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31 MAY 1946

ARMY SERVICE FORCES ★ WAR DEPARTMENT

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HEALTH

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'HEALTH OF THE ARMY'

The 31 May 1946 report is the final issue of HEALTH to be prepared as a section of the Army Service Forces Monthly Progress Report series. This report, originally required primarily for submission to the Secretary of War, the Chief of Staff and the Commanding General, Army Service Forces has been extremely useful to commanding generals and surgeons of overseas theaters, commanding generals of divisions and operating sections of the War Department, and to almost every division within The Surgeon General's Office.

It is contemplated that the report will be continued, although its content will be slightly altered and it will be combined, in the future, with at least three recurrent reports which were prepared in the past by operating divisions of The Surgeon General's Office. These reports, essentially statistical in nature, contained data on current morbidity trends in every post, camp and station in the United States, reviewed current authorizations for beds and trends of occupancy in the ASF hospitals, and dispositions of patients from station, general, and regional hospitals in the Zone of Interior. These reports will be incorporated in the revised HEALTH, the title of which will be HEALTH OF THE ARMY.

The new report, HEALTH OF THE ARMY, will contain, in addition to current reports on morbidity, hospitalization, evacuation, inductions, dispositions, and the like; for the Army in the United States and overseas, interim reports summarizing the experience of the Army during the past war and in previous years of peace with morbidity from various diseases and with the problems which arose in the provision of adequate medical services. Summary or reference tables will be published, from time to time, which contain data obtained from Medical Department records and useful to other sections of the War Department for estimate and planning.

SUMMARY

HEALTH IN OCCUPIED AREAS Disease incidence among troops in Japan is generally higher than for troops in the remainder of the Western Pacific, with respiratory and venereal disease incidence contributing most heavily. There is notably less difference in the levels between the rates for troops in the occupied area of the European Theater and the remainder of the European Theater, than there is for the same breakdown in the Pacific, while the general level for the European Theater is close to that of Japan. (See page 2)

ENLISTMENT, HEALTH, AND DISCHARGE OF WAC The experience which the Army has had with the Women's Army Corps in terms of defects found at enlistment, health while in service, and causes for disability discharge is reviewed. About 140,000 women served in the WAAC and its successor the WAC. By the end of 1945, 21 percent of these had been discharged for disability. (See pages 4 through 14)

VENEREAL DISEASE In general admissions in May were below those of April. In the Middle Pacific where the level of incidence is still a small fraction of the experience encountered in other theaters, the rate for May was considerably above any previous level for the theater. (See page 15)

NONEFFECTIVES The average patient population for April was 116,500 with 17 percent overseas. The decrease in the noneffective rates are attributable to the downward movement of disease rates coincident with the passing of the winter season. (See pages 16 and 17)

ADMISSIONS The most recent rates for admissions to hospital and quarters are higher for overseas troops than for personnel in the United States. The preliminary May rate for the United States is 581. The overall decline in the admission rate for all disease is largely the result of the drop in the incidence of respiratory disease. (See pages 18 and 19)

HOSPITALIZATION OVERSEAS At the present time there have been no additional provisions authorized to provide complete medical service for U. S. nationals who are employed by the War Department overseas, and for the dependents of both military and civilian employees. At the present time such patients must be cared for within the limits of the capacity based on the present authorizations for military personnel only. (See pages 22 and 23)

HOSPITALIZATION IN THE ZONE OF INTERIOR The rapid decline in patient load in the general and convalescent hospital system that began in July 1945 continued through the current month to yield an end month May patient population of 58,000. The closure of 13 general hospitals and the continuing necessity to consolidate specialized centers in view of the limited number of specialized personnel available made necessary a re-evaluation of the specialized bed structure of the general hospitals remaining open after 30 June 1946. (See pages 25 to 27)

INDUCTION EXPERIENCE SINCE V-J DAY On the basis of recent preinduction and induction experience, it might be expected that 40 percent of the registrants called up for the first time will be rejected as unfit assuming that physical, mental and administrative standards, and age limits for induction remain as they were prior to 15 May 1946. Most of the 4-F group have irremediable defects, so that only a small proportion of this group could be considered for re-examination. (See pages 28 to 30)

DISEASE AND INJURY

HEALTH IN OCCUPIED AREAS

The general trend in the incidence of disease among U. S. troops stationed in Japan has been upward since the beginning of the occupation. From a rate of 515 admissions per thousand men per year in September, the rate for all disease climbed steadily to reach 949 in March. The drop to 786 in April was the first reversal of the upward movement. In Korea the admission rate for all disease also showed a general increase from September through April. However, it is noteworthy that month for month the Korean rates are significantly lower than those for Japan. The September rate was 334 admissions per thousand men per year, and by April the rate for the XXIV Corps had risen to 634. Although some increase in disease rates for the troops sent to Japan for occupation duty was expected, the levels reached have exceeded anticipations. The rates for men in Japan soon surpassed those for men in the Western Pacific Area excluding Japan and Korea and by December were 50 percent higher. The Korean rate has been consistently below that for troops in Japan. From September 1945 through January 1946, the rate for Korea was less than that for the Western Pacific excluding Japan and Korea, although beginning with February the rate for Korea exceeded it, and in March surpassed it by 21 percent.

The disease contributing most heavily to the high morbidity level in Japan are the venereal and respiratory diseases. In November, venereal disease incidence in Japan had reached a rate of 117 admissions per thousand men per year and by January was above the 200 mark. From January through April there was relatively little fluctuation, with the high point of 241 occurring in March. This figure is about six times the corresponding rate for Korea, and is nearly 70 percent above the March rate for troops in the remainder of the Western Pacific.

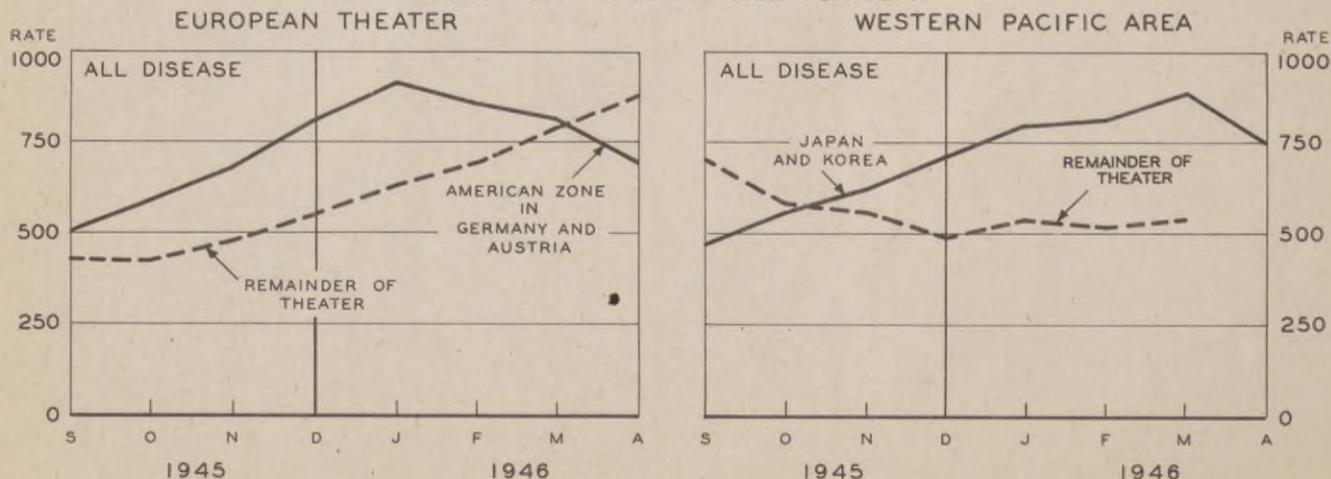
Admissions for the common respiratory diseases and influenza in Japan from the start of the occupation have been generally on the increase, rising from a rate of 94 in September to an apparent seasonal peak of 207 admissions per thousand men per year in March. For the three month period through April 1946 the average admission rate for respiratory diseases in Japan was twice that for troops in Korea. Since the seasons are reversed for troops in the northern and southern parts of the Western Pacific it was not surprising to find the rates for the troops in Japan in excess of those for the personnel in the Philippines, in New Guinea, and on Okinawa. However, the location of Japan in the north temperate zone with its climate moderated by the influence of the Japanese Current might have been expected to have produced lower respiratory disease rates for the troops stationed there than for those troops in Korea.

Admissions for malaria in Japan increased from 22 per thousand men per year for September to a peak of 83 in December, dropping to 43 by April. From October on, the rates for malaria among troops in Japan were definitely higher than those for troops in the remainder of the Western Pacific. These rates approached equalization in March as admissions among troops in the Philippines, New Guinea, and Okinawa increased.

Since October the admission rate for scabies in Japan has been increasing by 30 percent each month reaching 17 admissions per thousand men per year in April without a reversal in trend since the beginning of the occupation.

DISEASE ADMISSIONS AMONG TROOPS IN OCCUPATION ZONES

RATES PER THOUSAND MEN PER YEAR



DISEASE AND INJURY

HEALTH IN OCCUPIED AREAS (Continued)

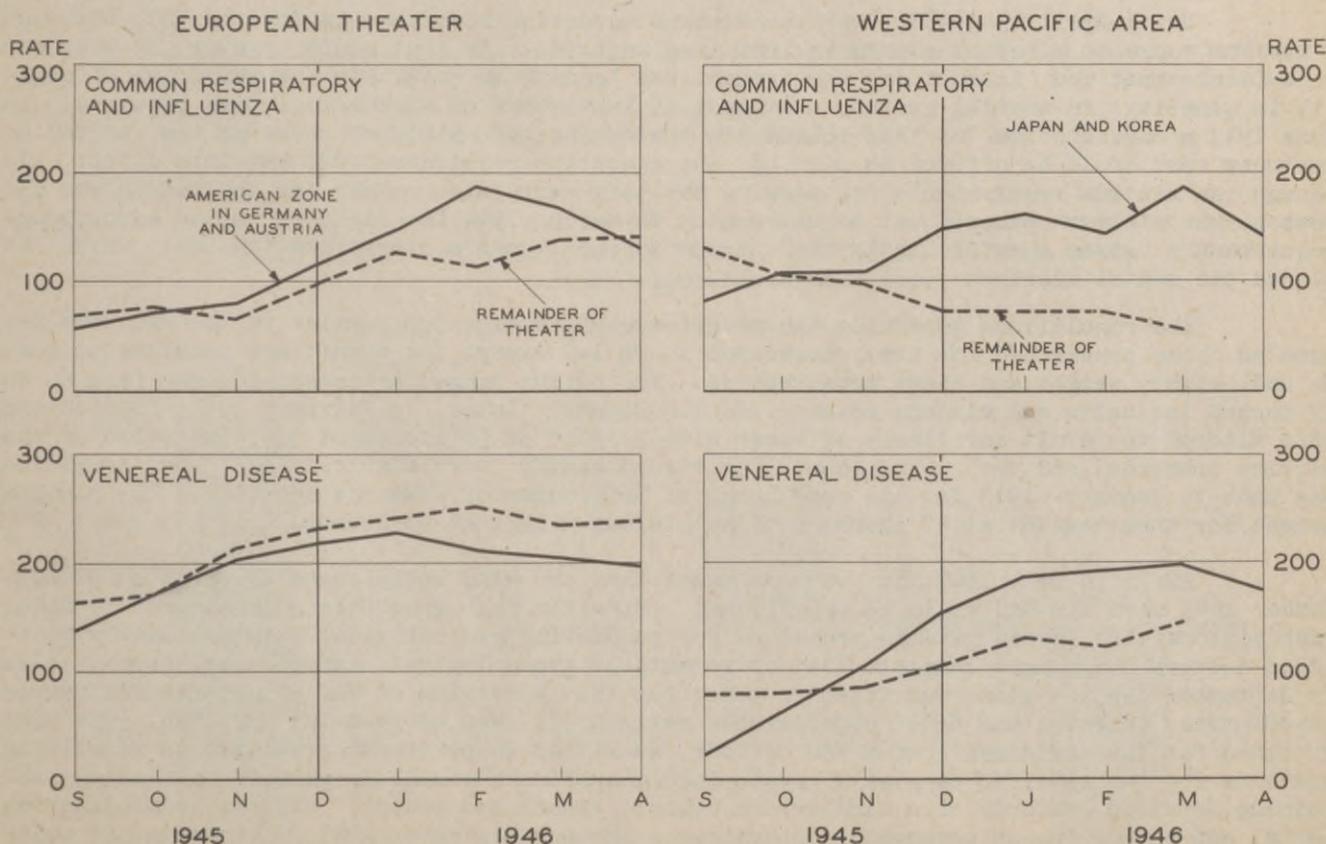
The only significant instances of relatively low disease incidence for troops stationed in Japan are to be found in the rates for neuropsychiatric disease, and to some extent, the diarrhea and dysentery rates. Since the start of the occupation the neuropsychiatric rates for the troops in both Japan and Korea have been distinctly below those for other troops in the Western Pacific, and the April neuropsychiatric admission rate in Japan of 10.5 per thousand men per year is less than half the corresponding rate for troops stationed in the United States. The diarrhea and dysentery trend since September has been declining for all troops in the Western Pacific. The level of the rates for Japan and Korea has been below that for the rest of the theater. The diarrhea and dysentery admission rate of 4.8 admissions per thousand men per year for troops in Japan and Korea during April is still somewhat higher than that of 2.3 for troops in the United States.

The general trend of disease incidence in the U. S. occupation zone in Germany since January 1946 has been downward. The April rate for all disease for the occupation troops is 698 per thousand men per year, 24 percent below the January peak of 922, and less than seven percent below the combined April rate for Japan and Korea. The admission rate for all disease for troops in the remainder of Europe from October 1945 has been increasing at an average of more than 11 percent per month, reaching a rate of 874 admissions per thousand men per year for all diseases in April, the first month for which this rate exceeded that for the occupation troops in the European Theater.

Although venereal disease admissions tended to be slightly lower among occupation troops in the European Theater, the level of venereal disease morbidity for troops in both the occupation zone and the remainder of the European Theater since November is almost identical to the recent level in Japan, with admissions fluctuating between 200 and 250 admissions per thousand men per year.

Except for the month of February, respiratory disease incidence among troops in the American zone varied from the rates for troops in other parts of the European Theater by from about three to twenty percent. The April rate of 138 for the latter was seven percent above the April rate for the occupation troops.

