

SPMC 720

# HEALTH



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# SUMMARY

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NONEFFECTIVES The number of Army patients in hospital and quarters averaged 448,000 during July, bringing the noneffective rate down to 54 per thousand strength. The greatest declines occurred in the European theaters as a result of the accelerated evacuation policy. In the Z/I, on the other hand, the patient count reached a new high of 300,000, two-thirds of whom were evacuees. All the leading overseas theaters except the Asiatic reported lower noneffective rates for July. (See pages 4 and 5)

ADMISSION RATES Army patients admitted to hospital totalled 337,000 during July, less than during June and substantially below the February peak. The August rate for the U. S. is quite satisfactory. Disease admissions to hospital and quarters overseas are generally more favorable than in the past few years, the Asiatic theaters showing the greatest decline and the Pacific the least. (See pages 6 and 7)

RESEARCH ON ARTIFICIAL LIMBS The War Department has recently assumed a larger measure of responsibility for the development of improved prosthetic appliances for the 15,000 Army amputees estimated to require such aid. (See page 8)

HEALTH BRIEFS Except in the Western Pacific, admission rates for diarrhea and dysentery are the most favorable of the war, the improvement in the Asiatic theaters being most notable. U. S. occupation troops in Japan will face more serious disease hazards than those in Germany, the level of admission rates depending largely upon the extent of their contact with civilians. From China are reported the first few cases of cholera in the U. S. Army in the present war, but no considerable number is expected. In both the European and the Mediterranean Theaters current neuropsychiatric admission rates are the lowest ever reported by any major theater during the war, merely 10 to 12 admissions per 1,000 men per year. Veneral disease admissions continued to rise during July and early August in the European Theater, as in the Mediterranean, but were unchanged in the Western Pacific in June. (See pages 9 to 11)

HOSPITALIZATION OVERSEAS The fixed hospital population overseas declined from 138,000 to 110,000 during July with all major theaters participating. By 10 September 78,000 fixed beds had been returned to the Z/I from overseas, 5,000 beds had been inactivated, and another 86,000 had been ordered or recommended for early inactivation. (See pages 12 to 14)

TREND OF EVACUATION Consonant with rapidly falling strengths in overseas theaters as well as the reduction in the number of wounded hospitalized overseas, the number of evacuees debarked in the Z/I continued to decline during August, reaching 26,000, the lowest for any month since November. (See page 15)

Z/I HOSPITALIZATION Patient loads in general and convalescent hospitals declined sharply as a result of the reduction in the volume of evacuation. Substantial reduction in hospital capacity will be effected during the next nine months. By 30 June 1946, there will be only 14 general hospitals in operation with a capacity of 45,000 beds while the five remaining convalescent hospitals will have a capacity of 7,000. (See pages 16 to 18)

NUTRITION SURVEY A recent mess survey by The Surgeon General reveals that the diet of Z/I troops on the Army ration is nutritionally adequate but that action needs to be taken to reduce waste and to increase the acceptability of food. (See page 19)

DEMOBILIZATION OF MEDICAL DEPARTMENT PERSONNEL Reduction in the hospital population will cause a sharp drop in the need for medical personnel. Newly approved criteria for the separation of medical personnel are given. (See page 20)

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**DISEASE AND INJURY**

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HEALTH OUTLOOK FOR PERIOD II

With the cessation of hostilities in the Pacific, the size but not the complexity of the medical burden of the Army will decline almost in proportion to troop strength. A few major health problems will cease to exist altogether, notably the surgical support of combat operations, but most medical problems will be concerned with disease and accidental injury and will continue either unabated or in attenuated form. In the sphere of preventive medicine the work of the Medical Department is related to troop strength and to the nature of the areas where troops are stationed, so that its volume but not its intricacy will accordingly shrink with the size of the Army. Even in the field of hospital care, where it might be expected that there would be some lag in the reduction of the medical load, it is now anticipated that any lag will be of short duration and that the number of patients requiring hospitalization will soon decline at least as fast as the strength of the Army.

The great importance of preventive medicine will continue as the Army moves toward a peace-time status. There is now a body of 4,500,000 men overseas, large numbers of them in areas where health precautions must be more intensive than in the U. S. Even here, however, the possibility of an influenza epidemic is always present, and this fact coupled with the few signs observed this year underscores the importance of planning for a high standard of housing this winter. Also, an army of occupation is moving into the Islands of Japan, where it must be protected against many of the old familiar dangers and some new ones as well, e.g. Japanese B encephalitis, already identified in a limited number of cases on Okinawa. But as the overseas population narrows down to the two armies of occupation and garrisons at more permanent bases, troops should benefit to an increasing extent from garrison-type living conditions, with sanitary safeguards developed to the maximum degree possible. No longer will the pressure of combat serve as an excuse for poor sanitary control and discipline. Morbidity should be reduced accordingly, and admission rates formerly tolerated because of combat conditions will no longer be acceptable. In protecting troops, both at home and abroad, all the useful weapons employed during the war must continue to be applied as needed. Many new and greatly improved techniques have been devised, and none of these will be laid aside. Research will continue to be necessary so that the Army may continue to provide maximum protection to its troops, not only against dangers already encountered but also in anticipation of others. Moreover, the rapid return to the Z/I and demobilization of millions of soldiers place new emphasis upon the responsibility of the Army to prevent the importation and spread of diseases not generally found here. The routine Army system of medical care, buttressed by special screening procedures already in effect, can be relied upon to insure satisfactory discharge of this responsibility.

The volume of medical work thus will be maintained to a greater degree than the volume of surgical work, despite the longer stay of surgical patients, because disease will always cause a relatively large number of admissions to sick report, especially at overseas stations. In the Philippines and in the army of occupation in Japan high standards of medical care will be especially important. Entirely new disease problems may be met. Cessation of hostilities will not mean the abandonment of investigative work on the treatment of diseases of importance in these areas. Continued research is required to insure the best results of treatment for relatively large numbers of personnel having such chronic diseases as malaria and schistosomiasis. Should a respiratory epidemic develop this winter, as some fear, a very heavy medical load would result. Nevertheless, the continued maintenance of the highest professional standards does not mean that the total medical load will not respond rather directly to changes in Army strength.

In the field of surgery, emphasis on life-saving techniques gives way to concern with reparative surgery and rehabilitation. A population of 117,000 wounded remained to be cared for at the end of July, most of whom will remain in Army hospitals for many months. The matters of prime concern are now repair, treatment, restoration of function, provision of prosthetic appliances, and the like. Attention must also be paid to the evaluation of methods of treatment. As discussed elsewhere (see page 8), greater importance is being placed on a research program to improve prosthetic appliances, especially artificial limbs.

Termination of hostilities brings to all a reprieve which should eliminate a considerable part of the psychiatric problem. Largely precipitated or facilitated by the pressures of combat and by the uncertainties of continued or prospective foreign service, neuropsychiatric admission rates have already declined sharply in Europe and should decline elsewhere in similar fashion. Apart from induction screening and supervision of the adjustment of newly inducted personnel, the chief neuropsychiatric problem of Period II will concern those in foreign service. It may again become serious if adequate and just rotation and replacement policies are not announced and carefully implemented. It is highly desirable either that the point system be continued in modified form to accommodate the different charac-

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## DISEASE AND INJURY

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## HEALTH OUTLOOK FOR PERIOD II (Continued)

teristics of the occupation period, or that a definite limit, e.g. 12 months, be placed upon army-of-occupation service for those entering the Army from now on, in addition to the continued use of the point system for those with war-time service.

At the end of August about 400,000 patients remained in Army hospitals in the Z/I and overseas. Although there was only a slight change in Army strength during July and August, the estimated 400,000 patients represented approximately a 15 percent reduction below the census at the end of June, when the Z/I hospital population reached its maximum at about 320,000 patients and there were 164,000 patients overseas. Recently completed forecasts, based, however, on preliminary strength projections, suggest that the total Army hospital load should continue to decline steadily, reaching about 290,000 patients at the end of 1945 and 110,000 to 115,000 at the end of June 1946 when the assumed Army strength would be in the neighborhood of 2,500,000. A census of this size is only roughly 30 percent of that for the end of August, as is also true of the strength forecast. Projections for the Z/I portion of the total load depend upon the length of hospitalization required by patients evacuated from overseas. It is now estimated that the census of Army patients will decrease to about 220,000 at the end of 1945, and to about 75,000 at the end of June 1946. Similarly, the overseas population is expected to fall to about 70,000 or less by 31 December 1945 and to about 35,000 to 40,000 by the end of June.

During the past half-year almost a fourth of the Z/I hospital population has been comprised of overseas patients on sick leave or furlough from general and convalescent hospitals pending further treatment. Because they will have to return to hospital for care which has merely been postponed, the number of occupied beds will not decline as rapidly as the census of patients remaining. Until the first of the year the Z/I troop strength should be fairly well sustained with the result that changes in the population of patients of Z/I origin will not be extensive. However, the decline in overseas patients in Z/I hospitals will be great and is expected to permit perhaps 20 named general hospitals with 40,000 beds to be cleared out by the end of the year. Another 15 hospitals should be emptied by 31 March and still others by 30 June 1946, when about 14 general hospitals with a capacity of 45,000 beds will be required.

The manpower needs of the Army dictate the continued induction of tens of thousands monthly, whether under present or modified legislation. The Medical Department must continue to determine whether eligibles are fit according to realistic Army standards. Similarly, the rapid flow of men from the Army will for many months maintain the rate of discharge or retirement for disability and will thus have important implications for the volume of medical work. The separation centers currently process about 160,000 men monthly, and a capacity of 800,000 is planned for 1 December 1945. Each man must receive a terminal physical examination to determine his freedom from disease and also to record with care his defects prior to separation. Enough medical personnel must be placed on the job so as not to delay the rapid demobilization which all have accepted as a first obligation.

# DISEASE AND INJURY

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## NONEFFECTIVES IN HOSPITAL AND QUARTERS, U. S. AND OVERSEAS

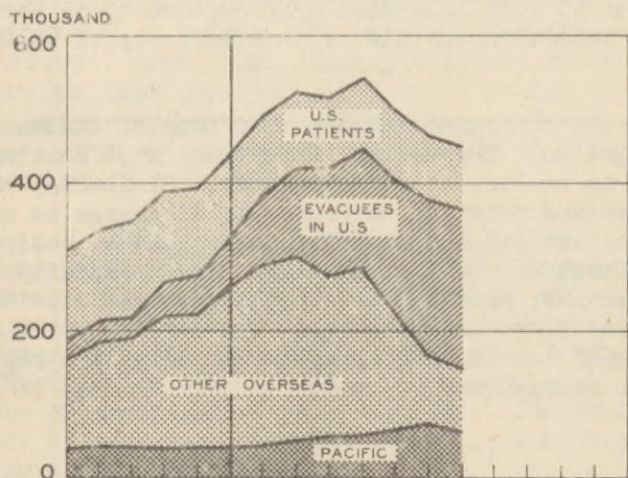
In July the average number of patients in hospital and quarters throughout the Army declined again, falling to a level of 448,000, the lowest this year. The greatest changes occurred in the European and Mediterranean Theaters in consequence of the War Department policy to evacuate all transportable wounded within 90 days after V-E Day and to evacuate non-battle patients according to a 60-day evacuation policy. (Effective 1 August, however, a 120-day evacuation policy was resumed in these theaters.) On 27 July only 311 wounded patients remained in the European Theater and 58 in the Mediterranean. Beginning in September a similar reduction on a much smaller scale should result from the change to a 60-day policy in the Pacific. During July the average Z/I patient count, including evacuees, reached a new high of 300,000. More than two-thirds of the total consisted of evacuees in the general and convalescent hospitals, fewer than 90,000 patients being of Z/I origin.

The noneffective rate for the entire Army dropped to 54 per thousand strength during July, three percent below that for June, and 18 percent lower than the peak rate of 66 attained in April 1945. This decline results largely, but not entirely, from the decline in the number of wounded under treatment. On 28 January there were 140,000 battle casualties in Army hospitals, 66 percent of them overseas, but six months later the total had declined to 117,000, only four percent of whom were overseas. For the Z/I the uncorrected July rate is 95 and the August rate 86 per thousand strength. Since the absolute number of patients was virtually unchanged, the decline may be attributed primarily to the increase in troop strength. The corrected Z/I rate, reflecting only patients of Z/I origin, fell slightly in July to 27.5 but increased again in August to 28.5. The overseas rate dropped to 29 per thousand strength, the lowest since October 1942.

