1946
Great Lakes, Ill.			12 Oct. 1911
Houston, Tex.	15 Mar. 1944	14 July 1945	1 Mar. 1946
Jacksonville, Fla.		1 July 1941	1 July 1941
Key West, Fla.			19 Oct. 1942
Long Beach, Calif.			15 Dec. 1942
Mare Island, Calif.			Jan. 1864 Apr. 1900

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APPENDIX M (Cont'd.)

AUTHORITY BUMED
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HOSPITAL	FEDERAL BOARD APPROVAL	DESIGNATED & ESTABLISHED	COMMISSIONED
Memphis, Tenn.		11 Jan. 1943	17 Mar. 1943
New Orleans, La.			1 June 1943
Newport, R. I.			6 Feb. 1943
Norfolk, (NOB) Va.		20 Jan. 1942	2 Nov. 1942
Norman, Okla.	26 Aug. 1942	27 Oct. 1942	15 Nov. 1942
Oakland, Calif.		27 Oct. 1942	3 Sept. 1943
Parris Island, S. C.			1919
Pensacola, Fla.			11 June 1875
Philadelphia, Pa.			July 1868 12 Apr. 1938
Portsmouth, N. H.			21 Dec. 1891 16 Dec. 1913
Portsmouth, Va.	16 Dec. 1913		1830
Quantico, Va.		1 July 1941	1 July 1941
Sampson, N. Y.		29 Sept. 1942	27 Feb. 1943
San Diego, Calif.			22 Aug. 1922
San Francisco Receiving Hospital	(Mobile 113 on 9 Dec. 1944)	Decommissioned	8 Jan. 1945 15 Dec. 1945
San Francisco, Calif. (Treasure Island)	30 Dec. 1941	20 Jan. 1942	4 Apr. 1942
San Leandro, Calif.	20 Jan. 1944	7 Sept. 1943	15 Aug. 1944
Santa Margarita Ranch, Calif. (Oceanside)		18 Nov. 1942	3 Sept. 1943
Seattle, Wash.		20 Jan. 1942	22 Aug. 1942
Shoemaker, Calif.	21 May 1943	5 May 1943	1 Oct. 1943
St. Albans, N. Y.		24 Nov. 1942	15 Feb. 1943

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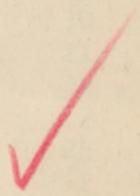
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APPENDIX N

- 
1. Continental Naval Hospitals--V-J Day
 2. Regular Hospitals Ranked According to Bed Capacity at the Close of the War (13 Aug. 1945)
 3. Special Hospitals Ranked According to Bed Capacity at the Close of the War (13 Aug. 1945)
 4. Regular Hospitals Ranked According to Beds Occupied at the Close of the War (13 Aug. 1945)
 5. Special Hospitals Ranked According to Beds Occupied at the Close of the War (13 Aug. 1945)

Source: Files of Medical Statistical Division

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APPENDIX N 23 1947

CONTINENTAL NAVAL HOSPITALS -- V-J Day

REGULAR HOSPITALS	Beds Authorized	Rank	:: ACTUAL PATIENT LOAD AT END OF WAR Patients	Rank
::				
Annapolis, Md.	275	41	284	42
Astoria, Oregon	441	37	414	40
Bainbridge, Md.	1,203	19	1,979	16
Bethesda, Md.	1,509	13	2,426	13
Brooklyn, N. Y.	722	30	1,125	29
Charleston, S. C.	675	32	697	36
Chelsea, Mass.	1,523	12	2,701	9
Corona, Calif.	3,045	4	3,611	5
Corpus Christi, Tex.	713	31	1,115	30
Corvallis, Oregon	1,900	9	1,587	21
Dublin, Ga.	500	36	787	34
Farragut, Idaho	3,977	3	2,489	12
Fort Eustis, Va.	1,200	21	1,339	24
Great Lakes, Ill.	4,507	2	7,532	2
Jacksonville, Fla.	987	25	1,825	17
Key West, Fla.	295	40	506	38
Long Beach, Calif.	1,287	18	2,609	10
Mare Island, Calif.	1,413	15	2,281	14
Memphis, Tenn.	845	27	1,321	25
New Orleans, La.	600	34	1,212	28
Newport, R. I.	1,000	24	1,305	26
New River, N. C.	1,007	23	1,730	19
Norfolk, Va.	1,136	22	1,652	20
Norman, Okla.	819	29	1,811	18
Oakland, Calif.	2,374	6	5,400	3
Palm Beach, Fla.	1,400	16	727	35
Parris Island, S. C.	349	39	651	37
Pensacola, Fla.	836	28	1,073	31
Philadelphia, Pa.	1,650	11	3,316	6
Portsmouth, N. H.	354	38	390	41
Portsmouth, Va.	1,850	10	3,103	7
Puget Sound, Wash.	662	33	871	33
Quantico, Va.	270	42	451	39
Rec. Hospital				
San Francisco, Calif.	2,000	8	927	32
Sampson, N. Y.	1,418	14	2,119	15
San Diego, Calif.	10,499	1	8,069	1
San Leandro, Calif.	850	26	1,373	23
Santa Margarita, Oceanside, Calif.	1,200	20	1,534	22
Seattle, Wash.	1,389	17	2,554	11
Shoemaker, Calif.	2,398	5	3,031	8
St. Albans, N. Y.	2,359	7	4,642	4
Treasure Island, Calif.	572	35	1,276	27
TOTALS	64,009	::	85,845	::

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APPENDIX N (Cont'd.)
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REGULAR HOSPITALS RANKED ACCORDING TO BED CAPACITY
AT THE CLOSE OF THE WAR (13 Aug. 1945)*