DISEASE ADMISSIONS AMONG TROOPS IN OCCUPATION ZONES RATES PER THOUSAND MEN PER YEAR



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DISEASE AND INJURY

ENLISTMENT, HEALTH, AND DISCHARGE OF WAC

The problems of medical service associated with maintaining a Women's Army Corps in terms of examinations at enlistment, maintenance of health while in service, and discharge from service for physical or mental reasons are particularly important at this time when consideration is being given to establishing the WAC as a permanent adjunct to the Regular Army. The data collected by the Medical Department during the past four years which detail the experience the Army has had with the WAC, while not complete, are sufficiently general and accurate to illustrate some of the problems raised by the existence of a large group of females both from the standpoint of their relation to the rest of the Army and with regard to the problems they themselves raise. Although the task of assessing the utility of females in the Armed Forces over and above their availability as civilian employees of the War Department is outside the purview of the Medical Department, many of the considerations necessary for a description of the provisions for female health which are necessary for the solution of the problem are available in documents of the Medical Department.

The initial authorization for a Women's Army Corps as an auxiliary to the Army was established in May 1942 when the personnel ceiling was set at 150,000 women who were to be enrolled for a period of one year. In June 1942 the period of service was extended to the duration of the war-plus six months. At this time and until the conversion of the corps from an auxiliary into a regular part of the Army the age limits for volunteers were set between a minimum of 21 and a maximum of 45, although officer candidates over age 45 were accepted for training. In October 1943 the age limits were extended to encompass women between the ages of 20 and 49.

The policies concerning enrollment of women with dependents varied considerably during the war. The initial regulations of May 1942 imposed specific restrictions upon the induction of such persons. However, in July 1942 it was ruled that only in exceptional cases would candidates with children under 14 years of age be enrolled. The most important variation in this ruling was affected soon after the WAC was established in 1943, and remained substantially the same thereafter. Applicants with children under 14 were eligible only if divested of their care at least 18 months prior to application for enlistment. However, under the Servicemen's Dependents Allowance Act of 1942, support for children age 14 to age 18 could be obtained, and consequently applicants with children in that age range were acceptable. Applicants with children between 18 and 21 were ineligible except when state laws specified some other age when children were no longer under legal parental control and support. These later changes in policy are important only insofar as they affected enrollment of women in older age groups.

Until April 1943 there were no minimum education requirements for the WAC, although a minimum score on a mental alertness test was required. In that month however, in response to evidence that the lack of any requirement was tending to result in the sacrifice of quality to quantity in meeting quotas, a minimum of two years of high school was required. In June 1943 a modification of this policy to the extent that a higher score on the mental alertness test could be offered in lieu of the education requirement was put into effect, although the minimum requirements for passing the test were also raised for applicants who did possess the minimum educational requirement. In March 1944 the right to waive educational requirements given a sufficiently high score in the women's classification test, which replaced the mental alertness test, was abolished.

The regulations governing the acceptance of females for service in the WAC were the same as those prescribed for Army personnel in MR 1-9 except for conditions peculiar to women and height, weight and chest measurements. The height range for acceptance was from 60 to 72 inches inclusive and minimum weight was 100 pounds. Later, in February 1943, regulations were altered to permit enrollment of women with heights of 58 inches at the discretion of the service commands, and the requirements for visual acuity were also reduced. When provision was made in January 1943 for the enrollment of 500 women of Japanese ancestry, the minimum height for them was set at 57 inches and the minimum weight at 95 pounds.

Early in July 1943, it was announced that the WAAC would cease to exist on 30 September 1943 when the WAC would be established. Directly following this announcement detailed instructions were issued guiding procedure for conducting gynecological examinations by qualified doctors and a more complete list of rejectable gynecological defects was issued. Also in September 1943, a plan was first proposed for the screening of WAC applicants for neuro-psychiatric defects, and after considerable revision it was adopted in May 1944. The plan provided for the assignment of a WAC officer, qualified in personnel problems, to recruiting stations for the specific purpose of developing a complete screening program. This involved obtaining detailed records of a candidate's social, school and medical history, administering tests, and conducting or arranging interviews. Through September 1943, standards for teeth

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DISEASE AND INJURY

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ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

were adopted from MR 1-9. After the conversion of the WAAC to the WAC in September 1943 the dental requirements were derived from the provisions for acceptance of the Army Nurse Corps until the WAC reverted to the provisions of MR 1-9 in April 1944. The standards were considerably lower in MR 1-9 than were those for the nurses.

During the past war about 140,000 women served in the WAC, although the strength of the Corps never exceeded 100,000, and did not reach its peak until May 1945, about three years after recruiting began. Working against a ceiling of 150,000 persons it was never possible to attract sufficient applicants who could qualify for enlistment. In all, only between 250 and 300 thousand women applied for enlistment or commission. The table below summarizes briefly the disposition of those persons who were enrolled in the WAC through December 1945. The data pertain only to enlisted women and are derived from the strength reports of The Adjutant General. Of interest is the fact that when the WAAC was converted into the WAC about 14,200 enlisted women were separated at their own request.

Rejections at Enlistment

In evaluating the statistics which have been accumulated at the time women applied for enlistment in the WAC, not much recourse may be had, for comparative purposes, to similar data relating to the processing of selectees through the induction system. The existence of

ACCESSIONS AND SEPARATIONS OF WAC ENLISTED PERSONNEL
May 1942 Through December 1945

Item	Number in Thousands	Percent of Accessions
Accessions	140.0	100.0
Separations		
Deaths	0.1	0.1
Discharge		
Physical and Mental Disqualification	21.4	15.3
Conversion of WAAC to WAC <u>a/</u>	14.2	10.1
To Accept Commission or Warrant <u>b/</u>	7.7	5.5
Demobilization	16.3	11.6
Other <u>c/</u>	32.1	22.9

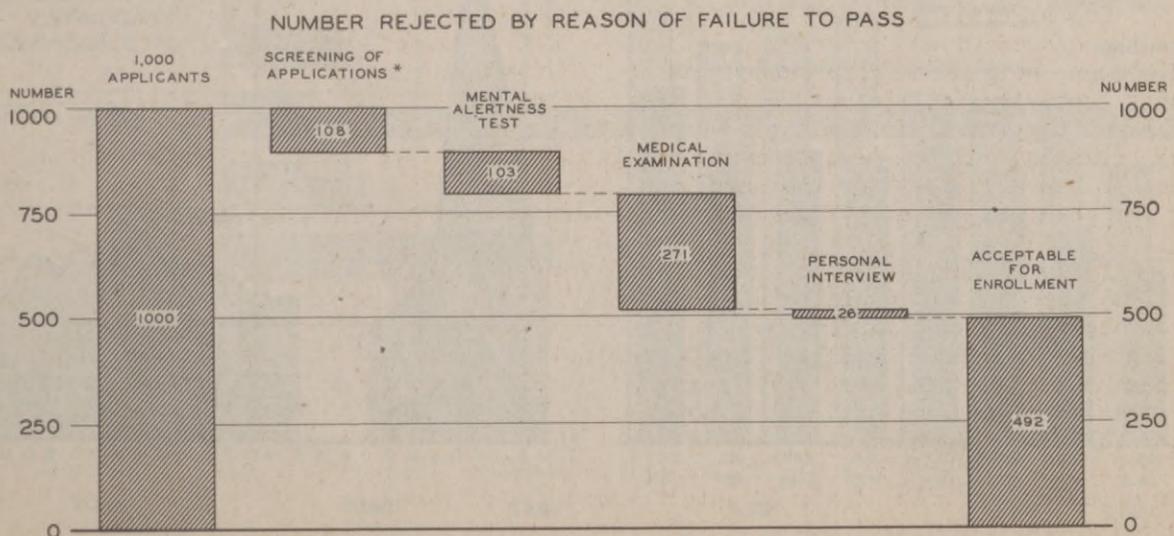
a/ Separated at own request.

b/ In WAC or Medical Department.

c/ Includes miscellaneous honorable discharges and other than honorable discharges.

PROCESSING OF APPLICANTS FOR ENLISTMENT IN THE WAC

OCTOBER 1943 - JUNE 1945



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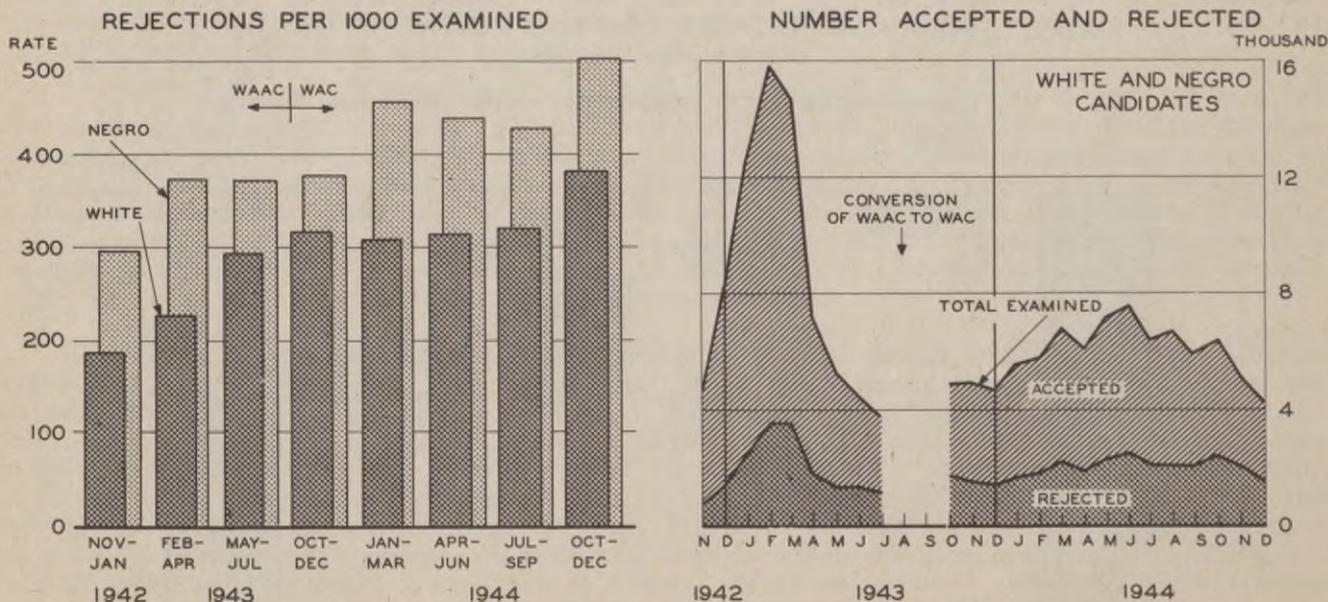
ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

a primary selection among women to the extent that application for entry into service was entirely voluntary had no counterpart among male personnel who saw military service. Only about 22 percent of all enlisted men who served between July 1940 and December 1945 entered the Army of their own volition in the sense that they requested enlistment. In addition, recruiting policies aimed at inducing women with special qualifications to enlist for particular positions or for service in an area of their own choosing was never duplicated for men until late in 1945, when it was made possible for men to enlist and particularly to re-enlist for periods of varying length and for service in the theater of their choice. None of the data which are available for a discussion of rejections of applicants for enrollment in the WAC cover the entire period of the existence of the corps. However, those which are available do encompass a sufficiently large time interval to insure an adequate basis for discussion.

Between October 1943 and June 1945, about 189,000 women applied for enrollment in the Women's Army Corps. These candidates were screened four times before their eligibility for enrollment was established, and during the process more than 50 percent were rejected. Although the considerations of rejections of applicants for the WAC are to be essentially concerned with an analysis of the results of medical examinations given to the candidates, it is of interest to evaluate the importance of the medical examinations as causes of rejection. In the chart at the bottom of the previous page, the proportions rejected at each stage of the screening process are compared in terms of the experience of an initial group of 1,000 applicants. Of the 508 rejected, 54 percent were disqualified on the basis of medical examination and the remainder for administrative reasons of one sort or another. At the first stages of the screening process, recruiting officers rejected 10.8 percent of all the applications, and 11.5 percent of the applicants who passed the recruiting officers failed the mental alertness test. More than one-third of the applicants surviving the test were not qualified medically, and five percent of those who were found to be physically sound within the meaning of the enlistment standards were rejected at a personal interview.

The trend of rejection rates for medical causes for WAC candidates from November 1942, the first month for which data are available, through December 1944 is generally upward, both for Negro and for white applicants. From the quarterly rejection rates shown in the left hand panel below it may be seen that in this interval of 26 months the rates for white candidates more than doubled while those for Negro applicants increased by about 70 percent. In the right hand panel the number of candidates, both white and Negro, who were medically examined and either found acceptable for enrollment or rejected is shown month by month. In both panels the data for August and September 1943, the period during which the transition of the WAAC to the WAC was being accomplished are not shown. There is no ready explanation for the interim decline in the rejection rates, particularly in those for white candidates, shortly after the establishment of the WAC. Although generally the standards for enrollment in the WAC were more severe than they had been for the Auxiliary it is possible

REJECTION OF WAC CANDIDATES AT MEDICAL EXAMINATION



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ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

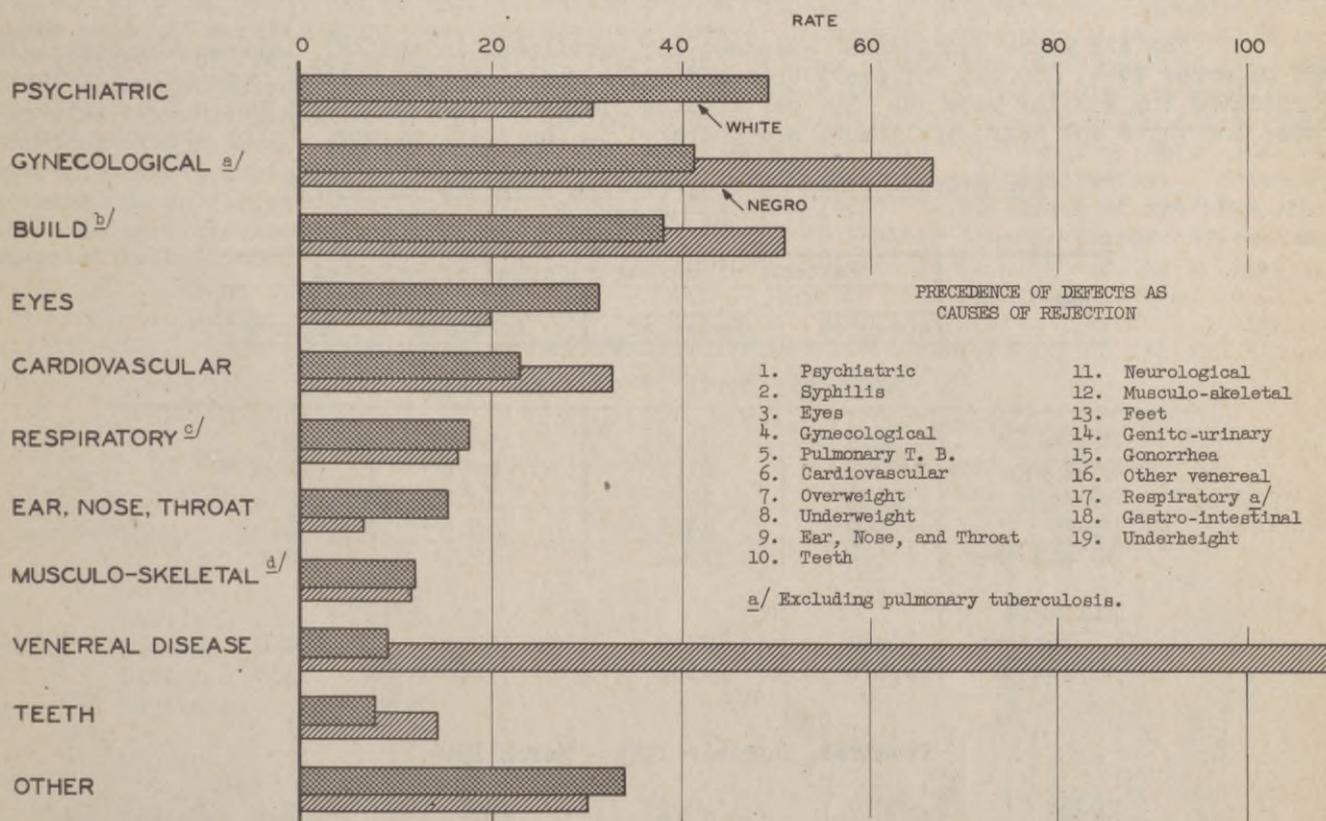
that more leniency may have been exercised initially, particularly in view of the fact that a concerted program to recruit large numbers of WAC for service in the Army Air Forces was begun in October 1943.