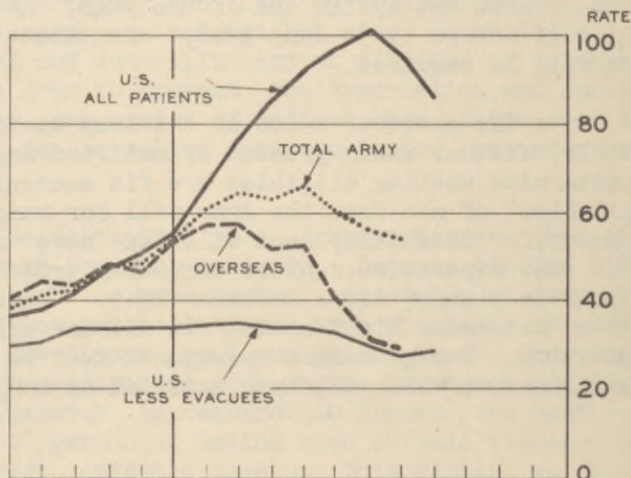
### AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

ALL CAUSES

AVERAGE NUMBER OF PATIENTS EACH MONTH

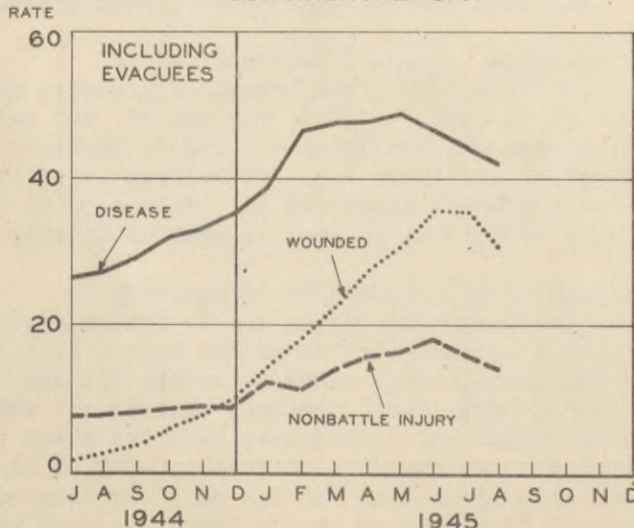


CONTINENTAL U.S. AND OVERSEAS

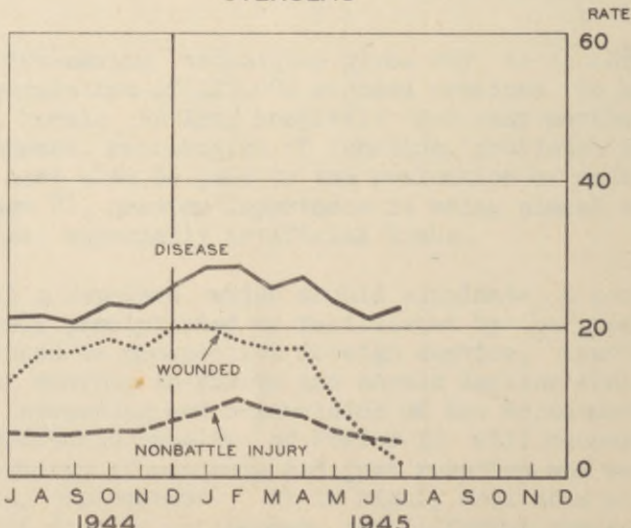


MAJOR CAUSES

CONTINENTAL U.S.



OVERSEAS



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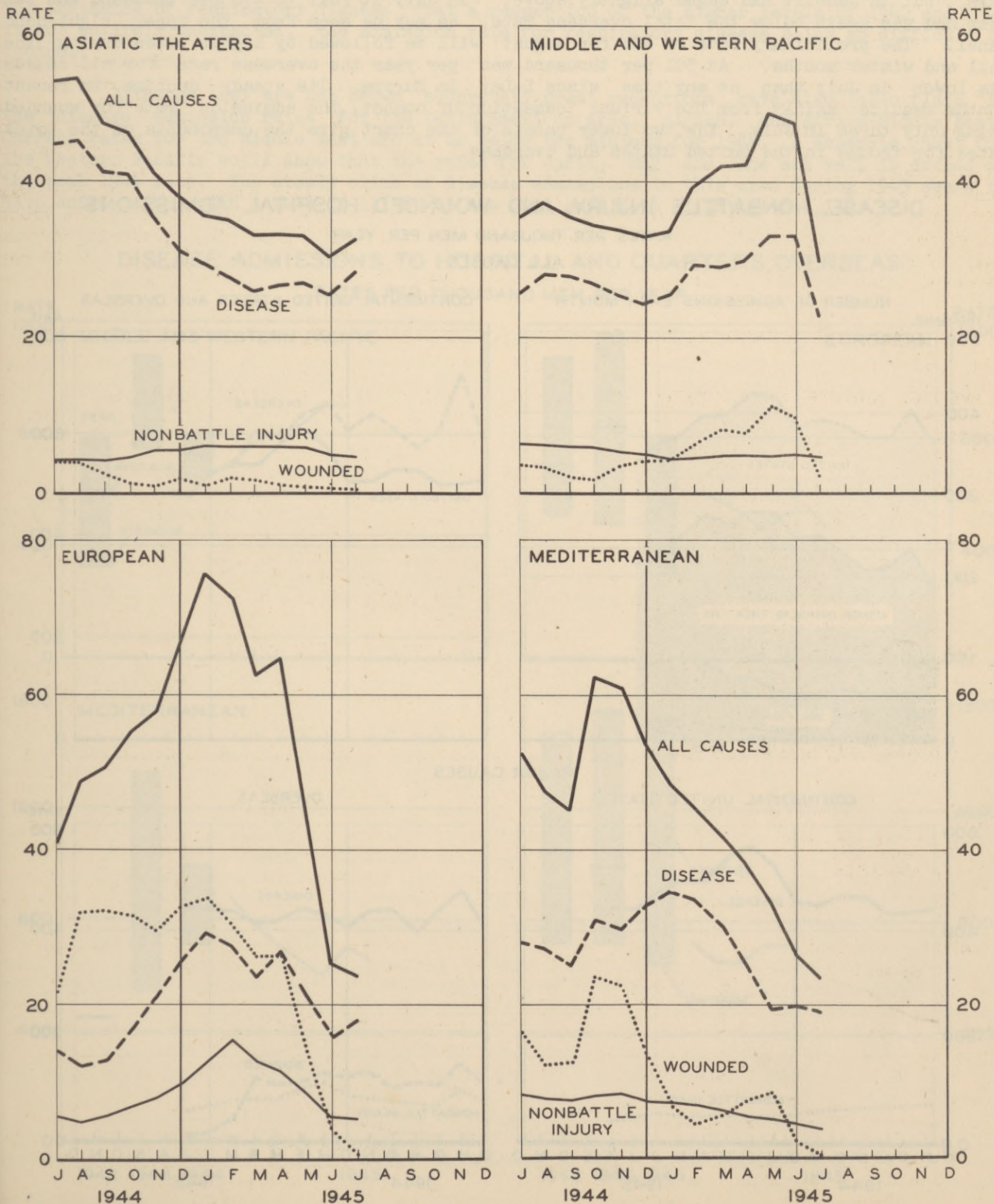
# DISEASE AND INJURY

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NONEFFECTIVES IN HOSPITAL AND QUARTERS, U. S. AND OVERSEAS (Continued)

A comparison of trends for the areas of greatest troop concentration is made below. The total rates declined during July in all major theaters except the Asiatic, where the increase mirrored an elevation in the rate for disease. The continued rise in the Middle Pacific disease rate was not large enough to offset the sharp drop in the wounded under treatment in that area. The Western Pacific noneffective rate for disease declined from 49 in June to 44 in July in response to more favorable admission rates.

**AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH PATIENTS IN HOSPITAL AND QUARTERS**



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# DISEASE AND INJURY

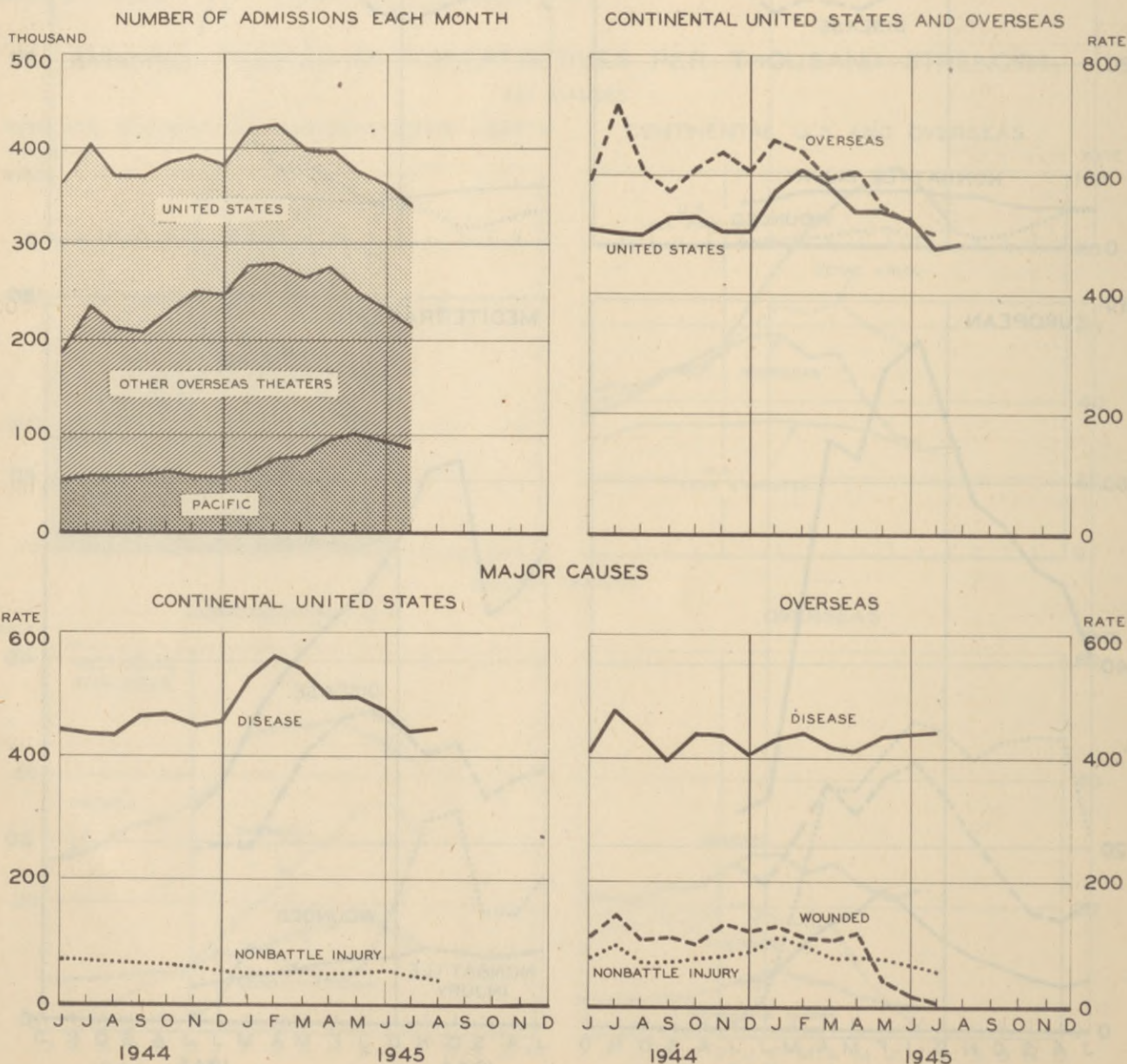
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## TREND OF HOSPITAL ADMISSIONS IN THE U. S. AND OVERSEAS

During July 337,000 Army patients were admitted to hospital directly or transferred to hospitals from non-hospital medical installations. This total is 19,000 smaller than that for June and 87,000 below the peak figure for February. For troops in the United States hospital admissions in July numbered 125,000 and were only two and a half percent less than in June. Overseas there was a seven percent decrease in admissions among Army personnel. Admissions in the Pacific theater declined for the second successive month and represented about 42 percent of all admissions overseas, as indicated in the first panel below.

The U. S. admission rate for all causes has generally been lower than the overseas rate, but in June it had edged slightly above. In July it fell to 478 per thousand men per year and was again below the total overseas rate, as may be seen from the upper right-hand panel. The preliminary rate of 481 for August will be followed by higher rates during the fall and winter months. At 501 per thousand men per year the overseas rate for all causes was lower in July than at any time since D-Day in Europe. Its steady decline in recent months results mainly from the virtual cessation of combat, the admission rate for wounded being only three in July. The two lower panels of the chart give the components of the total rates for troops in the United States and overseas.