1. San Diego, Calif.	10,499	21. Norfolk, Va. (NOB)	1,136
2. Great Lakes, Ill.	4,507	22. New River, N. C.	1,007
3. Farragut, Idaho	3,977	23. Newport, R. I.	1,000
4. Corona, Calif.	3,045	24. Jacksonville, Fla.	987
5. Shoemaker, Calif.	2,398	25. San Leandro, Calif.	850
6. Oakland, Calif.	2,374	26. Memphis, Tenn.	845
7. St. Albans, N. Y.	2,359	27. Pensacola, Fla.	836
8. Corvallis, Oregon	1,900	28. Norman, Okla.	819
9. Portsmouth, Va.	1,850	29. Brooklyn, N. Y.	722
10. Philadelphia, Pa.	1,650	30. Corpus Christi, Tex.	713
11. Chelsea, Mass.	1,523	31. Charleston, S. C.	675
12. Bethesda, Md.	1,509	32. Puget Sound, Wash.	662
13. Sampson, N. Y.	1,418	33. New Orleans, La.	600
14. Mare Island, Calif.	1,413	34. Treasure Island, Calif.	572
15. Palm Beach, Fla.	1,400	35. Dublin, Ga.	500
16. Seattle, Wash.	1,389	36. Astoria, Oregon	441
17. Long Beach, Calif.	1,287	37. Portsmouth, N. H.	354
18. Bainbridge, Md.	1,203	38. Parris Island, S. C.	349
19. Fort Eustis, Va.	1,200	39. Key West, Fla.	295
20. Santa Margarita, Oceanside, Calif.	1,200	40. Annapolis, Md.	275
		41. Quantico, Va.	270
		Receiving Hospital, San Francisco, Calif.	2,000

SPECIAL HOSPITALS RANKED ACCORDING TO BED CAPACITY
AT THE CLOSE OF THE WAR (13 Aug. 1945)

1. Asbury Park, N. J.	1,500	7. Glenwood Springs, Colo.	540
2. Sun Valley, Idaho	1,035	8. Sea Gate, N. Y.	461
3. Banning, Calif.	1,000	9. Springfield, Mass.	450
4. Beaumont, Calif.	936	10. Arrowhead Springs, Calif.	450
5. Santa Cruz, Calif.	886	11. Asheville, N. C.	404
6. Yosemite, Calif.	642	12. Harriman, N. Y.	80

* Bed capacity is rated on basis of 8 foot centers.

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APPENDIX N. (Cont'd.)

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REGULAR HOSPITALS RANKED ACCORDING TO BEDS OCCUPIED
AT THE CLOSE OF THE WAR (13 Aug. 1945)

1. San Diego, Calif.	8,069	22. Santa Margarita, Oceanside, Calif.	1,534
2. Great Lakes, Ill.	7,532	23. San Leandro, Calif.	1,373
3. Oakland, Calif.	5,400	24. Fort Eustis, Va.	1,339
4. St. Albans, N. Y.	4,642	25. Memphis, Tenn.	1,321
5. Corona, Calif.	3,611	26. Newport, R. I.	1,305
6. Philadelphia, Pa.	3,316	27. Treasure Island, Calif.	1,276
7. Portsmouth, Va.	3,103	28. New Orleans, La.	1,212
8. Shoemaker, Calif.	3,031	29. Brooklyn, N. Y.	1,125
9. Chelsea, Mass.	2,701	30. Corpus Christi, Tex.	1,115
10. Long Beach, Calif.	2,609	31. Pensacola, Fla.	1,073
11. Seattle, Wash.	2,554	32. Rec. Hospital, San Francisco, Calif.	927
12. Farragut, Idaho	2,489	33. Puget Sound, Wash.	871
13. Bethesda, Md.	2,426	34. Dublin, Ga.	878
14. Mare Island, Calif.	2,281	35. Palm Beach, Fla.	727
15. Sampson, N. Y.	2,119	36. Parris Island, S. C.	651
16. Bainbridge, Md.	1,979	37. Key West, Fla.	506
17. Jacksonville, Fla.	1,825	38. Quantico, Va.	451
18. Norman, Okla.	1,811	39. Astoria, Oregon	414
19. New River, N. C.	1,730	40. Portsmouth, N. H.	390
20. Norfolk, Va. (NOB)	1,652	41. Annapolis, Md.	284
21. Corvallis, Oregon	1,587	42. Charleston, S. C.	79

SPECIAL HOSPITALS RANKED ACCORDING TO BEDS OCCUPIED
AT THE CLOSE OF THE WAR (13 Aug. 1945)

1. Sun Valley, Idaho	978	7. Asbury Park, N. J.	551
2. Santa Cruz, Calif.	891	8. Glenwood Springs, Colo.	528
3. Banning, Calif.	831	9. Springfield, Mass.	424
4. Yosemite, Calif.	709	10. Asheville, N. C.	367
5. Arrowhead Springs, Calif.	692	11. Beaumont, Calif.	240
6. Sea Gate, N. Y.	685	12. Harriman, N. Y.	64

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APPENDIX O

Continental Naval Hospitals--V-J Day--Special Hospitals
Arranged Alphabetically

Source: Files of Medical Statistical Division

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APPENDIX P

West Coast Hospitals--1 January 1945

Source: Compiled from Appendix Q

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APPENDIX P

WEST COAST HOSPITALS - 1 JANUARY 1945

	Authorized	Patients			TOTAL
	Capacity	Officers	Enlisted	Nurses	
Astoria	422	21	417	6	444
Corona	3,234	169	2,974	20	3,163
Farragut	1,977	32	1,615	28	1,675
Long Beach	1,159	312	1,792	194	2,198
Mare Island	1,113	133	1,454	75	1,662
Oakland	2,374	404	4,363	157	4,924
Shoemaker	2,398	78	2,683	164	2,925
Puget Sound	662	46	663	42	751
San Diego	10,482	673	11,069	326	12,068
Santa Margarita Ranch	1,200	62	1,211	24	1,297
Seattle	1,389	151	1,885	78	2,114
San Francisco	572	87	834	6	927
San Leandro	850	91	1,001	9	1,101
	<u>27,832</u>	<u>2,159</u>	<u>31,961</u>	<u>1,129</u>	<u>35,249</u>