Some of the variations in the trend of the total medical rejection rate for WAC candidates may be explained in terms of certain characteristics of WAC applicants such as color, age, marital status, and occupation at time of application. Changes in standards with regard to dependents and age limits, or special appeals for personnel which attracted candidates with particular occupational backgrounds resulted, as may be seen from some of the data in the table at the bottom of the next page, in variations in the proportions of candidates falling in various of the descriptive classes.

Two samples of data are available for which WAC candidates accepted and rejected at medical examination have been classified according to some of their more important characteristics. The first sample is based upon the experience of 15,200 applicants who were examined from April through June 1943 as candidates for enrollment in the WAAC. The second group is composed of 32,600 applicants examined for enrollment in the WAC between October 1943 and March 1944. Therefore, the first group was examined during a period when standards for acceptance were generally more lenient and when the age limits for acceptance were narrower.

One of the prime points observable from these data is the fact that accepted candidates were younger than those who were rejected. More than half of the accepted white candidates in both groups were under 25. For rejected white candidates, 63 percent were 25 years of age or older in the earlier group, and in the second 60 percent were over age 24. Age

CAUSES OF REJECTION OF WAC CANDIDATES MEDICALLY EXAMINED
REJECTIONS PER 1,000 EXAMINED, NOVEMBER 1942-DECEMBER 1944



^{a/} Including genito-urinary
^{b/} Weight and height
^{c/} Including pulmonary tuberculosis
^{d/} Including feet

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ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

differences between colored candidates accepted or rejected were not so marked as for the white applicants primarily because of the relatively few Negro candidates over age 30. Comparison of the age distributions for candidates in the two periods reflects the change in age limits for acceptance mentioned previously. During its period as an auxiliary the age limits for enrollment in the women's corps were 21 to 44. When the WAAC was converted the acceptable age range was expanded to 20 to 49 years. The increase in the percentages accepted and rejected for all candidates in the age groups 20-24 and 40 and over for those persons examined in October through March 1944 over those examined earlier indicates this change.

Variations in the marital status of WAC candidates, both accepted and rejected, for those examined during both periods are traceable in part to the age distributions of the women being studied. Thus, the observed fact that 61 percent of white candidates accepted at medical examination between October 1943 and March 1944 were single in contrast to only 52 percent of the rejected candidates as indicated in the table on the next page is but a reflection of the younger average age of accepted candidates as shown in the table below. As compared with WAC candidates, a considerably higher percentage of WAAC applicants, both accepted and rejected were single as may be seen in the table at the bottom of the page. For older women this situation may have resulted in part from the fact that when the WAAC was integrated with the Army, the Servicemen's Dependents Allowance Act became applicable. As a result women with financial responsibilities for husbands or children between the ages of 14 and 18 became eligible. Also the extension of the maximum age limit from 44 to 49 would act toward increasing the proportion of married women, not only because a larger percentage of older women are married but also because older married women are probably more relieved of financial responsibility for children, if indeed not for their care, than are younger married women. These observations may also be considered as applying generally to those candidates who were widowed, divorced or separated. That higher proportions of these women were rejected than was the case for single women is almost entirely attributable to the fact that they were older and hence subject to higher medical rejection rates.

For all white candidates examined for enrollment in the WAC between November 1942 and December 1944, 280 out of every thousand were rejected for medical reasons. For Negro candidates the similar rate was 390 per thousand persons medically examined. The rejection rates for white and Negro applicants are compared in the chart on page 7 for the more impor-

AGE DISTRIBUTIONS OF ACCEPTED AND REJECTED CANDIDATES
BY COLOR

Age Group	Percent of Number Accepted or Rejected			
	White		Negro	
	Accepted	Rejected	Accepted	Rejected
Examined, April 1943 - June 1943				
20-24	50.3	36.9	58.7	52.4
25-29	22.3	21.1	22.4	24.2
30-34	11.8	12.7	10.4	12.4
35-39	9.2	14.1	5.6	8.4
40 and over	6.4	15.2	2.9	2.6
All Ages				
Percent	100.0	100.0	100.0	100.0
Number	10,576	3,582	664	332
Examined, October 1943 - March 1944				
20-24	55.7	40.2	69.3	63.3
25-29	15.5	14.4	16.1	17.4
30-34	9.0	10.3	6.4	5.7
35-39	8.6	10.5	4.7	7.9
40 and over	11.2	24.6	3.5	5.7
All Ages				
Percent	100.0	100.0	100.0	100.0
Number	21,506	9,779	779	569

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ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

tant causes of disqualification. The bars denoting the rates for the various causes have been ranked according to the rejection rates for white candidates. The inset in the chart lists the major disqualifying defects in the order in which they were generally assigned during the period as causes of rejection for candidates exhibiting more than one impairment. The variation between the causes of rejection, particularly with regard to psychiatric disorders is complicated by the fact that persons with obvious psychiatric conditions could be eliminated by recruiting officers and because psychiatric rejections included, in general, only those for emotional and mental disorders. Mental deficiency was not a factor in medical causes for rejection because applicants with low mentality were excluded prior to medical examination, particularly by the mental alertness test. For white candidates psychiatric rejections equalled 49 per thousand examined, and for Negro candidates the rate was 31. However, on the evidence presented by the proportions of candidates failing the mental alertness test in May and June 1945 a possible explanation of the lower psychiatric rejection rate for Negroes is their higher rejection rate at the level of the alertness test. Considering the trend of psychiatric rejections, disqualifications on medical examinations for this cause increased relatively steadily throughout 1943 and 1944 and assumed greater importance, as time passed. There are indications that rejections for psychiatric disorders were approaching one-third of all medical rejections by the end of 1944. The rate varied from between 40 to 70 per thousand medically examined each quarter from May 1943 through September 1944. For the last quarter of 1944 it rose abruptly to 104 per thousand medically examined.

Comparison of medical rejection rates for white WAC candidates with those for rejections at preinduction examinations of selective service registrants, not previously examined, for the period from August through December of 1944 indicates that psychiatric rejection rates for selectees generally followed the same trend as did those for WAC applicants. The implications of this are suggestive of changes in policies of psychiatric screening which prevailed at Army examination centers. At many of these both men and women were examined. Although no change in regulations affecting psychiatric examinations had been made, increasing emphasis had been placed on this phase of the examination procedures. In addition to those conditions which might have operated to induce concurrent increases in psychiatric rejections for both men and women, the WAC recruiting program which toward the end of 1944 was being increasingly aimed toward the procurement of female personnel with special qualifications in contradistinction to the obtaining of people with general aptitude for office-type work, may, because of the special qualifications necessary for the new jobs have induced more rigorous scrutiny of the mental and emotional characteristics of applicants. Increased hospital needs for men returned from overseas and the projected large volume of evacuees soon to be shipped resulted in wide-spread recruiting for physiotherapy aides, nurses' aides, and hospital technicians.

PERCENTAGE DISTRIBUTION OF WHITE WAC CANDIDATES BY
MARITAL STATUS AND RESULT OF EXAMINATION ^{a/}

Marital Status	Percent of Number Accepted or Rejected			
	Examined October 1943 Through March 1944 for WAC		Examined April 1943 Through June 1943 for WAAC	
	Accepted	Rejected	Accepted	Rejected
Single	61.1	52.0	71.7	67.5
Married	21.8	25.0	16.1	15.7
Widowed	3.5	5.7	1.9	2.5
Divorced	10.8	13.9	8.3	11.0
Separated	2.8	3.4	2.0	3.3
Total				
Percent	100.0	100.0	100.0	100.0
Number	21,506	9,779	10,576	3,582

^{a/} Analysis for Negro applicants not feasible, there being too few to warrant consideration.

RESTRICTED

DISEASE AND INJURY

RESTRICTED

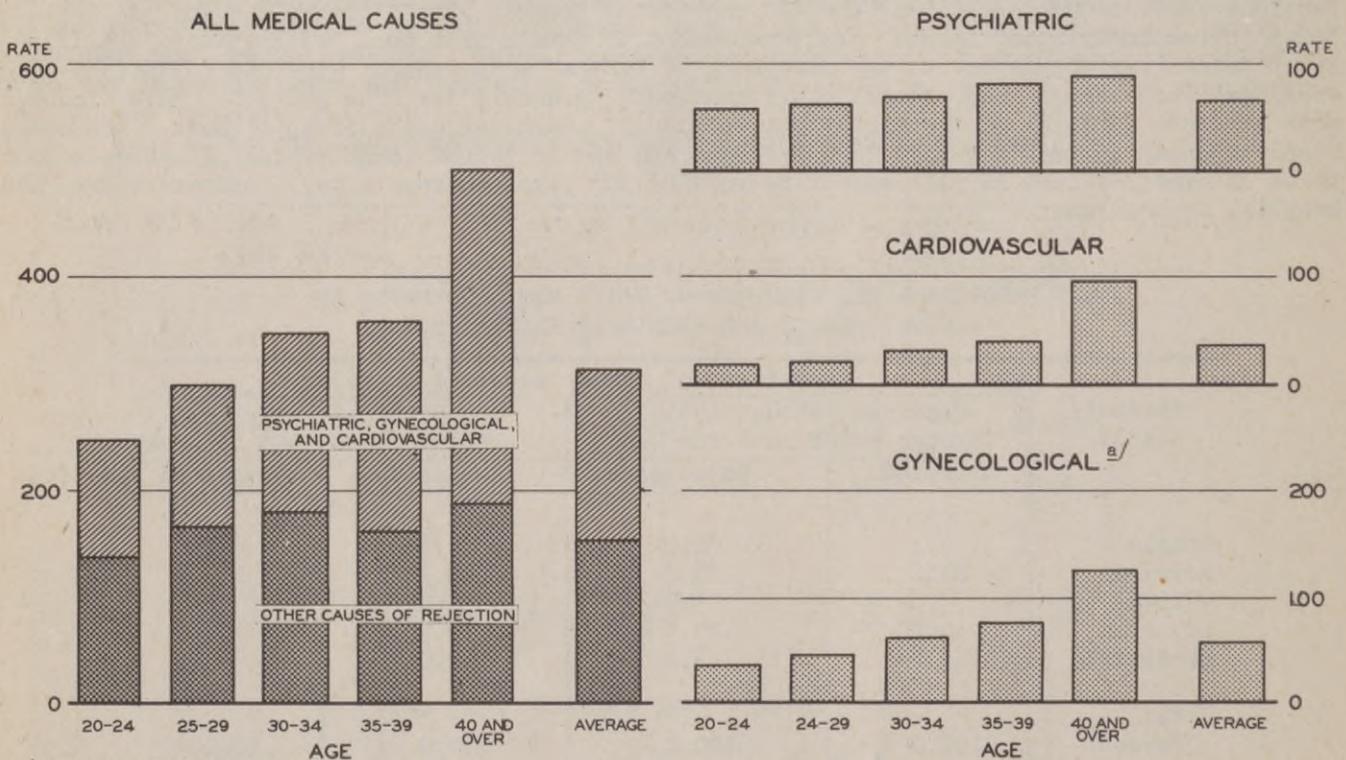
ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

The second most prominent cause of medical rejections for WAC applicants was for gynecological causes. The highest rate for this type of rejection occurred in December 1944 when 52 of each 1000 women examined were rejected for these defects. Inspection of the trend of rejections for gynecological and psychiatric defects indicates an inverse correlation between the rates for these two classes of impairments. About one-third of the candidates rejected for psychiatric reasons had gynecological defects and about one-fifth of those with gynecological defects were rejected for psychiatric reasons. The operation of a relationship of this sort would tend to produce some reduction in gynecological rejection rates when those for psychiatric rejections were high and vice versa. During the period being considered gynecological and genito-urinary defects accounted for 15 percent of all rejections of white candidates and for 17 percent of those for Negro candidates.

The most pronounced difference in rejection rates for white and Negro candidates occurred for venereal disease which was the principal cause of medical rejection for Negro women, but was ninth for white candidates. Psychiatric rejections, first for white candidates, were fifth as a cause of rejection for Negroes, and the second major source of physical disqualification for white applicants, gynecological impairments, was second for Negroes.

Another fruitful method of analyzing WAC rejection at medical examinations is to consider the age-specific rates at which disqualifying impairments are found. The charts below show these rates, for white candidates examined between October 1943 and March 1944, for all medical causes and for psychiatric, cardiovascular and gynecological reasons. The bars for all causes have been subdivided to indicate the proportion of the total rates attributable to conditions other than those shown separately as well as the aggregate contribution of these three diagnoses. So few Negro candidates were examined during this interval that it was not feasible to compute similar rates for these applicants.