### DISEASE, NONBATTLE INJURY, AND WOUNDED HOSPITAL ADMISSIONS RATES PER THOUSAND MEN PER YEAR ALL CAUSES



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# DISEASE AND INJURY

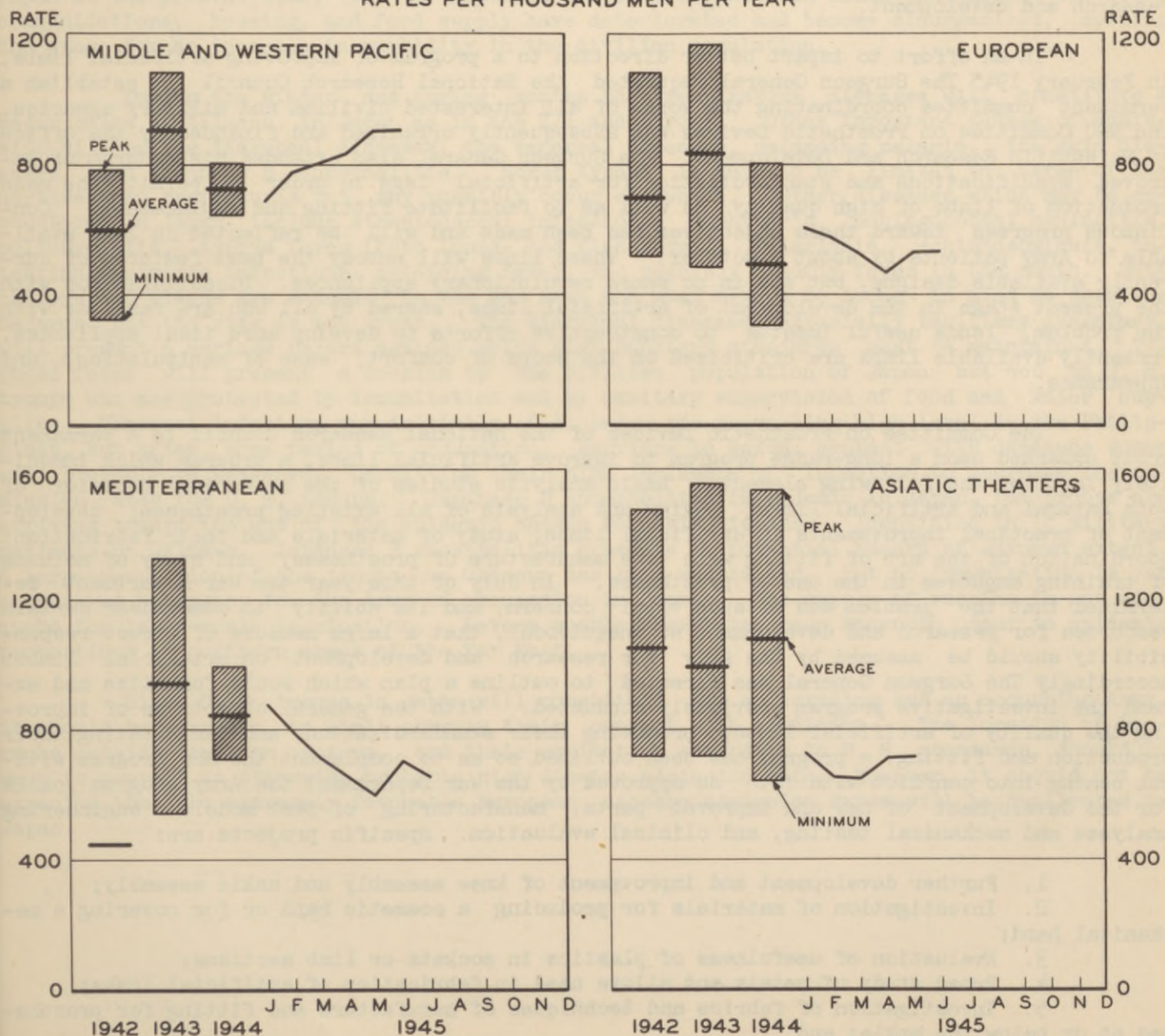
## DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS IN OVERSEAS THEATERS

In comparing the incidence of morbidity in the major overseas theaters it is more convenient to employ admissions to both hospital and quarters rather than, as on the preceding page, to hospital only. The course of the disease admission rates in the four leading theaters is presented in the charts below from 1942 to date. The bars for 1942, 1943, and 1944 show the range of the monthly rates in each year, the bottom being the minimum and the top the maximum rate for the year. The horizontal line across each bar gives the average for the year. In comparison with the earlier rates those currently reported, shown separately by month for 1945, are quite favorable. Perhaps the greatest decline in incidence has occurred in the Asiatic theaters and the least in the Pacific. The 1945 rates for the European Theater are quite favorable, but morbidity statistics in this theater are so dependent upon the incidence of respiratory disease that a resumption of the higher levels of 1942 and 1943 is not entirely unexpected, the admission rate for respiratory disease being so difficult to control.

Although they are not shown separately great reductions have also taken place in the disease admission rates for the Latin American area, Alaska, and Africa-Middle East. Current rates for the Middle East are at or below the minimum for 1944. A separate chart for the Western Pacific would show that the rates for April, May, and June are well in excess of the peak 1944 rate. The steady climb of disease admissions in this area during 1945 seems to have ended in May with a rate of 1,140, as the June rate fell slightly to 1,130.

## DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS

RATES PER THOUSAND MEN PER YEAR



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## DISEASE AND INJURY

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### RESEARCH ON ARTIFICIAL LIMBS

Loss of limb is a matter of such grave concern to the individual so affected that few other medical or surgical disabilities have attracted as much public attention and insistence that "something be done". Numerically the problem is also considerable, for it is estimated that roughly 15,000 men, or 2.5 percent of the wounded, have sustained major amputations, that is, amputations requiring prosthetic appliances.

Early recognition of the importance of the problem to the Army came in March 1943. At that time the Army designated amputation centers in the Z/I where surgical revision, the furnishing of provisional appliances, and training of amputees in the use of prostheses could all be handled most efficiently by highly specialized personnel. Historically there was division of responsibility between the Army and the Veterans Administration to the extent that the latter provided the permanent prosthesis required in each case after discharge from the Army and when the amputation stump had finally become static. However, its responsibility for the selection of provisional devices and for training amputees in the use of limbs has inevitably involved the Army in an extensive program of standardization and improvement of limbs. Prior to the war there had never been a coordinated research program for artificial limbs. Specifications were meager, standardization nonexistent, and production facilities widely scattered among small manufacturers. In initiating its prosthetic program in 1943 the Army adopted the only standard, commercial limb readily available in sufficient quantities and capable of meeting the fitting requirements. Liaison was maintained with manufacturers and with the Panel on Amputations of the National Research Council in an effort to encourage further improvements in artificial limbs. Its clinical material, experienced orthopedic surgeons, and hospital orthopedic shops placed the Army in an unprecedented position to aid research and development.

In an effort to impart better direction to a program of improving artificial limbs, in February 1945 The Surgeon General requested the National Research Council to establish a permanent committee coordinating the work of all interested civilian and military agencies. The NRC Committee on Prosthetic Devices was subsequently organized and financed by the Office of Scientific Research and Development. The Surgeon General also extended his program of improved specifications and standardization for artificial legs in order to permit the mass production of limbs of high quality as well as to facilitate fitting and replacement. Continuous progress toward these objectives has been made and will be reflected in legs available to Army patients by about 1 October. These limbs will embody the best features of currently available designs, but are in no sense revolutionary appliances. Dissatisfaction with the present stage in the development of artificial limbs, shared by all who are familiar with the problem, lends useful impetus to constructive efforts to develop more ideal appliances. Presently available limbs are criticized on the score of comfort, ease of manipulation, and appearance.

The Committee on Prosthetic Devices of the National Research Council is a permanent group embarked upon a long-range program to improve artificial limbs, a program which immediately involves the following elements: basic analytic studies of the mechanical behavior of both natural and artificial limbs; review and analysis of all existing prostheses; development of practical improvements in artificial limbs; study of materials and their fabrication; coordination of the art of fitting with the manufacture of prostheses; and study of methods of training amputees in the use of prostheses. In July of this year the War Department determined that the problem was of such vital concern, and its ability to commandeer certain resources for research and development so unequivocal, that a large measure of direct responsibility should be assumed by the Army for research and development on artificial limbs. Accordingly The Surgeon General was directed to outline a plan which would formalize and extend the investigative program previously conducted. With the general objectives of improving the quality of artificial limbs, promoting their standardization, and facilitating their production and fitting, a program has been outlined so as to complement the NRC program without coming into conflict with it. As approved by the War Department the Army program calls for the development of new and improved parts, manufacturing of test models, engineering analyses and mechanical testing, and clinical evaluation. Specific projects are:

1. Further development and improvement of knee assembly and ankle assembly;
2. Investigation of materials for producing a cosmetic hand or for covering a mechanical hand;
3. Evaluation of usefulness of plastics in sockets or limb sections;
4. Broad study of metals and alloys used in fabrication of artificial limbs;
5. Investigation of fabrics and techniques of manufacture and fitting for prostheses at or below the ankle; and
6. Production of a motion picture record of the Army amputation and prosthetic program.

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## DISEASE AND INJURY

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### HEALTH BRIEFS

#### Diarrhea and Dysentery

Except in the Western Pacific, where the most recent rate (that of 138 for June) is the highest in the history of the theater, current admissions for diarrheal disease are the most favorable of the war. Most notable is the improvement registered by the Asiatic theaters, where the rates of 116 and 118 for April and May of this year contrast sharply with those of 186 and 214 reported for April and May of 1944. The initial post-war rates for the Mediterranean Theater differ dramatically from those for corresponding months of earlier years, the rates for June and July of this year being but a third to a fourth of those for 1944, for example. In the Middle East and the Persian Gulf Command the recent 1945 rates are about half those for the same months of 1944.

#### Health of U. S. Troops in Japan

As U. S. occupation troops pour into Japan the disease hazards facing them there become of primary concern. Although first-hand epidemiological reports are not yet available from the occupation forces themselves, studies previously made coupled with knowledge of the extensive damage to metropolitan areas give some indication of the hazards in prospect.

The initial incidence of some diseases will reflect in part exposure prior to entering Japan, e.g. malaria, hepatitis, and certain diarrheal diseases. Later, however, morbidity will depend in large measure on the extent to which troops are placed in contact with civilians. No disease had been specifically reported to have a high epidemic incidence in Japan at the present time, but the reported scope of devastation means that health services, communications, housing, and food supply have deteriorated and become disorganized, setting the stage for an increase in morbidity in the civilian population.

During the winter and spring months the respiratory diseases will constitute a major cause of illness in Japan as in the Z/I and Europe. Other important causes of admission will be the diarrheal diseases, the venereal diseases, relapsing malaria, the skin diseases, and Japanese B encephalitis. Scrub typhus is said to be limited to three of the northwestern prefectures but may possibly occur elsewhere. Other diseases which may be encountered in Japan include streptococcal infections, diphtheria, meningococcal meningitis, poliomyelitis, typhus fever (both louse- and flea-borne), filariasis, schistosomiasis, intestinal helminth infections, relapsing fever, and possibly sandfly fever in the south. Both cholera and plague are endemic in the Far East and must always be borne in mind as possible hazards, but the risk is not great. The diarrheal diseases, especially bacillary dysentery, will present a serious hazard against which high sanitary standards must be maintained. Typhoid fever will present a problem to the civilian population of Japan but not to U. S. troops who are protected by immunization and by sanitary supervision of food and water supplies. Venereal infection may initially fall below the prevailing high level in the Philippines, but after some period of occupation, barriers to sexual contact with Japanese women will probably be weakened, permitting their high incidence of infection to increase the admission rates for U. S. troops. Japanese B encephalitis is endemic in Japan, but troops are arriving toward the end of the epidemic season for this disease. Identified in 18 military patients on Okinawa, Japanese B encephalitis presents a potential hazard of unknown extent. A large proportion of the troops on Okinawa has been vaccinated, but no immunization is yet considered necessary for the Army of occupation in Japan. The supply of vaccine is not adequate for large-scale vaccination. Severe scarlet fever has been known to occur in epidemic proportions in northern areas of the Far East.