Source: Compiled from Appendix Q

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APPENDIX O

CONTINENTAL NAVAL HOSPITALS -- V-J DAY

SPECIAL HOSPITALS	Beds	ACTUAL PATIENT LOAD AT END OF WAR		
	Authorized	Rank	Patients	Rank
Arrowhead Springs, Calif.	450	11	692	5
Asbury Park, N. J.	1,500	1	551	7
Asheville, N. C.	404	10	367	10
Banning, Calif.	1,000	3	831	3
Feaumont, Calif.	936	4	240	11
Glenwood Springs, Colo.	540	7	526	8
Harriman, N. Y.	80	12	64	12
Santa Cruz, Calif.	886	5	891	2
Sea Gate, N. Y.	461	8	685	6
Springfield, Mass.	450	9	424	9
Sun Valley, Idaho	1,035	2	978	1
Yosemite, Calif.	642	6	709	4
TOTALS	8,384		6,958	

Source: Files, Medical Statistical Division

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APPENDIX Q

1. Chart--Average Patient Census--All Naval Hospitals,
January 1942 - November 1945
2. SUMMARY OF AUTHORIZED CAPACITY AND PATIENT LOAD
IN CONTINENTAL HOSPITALS -- 1941-1945

Source: Files, Medical Statistical Division

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APPENDIX Q

SUMMARY OF AUTHORIZED CAPACITY AND PATIENT LOAD
IN CONTINENTAL HOSPITALS--1941-1945

DATE	Authorized Capacity			Patient Load			Vacant Beds minus or Excess of Patients Over Authorized Capa- city.
	General Hospitals	Special Hospitals	Total	General Hospital	Special Hospital	Total	
7 Dec. 1941	8,437		8,437	7,558		7,558	879 -
1 Jan. 1942	8,437		8,437	7,854		7,854	583 -
1 July 1942	8,787		8,787	12,210		12,210	3,423 +
1 Jan. 1943	22,890		22,890	22,792		22,792	98 -
1 July 1943	34,327	3,548	37,875	34,686	1,195	35,881	1,994 -
1 Jan. 1944	42,919	3,415	46,334	49,508	2,739	52,247	5,913 +
1 July 1944	44,489	4,161	48,650	53,188	3,460	56,648	7,998 +
1 Jan. 1945	52,888	6,961	59,849	72,199	6,238	78,437	18,588 +
1 July 1945	62,609	9,784	72,393	84,221	6,267	90,588	18,195 +
13 Aug. 1945	64,009	8,384	72,393	86,331	6,960	92,293	19,900 +

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APPENDIX CQI (Cont'd.)

CONTINENTAL NAVAL HOSPITALS

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATE

CALENDAR YEAR 1941

<u>Names of Hospitals</u>		<u>Date Nearest 7 December</u>		
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
	Beds			
	Authorized - - - - -			Beds Occupied
Annapolis, Md.	192	3	70	10
Brooklyn, N. Y.	580	37	403	149
Charleston, S. C.	117	6	96	22
Chelsea, Mass.	335	29	369	97
Corpus Christi, Tex.	420	43	151	12
Great Lakes, Ill.	501	15	321	14
Jacksonville, Fla.	400	38	167	4
Mare Island, Calif.	584	50	537	89
Newport, R. I.	465	14	170	61
Norfolk, Va.	1,298	36	1,074	89
Parris Island, S. C.	209	3	204	8
Pensacola, Fla.	386	40	175	12
Philadelphia, Pa.	663	22	164	643
Portsmouth, N. H.	190	9	81	34
Puget Sound, Wash.	308	22	224	53
Quantico, Va.	131	13	103	2
San Diego, Calif.	1,424	83	1,162	115
Washington, D. C.	234	66	117	27
Totals	8,437	529	5,588	1,441

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APPENDIX Q (Cont'd) 17

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PATIENTS IN CONTINENTAL NAVAL HOSPITALS AND SELECTED DATE

CALENDAR YEAR 1942

Names of Hospitals

Date Nearest 1 January

Beds

Authorized - - - - - Beds Occupied

Officer Enlisted Supers

Annapolis, Md.	192	6	443	6
Brooklyn, N. Y.	580	13	415	95
Charleston, S. C.	117	5	85	15
Chelsea, Mass.	335	35	337	76
Corpus Christi, Tex.	420	38	111	11
Great Lakes, Ill.	501	17	503	13
Jacksonville, Fla.	400	49	133	22
Mare Island, Calif.	584	59	751	37
Newport, R. I.	465	14	396	54
Norfolk, Va.	1,298	35	1,102	86
Parris Island, S. C.	209	0	248	6
Pensacola, Fla.	386	37	160	31
Philadelphia, Pa.	663	28	135	631
Portsmouth, N. H.	190	7	100	30
Puget Sound, Wash.	308	16	226	75
Quantico, Va.	131	10	74	5
San Diego, Calif.	1,424	77	1,085	83
Washington, D. C.	234	58	137	33
Totals	8,437	504	6,041	1,309

Source: From the files of Medical Statistical Division

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APPENDIX Q (Cont'd.)
DECLASSIFICATION BOARD

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATE

CALENDAR YEAR 1942

<u>Names of Hospitals</u>	<u>Date Nearest 1 July</u>			
	Beds			
	Authorized	Beds Occupied		
	<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>	
Annapolis, Md.	192	9	50	4
Brooklyn, N. Y.	580	65	578	121
Charleston, S. C.	117	11	171	39
Chelsea, Mass.	335	56	451	80
Corpus Christi, Tex.	420	44	223	58
Great Lakes, Ill.	501	17	1,201	9
Jacksonville, Fla.	400	56	280	20
Mare Island, Calif.	504	97	1,199	49
Newport, R. I.	465	26	418	78
Norfolk, Va.	1,298	63	1,544	88
Parris Island, S. C.	209	1	298	8
Pensacola, Fla.	386	50	254	21
Philadelphia, Pa.	663	34	343	531
Portsmouth, N. H.	190	4	68	22
Puget Sound, Wash.	308	22	294	57
Quantico, Va.	131	14	147	8
San Diego, Calif.	1,424	137	2,232	67
Washington, D. C.	234	89	220	40
Corona, Calif.	350	20	112	12
Totals	8,787	815	10,083	1,312

Source: From the files of Medical Statistical Division

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APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATE

CALENDAR YEAR 1943

<u>Names of Hospitals</u>	<u>Date Nearest 1 January</u>			
	Beds			
	Authorized - - - - -	Beds Occupied		
	<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>	
Annapolis, Md.	275	13	109	5
Brooklyn, N. Y.	1,200	132	1,392	146
Bethesda, Md.	700	190	457	41
Charleston, S. C.	600	17	291	98
Chelsea, Mass.	1,000	120	581	106
Corona, Calif.	1,000	15	233	9
Corpus Christi, Tex.	600	62	352	27
Great Lakes, Ill.	2,500	17	1,724	4
Jacksonville, Fla.	600	57	627	42
Key West, Fla.	150	12	196	11
Long Beach, Calif.	300	13	169	30
Mare Island, Calif.	1,000	132	1,673	49
Newport, R. I.	1,000	49	673	74
Norfolk, Va. (NOB)	750	90	1,050	7
Norman, Okla.	615	3	193	1
Oakland, Calif.	800	146	1,228	11
Parris Island, S.C.	400	9	412	7
Pensacola, Fla.	500	88	368	35
Philadelphia, Pa.	1,000	61	553	532

Source: From the files of Medical Statistical Division

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APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATE

CALENDAR YEAR 1943

<u>Names of Hospitals</u>	<u>Date Nearest 1 January</u>			
	Beds		Beds Occupied	
	Authorized - - - - -	Officer	Enlisted	Supers
Portsmouth, N. H.	350	6	197	32
Portsmouth, Va.	2,500	116	2,223	110
Puget Sound, Wash.	550	42	442	49
Quantico, Va.	200	43	150	3
San Diego, Calif.	3,000	232	3,415	82
Seattle, Wash.	800	54	378	15
Treasure Island, San Francisco, Calif.	<u>500</u>	<u>25</u>	<u>528</u>	<u>8</u>
Totals	22,890	1,744	19,514	1,534

Source: From the files of Medical Statistical Division

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APPENDIX D (Continued) CONTINENTAL NAVAL BOARD

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1943

Names of Hospitals

Date Nearest 1 July

Beds
Authorized - - - - - Beds Occupied

Officer Enlisted Supers

<u>Names of Hospitals</u>	Beds Authorized	Officer	Enlisted	Supers
Annapolis, Md.	289	18	114	22
Brooklyn, N. Y.	758	132	741	143
Bethesda, Md.	1,000	187	706	48
Charleston, S. C.	636	66	283	46
Chelsea, Mass.	1,063	152	651	99
Corona, Calif.	1,198	78	1,077	2
Corpus Christi, Tex.	700	84	553	75
Great Lakes, Ill.	2,036	80	2,364	14
Jacksonville, Fla.	931	81	553	10
Key West, Fla.	301	25	271	57
Long Beach, Calif.	309	81	682	57
Mare Island, Calif.	1,181	72	905	48
Newport, R. I.	1,000	44	697	62
Norfolk, Va. (NOB)	1,073	111	1,020	61
Norman, Okla.	615	29	336	16
Oakland, Calif.	1,765	254	2,300	7
Parris Island, S. C.	319	7	303	17
Pensacola, Fla.	624	121	365	50
Philadelphia, Pa.	1,345	105	680	539

Source: From the files of Medical Statistical Division

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AUTHORITY BUMED
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DECLASSIFICATION BOARD

APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1943

<u>Names of Hospitals</u>		<u>Date Nearest 1 July</u>		
		Beds		
		Authorized - - - - -	Beds Occupied	
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
Portsmouth, N. H.	356	12	156	20
Portsmouth, Va.	1,471	117	1,437	90
Puget Sound, Wash.	662	20	413	32
Quantico, Va.	345	37	139	3
San Diego, Calif.	5,818	405	6,603	94
Seattle, Wash.	786	62	709	3
Treasure Island, San Francisco, Calif.	500	99	630	8
Bainbridge, Md.	1,000	4	932	7
Farragut, Idaho	1,500	15	1,484	17
Memphis, Tenn.	600	45	339	0
New River, N. C.	927	46	508	4
St. Albans, N. Y.	1,346	94	1,522	39
Sampson, N. Y.	1,464	32	609	11
New Orleans, La.	409	25	153	3
<u>Special Hospitals</u>				
Asheville, N. C.	500	20	297	1
Harriman, N. Y.	80	23	0	0
Santa Cruz, Calif.	850	0	853	0

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APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1943

Names of Hospitals

Date Nearest 1 July

Beds

Authorized - - - - - Beds Occupied

Officer Enlisted Supers

Portsmouth, N. H.	356	12	156	20
Portsmouth, Va.	1,471	117	1,437	90
Puget Sound, Wash.	662	20	413	32
Quantico, Va.	345	37	139	3
San Diego, Calif.	5,818	405	6,603	94
Seattle, Wash.	786	62	709	3
Treasure Island, San Francisco, Calif.	500	99	630	8
Bainbridge, Md.	1,000	4	932	7
Farragut, Idaho	1,500	15	1,484	17
Memphis, Tenn.	600	45	339	0
New River, N. C.	927	46	508	4
St. Albans, N. Y.	1,346	94	1,522	39
Sampson, N. Y.	1,464	32	609	11
New Orleans, La.	409	25	153	3

Special Hospitals

Asheville, N. C.	500	20	297	1
Harriman, N. Y.	80	23	0	0
Santa Cruz, Calif.	850	0	853	0

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APPENDIX Q (Cont'd.)

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PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1943

Names of Hospitals

Date Nearest 1 July

Beds

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Officer Enlisted Supers

Palm Beach, Fla.	20	1	0	0
Yosemite Natl. Park, Calif.	700	0	0	0
Sun Valley, Idaho	<u>1,398</u>	<u>0</u>	<u>0</u>	<u>0</u>
Regular	34,327	2,740	30,235	1,711
Special	<u>3,548</u>	<u>44</u>	<u>1,150</u>	<u>1</u>
Totals	37,875	2,784	31,385	1,712

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APPENDIX Qe (Cont'd.)