MEDICAL REJECTIONS OF WHITE WAC CANDIDATES BY AGE AND CAUSE OF REJECTION
REJECTIONS PER 1000 EXAMINED OCTOBER 1943-MARCH 1944



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DISEASE AND INJURY

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ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

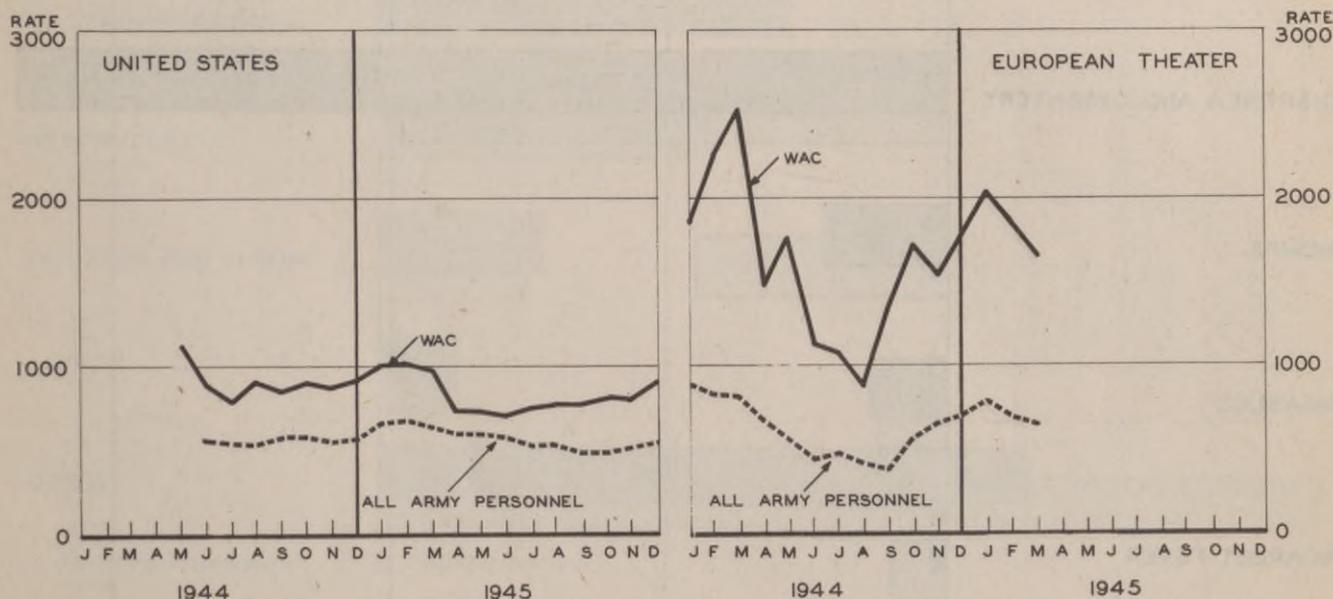
Health of the WAC

Data on which a discussion of the health of women in the Armed Forces might be based are not available on any regular basis. In addition, the small number of WAC in any overseas theater renders the interpretation of monthly trends in admission rates open to question because of the variations in rates based on small numbers.

The general proposition that sickness rates among women are generally higher than among men is borne out by the curves in the two panels below. There, the admission rate to hospital and quarters for disease and nonbattle injury combined for WAC personnel and for all Army personnel are compared for American forces in the United States and in the European Theater. Because of the small number of WAC present in Europe, no particular meaning should be attributed to the specific fluctuations in the admission rate for the women's corps. However, it is evident that the seasonal pattern of admissions for the WAC was similar to that for all personnel in the theater although the rates were much greater. A somewhat similar conclusion may be drawn with respect to the WAC rates and those for all personnel in the United States, although there the general level of morbidity was lower than in Europe. For the 19 month period between June 1944 and December 1945 the admission rate for disease for all troops in the United States was 506 per thousand men per year, about 36 percent below that of 793 for the WAC. In the chart at the bottom of the next page, the admission rates for some of the more common communicable diseases and for nonbattle injury for the WAC are compared with those for all Army personnel in the United States for this 19 month period.

For the European, Mediterranean and Western Pacific Theaters, where there were sizeable detachments of WAC, available data on hospital occupancy give some indication that relative to strength and the conditions to which they were exposed a greater proportion of hospital beds were needed in these areas for the WAC than for the Army as a whole. For example, in the Western Pacific between July 1944 and December 1945, 3.7 percent of the WAC was constantly in hospital as compared to 3.2 percent of all troops for disease and nonbattle injury only. In the Mediterranean from May 1944 through December 1945 the percentage for the WAC was 3.2 and that for all troops 3.1. Only in the European Theater was the percentage of WAC strength hospitalized less than that for all troops. There, for the same period as for the Mediterranean 2.2 percent of WAC strength was constantly in hospital in comparison with 2.5 percent for all troops for disease and nonbattle injury. Inasmuch as the WAC was not generally exposed to the chance of becoming battle casualties, the comparison of all WAC patients with only disease and nonbattle injury patients from among all troops is valid. How-

**COMPARISON OF ADMISSIONS FOR ALL ARMY PERSONNEL AND FOR WAC
DISEASE AND INJURY* ADMISSIONS PER THOUSAND TROOPS PER YEAR**



* Disease and Nonbattle injury combined.

RESTRICTED

DISEASE AND INJURY

RESTRICTED

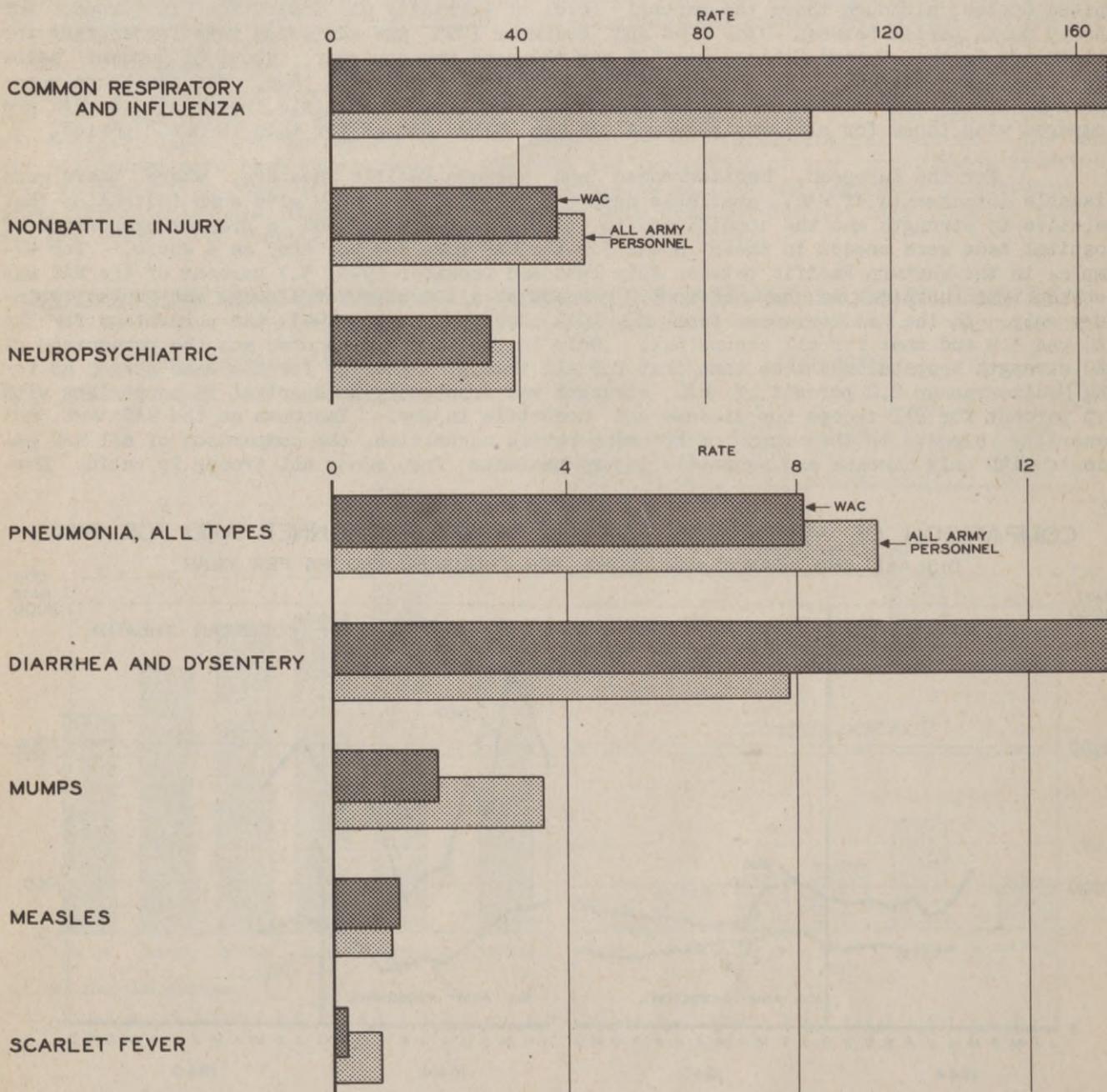
ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

ever, with respect to the fact that many morbid conditions and trauma among male personnel, such as trench foot and neuropsychiatric diseases among combat troops, are combat associated, the percentages for all troops in the theaters do not permit too clear an indication of the excess requirement of the WAC.

Discharges for Disability

During the period from May 1942 through December 1945 about 9,800 enlisted members of the WAC were discharged for disability. In terms of the average enlisted strength each year the discharge rates were 68.3 per thousand strength for 1943, 49.5 for 1944 and 44.4 for 1945. The marked drop between the rate for 1943 and those for later years, accountable for mainly by decreases in the rates of discharge for neuropsychiatric and genito-urinary de-

ADMISSIONS FOR ALL ARMY PERSONNEL AND FOR THE WAC IN THE UNITED STATES
RATES PER THOUSAND TROOPS PER YEAR, JUNE 1944 - DECEMBER 1945



RESTRICTED

DISEASE AND INJURY

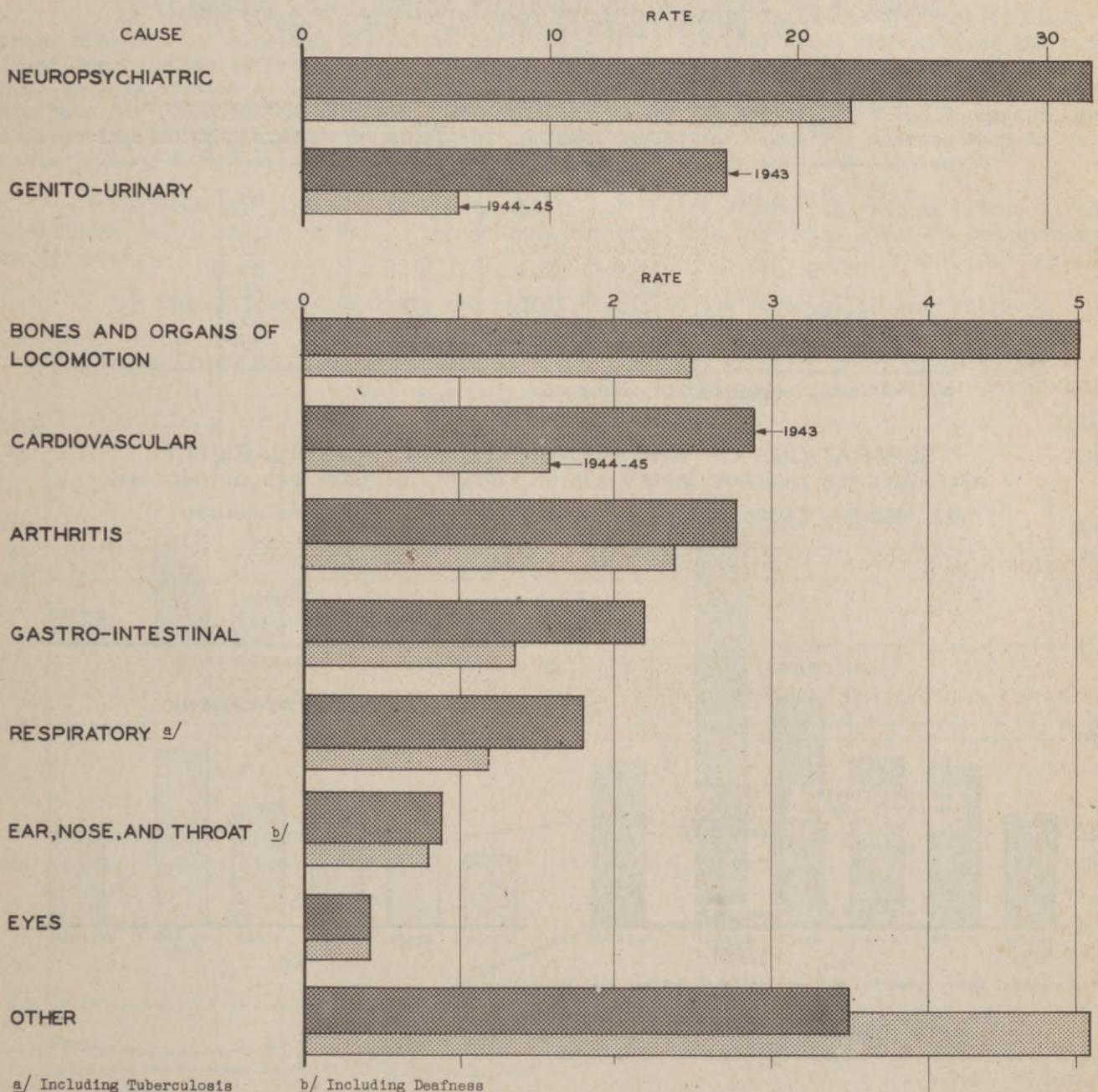
RESTRICTED

ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

facts, is most probably the result of the more stringent physical and mental standards for enrollment established directly upon the conversion of the WAAC to the WAC in September 1943, or shortly thereafter, and implemented during succeeding years. The chart below compares WAC separation rates for all personnel, for 1943 with those for 1944 and 1945 combined for some of the more important causes of discharge.

For a sample of the enlisted women who were discharged from the WAC, certain data are available which have been tabulated according to some of the characteristics of the women involved, and according to the defects found among them at enlistment. According to these data, which cover women discharged for medical reasons from October 1943 through October 1944

**SEPARATIONS OF ENLISTED WOMEN FOR DISABILITY
DISCHARGES PER 1000 ENLISTED STRENGTH PER YEAR, 1943-1945**



RESTRICTED

DISEASE AND INJURY

ENLISTMENT, HEALTH, AND DISCHARGE OF WAC (Continued)

and who were enlisted during the period October 1943 through March 1944, 57 percent were discharged with less than six months of service. In addition, the highest discharge rates obtained for those WAC who were 40 and over and were married as may be seen in the table below.