Since U. S. troops in Japan will constitute not an invading but an occupying Army, it should be possible to limit sharply their contact with civilians. The location of barracks outside civilian centers, and their sanitation according to U. S. standards, should do much to prevent an otherwise probable high disease admission rate. However, it should not be expected that the extremely favorable European disease admission rates will be duplicated in Japan.

# DISEASE AND INJURY

## HEALTH BRIEFS (Continued)

### Cholera in China

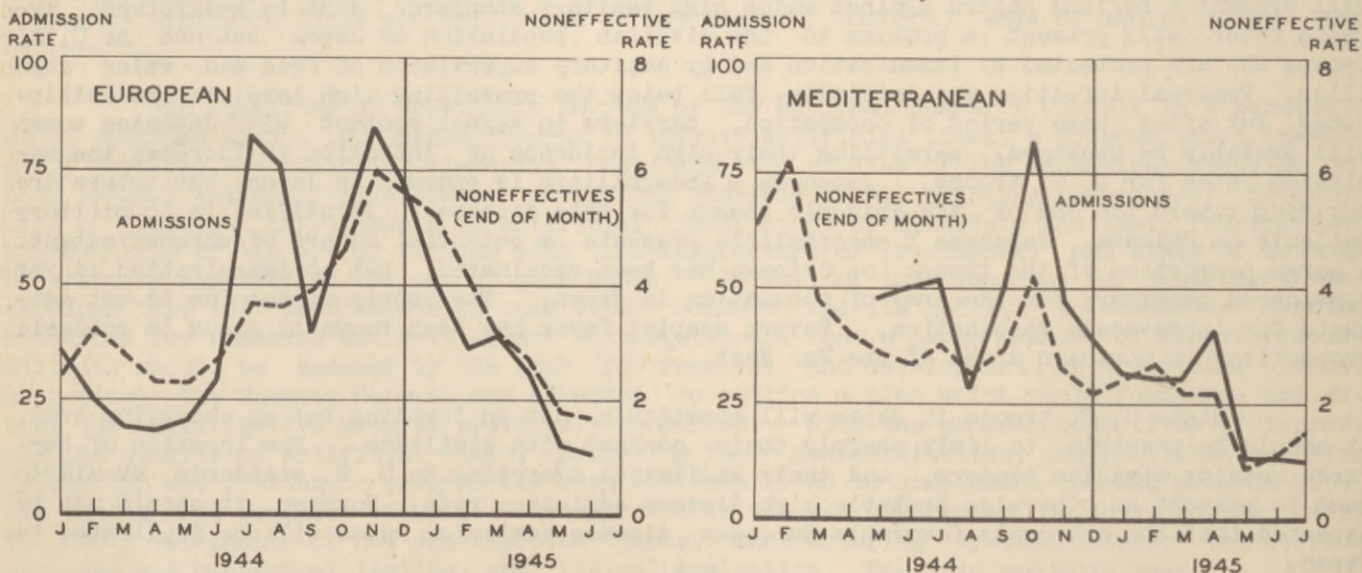
Although for several years U. S. troops in the Asiatic theaters have been exposed to cholera, an acute enteric disease of high epidemic potential, no case was ever reliably reported among U. S. Army personnel until the end of July 1945 near Chungking, China where a civilian epidemic has existed since June. According to incomplete radio reports seven or more cases and two deaths had occurred among U. S. troops by the middle of August. The reports were based upon clinical diagnoses, however, and had not yet been confirmed by bacteriological findings.

Cholera yields readily to effective sanitary control of food and drink, immunization being employed by the Army as a secondary measure. Cholera immunization is mandatory for personnel moving into the Asiatic theaters, and in China stimulating doses are required by the theater every four months. However, at least one of the two reported deaths had no record of cholera immunization, and some of those who became ill had been re-immunized with Chinese cholera vaccine rather than with the Army vaccine. In view of the protection afforded by immunization, but more particularly in view of the ease with which the disease may be controlled by proper sanitary practices, cholera should never present any substantial direct threat to U. S. Army forces, although the number of civilian cases in China is in the thousands each year. The extremely poor sanitation found everywhere in China makes the occurrence of sporadic cases of this disease in Army personnel a constant hazard which must be vigilantly guarded against. Such cases as have already occurred in the Army, or which may occur in the future, are likely to result from consumption of unauthorized food, water, or beverages.

### Neuropsychiatric Admission Rates

With the end of the war against Germany neuropsychiatric admission rates in both European theaters fell to the lowest levels reported by any major theater during the war period. Rates of 12 to 14 per 1,000 men per year were reported both for the Mediterranean from May through July and the European Theater from May through June, as may be seen in the chart below. In the Z/I the admission rate also fell during June and July, the July rate of 39 being the lowest reported since August 1944. Further decline in the Z/I rate is expected.

## NEUROPSYCHIATRIC ADMISSIONS PER THOUSAND MEN PER YEAR AND NONEFFECTIVES PER THOUSAND STRENGTH, OVERSEAS THEATERS





# DISEASE AND INJURY

## HEALTH BRIEFS (Continued)

### Venereal Disease

The sharp rise in the venereal disease rate in the European Theater immediately following V-E Day, shown in HEALTH for 31 July, has continued unabated. During the week ending 10 August the rate for troops on the Continent climbed to 180 per thousand strength per year, a sharp contrast with the rates of 50 or less before V-E Day. In the United Kingdom the rate reached 94, well above the level of 50 to 60 during the weeks preceding the collapse of German resistance. Venereal infection increased in Europe after the last war also, but comparable statistics are not available.

In the Mediterranean Theater the rate rose steadily after V-E Day, but not so sharply as in the European Theater. The April rate of 85 was followed by rates of 94 in May, 110 in June, and 128 in July. There was no further increase in the admission rate for troops in the Western Pacific during June, the rate being 97 for both May and June. Its future trend can hardly be predicted and will depend in large measure upon the extent of fraternization in Japan.

### Medical Work of Separation Centers

Until June 1945 the separation centers handled fewer than 50,000 separations monthly but in June the number increased to 128,000 and in August there were about 163,000. Current plans call for an expansion of capacity to 800,000 per month by 1 December 1945. Posts, camps, and stations other than separation centers may furnish additional capacity. The medical operation at the separation center constitutes a careful fact-finding examination of each man and requires about one doctor per 18 men separated per day, or roughly 1,700 doctors for the projected 800,000 separations per month. Administration of the terminal physical examination serves not only to screen out men who are ill or who need some medical or dental care prior to separation, but also provides data on all physical defects and conditions which might be the subject of future claims. Moreover, relatively difficult and time-consuming laboratory tests must be done for individuals exposed to, or showing possible signs of, certain tropical diseases, notably malaria, dysentery, and helminthiasis. This is essential both for the welfare of the individual and for the protection of the public.

A small proportion of men, between seven and ten percent, requires special study of one kind or another, but only one to two percent need to be admitted to hospital for this purpose. Dental patients represent by far the largest group requiring further study or treatment. The number of dental patients increased from about one percent of those separated in January to about three percent in May, June, and July. The need for dental work is much larger, perhaps 10 percent or more, but by no means all of the men have elected to have their dental work done prior to separation. There is reason to believe that the proportion of men requesting dental treatment may be further increased in the future. There is also evidence that the dental policy set for separation centers is being interpreted and presented to the men differently at the various centers, for the reported dental load varies widely among the centers. In July, for example, among the 19 centers reporting, four stated that less than one percent of all personnel processed were given dental treatment, while three centers reported more than five percent. The number of men held over for psychiatric or neurological study has been negligible, less than one-tenth of one percent in recent months. Malaria has also been a minor cause of review, less than half of one percent requiring further study or treatment. The number of men suspected of having pulmonary tuberculosis has also been very small, generally about one-tenth of one percent of those separated; in most of these cases the diagnosis was confirmed. From one-tenth to two-tenths of one percent have required further study because of suspected venereal disease.

Inspections by The Surgeon General have indicated that the staff needed to cope with the increasing volume of separations has not been provided by all service commands. In view of the pressure to separate men with minimal delay, shortages in medical staffs can only result in a deterioration of examination standards with all its untoward consequences.

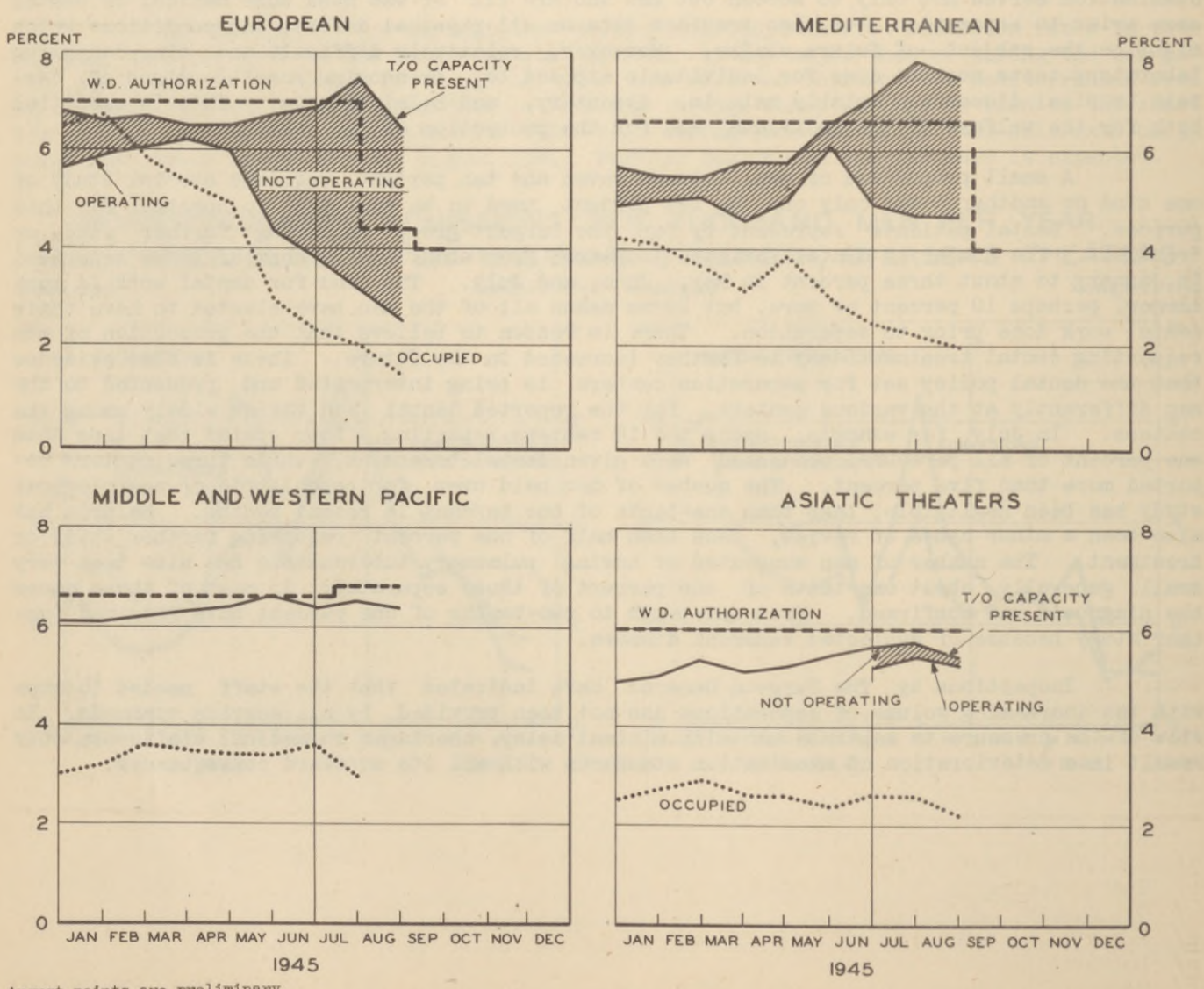
# HOSPITALIZATION

## OVERSEAS HOSPITALIZATION

The most important current problem concerning overseas hospitalization is, of course, the speedy return of all units in excess of realistic requirements. Although authorized levels for the European and Mediterranean Theaters were lowered to 4.0 percent early in September, others remain to be reduced. Recommended levels are three percent for the American theaters and five percent for Africa-Middle East, the Persian Gulf Command, both Asiatic theaters, and the Pacific. In terms of its 4.4 percent authorization in effect on 1 August, the European Theater had a relative excess of 72,000 beds, or about 70 percent of the authorized number. However, more than this number were out of operation because preparations were being made for their return to the Z/I. For all theaters combined, the fixed bed capacity present on 31 July was 28 percent above the authorized levels then in effect. The accompanying tables provide further details for this date, and the chart below shows current points against a background of the preceding months of 1945.