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PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1944

Names of Hospitals

Date Nearest 1 January

Beds

Authorized - - - - - Beds Occupied

Officer Enlisted Supers

<u>Names of Hospitals</u>	<u>Beds Authorized</u>	<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
Annapolis, Md.	275	20	116	12
Bainbridge, Md.	999	10	1,134	7
Bethesda, Md.	1,009	378	1,225	67
Brooklyn, N. Y.	843	177	747	123
Charleston, S. C.	600	50	401	155
Chelsea, Mass.	1,000	134	1,044	163
Corona, Calif.	2,261	67	1,185	16
Corpus Christi, Tex.	600	96	524	68
Farragut, Idaho	1,475	66	1,828	12
Great Lakes, Ill.	2,076	161	3,686	6
Jacksonville, Fla.	932	114	657	8
Key West, Fla.	301	21	289	32
Long Beach, Calif.	1,159	107	1,092	149
Mare Island, Calif.	1,554	87	1,251	33
Memphis, Tenn.	603	67	660	1
New Orleans, La.	409	76	797	18
Newport, R. I.	1,246	58	912	60
New River, N. C.	994	49	931	44
Norfolk, Va. (NOB)	1,000	138	1,124	72

Source: From the files of Medical Statistical Division

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APPENDIX Q (Cont'd.)
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PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1944

Names of Hospitals

Date Nearest 1 January

Beds
Authorized - - - - - Beds Occupied

Officer Enlisted Supers

<u>Names of Hospitals</u>	<u>Beds Authorized</u>	<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
Norman, Okla.	615	79	692	24
Oakland, Calif.	2,374	333	2,024	111
Parris Island, S. C.	349	8	417	22
Pensacola, Fla.	760	133	477	47
Philadelphia, Pa.	1,316	103	973	506
Shoemaker, Calif.	1,009	22	945	3
Portsmouth, N. H.	319	21	198	35
Portsmouth, Va.	1,492	208	2,489	166
Puget Sound, Wash.	662	41	607	37
Quantico, Va.	345	29	211	3
St. Albans, N. Y.	2,211	309	3,790	63
Sampson, N. Y.	1,455	33	1,306	14
San Diego, Calif.	7,483	361	6,573	281
Santa Margarita Ranch, Oceanside, Calif.	1,232	27	835	2
Seattle, Wash.	1,389	122	1,238	13
Treasure Island, Calif.	572	23	1,026	3

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APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1944

Names of Hospitals

Date Nearest 1 January

Beds

Authorized - - - - - Beds Occupied

Officer Enlisted Supers

Special Hospitals

Asheville, N. C.	404	10	214	0
Glenwood Springs, Colo.	512	32	307	0
Harriman, N. Y.	80	33	0	1
Santa Cruz, Calif.	877	0	862	0
Sun Valley, Idaho	900	31	807	2
Yosemite Nat'l. Park, Calif.	642	3	437	0
Arrowhead Springs, Calif.	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Regular	42,919	3,728	43,404	2,376
Special	<u>3,415</u>	<u>109</u>	<u>2,627</u>	<u>3</u>
Totals	46,334	3,837	46,031	2,379

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1944

<u>Names of Hospitals</u>		<u>Date Nearest 1 July</u>		
		Officer	Enlisted	Supers
Annapolis, Md.	275	17	70	25
Bainbridge, Md.	1,207	7	1,021	11
Bethesda, Md.	1,009	393	1,338	84
Brooklyn, N. Y.	821	94	762	109
Charleston, S. C.	635	29	383	68
Chelsea, Mass.	1,000	165	1,190	104
Corona, Calif.	1,984	111	2,613	12
Corpus Christi, Tex.	650	82	462	147
Farragut, Idaho	1,477	51	1,344	24
Great Lakes, Ill.	1,867	109	2,363	8
Jacksonville, Fla.	927	118	803	14
Key West, Fla.	295	35	266	44
Long Beach, Calif.	1,159	125	1,352	262
Mare Island, Calif.	1,113	104	1,194	77
Memphis, Tenn.	738	29	827	1
New Orleans, La.	409	39	648	7
Newport, R. I.	1,000	63	798	54
New River, N. C.	994	62	1,031	80
Norfolk, Va. (NOB)	1,000	99	1,141	49

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PATIENTS IN CONTINENTAL NAVAL HOSPITAL - SELECTED DATES

CALENDAR YEAR 1944

<u>Names of Hospitals</u>	Beds Authorized - - - - -	<u>Date Nearest 1 July</u>		
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
Norman, Okla.	705	34	609	32
Oakland, Calif.	2,374	233	3,757	142
Parris Island, S. C.	349	8	398	9
Pensacola, Fla.	822	75	390	62
Philadelphia, Pa.	1,650	125	1,312	555
Shoemaker, Calif.	2,398	38	2,342	109
Portsmouth, N. H.	319	18	217	67
Portsmouth, Va.	1,850	184	2,223	172
Puget Sound, Wash.	662	29	611	39
Quantico, Va.	345	35	248	6
St. Albans, N. Y.	2,359	218	2,926	133
Sampson, N. Y.	1,452	20	945	12
San Diego, Calif.	7,483	406	7,311	317
Santa Margarita Ranch, Oceanside, Calif.	1,200	36	1,450	8
Seattle, Wash.	1,389	134	2,133	24
Treasure Island, Calif.	572	64	450	4

Source: From the files of Medical Statistical Division

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PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1944

Names of Hospitals

Date Nearest 1 July

Beds

Authorized - - - - - Beds Occupied

Officer

Enlisted

Supers

Special Hospitals

Asheville, N. C.	404	20	359	7
Genwood Springs, Colo.	540	10	549	2
Harriman, N. Y.	80	63	0	0
Santa Cruz, Calif.	936	0	832	0
Sun Valley, Idaho	1,059	20	387	1
Yosemite Nat'l. Park, Calif.	642	22	657	0
Arrowhead Springs, Calif.	<u>500</u>	<u>0</u>	<u>519</u>	<u>12</u>
Regular	44,489	3,389	46,928	2,871
Special	<u>4,161</u>	<u>135</u>	<u>3,303</u>	<u>22</u>
Totals	48,650	3,524	50,231	2,893

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APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1945