The high discharge rates for women of 40 and over compared with discharge rates at the younger ages resulted from increases in practically all medical causes of discharge, but particularly from neuropsychiatric and genito-urinary defects, as may be seen in the chart at the bottom of the page.

For the same group of WAC discharges considered above it was found that 14 percent were discharged for the same or related impairments found at the time of enlistment examination, but which were not then considered to be disqualifying.

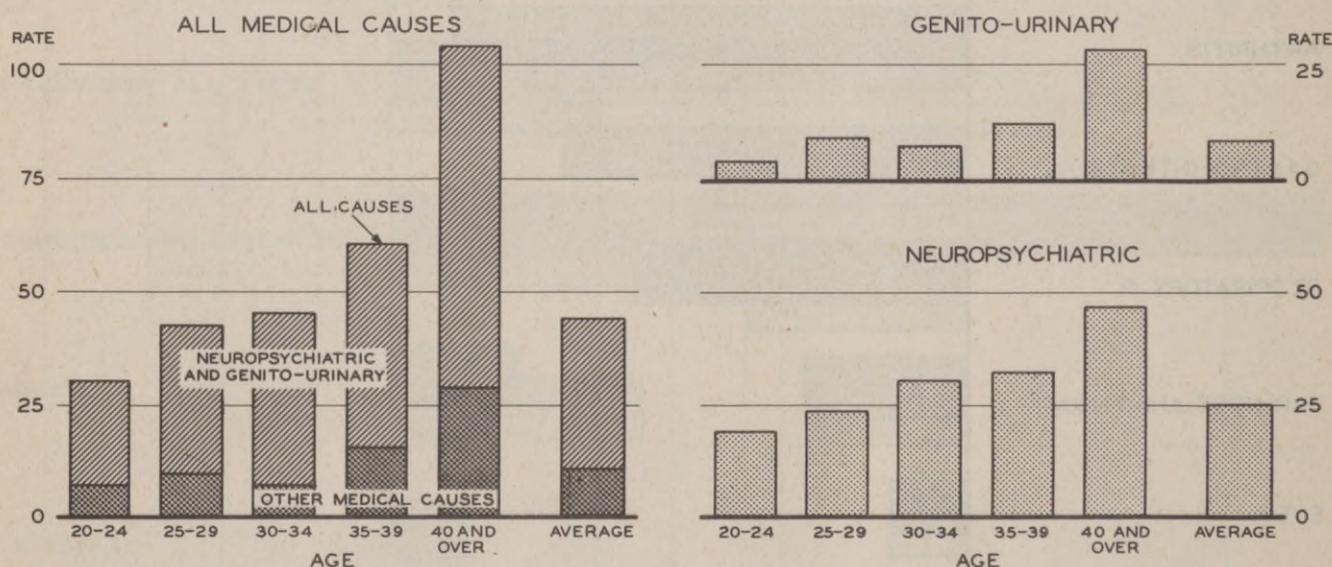
NUMBER OF WAC DISCHARGED FOR DISABILITY OCTOBER 1943 - OCTOBER 1944
WHO WERE ENLISTED OCTOBER 1943 - MARCH 1944

Discharges per 1000 White Enlisted Women

Age	Rate			
	Total	Single	Married	Other a/
All Ages	44.7	27.9	73.0	68.7
20-24	30.6	23.9	55.1	39.3
25-29	42.8	38.1	44.6	55.8
30-34	45.6	22.2	71.3	66.3
35-39	60.7	34.9	85.1	69.7
40 and over	104.4	58.3	145.9	99.5

a/ Widowed, separated or divorced

SEPARATIONS OF WHITE ENLISTED WAC FOR DISABILITY
DISCHARGES PER THOUSAND WHITE ENLISTED STRENGTH, OCTOBER 1943-OCTOBER 1944



* Discharges among personnel who were enlisted October 1943-March 1944.

DISEASE AND INJURY

RECENT TRENDS IN VENEREAL DISEASE

The April admission rates for venereal disease for troops overseas were generally below those for March. In the Mediterranean Theater, where in November 1945 the highest theater rate for the war period, 456 admissions per thousand men per year, was experienced, the April rate of 200 was 11 percent below that for March. While the April rate is not the lowest since November, it is nevertheless in line with the overall declining rate since November for the theater. After reaching a peak rate of 233 admissions per thousand men per year in January 1946, the rate in the European Theater has been declining for each month since January, although the April rate of 214 is but three points below the March figure for the theater.

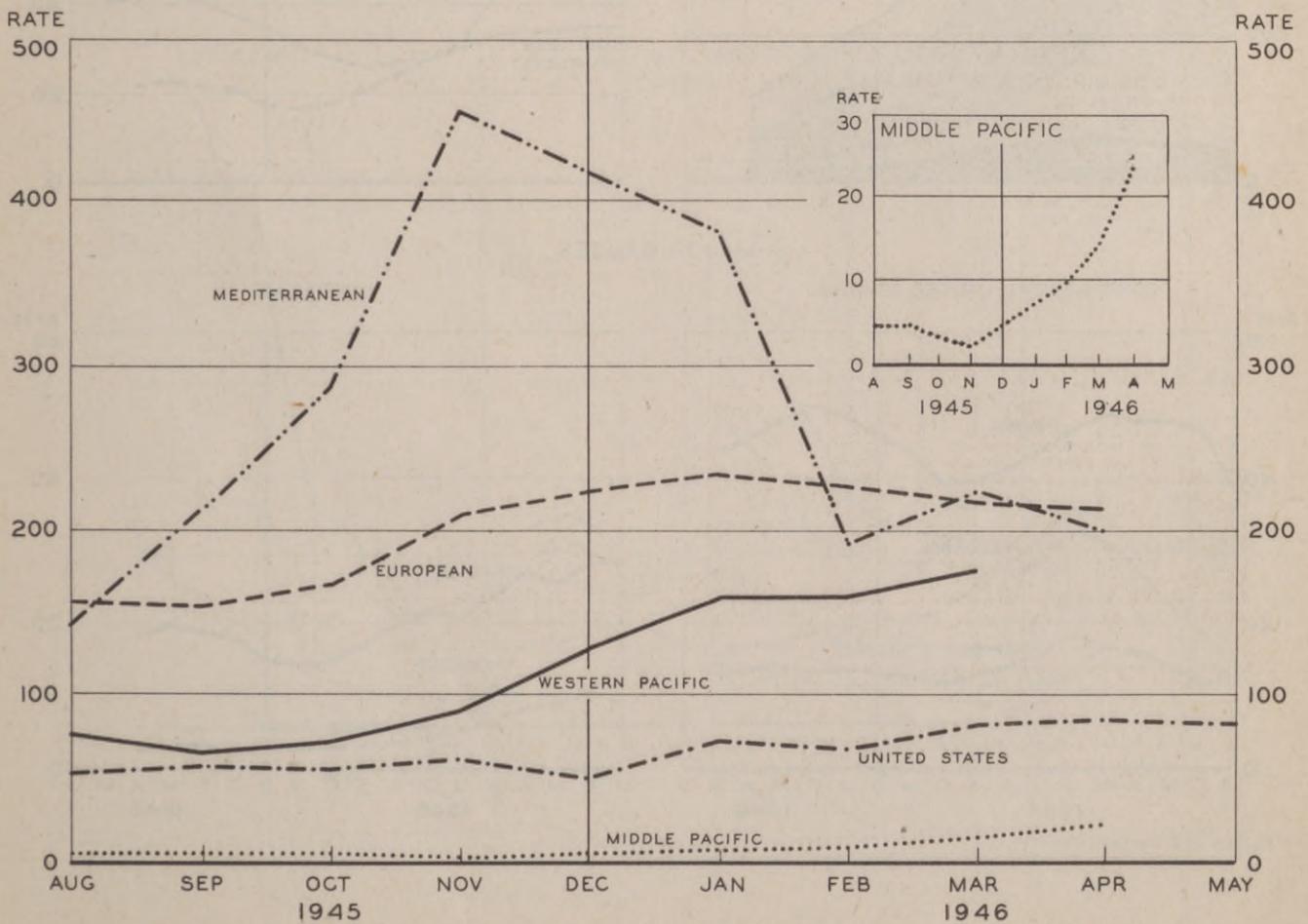
For the troops in Japan the admission rate of 215 for April represented a decrease of 11 percent below the March rate, while for troops in Korea the April admission rate of 41 per thousand per year is practically identical to that for March.

The recent trend of venereal disease rates for troops in the Middle Pacific Theater merits attention. Although the actual April rate of 23 is only about one-tenth of the rate prevailing in other epidemic areas, it should be noted that this is the highest rate experienced by this theater at least since January 1942, and that since December 1945 the admission rate for venereal disease has been doubling every two months. It would appear that an investigation is in order to avert the possibility of the venereal disease rate in this theater rising to the epidemic proportions experienced by other overseas theaters.

The venereal disease rate for troops in the United States has varied little in the three month period ending in May. The average rate for this period is about 83 per thousand men per year.

The charts below illustrate the recent trends in the venereal disease rates.

VENEREAL DISEASE ADMISSIONS IN THE UNITED STATES AND OVERSEAS
RATES PER THOUSAND MEN PER YEAR



DISEASE AND INJURY

NONEFFECTIVES IN HOSPITAL AND QUARTERS

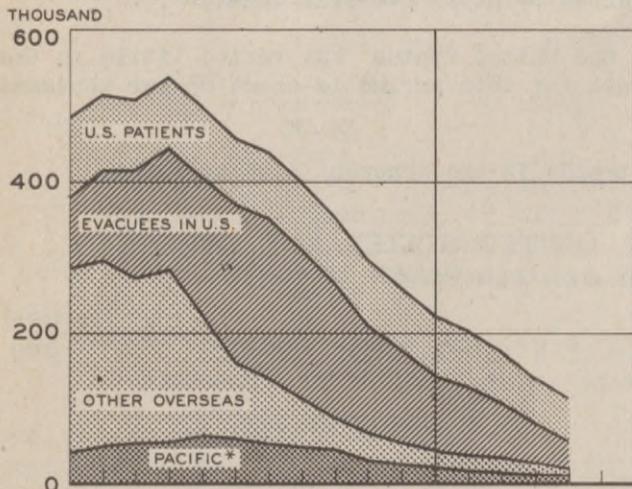
During April the Army noneffective population in the United States and the overseas theaters dropped by about 25,000 patients, or by 5,000 fewer than were discharged from medical supervision in March. The average patient population in hospital and quarters during the month was 116,500 of whom only 17 percent were overseas. With about 53,000 evacuees in Z/I hospitals there were more than two and one-half times as many patients in the United States who had originally been admitted overseas as there were patients overseas. In addition there were 20 percent more patients in the United States who were evacuees than there were patients of Z/I origin.

The most recent noneffective rates for the large aggregates of troops are all favorable. In the United States the preliminary rate for May, excluding evacuees, is 41. This is the same as that for April. The latest rate for all troops overseas, that for April, is 22 for all causes, one unit lower than for March. The moving factor responsible for the decline in the total rates has been the downward movement of the rates for disease which are dropping now that the winter season has passed.

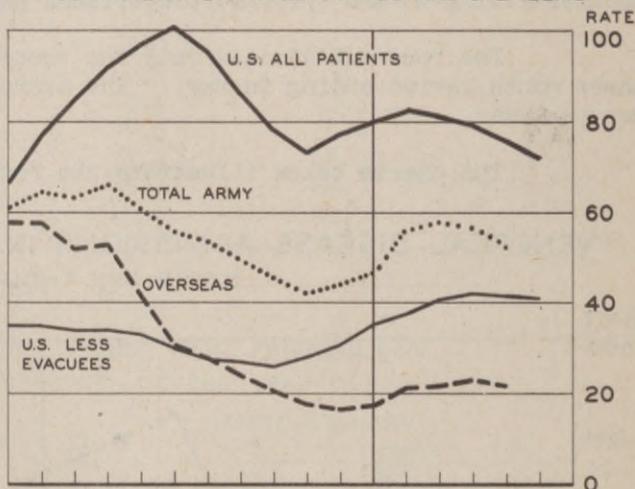
AVERAGE NUMBER OF NONEFFECTIVES PER THOUSAND STRENGTH