The fixed hospital population overseas declined from 138,000 to 110,000 during July, all major theaters participating in the decline. Even the Pacific reported a reduction of 8,000 patients during that month, the 31 July count being 44,000. Only in the Latin American and China theaters did the fixed hospital patients number more than 57 percent of T/O capacity present on 31 July. However, the factor of theater dispersion in the Pacific (see HEALTH, 31 July) operated to force the utilization of operating facilities more intensively than the table would indicate, for the Middle Pacific did not distinguish between beds operating and non-operating in its reports. In the Western Pacific operating fixed bed capacity was 76 percent filled on 31 July, an improvement over the 91 percent reported for 30 June.

**FIXED HOSPITALIZATION IN OVERSEAS THEATERS**  
BEDS AS PERCENT OF STRENGTH



August points are preliminary.

## HOSPITALIZATION

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## OVERSEAS HOSPITALIZATION (Continued)

The scheduled movement of fixed hospitals shown in HEALTH for 31 July is no longer operative, as may be seen from the fact that units of longer overseas service previously designated as Category I and intended for hospitalizing patients in the European Theater after V-E Day while units of shorter service were being redeployed, are now being returned to the United States ahead of Category II units. A revised schedule of movement, reflecting the changed military situation, is not yet available. It is not possible, therefore, to indicate the speed with which units may be expected to be returned to the Z/I for inactivation or other assignment. However, the chart on page 14 gives a summary of the disposition of field, station, and general hospitals by the European and Mediterranean Theaters. The inactive theaters had returned 78,000 fixed beds to the Z/I by 10 September and had inactivated an additional 1,000 beds overseas. This represents a decline of 32 percent in the total T/O capacity present in the European and Mediterranean Theaters on 31 May. In the Z/I fixed units with a total T/O capacity of 3,500 beds had been inactivated by 10 September. In addition to these completed actions there had been recommended for early inactivation in the Z/I fixed units with an aggregate capacity of 58,500 beds, and the War Department had directed the early inactivation of still other fixed units now overseas or en route to the Z/I with a total T/O capacity of 27,400 beds. It is expected that all units leaving overseas theaters after 10 September will arrive as Category IV units to be demobilized on arrival at ports of debarkation. No additional units are to be provided to the Pacific theater as the personnel in units already present there will be replaced on an individual basis as required. Exceptions to the general program of inactivation of hospital units are to be made in the case of certain units earmarked for the Strategic Striking Force, which will be Regular Army units as far as possible.

FIXED BEDS AVAILABLE AND OCCUPIED  
Number of Beds, 31 July 1945

Theater	W. D. Author-ization	T/O Present		Operating		Occupied <u>d/</u>
		Number <u>c/</u>	Percent of Author-ization	Number <u>d/</u>	Percent of T/O Present	
ALL THEATERS	250,494	320,975	128.1	<u>e/</u>	<u>e/</u>	110,245
American <u>a/</u>	4,513	4,525	100.3	4,880	107.8	2,612
European	103,435	175,850	170.0	76,200	43.3	47,450
Mediterranean	21,450	25,600	119.3	15,300	59.8	7,486
Pacific	100,698	96,600	95.9	<u>e/</u>	<u>e/</u>	44,235
Asiatic Theaters	17,592	16,825	95.6	15,725	93.5	7,558
Africa-Middle East <u>b/</u>	2,806	1,575	56.1	1,835	116.5	904

## Beds as Percent of Strength and Percent Occupied

Theater	Strength (Thousands) <u>f/</u>	W. D. Author-ization	T/O Present <u>c/</u>	Beds Occupied as		
				Percent of Strength	Percent of T/O Present	Percent of T/O Operating
ALL THEATERS	4,654	5.4	6.9	2.4	34.3	<u>e/</u>
American <u>a/</u>	150	3.0	3.0	1.7	57.7	53.5
European	2,351	4.4	7.5	2.0	27.0	62.3
Mediterranean	325	6.6	7.9	2.3	29.2	48.9
Pacific	1,488	6.8	6.5	3.0	45.8	<u>e/</u>
Asiatic Theaters	293	6.0	5.7	2.6	44.9	48.1
Africa-Middle East <u>b/</u>	47	6.0	3.4	1.9	57.4	49.3

a/ Includes Alaskan Department and excludes Eastern and Central Canada.

b/ Includes Persian Gulf Command.

c/ T.L.O.S. dated 1 August 1945.

d/ Reported by theaters telegraphically for 27 July 1945.

e/ Not available.

f/ Geographic strength by theater. Strengths for Asiatic theaters and all theaters include 70,000 Chinese in India-Burma.

**HOSPITALIZATION**

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OVERSEAS HOSPITALIZATION (Continued)

The T/O capacity of nonfixed hospitals declined only slightly from 84,000 to 83,000 beds during July, the former total being a correction upon that previously published. The figure for the European Theater shown on page 27 of the 31 July issue should have been 55,975 (not 49,175) with corresponding corrections in derived values. The number of patients in nonfixed hospitals in all theaters dropped from 27,000 to 19,000 during July, the decline being almost entirely in the European Theater and the Middle Pacific.

NONFIXED BEDS AVAILABLE AND OCCUPIED  
Overseas Theaters, 31 July 1945

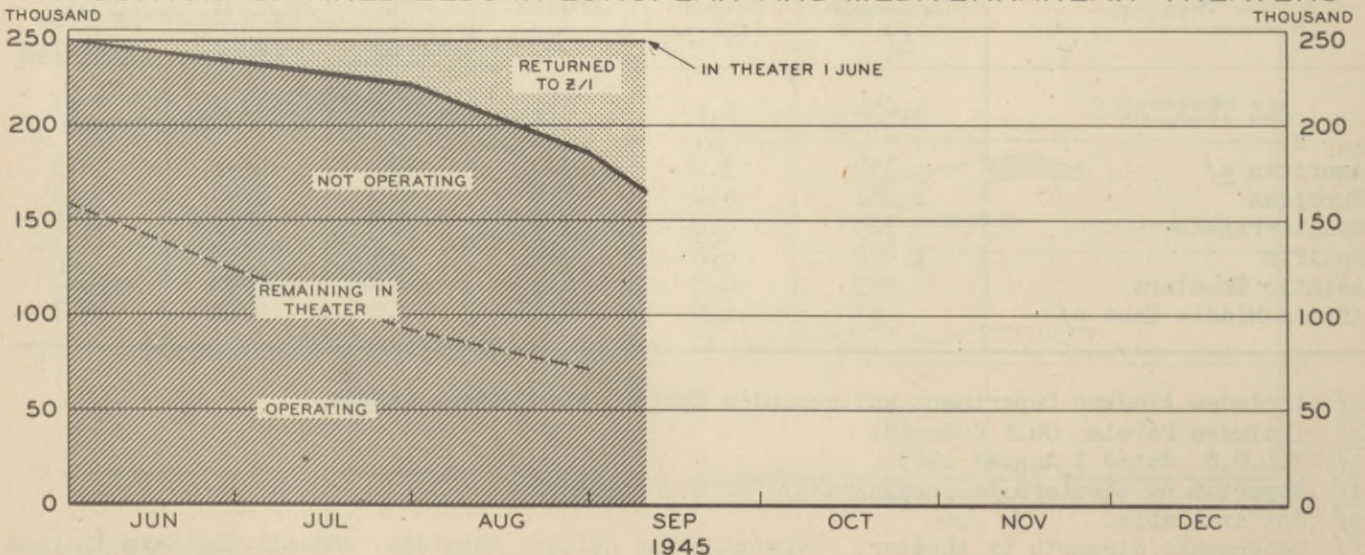
Theater	T/O Present		Operating		Total Occupied			Percent of Strength
	Number a/	Percent of Strength	Number b/	Percent of T/O Present	Number b/	Percent Present	Percent Operating	
ALL THEATERS	83,350	1.8	c/	c/	18,712	22.4	c/	0.4
European	55,975	2.4	25,800	1.1	7,806	13.9	30.3	0.3
Mediterranean	7,600	2.3	6,450	2.0	548	7.2	8.5	0.2
Pacific	14,800	1.0	c/	c/	8,341	56.4	c/	0.6
Asiatic Theaters	4,975	1.7	1,925	0.7	2,017	40.5	104.8	0.7

PATIENTS REMAINING IN NUMBERED FIXED AND NONFIXED HOSPITALS  
Overseas Theaters, 31 July 1945

Theater	Total Patients Remaining	Percent Remaining in		Percent Who Were		
		Fixed Units	Nonfixed Units	Army Patients	PW's	Others
ALL THEATERS	128,231	86.0	14.0	c/	c/	c/
American	2,612	100.0	-	93.1	-	6.9
European	55,256	85.9	14.1	86.5	9.2	4.3
Mediterranean	8,034	93.2	6.8	85.9	7.6	6.5
Pacific	52,576	84.1	15.9	c/	c/	c/
Asiatic Theaters	8,849	85.4	14.6	80.2	-	19.8
Africa-Middle East	904	100.0	-	85.4	-	14.6

- a/ T.L.O.S. dated 1 August 1945.
- b/ Reported by theaters telegraphically for 27 July 1945.
- c/ Not available.

DISPOSITION OF FIXED BEDS IN EUROPEAN AND MEDITERRANEAN THEATERS\*



\* Field, Station, and General Hospitals.

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TREND OF EVACUATION FROM OVERSEAS

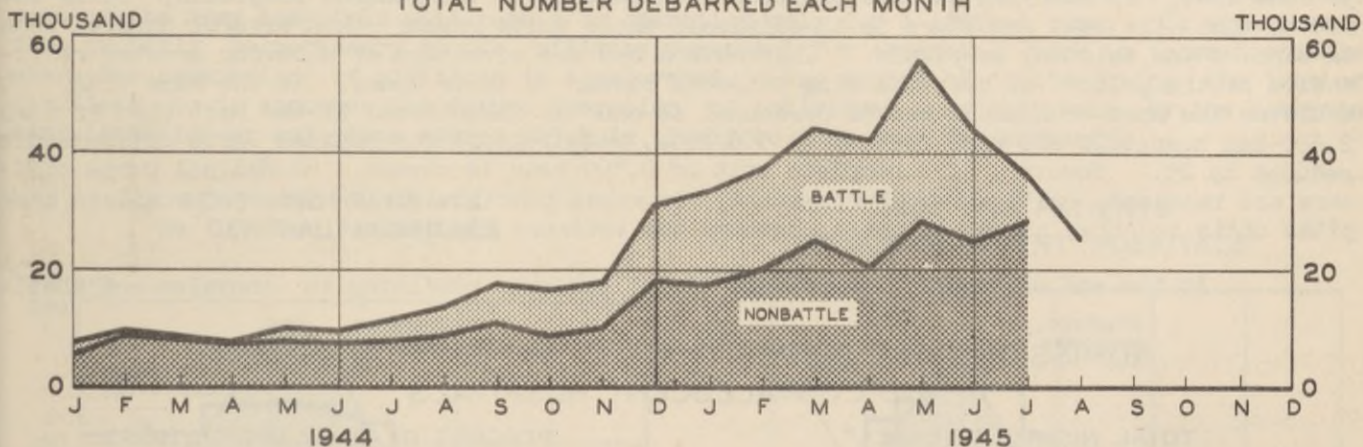
During August there was a further decline in the number of Army patients received in the Z/I from overseas. The provisional total of 26,000 is the lowest reported for any month since November 1944. Evacuation from the Pacific declined sharply, reaching its lowest level in the past six months, and the volume from the European Theater continued to fall rapidly, the August total of 16,000 being the lowest since November 1944. Most of the decline occurred in the water lift, the 25,000 figure for July shrinking to 17,000 for August. The volume of air evacuation fell from 12,000 to 9,000.

The charts below give the major trends of consequence, only the Pacific being shown separately. On 10 August the Pacific was requested to utilize all available lift for patients even if it necessitated reduction in the evacuation policy to 60 days, and on 20 August a 60-day policy was explicitly suggested by the War Department. On 5 September the War Department ordered the China and India-Burma Theaters to evacuate all patients by 1 March 1946. The census of patients in the Pacific is not so large that wholesale evacuation such as occurred from the European Theater will be necessary, but perhaps 10,000 to 12,000 per month will be evacuated from the Pacific during September, October, and November. The number of Army patients evacuated from all theaters is expected to be on the order of 20,000 each month during this period. In addition to these Army patients there will be perhaps 15,000 to 17,000 RAMP's from the Pacific in the next few months, all of whom are to be screened by the debarkation hospitals. Those found in need of hospitalization, estimated by some to number as high as 80 percent of the total, will be sent to appropriate named general hospitals.