<u>Names of Hospitals</u>	Beds Authorized - - - - -	<u>Date Nearest 1 January</u>		
		Beds Occupied		
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
Annapolis, Md.	275	23	105	22
Astoria, Oreg.	422	21	417	6
Bainbridge, Md.	1,203	34	2,080	6
Bethesda, Md.	1,509	443	1,620	122
Brooklyn, N. Y.	762	98	954	96
Charleston, S. C.	675	49	532	75
Chelsea, Mass.	1,250	187	1,730	110
Corona, Calif.	3,234	169	2,974	20
Corpus Christi, Tex.	600	82	695	129
Farragut, Idaho	1,977	32	1,615	28
Great Lakes, Ill.	2,291	177	3,560	18
Jacksonville, Fla.	987	144	902	14
Key West, Fla.	258	30	365	34
Long Beach, Calif.	1,159	212	1,792	194
Mare Island, Calif.	1,113	133	1,454	75
Memphis, Tenn.	705	33	1,017	13
New Orleans, La.	609	95	923	39
Newport, R. I.	1,000	65	942	67
Camp LeJeune, N. C.	994	48	1,202	50

Source: From the files of Medical Statistical Division

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APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1945

<u>Names of Hospitals</u>	Beds Authorized - - - - -	<u>Date Nearest 1 January</u>		
		Beds Occupied		
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
Norfolk, Va. (NOB)	1,000	121	1,290	57
Norman, Okla.	819	60	1,103	40
Oakland, Calif.	2,374	404	4,363	157
Fort Eustis, Va.	1,000	76	1,103	13
Parris Island, S. C.	349	16	409	15
Pensacola, Fla.	836	83	558	101
Philadelphia, Pa.	1,650	234	1,980	594
Shoemaker, Calif.	2,398	78	2,683	164
Portsmouth, N. H.	353	14	364	77
Portsmouth, Va.	1,850	205	2,713	105
Puget Sound, Wash.	662	46	663	42
Quantico, Va.	270	43	399	3
St. Albans, N. Y.	2,359	453	4,152	130
Sampson, N. Y.	1,452	63	1,424	22
San Diego, Calif.	10,482	673	11,069	326
Santa Margarita Ranch, Oceanside, Calif.	1,200	62	1,211	24
Seattle, Wash.	1,389	151	1,885	78
Treasure Island, Calif.	572	87	834	6

Source: From the files of Medical Statistical Division

APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1945

<u>Names of Hospitals</u>	Beds Authorized - - - - -	<u>Date Nearest 1 January</u>		
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
San Leandro, Calif.	850	91	1,001	9
Dublin, Ga.	0	0	0	0
<u>Special Hospitals</u>				
Asheville, N. C.	404	23	411	8
Glenwood Springs, Colo.	540	10	521	4
Harriman, N. Y.	80	51	0	0
Santa Cruz, Calif.	886	1	840	2
Sun Valley, Idaho	1,059	17	700	1
Yosemite Nat'l. Park, Calif.	642	7	378	0
Arrowhead Springs, Calif.	400	17	652	26
Banning, Calif.	1,000	0	921	0
Beaumont, Calif.	1,000	0	493	2
Sea Gate, N. Y.	500	0	712	0
Springfield, Mass.	<u>450</u>	<u>0</u>	<u>424</u>	<u>17</u>
Regular	52,888	5,035	64,083	3,081
Special	<u>6,961</u>	<u>126</u>	<u>6,052</u>	<u>60</u>
Totals	59,849	5,161	70,135	3,141

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APPENDIX Q (Cont'd.)

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PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1945

<u>Names of Hospitals</u>		<u>Date Nearest 1 July</u>		
		Beds		
		Authorized - - - - -	Beds Occupied	
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
Annapolis, Md.	275	38	176	24
Astoria, Oreg.	441	26	426	21
Bainbridge, Md.	1,203	28	2,082	11
Bethesda, Md.	1,509	522	1,729	147
Brooklyn, N. Y.	722	120	914	146
Charleston, S. C.	675	48	728	86
Chelsea, Mass.	1,523	252	2,239	213
Corona, Calif.	3,045	200	3,277	74
Corpus Christi, Tex.	713	95	844	166
Farragut, Idaho	3,977	46	2,510	24
Great Lakes, Ill.	4,507	325	6,809	36
Jacksonville, Fla.	987	196	1,368	3
Key West, Fla.	295	38	425	38
Long Beach, Calif.	1,287	279	1,937	266
Mare Island, Calif.	1,413	215	1,732	137
Memphis, Tenn.	845	98	1,134	21
New Orleans, La.	600	116	973	66
Newport, R. I.	1,000	69	973	98
Camp LeJeune, N. C.	1,007	77	1,631	56

Source: From the files of Medical Statistical Division

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APPENDIX Q (Cont'd.)

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PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1945

Names of Hospitals

Date Nearest 1 July

Beds
Authorized - - - - - Beds Occupied

Officer Enlisted Supers

Dublin, Ga.	500	29	766	31
Corvallis, Oregon	1,900	20	1,354	24
Rec. Hospital, San Francisco, Calif.	2,000	108	1,398	1

Special Hospitals

Asheville, N. C.	404	16	354	5
Glenwood Springs, Colo.	540	5	325	7
Harriman, N. Y.	80	59	0	0
Santa Cruz, Calif.	886	0	666	6
Sun Valley, Idaho	1,035	20	518	5
Yosemite Nat'l. Park, Calif.	642	28	533	11
Arrowhead Springs, Calif.	450	20	618	31
Banning, Calif.	1,000	0	739	19
Beaumont, Calif.	936	0	90	0
Sea Gate, N. Y.	461	10	591	3
Springfield, Mass.	450	0	328	33
Palm Beach, Fla.	1,400	5	655	4
Asbury Park, N. J.	1,500	0	557	6

Regular 62,609 6,077 74,192 4,052

Special 9,784 163 5,974 130

Totals 72,393 6,240 80,166 4,182

Source: From the files of Medical Statistical Division

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APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED

CALENDAR YEAR 1945

<u>Names of Hospitals</u>	Beds Authorized	<u>Date Nearest 1 July</u>		
		--- Bed Occupied		
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
Norfolk, Va. (NOB)	1,136	135	1,504	55
Norman, Okla.	819	85	1,705	43
Oakland, Calif.	2,374	541	4,220	198
Fort Eustis, Va.	1,200	39	1,448	18
Parris Island, S. C.	349	12	568	17
Pensacola, Fla.	836	79	754	79
Philadelphia, Pa.	1,650	238	2,401	605
Shoemaker, Calif.	2,398	57	2,559	144
Portsmouth, N. H.	354	25	277	75
Portsmouth, Va.	1,850	196	2,888	124
Puget Sound, Wash.	662	69	702	66
Quantico, Va.	270	60	369	4
St. Albans, N. Y.	2,359	511	4,037	139
Sampson, N. Y.	1,418	113	2,269	43
San Diego, Calif.	10,499	546	7,171	426
Santa Margarita Ranch, Oceanside, Calif.	1,200	47	1,156	46
Seattle, Wash.	1,389	169	2,220	233
Treasure Island, Calif.	572	155	1,085	27
San Leandro, Calif.	850	55	1,354	21

Source: From the files of Medical Statistical Division

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APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1945

<u>Names of Hospitals</u>		<u>Date Nearest 13 August</u>		
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
	Beds			
	Authorized - - - - -		Beds Occupied	
Annapolis, Md.	275	53	197	34
Astoria, Oregon	441	25	365	24
Bainbridge, Md.	1,203	26	1,932	21
Bethesda, Md.	1,509	524	1,779	123
Brooklyn, N. Y.	722	114	867	144
Charleston, S. C.	675	54	564	79
Chelsea, Mass.	1,523	277	2,208	216
Corona, Calif.	3,045	229	3,297	85
Corpus Christi, Tex.	713	103	830	182
Corvallis, Oregon	1,900	25	1,517	45
Dublin, Ga.	500	36	714	37
Farragut, Idaho	3,977	52	2,390	47
Fort Eustis, Va.	1,200	50	1,259	30
Great Lakes, Ill.	4,507	326	7,156	50
Jacksonville, Fla.	987	173	1,519	133
Key West, Fla.	295	41	431	34
Long Beach, Calif.	1,287	267	2,007	335
Mare Island, Calif.	1,413	190	1,960	131
Memphis, Tenn.	845	97	1,208	16

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APPENDIX Q (Cont'd.) AUTHORITY BUMED
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PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1945

<u>Names of Hospitals</u>	Beds Authorized - - - - -	<u>Date Nearest 13 August</u>		
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
New Orleans, La.	600	110	1,027	75
Newport, R. I.	1,000	105	1,110	90
New River, N. C.	1,007	89	1,572	69
Norfolk, Va.	1,136	151	1,428	73
Norman, Okla.	819	85	1,675	51
Oakland, Calif.	2,374	528	4,525	347
Palm Beach, Fla.	1,400	4	718	5
Parris Island, S. C.	349	11	628	12
Pensacola, Fla.	836	81	872	120
Philadelphia, Pa.	1,650	250	2,491	575
Portsmouth, N. H.	354	25	294	71
Portsmouth, Va.	1,850	209	2,753	141
Puget Sound, Wash.	662	60	746	65
Quantico, Va.	270	47	398	6
Rec. Hospital, San Francisco, Calif.	2,000	59	852	16
Sampson, N. Y.	1,418	119	1,955	45
San Diego, Calif.	10,499	563	7,088	418
San Leandro, Calif.	850	103	1,247	23
Santa Margarita Ranch, Oceanside, Calif.	1,200	106	1,384	44

Source: From the files of Medical Statistical Division

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APPENDIX Q (Cont'd.)

PATIENTS IN CONTINENTAL NAVAL HOSPITALS - SELECTED DATES

CALENDAR YEAR 1945

<u>Names of Hospitals</u>	Beds Authorized - - - - -	<u>Date Nearest 13 August</u>		
		<u>Officer</u>	<u>Enlisted</u>	<u>Supers</u>
Seattle, Wash.	1,389	225	2,075	254
Shoemaker, Calif.	2,398	55	2,823	153
St. Albans, N. Y.	2,359	491	3,990	161
Treasure Island, Calif.	572	149	1,097	30
<u>Special Hospitals</u>				
Arrowhead Springs, Calif.	450	20	635	37
Asbury Park, N. J.	1,500	0	546	5
Asheville, N. C.	404	17	345	5
Banning, Calif.	1,000	1	815	15
Beaumont, Calif.	936	0	239	1
Glenwood Springs, Colo.	540	8	506	14
Harriman, N. Y.	80	64	0	0
Santa Cruz, Calif.	886	100	779	12
Sea Gate, N. Y.	461	15	661	9
Springfield, Mass.	450	0	395	29
Sun Valley, Idaho	1,035	22	943	13
Yosemite, Calif.	642	64	633	12
Regular	64,009	6,773	74,948	4,610
Special	8,384	311	6,497	152
Totals	72,393	7,084	81,445	4,762