ALL CAUSES

AVERAGE NUMBER OF PATIENTS EACH MONTH

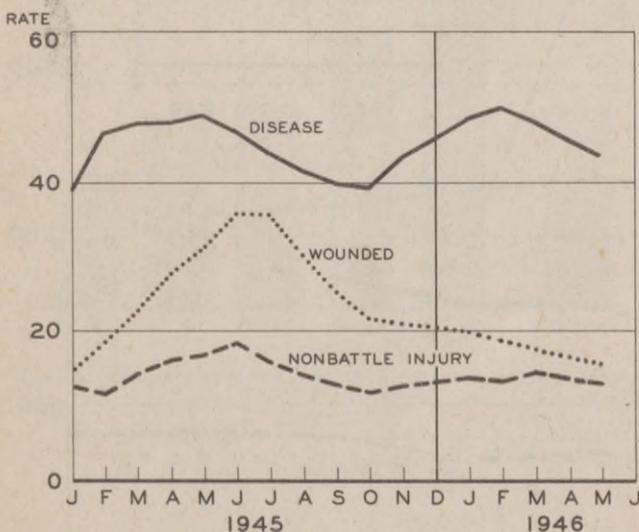


CONTINENTAL UNITED STATES AND OVERSEAS

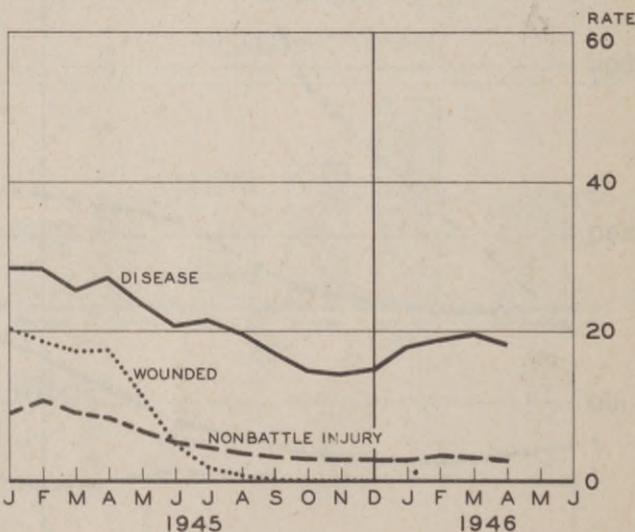


MAJOR CAUSES

CONTINENTAL UNITED STATES



OVERSEAS



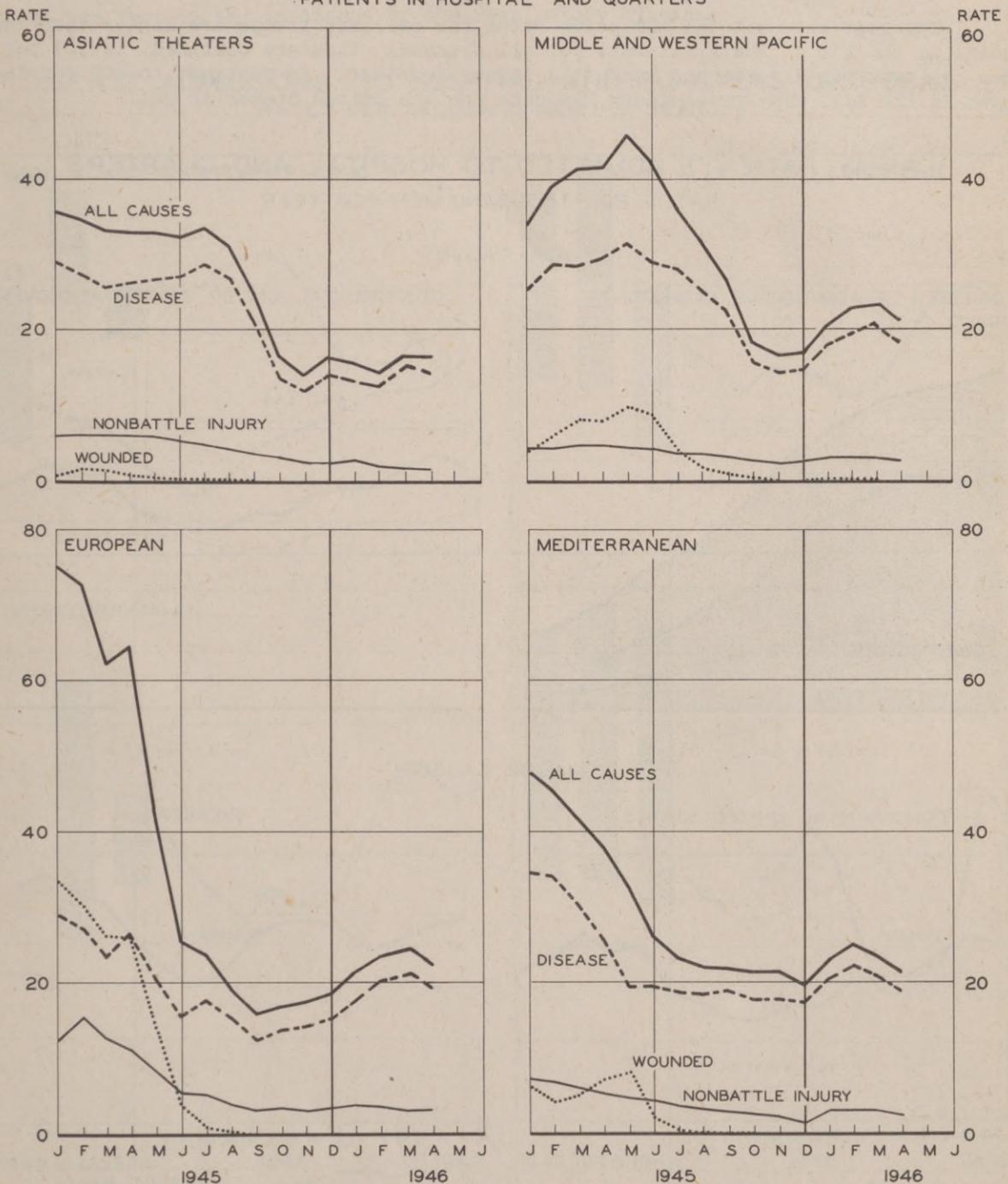
* Middle and Western Pacific

DISEASE AND INJURY

NONEFFECTIVES IN HOSPITAL AND QUARTERS (Continued)

Noneffective rates for all causes, and for disease and nonbattle injury declined in the major overseas theaters during April as may be seen from the chart below. Concurrently with the end of the respiratory season, and a certain stabilization of theater strengths, the noneffective rates are again exhibiting trends in agreement with variations in epidemiological conditions. The latest rates for all causes are 16 for the Asiatic Theaters, 22 for the European Theater, 21 for the Mediterranean Theater and 24 for the Middle and Western Pacific. For the Caribbean and Alaska, not shown below, the April rates for all patients, were 19 and 18 per thousand strength respectively.

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



DISEASE AND INJURY

TREND OF HOSPITAL AND QUARTERS ADMISSIONS IN THE UNITED STATES AND OVERSEAS

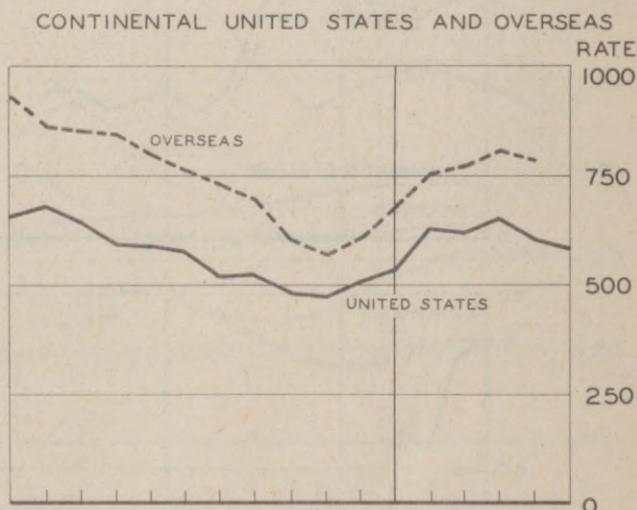
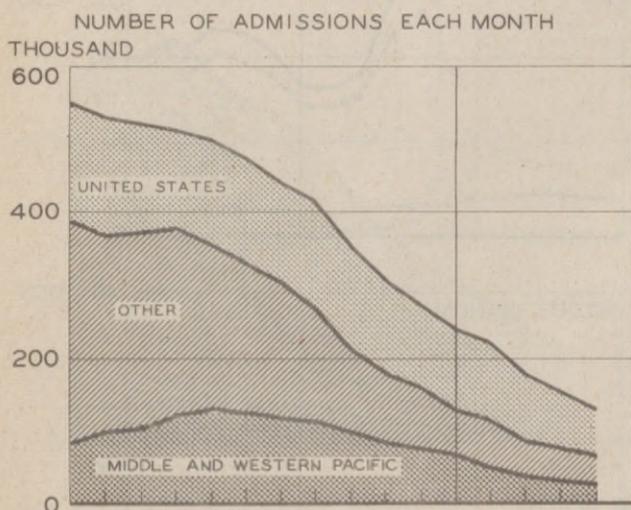
With this issue of HEALTH it is again possible to present relatively current rates for hospital and quarters admissions for overseas troops.

Hospital and quarters admission rates are better indexes of general morbidity than hospital rates because their base includes minor diseases which, while they may not all be significant contributors to overall noneffectiveness, can at particular times render large groups of troops noneffective. In the United States where the proportion of admissions confined to quarters is relatively constant at about ten to fifteen percent the hospital admission rate is adequate. However, the proportion of admissions which do not go to hospital overseas is extremely variable both between theaters and from month to month for each theater.

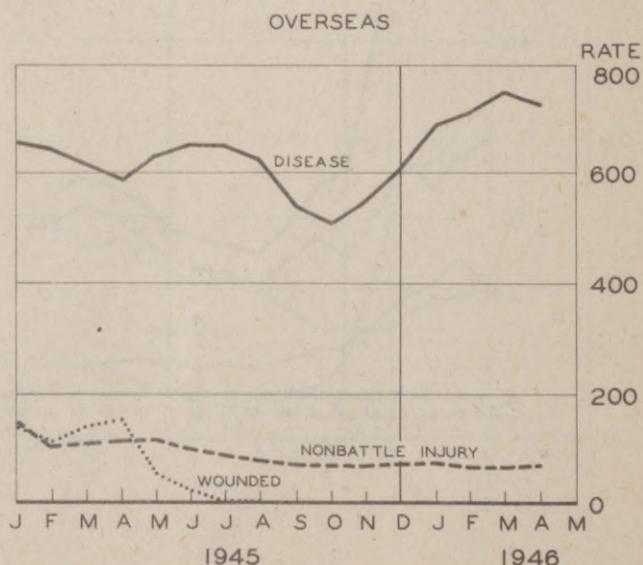
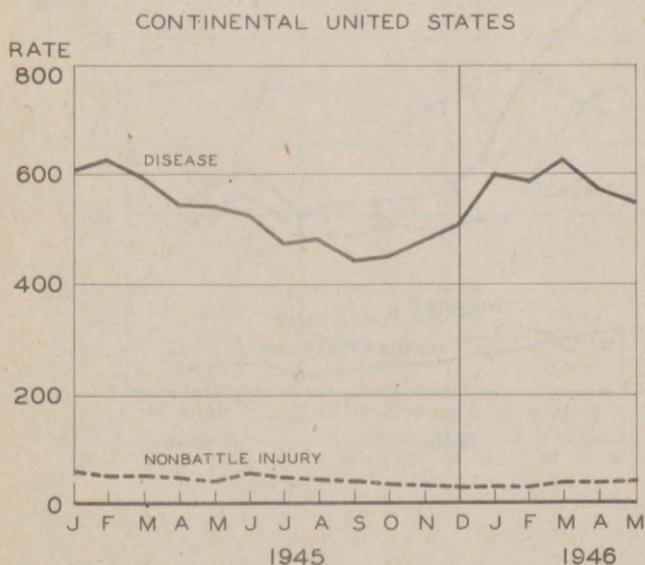
The most recent total admission rates for overseas troops are higher than those for personnel in the Z/I. The April rate for all overseas theaters combined, is 787 per thousand men per year for disease and nonbattle injury together, in contrast to 605 for the troop strength in the Z/I. The preliminary May rate for the United States is 581.

ARMY PATIENTS ADMITTED TO HOSPITAL AND QUARTERS RATES PER THOUSAND MEN PER YEAR

ALL CAUSES



MAJOR CAUSES



DISEASE AND INJURY

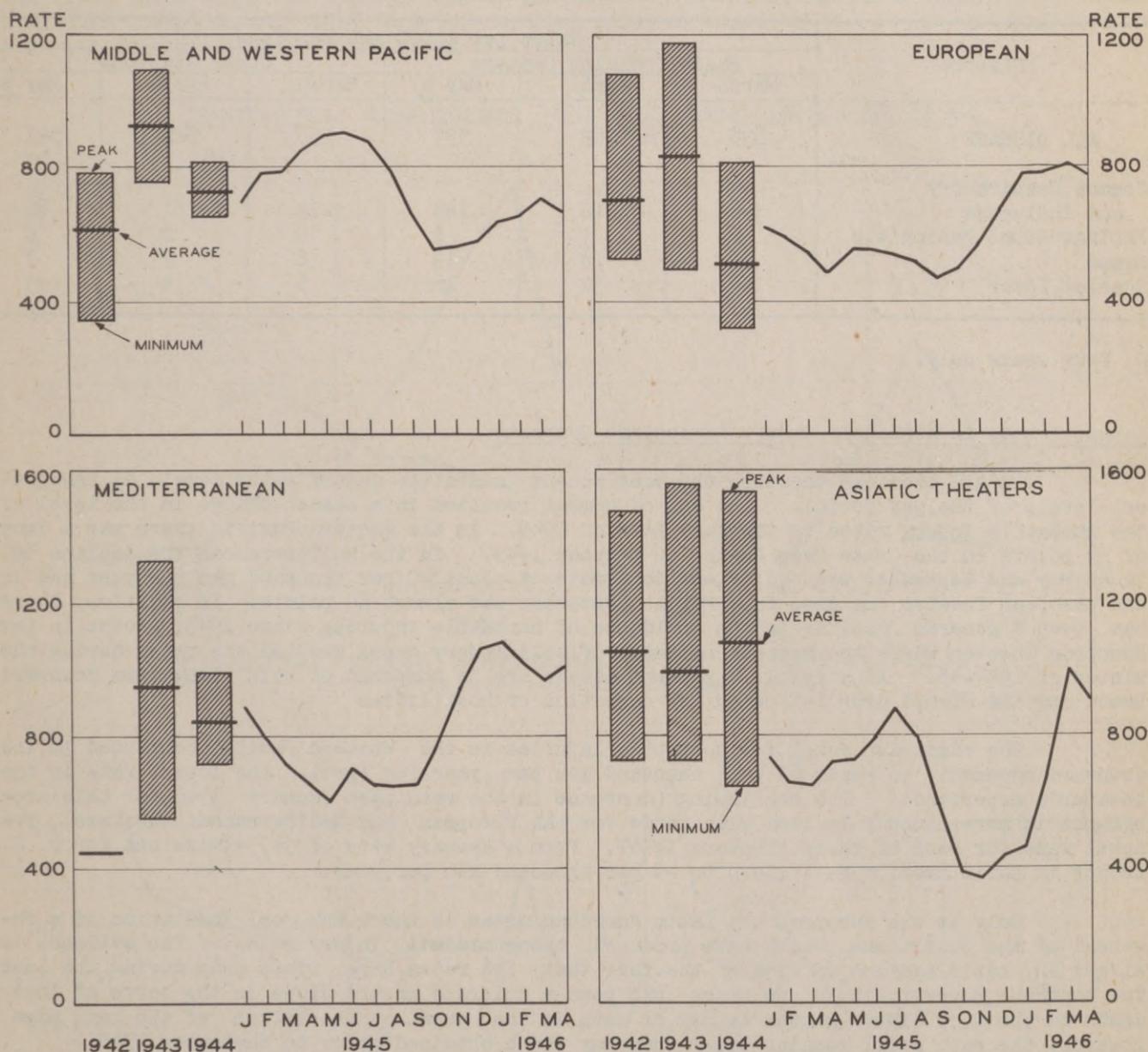
DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS

After rising steadily from a rate of 456 per thousand men per year, hitting a peak of 802 in March, the admission rate in the European Theater for April dropped to 775, approximating very closely the January rate. Similarly, while increasing month by month from 542 in October to 695 in March, the April rate of 668 for the Middle and Western Pacific was about midway between its February and March rates.