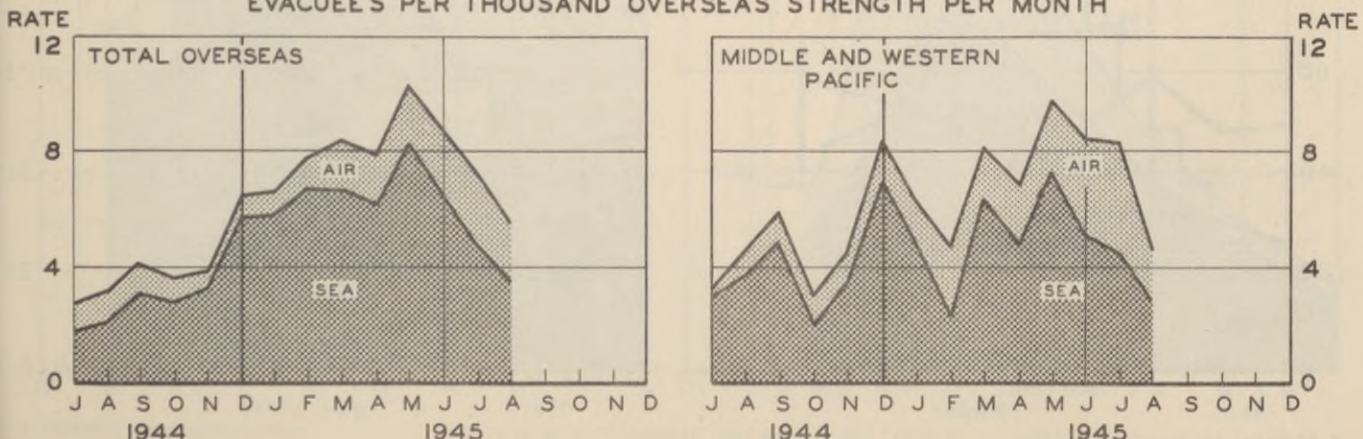
In keeping with reduced requirements for water evacuation and the availability of casual medical personnel returning to the Z/I, all medical hospital ship platoons (separate) are being inactivated. During the first week in September about two-thirds of the 332 platoons were directed to be inactivated in the Z/I, and others will be similarly inactivated as requirements are reduced. To date two of the 29 hospital ship complements have also been inactivated. Personnel from these units remains under the control of the Chief of Transportation for appropriate disposition.

EVACUATION OF ARMY PATIENTS FROM OVERSEAS

TOTAL NUMBER DEBARCKED EACH MONTH



EVACUEES PER THOUSAND OVERSEAS STRENGTH PER MONTH



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# HOSPITALIZATION

## HOSPITALIZATION IN THE ZONE OF INTERIOR

During August, 25,892 overseas patients were processed through debarkation hospitals, a decrease of approximately 11,000 from the number received in July. Current forecasts indicate that overseas evacuations during September will be about 23,000. Approximately 18,000 patients were debarked on the east coast in contrast to 8,000 on the west coast. The west coast debarkations are noticeably below Pacific evacuations for previous months, apparently as the result of rearrangement of shipping in the Pacific following cessation of hostilities with Japan. According to estimates prepared by the theaters, evacuations of patients from the Pacific will average around 12,000 a month for the next four months as remaining battle casualties, RAMPS, and civilian internees are returned to the Z/I. During this period, the theaters will be operating on a 60-day evacuation policy.

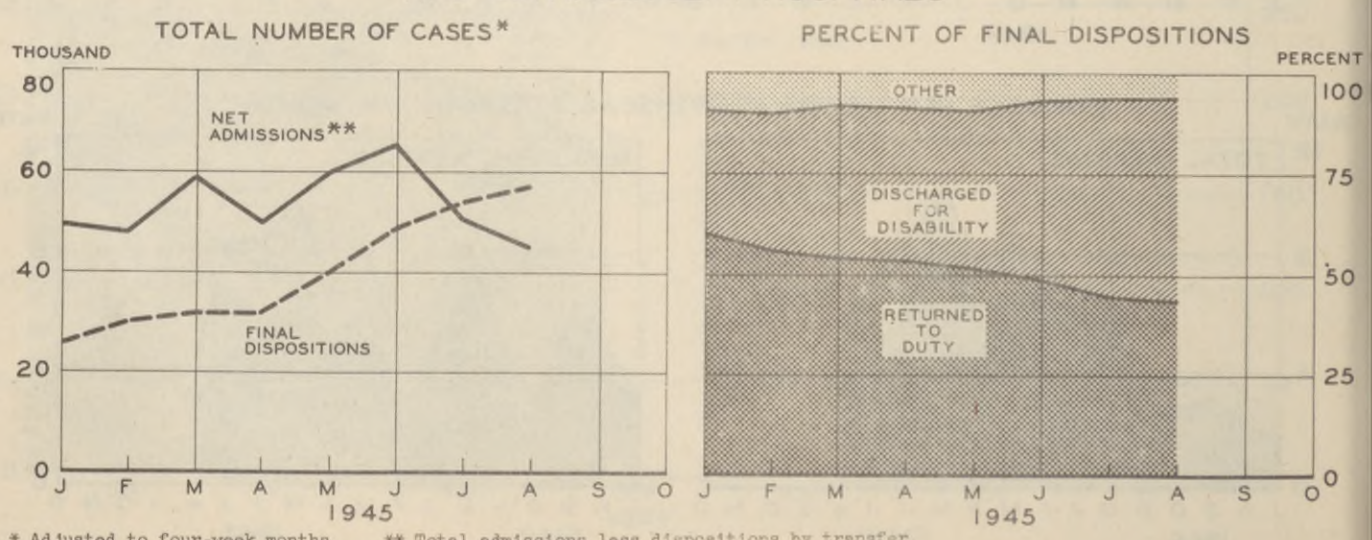
At the end of August, a total of 225,911 patients were remaining in the general and convalescent hospitals in the Zone of Interior, a decrease during the month of approximately 13,000 patients. Patients on furlough from the general and convalescent hospitals at the end of August totalled 67,414, a decrease of 6,000 from the end of July, mainly in the general hospitals. Final dispositions continued to increase during August and in the last week reached a peak of 15,522. Most of this rise was due to CDD's. The percentage of patients returned to duty has steadily decreased during the last several months.

Only small changes occurred in the authorized and effective bed capacities of general hospitals during August. Patients remaining in general hospitals at the end of August totalled 183,774, a reduction of 8,171 patients since the end of July. Beds occupied in general hospitals decreased more slowly, from 131,813 at the end of July to 126,850 at the end of August. Patients on furlough at the end of the month totalled 56,924.

Following the early cessation of hostilities with Japan, a detailed review of the future contraction of general hospitals has been undertaken, based on preliminary data for projected troop strengths and anticipated evacuations. The first major decrease in general hospital bed requirements will probably occur in December, when it is anticipated that approximately twenty general hospitals with 40,000 bed capacity can be closed out. Further reductions will be made in the first half of 1946 with the result that of the sixty-five general hospitals now in the system, there will probably remain only fourteen in operation by 30 June 1946. In carrying out the proposed contraction of the general hospitals, it is believed that the best procedure is to eliminate whole units rather than several hundred beds in each of the existing hospitals. This method has the advantage of allowing greater realization of the policy of hospitalizing patients closer to their homes. At the same time, it achieves the most economical use of personnel as can be illustrated by the fact that if five 2,500-bed hospitals are each reduced by 500 beds, requirements for Medical Corps officers are reduced by 25. However, if a complete unit of 2,500 beds is closed, 60 Medical Corps officers are released, or 35 more. Furthermore, it makes possible the transfer of complete hospital units to other potential users, such as the Veterans Administration.

At the end of August, there were 42,137 patients remaining in convalescent hospitals.

### ADMISSIONS AND DISPOSITIONS OF PATIENTS IN GENERAL AND CONVALESCENT HOSPITALS



\* Adjusted to four-week months. \*\* Total admissions less dispositions by transfer.

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# HOSPITALIZATION

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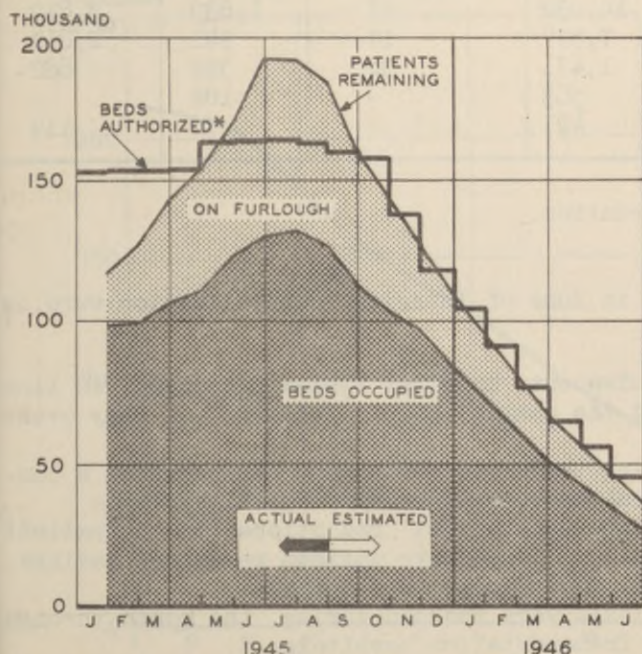
## HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

tals, a decrease of more than 5,000 from the total remaining a month earlier. Bed occupancies decreased during the month from 34,471 to 31,647. Patients on furlough from the convalescent hospitals totalled 10,490 at the end of August. It is anticipated that the shrinkage in the convalescent hospital system will probably proceed more quickly than in the general hospitals. Wakeman Convalescent Hospital is already completely blocked for the receipt of more patients, and the properties are being turned over to the personnel center to increase capacity for separations. Pickett Convalescent Hospital will be closed by the end of this year. Cut-backs will take place in all other convalescent hospitals by the end of the year except at Percy Jones in the Sixth Service Command and on the west coast, where there are relative shortages of convalescent hospital capacity. During the second quarter of 1946 only the following hospitals will be operating and these at reduced capacities; Upton in the northeast; Welch in the southeast; Percy Jones in the north central; Brooke in the south central; and Madigan on the west coast. As indicated by the chart, requirements for March will be about 15,000 beds and for June, 7,000 beds.

Bed authorizations in station and regional hospitals decreased substantially during August as a result of the closing of a major portion of the debarkation sections of Chief of Transportation hospitals on the east coast. The patient load in Zone of Interior station and regional hospitals will remain substantially static throughout this year, except for seasonal increases. Sharp reductions will probably occur early in 1946 in line with the decline in troop strength.

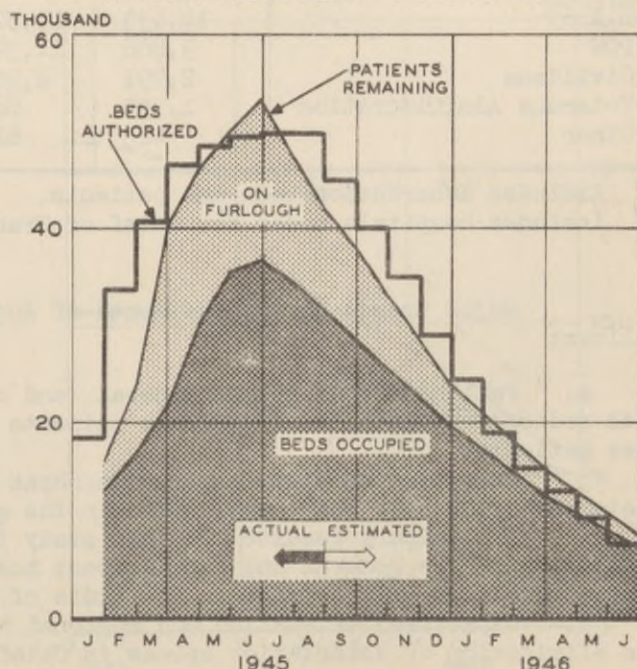
At the end of August the manning of the hospital system in the Zone of Interior required 174,000 persons, including 7,000 Medical Corps officers and 16,000 nurses. The number assigned was only 170,000 persons, including 63,000 civilians. This indicates a shortage of 4,000 in the total hospital system, largely in unmet requirements for administrative officers and enlisted men. The past month was the first which witnessed a considerable turnover in personnel as a result of shipments of individuals to the Pacific and the restaffing of category II indirect units originally slated for movement to the Pacific, and separations to civilian life. Under the new criteria for the separation of Medical Department personnel there will be a very large number of separations during the coming months. One of the most serious personnel problems which will confront the hospital system during this period is the probability that civilians will seek other positions as they become aware of the fact that most of the Army hospitals will remain in operation only for a limited time. It will therefore probably be necessary to use military personnel for essential work in those hospitals where the separation of civilians is accelerated. One method of counteracting the loss of civilians is to announce the future operation of individual Army hospitals by the Veterans Administration or any other agency which is likely to take over the property.