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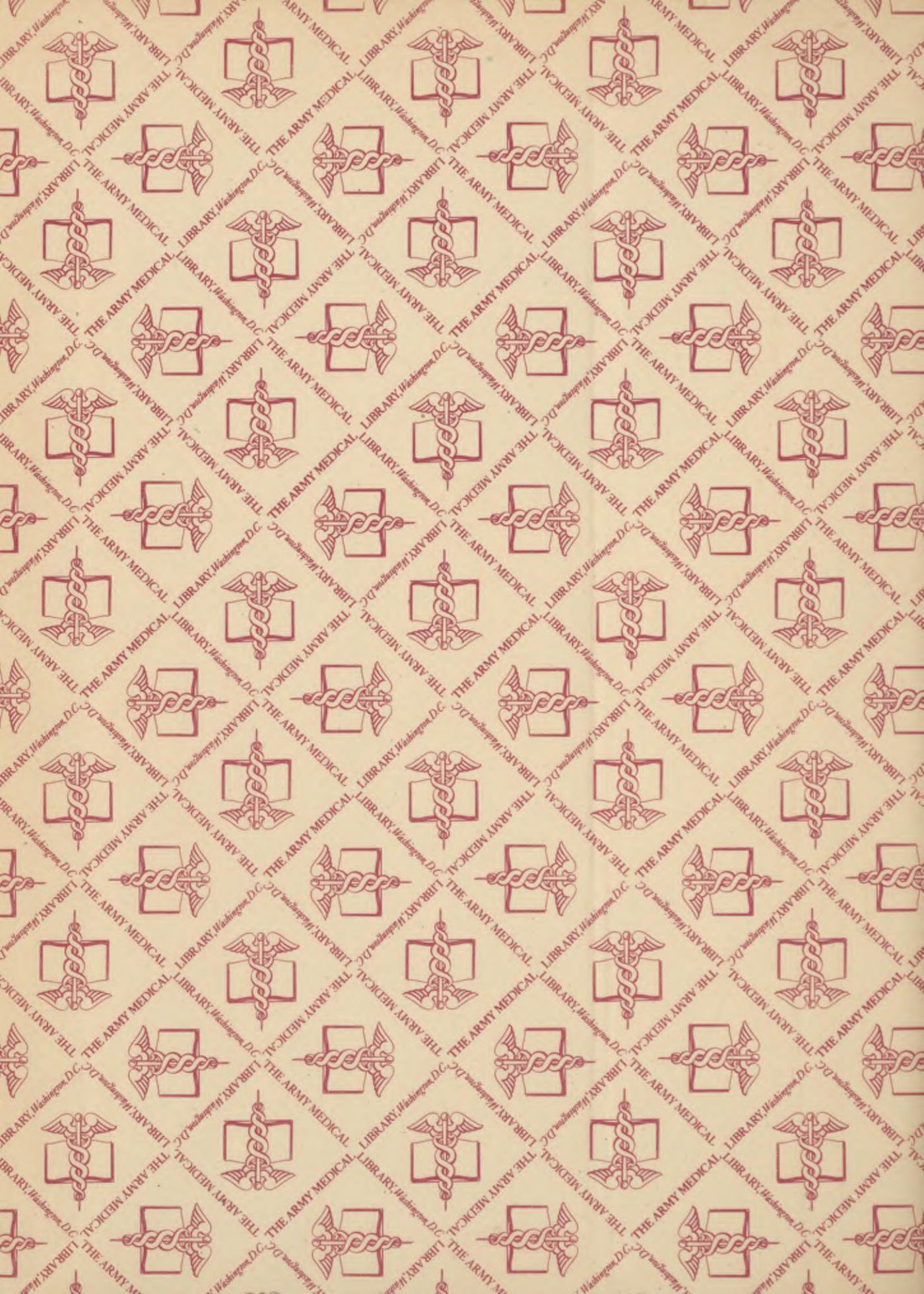
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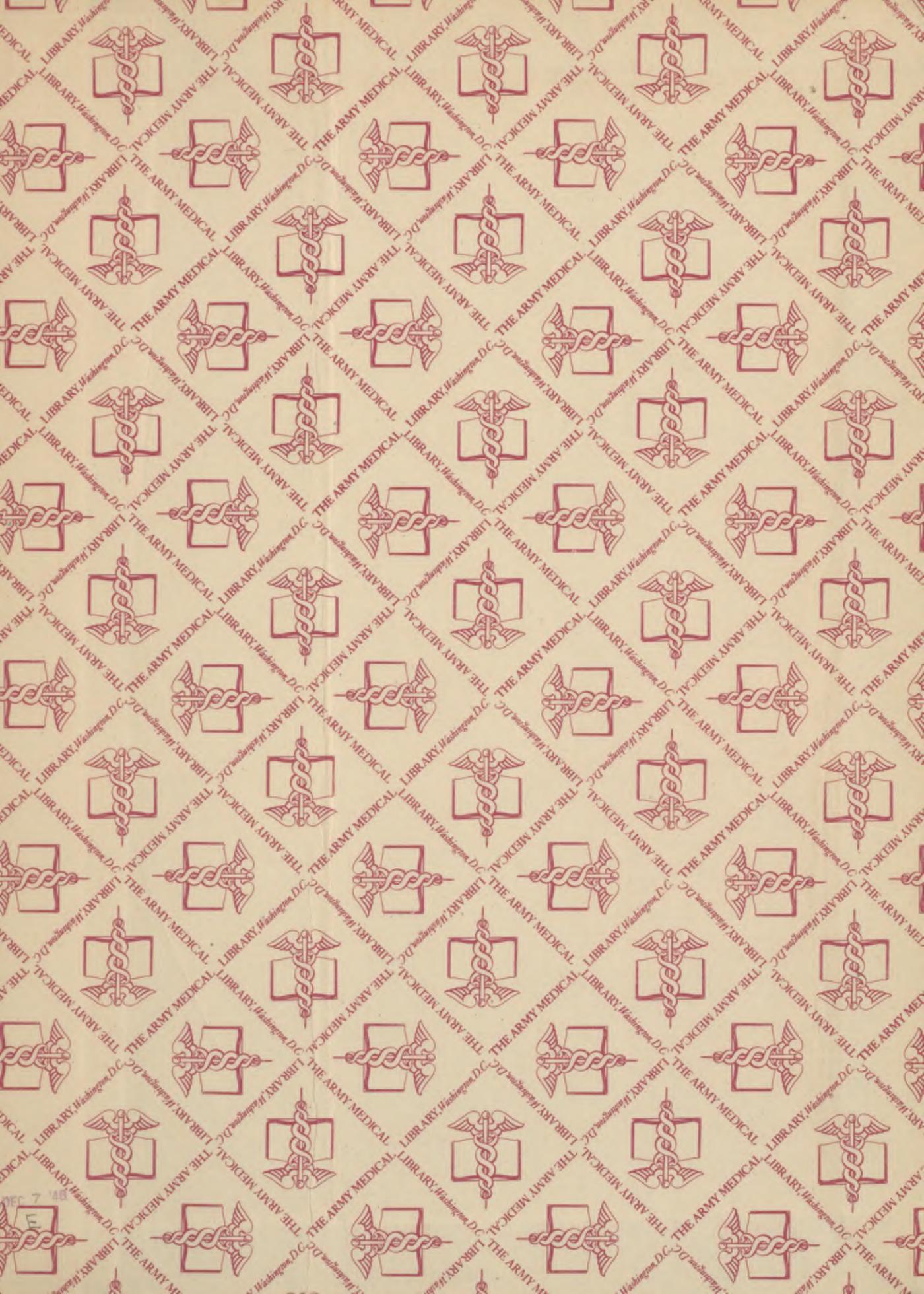
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