For the Mediterranean Theater, however, where the trend since January 1946 appeared to be downward, the April rate of 1004 exceeded that for March by some 40 admissions per thousand men per year, and was identical to the rate for February.

The overall decline in the admission rate for all disease reflects to a considerable extent the drop in the incidence of the respiratory diseases.

DISEASE ADMISSIONS TO HOSPITAL AND QUARTERS OVERSEAS RATES PER THOUSAND MEN PER YEAR



DISEASE AND INJURY

HEALTH BRIEFS

Basic Training Centers

During May a further drop in admission rates was recorded for the thirty percent of the U. S. troop strength in basic training centers. The rate for all disease was 597, about 30 percent lower than the peak rate which was reported during March. However, the disease rate for these stations remains above that for troops in other than basic training centers, where the rate was only 521 during May and 522 in April. Although the epidemics among troops at Fort Belvoir and Camp Crowder have subsided, abnormally high admission rates are currently being reported at Buckley Field, Colorado; Fort Eustis, Virginia; and Camp Shelby, Mississippi. Fort Eustis is a training center and Camp Shelby is a personnel center. The disease rate for troops at the Aberdeen Proving Grounds remains within the highest seven reported from the various posts during May. The table below indicates the latest available rates for basic training centers and other stations in comparison with those for the last two months.

LATEST ADMISSION RATES FOR TROOPS IN BASIC TRAINING CENTERS

Disease	Rates per 1,000 Men per Year					
	Basic Training Centers			Other Stations		
	March	April	May a/	March	April	May a/
ALL DISEASE	835	682	597	550	522	521
Common Respiratory and Influenza	366	212	145	113	81	80
Meningococcal Meningitis	2	1	1	0	0	0
Mumps	22	18	13	8	7	7
Scarlet Fever	43	32	16	5	4	3

a./ Four weeks only.

Latest Trends in Nonbattle Injury Admissions Overseas

In all overseas theaters the most recent nonbattle injury rates remain at the lowest levels of the war period. The end of combat resulted in a sudden change in the level of the nonbattle injury rates in the last half of 1945. In the Western Pacific there was a drop of 24 points in the rate from August to October 1945. In the Mediterranean the decline between May and September was equivalent to a rate of about 40 per thousand men per year and in the European Theater the drop from May to September was almost 60 points. In addition, there has been a general decline in the incidence of nonbattle injuries since 1943, except in the European Theater where the massive epidemic of cold injury cases swelled the rates during the winter of 1944-45. As a result, present levels are a compound of this long term downward trend and the abrupt drop following the cessation of hostilities.

The admission rate for nonbattle injuries in the Western Pacific continued in its downward movement to reach 63 per thousand men per year for April, the lowest rate in the theater's experience. The continuing decrease in the rate past January 1946 for this area brought it more closely in line with those for the European and Mediterranean theaters. The April rate for each of these theaters is 67. From a January rate of 34, admissions for U. S. troops in Latin America have risen to 49 per thousand men per year.

Only in the European and Latin American areas is there any real indication of a reversal of the conditions which have produced these minimal injury rates. The evidence is slight in Latin America in view of the fact that the rates have risen only during the last few months. However, in Europe there has been a moderate upward slope in the curve of incidence in the last eight months as may be seen in the panel at the bottom of the next page. However, the rate still remains lower than any which obtained prior to September 1945.

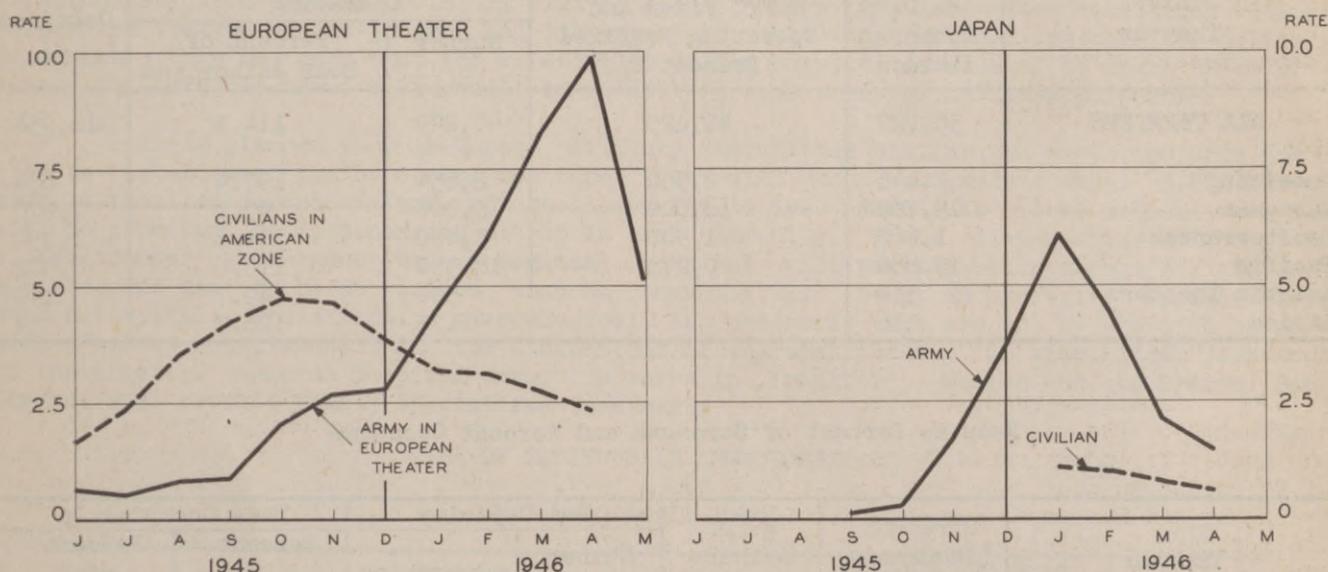
DISEASE AND INJURY

HEALTH BRIEFS (Continued)

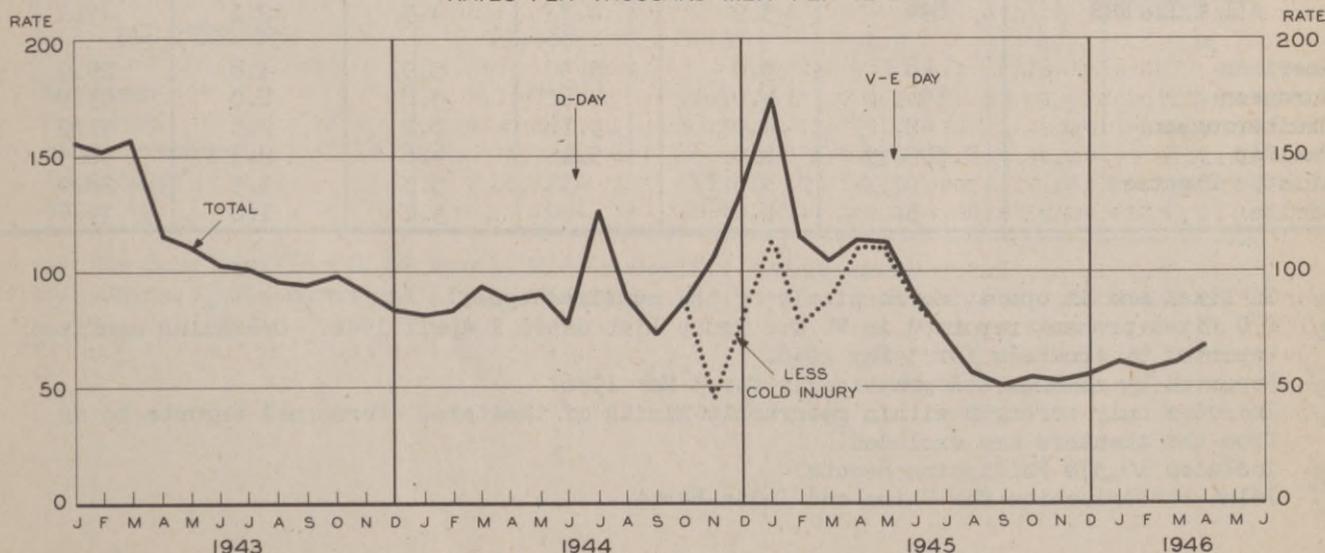
Diphtheria

With the passing of the winter seasons in the European Theater and Japan, the epidemics of diphtheria which have occurred among U. S. Army personnel in these areas during the past six months are subsiding. The preliminary May rate for all troops in the European Theater, 5.1 per thousand men per year, is almost fifty percent less than the peak rate of 9.9 for April. The latest available rate for the forces in Japan, that for April, is 1.5, about one-fourth the peak rate of 5.1 for January. The panels below indicate the course of the epidemics in these two areas and compares for the European Theater the rates for all U. S. troops with those for German civilians in the U. S. occupation zone. The high incidence among army troops is the direct result of epidemic incidence among the civilian populations. Although the incidence among the German civilians has declined since the peak reported in October this drop represents no more than a normal seasonal fluctuation superimposed on a widespread epidemic both in time and geographically. Incidence among civilians in the British, U. S., and French zones during the past winter was the highest ever recorded during the war and about three times the 1928-38 pre-war median. Rates for civilians in Japan first became available during January 1946 and the reported cases averaged about 0.9 per thousand persons per year for the first four months of the year.

DIPHThERIA ADMISSIONS PER THOUSAND MEN PER YEAR



NONBATTLE INJURY ADMISSIONS IN THE EUROPEAN THEATER RATES PER THOUSAND MEN PER YEAR



RESTRICTED**HOSPITALIZATION**HOSPITALIZATION OVERSEAS

During April the capacity of hospitals overseas was further reduced in line with the declining needs concomitant upon reduced strength and favorable admission rates. By the end of the month only 42,100 beds remained in T/O fixed and operating nonfixed units. However, only 40,300 of these were operating and occupancy was equivalent to but 47 percent of this latter total. In all theaters the present hospital load is well below critical levels, exceeding 50 percent of the operating capacity only in the European Theater and averaging 47 percent for all theaters combined.

The tables below are similar to those which have appeared in previous issues of HEALTH and have been included more to maintain a continuity in the various series than for current usefulness of all of the data. The percentages for the Asiatic Theaters reflect the rapid closeout of medical facilities in India-Burma which was inactivated on 31 May. For the Detachment, U. S. Army in India two medical officers each with a small amount of dispensary equipment have been left in Calcutta and New Delhi to insure the adequacy of the medical care

BEDS AVAILABLE AND OCCUPIED IN OVERSEAS THEATERS ^{a/}

Number of Beds, 30 April 1946

Theater	W. D. Author-ization	T/O Fixed and Operating Nonfixed Present ^{b/}	Operating		Occupied ^{c/}
			Number ^{c/}	Percent of Beds Authorized	
ALL THEATERS	35,227	42,125	40,279	114.3	18,954
American	1,446	2,550	2,854	197.4	854
European	15,769	18,000	15,000	95.1	7,970
Mediterranean	1,662	1,300	3,400	204.6	1,054
Pacific	15,880	20,275	18,350	115.6	8,902
Asiatic Theaters	334	-	500	149.7	140
Africa	136	-	175	128.7	34

Beds as Percent of Strength and Percent Occupied

Theater	Strength (Thousands) ^{d/}	W. D. Author-ization	Bed Capacity		Beds Occupied As	
			Number Present	Operating	Percent of Strength	Percent of Operating
ALL THEATERS	894	3.9	4.7	4.5	2.1	47.1
American	48	3.0	5.3	5.9	1.8	29.9
European	394	4.0	4.6	3.8	2.0	53.1
Mediterranean	42	4.0	3.1	8.2	2.5	31.0
Pacific	397 ^{e/}	4.0	5.1	4.6	2.2	48.5
Asiatic Theaters	9	3.5 ^{f/}	-	5.3	1.5	28.0
Africa	3	4.0	-	5.1	1.0	19.4

^{a/} In fixed and in operating hospitals of the nonfixed type.

^{b/} T/O fixed present reported in W. D. Troop List dated 1 April 1946. Operating nonfixed reported by theaters for 3 May 1946.

^{c/} Reported by theaters telegraphically for 3 May 1946.

^{d/} Includes only strength within geographic limits of theaters. Personnel enroute to or from the theaters are excluded.

^{e/} Includes 10,376 Philippine Scouts.

^{f/} Joint authorization for China and India-Burma.

RESTRICTED

HOSPITALIZATION

RESTRICTED

HOSPITALIZATION OVERSEAS (Continued)

received by troops who remain in the area and are concentrated in these cities. U. S. personnel needing hospitalization are to be cared for in British military and civilian hospitals. The last U. S. hospitals in India-Burma were inactivated on 2 May and all patients remaining were transferred to a 50-bed dispensary. On 29 May all patients remaining in this unit, were transferred to the last troopship leaving Calcutta.

The most important problem facing the medical department in the overseas theaters at the present time is the requirement that it provide complete medical services for U. S. nationals who are employed by the War Department overseas, and for the dependents of both the military and civilian employees. At the present time no additional provisions for personnel or equipment have been authorized, and the civilian personnel must be cared for within the limits of the capacity based on the present authorizations for military personnel only. Although on 31 March, the latest date for which a count is available, there were only 23,000 civilian employees overseas, and although only about 3200 dependents were embarked for overseas between February and May, there are indications that the total added population may well reach 100,000. The table below shows, as of 19 April the composition of the hospital load in the overseas areas. For all the theaters combined, 13 percent of the patients in hospital on that date were non-army, and civilians alone constituted more than five percent. Undoubtedly the sick rates for the large number of women and children will be greater than those for army troops in the theaters. However, inasmuch as these dependents will be maintaining regular households it is to be expected that some or all of their convalescent time associated with recovery from disease or injury will be spent at home, and that minor conditions will be more often treated by out-patient and dispensary services than has been the case for military personnel. This may mean that the relative needs for hospital service of at least those civilians who have dependent status will be relatively less than for military personnel.

It is planned that in Europe military communities similar to peacetime Army posts will be established in the occupation zone. They will each accommodate about 3,000 troops plus authorized dependents and all ancillary facilities. Immediate local medical service will be provided by dispensaries set up in each community. These dispensaries will contain a small number of emergency beds. Regional hospitals will provide bed coverage for all communities and are to be so located that no community will be at an excessive distance from such a hospital. Obstetrical, gynecological and pediatric care are to be provided at certain of these hospitals within the limitations of the availability of specialized personnel in the theater. General hospital care, in units in Frankfurt, Munich and the Bremen Port Command will provide highly specialized treatment.