**BEDS AND PATIENTS IN GENERAL HOSPITALS**



\* Includes debarkation beds.

**BEDS AND PATIENTS IN CONVALESCENT HOSPITALS**



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## HOSPITALIZATION

## HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

SUMMARY ASF HOSPITALIZATION IN THE ZONE OF INTERIOR  
End of August 1945

Type of Hospital	Patient Capacity		Patients Remaining		Beds Occupied	Personnel Shortages <sup>c/</sup>		
	Authorized	Effective <sup>a/</sup>	Number <sup>b/</sup>	Percent of Effective Beds		MC	ANC	Total
Total	283,605	255,240	271,037	106.2	202,393	84	-1,745	4,308
General	162,924	151,279	183,774	121.5	126,850	49	-1,256	3,327
Convalescent	50,000	49,656	42,137	84.9	31,647	118	5	670
Regional	31,656	25,325	23,484	92.7	22,495	-1	-387	-196
Station <sup>d/</sup>	39,025	28,980	21,642	74.7	21,401	-82	-107	507

<sup>a/</sup> Authorized beds less debarkation beds and beds held for debarkation back-up purposes.<sup>b/</sup> Data exclude patients in triage at debarkation hospitals.<sup>c/</sup> Civilian nurses included. Overages are denoted with a minus sign (-) in all columns.<sup>d/</sup> Includes station hospitals under the Chief of Transportation.

## Summary

BEDS AUTHORIZED AND PATIENTS REMAINING IN ASF HOSPITALS  
BY TYPE OF CARE AND TYPE OF HOSPITAL <sup>a/</sup>  
End of August 1945

Type of Patient	Beds Authorized	Patients Remaining				
		Total	General	Convalescent	Regional	Station <sup>b/</sup>
Total	269,816	271,037	183,774	42,137	23,484	21,642
General-Convalescent Care	177,647	198,733	157,002	41,731	-	-
Evacuees		186,753	145,878	40,875	-	-
Z/I		11,980	11,124	856	-	-
Regional-Station Care	77,534	56,776	16,740	359	21,845	17,832
Regional	12,104	9,284	3,428	-	5,856	-
Station	65,430	47,492	13,312	359	15,989	17,832
Non-Army	14,635	15,528	10,032	47	1,639	3,810
POW	9,866	11,346	7,577	17	941	2,811
Civilians	2,991	2,903	1,471	30	520	882
Veterans Administration	1,355	665	563	-	102	-
Other	423	614	421	-	76	117

<sup>a/</sup> Excludes debarkation beds and patients.<sup>b/</sup> Includes hospitals under the Chief of Transportation.

Major trends during the month of August in Zone of Interior hospitalization were as follows:

a. Patient loads in the general and convalescent hospital system decreased in line with reduced evacuations of overseas patients and the completion of treatment of many overseas patients.

b. Cessation of hostilities with Japan during the month of August has required a complete re-estimate of bed requirements in the general and convalescent hospital system.

c. Preliminary results of this study indicate substantial reductions in the patient capacities of the general and convalescent hospitals. To achieve maximum personnel savings, these reductions will be made on the basis of closing out complete hospitals.

d. Capacities of station and regional hospitals were reduced during the month through the elimination of debarkation spaces in Chief of Transportation hospitals.

e. Patients remaining in station and regional hospitals changed only slightly. Troop strength projections indicate a constant patient population through the end of this year.

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**MISCELLANEOUS**

DEMOBILIZATION OF MEDICAL DEPARTMENT PERSONNEL

Reflecting the projected decline in the general and convalescent hospitals over the next year (see pages 16 to 18), there will be a sharp decrease in the need for medical personnel. The only offset to this drop is the expansion of the separation centers to a peak by the end of 1945. At that time some 1,700 Medical Corps officers will be needed for such work. Current personnel needs in the Z/I, numbering 215,500, and including 10,400 medical officers and 16,400 nurses, will decline to a 79,000 total by next June, with Medical Corps and Army Nurse Corps each down to approximately 5,000, as shown in the charts below.

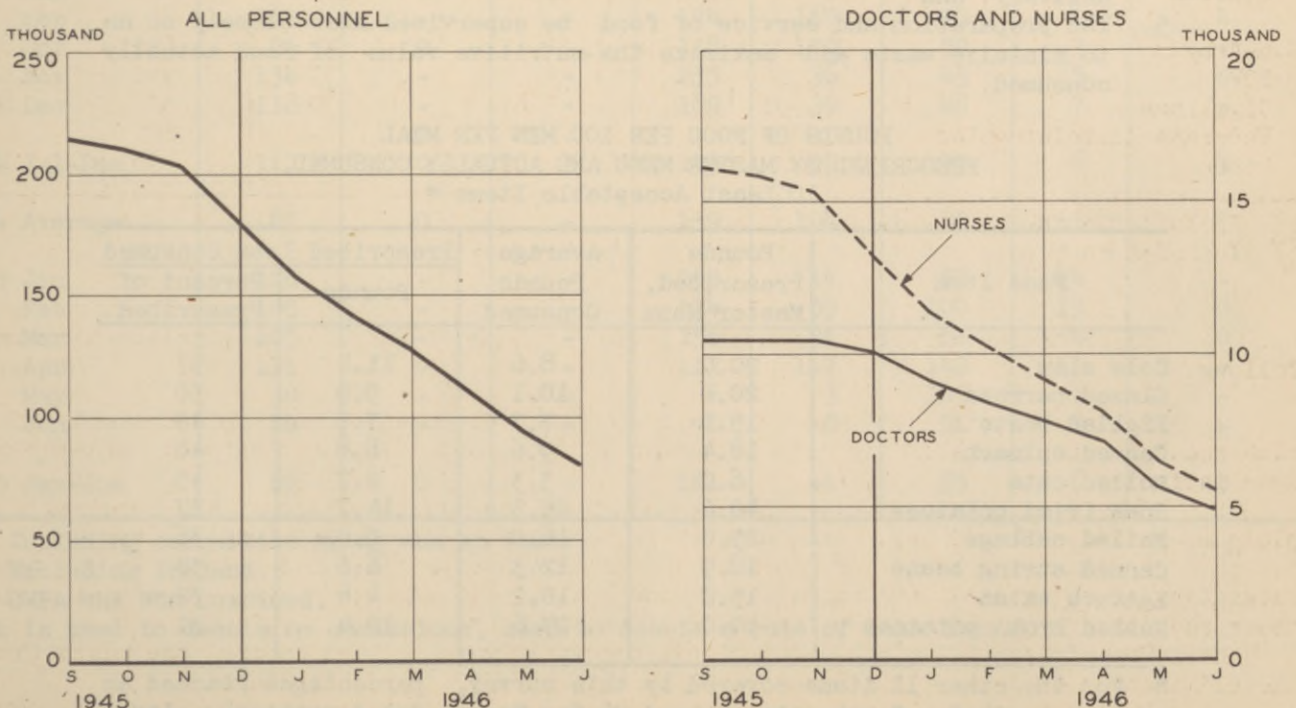
Although some personnel will still have to be sent abroad to permit return of individuals with high scores or long service, the radical reduction in strength overseas should permit very large numbers of Medical Department personnel to be declared surplus and should minimize the readjustment program. On the basis of a two-and-a-half million Army, it is estimated that the Army will be able to release approximately 30,000 Medical Corps officers, 40,000 nurses, and 10,000 dentists. On V-E Day there were 45,000 medical officers; 56,000 nurses, and 15,000 dental officers. A quick and orderly demobilization of Medical Department personnel after V-E Day had been complicated by the relatively high requirements of ASF in the Z/I, a somewhat easier situation in the AAF, the location of most of the surplus in the European Theater, and the building up of strength in the Pacific. Since V-J Day the Separations Board of The Surgeon General, consisting of representatives of the AGF, AAF and ASF, has approved the following criteria, any one of which is sufficient for separation:

**CRITERIA FOR SEPARATIONS**

Corps	Adjusted Service Rating	Age	Length of Service
MC	80	48	Pearl Harbor <u>a/</u>
DC	80	48	Pearl Harbor
VC	80	42	Prior to 1941
SnC	70	42	Pearl Harbor
MAC	70	42	Pearl Harbor
ANC <u>b/</u>	35	35	--
MDD <u>b/</u>	40	40	--
PT <u>b/</u>	40	40	--

- a/ Except grades A, B, C, of MOS 3,106, 3,153, and 3,303 and all grades of MOS 3,130 and 3,152.
- b/ Female personnel, married or with dependents under 14, are also eligible for separation.

**ESTIMATED REQUIREMENTS FOR MEDICAL DEPARTMENT PERSONNEL**



## MISCELLANEOUS

### RESULTS OF NUTRITION SURVEY

In the discharge of his responsibility for the nutritional adequacy of the Army ration, The Surgeon General continually reviews menus and analyzes food consumed in the Army mess. A survey of 45 representative ground force messes in the Z/I, covering 76,000 rations over a seven-day period at the end of May, reveals that the dietary of troops on the ration is nutritionally adequate but that action needs to be taken to reduce waste and to increase the acceptability of food. Contrary to monthly food service reports, this survey, like others of its kind, indicates that while edible food waste is not extreme, it is greater than shown in those reports, amounting to about 4 oz. per man per day or about five percent of the food purchased.

Analysis shows the major causes of waste to be:

1. Failure to provide separate planned menus suitable for sedentary troops and in keeping with their physical needs;
2. Overdrawing of rations (the average of all messes surveyed was five percent rations overdrawn);
3. Relative unacceptability of certain foods in the Master Menu (see table below);
4. Poor quality of some perishable vegetables because market centers send camps a fifteen- to thirty-day supply, some of which deteriorates during storage;
5. Improper cooking methods and poor timing of food preparation and service in some messes; and
6. Failure to render fats properly.

Since many of these factors stem from inadequate supervision, and since there is reason to anticipate further deterioration of such supervision during Period II because of rapid personnel turnover, it is evident that food waste will increase unless effective means are found to combat the causes listed above.

From the surveys it appears desirable that:

1. Troops be fed according to their activity. A combined Quartermaster and Medical Department study should be undertaken to determine the most practical method of accomplishing this objective;
2. Action be taken to eliminate overdrawing of rations;
3. Adjustments be made in the Master Menu to conform more closely with the food habits of troops;
4. Market centers furnish perishable foods at more frequent intervals and in amounts which will be consumed within a reasonable time after delivery; and
5. The preparation and service of food be supervised more closely so as to minimize waste and maximize the nutritive value of food actually consumed.

POUNDS OF FOOD PER 100 MEN PER MEAL  
PRESCRIBED BY MASTER MENU AND ACTUALLY CONSUMED,  
10 Least Acceptable Items \*

Food Item	Pounds Prescribed, Master Menu	Average Pounds Consumed	Prescribed Less Consumed	
			Pounds	Percent of Prescribed
Cole slaw	20.0	8.6	11.4	57
Glazed carrots	20.0	10.1	9.9	50
Pickled beets	15.0	7.7	7.3	49
Canned spinach	18.4	9.6	8.8	48
Rolled oats	6.0	3.3	2.7	45
Home fried potatoes	40.0	25.3	14.7	37
Boiled cabbage	25.0	16.0	9.0	36
Canned string beans	18.9	12.3	6.6	35
Lettuce salad	15.0	10.2	4.8	32
Hashed brown potatoes	40.0	27.6	12.4	31

\* For the other 11 items covered by this survey, percentages reached as high as 94 for fresh spinach and 96 for French fried potatoes. Average amounts consumed pertain to this survey only; revision of allowances in Master Menu would require further study.

# STATISTICAL TABLES

RESTRICTED

## STATISTICAL TABLES

Admission rates for selected diseases and for nonbattle injury in the United States and in overseas theaters are shown in the tables on the following pages. The rates include cases admitted to hospital or confined to quarters for a day or more, and have been derived from AGO Form 8-122 (formerly MD Form 86ab), both regular and telegraphic, submitted to The Surgeon General by each overseas theater or lesser command, and by posts, camps, and stations in the United States. Only the major overseas areas are shown separately, but the total overseas rates are based upon a complete consolidation. The rates for each month are based upon the experience of four or five weeks depending upon the number of Fridays in a month. Admission rates for wounded in action, presented in the table below, pertain to calendar-month periods and are derived from The Adjutant General's report, Battle Casualties of the Army, which covers hospital admissions only. The rates in each case apply to all Army strength in the particular area; air, ground, and service. Rates computed from incomplete reports and those derived from the weekly telegraphic reports are distinguished from those based on the final monthly report.

The venereal disease rates derived from AGO Form 8-122 are generally higher than those based on the Monthly Venereal Disease Statistical Report. Venereal infections contracted prior to service have been excluded from the rates. Tentative neuropsychiatric admission rates are presented for 1944 and 1945. Not systematically reported on AGO Form 8-122 until late in 1943, these rates may not be as firm as those for communicable diseases. Malaria rates for the continental United States reflect only infections acquired in the United States; rates based on all admissions are much higher. They also measure diagnosed malaria only, but include both primary attacks and recurrences insofar as these are reported as malaria. A variable amount of malaria, differing from theater to theater, is at first reported as fever of undetermined origin. Many of these cases are later correctly diagnosed and enter into the rates. Since the system of reporting does not make it possible to subtract such cases from the undiagnosed category, some duplication continues to exist.

WOUNDED IN ACTION, AS REPORTED TO THE ADJUTANT GENERAL  
Hospital Admissions per Thousand Men per Year

Month and Year	Total <sup>a/</sup> Overseas	Overseas' Commands						Africa-Middle East
		North American	Latin American	ETO <sup>b/</sup>	MTO	Pacific <sup>c/</sup>	CBI	
1943 Average	23	6	0	7	62	15	4	4
1944 Jan-Jun	45	0	0	44	108	23	14	9
Jul	143	-	-	269	94	30	24	19
Aug	100	-	-	189	73	14	8	5
Sep	112	-	-	174	165	20	2	4
Oct	96	0	-	118	170	52	3	-
Nov	134	-	-	235	36	43	5	0
Dec	118	-	-	189	30	48	7	-
1944 Jul-Dec	117	0	-	193	99	35	8	5
1944 Average	87	0	-	139	104	30	11	7
1945 Jan	126	-	-	202	14	52	14	-
Feb	105	-	-	134	59	100	15	0
Mar	105	-	-	156	34	61	4	0
Apr	111	0	-	113	147	140	1	-
May	30	-	-	6	3	105	1	-
Jun	14	-	-	0	0	51	0	-
1945 Jan-Jun	82	0	-	101	44	85	6	0

<sup>a/</sup> Including casualties among men en route.

<sup>b/</sup> Excluding Iceland.

<sup>c/</sup> SWPA and POA combined.

Dash is used to denote no admissions, zero to denote a rate of less than 0.5.

RESTRICTED

# STATISTICAL TABLES

STATISTICAL TABLES (Continued)

## ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Caribbean	ETO <u>a/</u>	MTO	POA	SWPA	Asiatic	ME and PGC
ALL DISEASE										
1942 Average	664	676	667	823	693	452	519	821	1,048	1,330
1943 Average	739	889	624	670	837	943	971	1,046	991	1,107
1944 Jan-Jun	619	695	566	528	578	812	600	902	967	949
Jul-Dec	495	623	351	536	440	880	513	804	1,152	842
Average	563	654	478	531	492	846	561	840	1,077	896
1945 Jan	603	656	337	529	605	878	420	799	728	658
Feb	626	649	363	587	577	790	526	905	652	554
Mar	592	612	384	546	530	714	412	973	647	631 <sub>b/</sub>
Apr	543	587	411	553	469	657	414 <sub>b/</sub>	1,058	710	573
May	541	(643) <sub>b/</sub>	658	515	531	600	(387) <sub>b/</sub>	1,144	712	603 <sub>b/</sub>
Jun	515	(631) <sub>b/</sub>	435	629	532	704		1,128		532
Jan-Jun	569		426	562	538	726		1,006		
Jul	471	(636) <sub>b/</sub>	381	572		654				
Aug	480 <sub>b/</sub>									
Sep										
Oct										
Nov										
Dec										

## NONBATTLE INJURY

1942 Average	91	123	152	107	109	96	104	176	80	158
1943 Average	80	136	182	105	100	149	131	171	84	140
1944 Jan-Jun	69	114	145	75	85	145	118	151	95	107
Jul-Dec	66	112	100	61	105	131	102	132	97	92
Average	67	113	127	68	97	138	111	139	96	99
1945 Jan	55	141	102	60	174	103	92	104	105	69
Feb	50	105	94	67	114	88	84	103	99	73
Mar	49	102	109	61	104	89	71	128	105	69 <sub>b/</sub>
Apr	48	108	100	65	113	98	92 <sub>b/</sub>	115	104	64
May	49	(107) <sub>b/</sub>	84	57	112	97	(87) <sub>b/</sub>	119	91	60 <sub>b/</sub>
Jun	53	(88) <sub>b/</sub>	92	59	87	85		113		62
Jan-Jun	51		97	61	115	93		114		
Jul	48	(81) <sub>b/</sub>	89	54		72				
Aug	44 <sub>b/</sub>									
Sep										
Oct										
Nov										
Dec										

a/ Excluding Iceland.

b/ Based on Incomplete Reports.

( ) Telegraphic Reports.

# STATISTICAL TABLES

STATISTICAL TABLES (Continued)

## ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Caribbean	EFO <u>a/</u>	MTO	POA	SWPA	Asiatic	ME and PGC
ALL VENEREAL DISEASE										
1942 Average	39	32	7	74	38	36	12	32	64	80
1943 Average	26	34	3	56	43	56	5	15	52	68
1944 Jan-Jun	30	37	3	33	26	96	6	9	53	60
Jul-Dec	37	45	7	33	40	125	4	6	50	62
Average	33	42	5	33	35	111	5	7	51	60
1945 Jan	47	46	6	29	48	124	4	5	54	80
Feb	43	42	8	29	45	105	3	8	57	75
Mar	43	47	10	26	48	94	3	40	51	74 <u>b/</u>
Apr	43	51	8	27	46	85	3 <u>b/</u>	84	43	84
May	43		8	25	62	94		97	40	65 <u>b/</u>
Jun	44		12	20	105	110		97		69
Jan-Jun	44		9	26	60	102		57		
Jul	46		7	26		128				
Aug	52 <u>b/</u>									
Sep										
Oct										
Nov										
Dec										

## DIAGNOSED MALARIA

1942 Average	0.6	33	0	99	0	11	12	52	165	127
1943 Average	0.2	96	0	37	3	54	208	245	181	123
1944 Jan-Jun	0.1	43	-	16	10	61	67	75	113	66
Jul-Dec	0.2	34	-	12	8	63	13	41	216	52
Average	0.2	38	-	14	9	62	43	53	174	59
1945 Jan	0.1	14	0	7	5	19	8	27	74	11
Feb	0.2	14	-	7	5	16	6	43	49	9
Mar	0.1	18	-	7	8	21	4	62	28	10 <u>b/</u>
Apr	0.2	23	-	9	11	28	5 <u>b/</u>	75	29	11
May	0.1		0	11	11	31		72	23	10 <u>b/</u>
Jun	0.1		0	12	9	26		65		14
Jan-Jun	0.1		0	9	8	23		58		
Jul	0.1		1	12		24				
Aug	0.1 <u>b/</u>									
Sep										
Oct										
Nov										
Dec										

a/ Excluding Iceland.

b/ Based on incomplete reports.

Dash is used to denote no admissions, zero to denote a rate of less than 0.5.

# STATISTICAL TABLES

STATISTICAL TABLES (Continued)

## ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Carib-bean	ETO <u>a/</u>	MTO	POA	SWPA	Asiatic	ME and PGC
COMMON RESPIRATORY AND INFLUENZA										
1942 Average	243	159	244	113	287	151	89	146	150	197
1943 Average	247	181	222	99	409	142	86	108	159	201
1944 Jan-Jun	198	174	245	84	225	185	97	90	177	254
Jul-Dec	85	100	105	77	92	138	70	78	176	182
Average	147	132	188	81	142	162	85	83	176	219
1945 Jan	167	146	106	67	166	190	70	95	135	180
Feb	192	144	135	71	157	182	60	128	135	149
Mar	167	122	115	65	125	152	54	125	131	164 <u>b/</u>
Apr	122	99	143	74	93	106	56 <u>b/</u>	131	130	127
May	124		417	75	87	79		139	136	95 <u>b/</u>
Jun	101		182	193	63	70		145		88
Jan-Jun	145		177	95	112	132		128		
Jul	77		90	150		61				
Aug	79 <u>b/</u>									
Sep										
Oct										
Nov										
Dec										

## DIARRHEA AND DYSENTERY

1942 Average	8	28	5	19	17	33	34	57	120	185
1943 Average	12	66	8	16	12	132	43	70	146	170
1944 Jan-Jun	9	35	3	13	11	41	28	58	182	101
Jul-Dec	10	40	3	12	14	67	28	54	180	129
Average	9	38	3	13	13	54	28	55	181	115
1945 Jan	8	30	1	11	17	20	17	76	69	56
Feb	8	36	2	14	20	21	27	99	68	31
Mar	6	34	2	21	13	19	14	119	83	45 <u>b/</u>
Apr	6	33	3	14	15	18	18 <u>b/</u>	90	116	81
May	6		2	14	16	22		88	118	140 <u>b/</u>
Jun	7		0	16	14	31		138		90
Jan-Jun	7		2	15	16	22		104		
Jul	6		1	15		30				
Aug	7 <u>b/</u>									
Sep										
Oct										
Nov										
Dec										

a/ Excluding Iceland.

b/ Based on Incomplete Reports.

# STATISTICAL TABLES

STATISTICAL TABLES (Continued)

## ADMISSIONS TO HOSPITAL AND QUARTERS Rates Per Thousand Men Per Year

Month and Year	United States	Overseas Commands								
		Total	Alaska	Carib-bean	ETO <u>a/</u>	MTO	POA	SWPA	Asiatic	ME and PGC
FEVER OF UNDETERMINED ORIGIN										
1943 Average	<u>c/</u>	52	0	64	1	75	19	166	71	21
1944 Jan-Jun	<u>c/</u>	35	1	37	1	57	26	102	69	16
Jul-Dec	<u>c/</u>	40	0	31	3	85	13	80	174	37
Average	<u>c/</u>	38	1	34	2	71	20	88	131	27
1945 Jan	<u>c/</u>	24	0	20	4	39	5	70	87	12
Feb	<u>c/</u>	26	-	10	4	43	9	95	60	24
Mar	<u>c/</u>	29	0	10	6	41	3	117	56	31b/
Apr	<u>c/</u>	29	-	9	8	43	8 <u>b/</u>	104	59	33
May	<u>c/</u>		0	10	9	38		113	70	33b/
Jun	<u>c/</u>		0	10	6	50		98		29
Jan-Jun	<u>c/</u>		0	12	6	42		100		
Jul	<u>c/</u>		1	7		57				
Aug	<u>c/</u>									
Sep	<u>c/</u>									
Oct										
Nov										
Dec										

## NEUROLOGICAL AND PSYCHIATRIC DISORDERS

1944 Jan-Jun	29	29	11	21	24	37	26	48	23	27
Jul	32	59	10	16	84	52	27	58	16	31
Aug	36	50	12	18	76	28	25	48	17	21
Sep	46	41	13	25	40	50	32	53	16	19
Oct	48	56	13	23	65	82	32	39	21	21
Nov	47	60	13	27	85	47	28	41	23	16
Dec	47	56	12	22	72	39	29	53	20	26
Jul-Dec	45	53	12	22	69	50	29	49	19	22
Average	36	43	12	21	52	43	27	48	20	25
1945 Jan	50	43	14	25	51	32	35	43	19	20
Feb	49	39	9	27	36	31	25	70	20	15
Mar	50	40	13	29	39	31	25	74	22	20b/
Apr	45	36	13	26	31	41	34b/	60	24	11
May	49		9	20	15	13		67	22	7b/
June	43		14	20	13	13		49		13
Jan-Jun	48		12	24	30	27		60		
Jul	39		11	23		12				
Aug										
Sep										
Oct										
Nov										
Dec										

a/ Excluding Iceland. b/ Based on incomplete reports. c/ Not available.  
Dash is used to denote no admissions, zero to denote a rate of less than 0.5.