TYPE OF PATIENTS IN ARMY HOSPITALS

19 April 1946

Theater	Number of Patients	Percent Who Were			
		Army	Other Armed Forces	PW	Civilians
ALL THEATERS	21,488	87.1	3.3	4.2	5.4
American	734	91.3	0.2	0.3	8.2
European	8,207	88.3	5.8	1.4	4.5
Mediterranean	1,126	86.1	2.9	4.2	6.8
Pacific a/	11,122	86.3	1.5	6.6	5.6
Other b/	299	80.9	11.4	1.0	6.7

a/ Western Pacific for 12 April; Middle Pacific for 19 April.
 b/ China, India-Burma and Africa Theaters.

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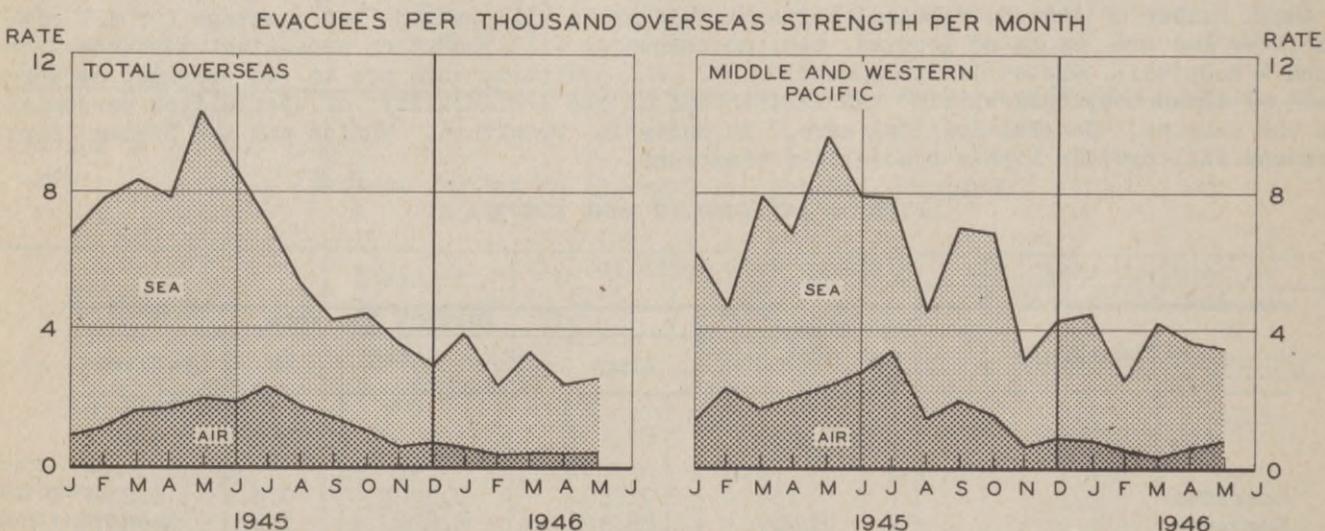
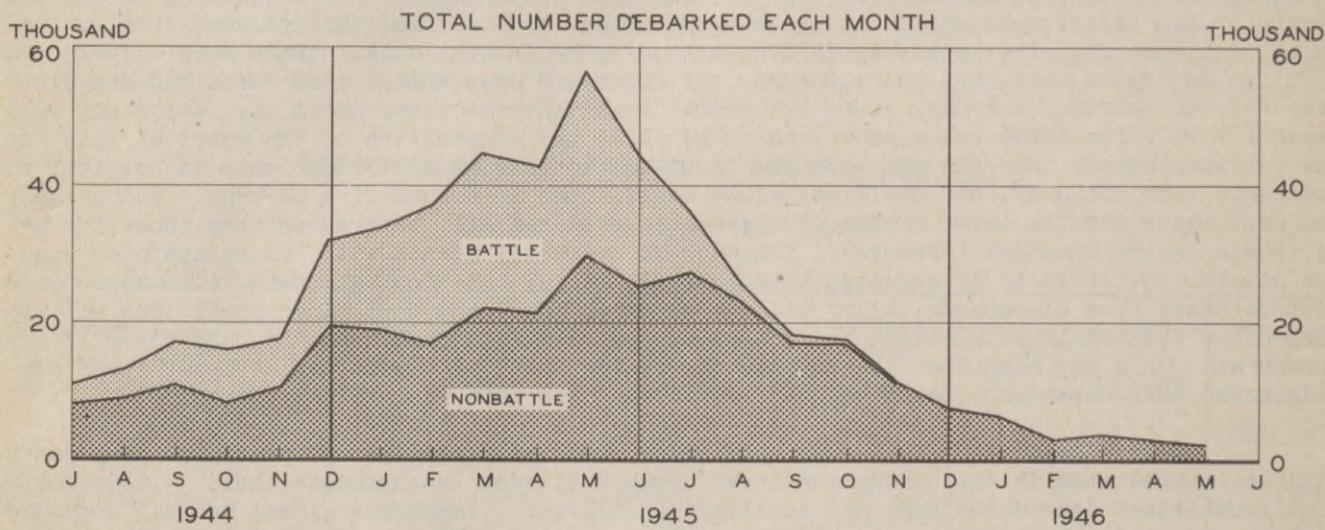
HOSPITALIZATION

RESTRICTED

EVACUATION FROM OVERSEAS

In the month of May 2,300 Army patients were debarked in the Z/I, slightly less than the number arriving in April. In contrast, the total evacuation rate of 2.6 per thousand and overseas strength per month for May is a trifle higher than the April figure of 2.5 as the result of a decline in overseas troop strength which was proportionately greater than the drop in the number of evacuees received. The rate of debarkation by air in May is the same as that of 0.4 which obtained in April. The air evacuation rate for May for the Middle and Western Pacific is 0.8, and the combined sea and air rate is 3.5.

EVACUATION OF ARMY PATIENTS FROM OVERSEAS



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HOSPITALIZATION

HOSPITALIZATION IN THE ZONE OF INTERIOR

The rapid decline in patient load in the general and convalescent hospital system that began in July 1945 continued uninterruptedly through the current month. During May, the number of patients remaining in general and convalescent hospitals decreased by an additional 11,000. However, the number of beds occupied declined by only 7,000 indicating a substantial cut in the number of patients absent from hospitals due to furloughs and sick leave.

By the end of May, the patient load of the general and convalescent hospital system totaled only 58,000 as compared to 69,000 at the end of the previous month and 245,000 less than a year ago. Eighty percent of the patients were present in the hospitals at the end of the month, the highest ratio registered since January 1945. The number of overseas evacuees included in the patient load declined from 42,000 at the beginning of the month to 33,000 at the end of the month. The reduction of 9,000 in this figure was a net between 11,000 dispositions and 2,000 new arrivals. Battle casualties remaining declined by 4,000 during the month, totaling 16,000 at the end of May.

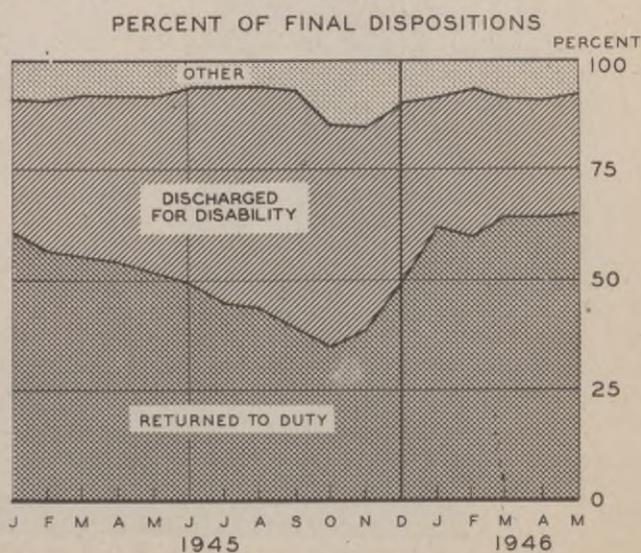
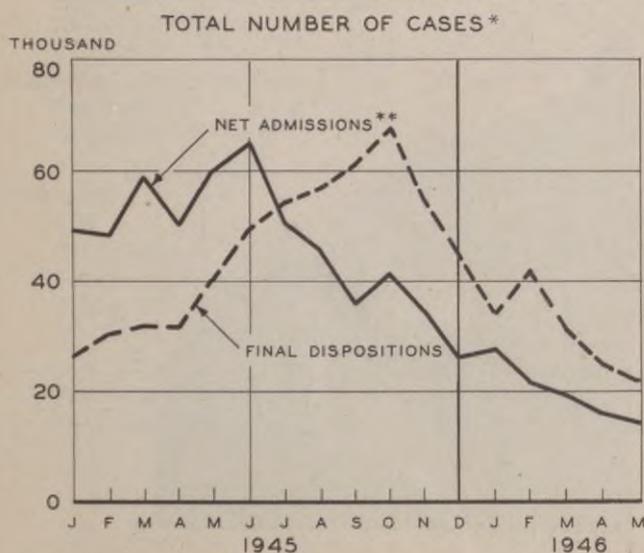
The patient capacity of the general and convalescent hospital system was reduced by 7,500 during May. A total of 9,500 beds was eliminated by the closure of Crile General Hospital and the reduction of authorized capacities in the hospitals scheduled to close in June. In addition, 500 beds were eliminated from the authorized capacity of Beaumont General Hospital. Partially offsetting these reductions, the designation of Waltham, Coral Gables and Pasadena Area Regional Hospitals as Murphy, Pratt, and McCornack General Hospitals respectively on 15 May 1946 added 2,500 beds to the general hospital system.

The planned closure of eleven general hospitals and two convalescent hospitals in June in addition to the two general hospitals already closed during this quarter necessitate the transfer of approximately 7,000 patients requiring further treatment to hospitals remaining open after 30 June. The bulk of these patients were transferred during May. These patients were primarily orthopedic, plastic, neurosurgical and amputation cases whose treatment could not be completed within the three month blocking period.

As a result of the closure of the 13 general hospitals during this quarter, five neurosurgical, three amputation, three plastic and ten general and orthopedic surgery specialized centers will be discontinued by 30 June. The loss of these centers and the continuing necessity to consolidate specialized centers for the most effective utilization of the limited number of specialized personnel available made necessary a reevaluation of the specialized bed structure of the general hospitals remaining open after 30 June 1946 with the following results:

- a. The establishment of an amputation center at Letterman General Hospital.
- b. The establishment of plastic and ophthalmologic surgery centers at McCornack.
- c. The elimination of the plastic surgery and ophthalmologic surgery centers at Wakeman and Beaumont General Hospitals.
- d. The elimination of the neurosurgical and neurological centers at Mayo.
- e. The decision to continue operation of approximately 300 beds for deaf patients at Borden General Hospital for several months after 30 June when the remainder of the hospital will close. This was necessary because of the inability of the contractors

ADMISSIONS AND DISPOSITIONS OF PATIENTS IN GENERAL AND CONVALESCENT HOSPITALS



* Adjusted to four-week months.

** Total admissions less dispositions by transfer.

HOSPITALIZATION

HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

to meet the scheduled date for the completion of facilities for deaf patients at Walter Reed General Hospital.

Preliminary estimates of bed requirements for general hospitals for the end of September 1946 indicate the feasibility of closing Cushing, Mayo and O'Reilly General Hospitals during the third quarter of the year. The elimination of Cushing General Hospital in lieu of Halloran has been recommended in order to avoid transferring patients from the New York area to distant hospitals. The recent addition of Murphy General Hospital will provide the required beds in the New England area.

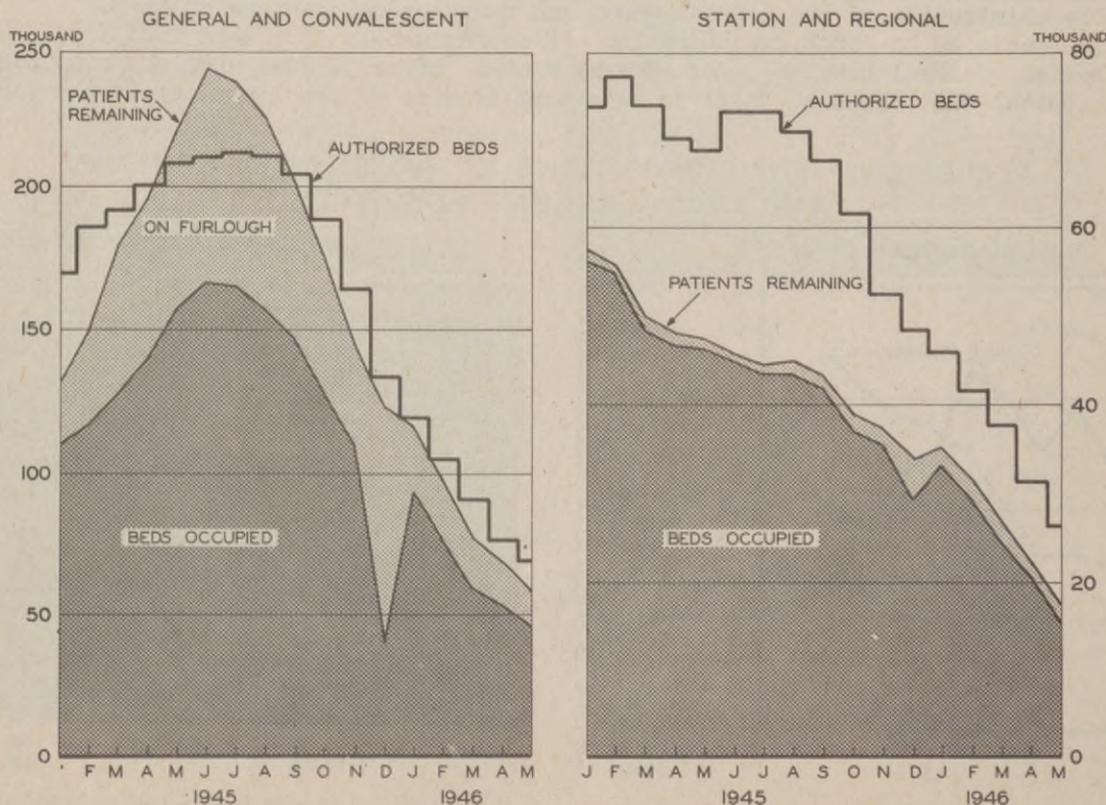
The number of patients remaining in station and regional hospitals declined by 4,600 during May. The decline in Army patients was greater but offsetting it was an increase of 500 in the number of Veterans Administration beneficiaries in station and regional hospitals. The number of beds authorized in station and regional hospitals decreased by 5,600. Approximately 1,000 of the decline in patients and 1,100 of the decline in beds is attributable to the redesignation of Waltham and Pasadena Area Regional Hospitals as general hospitals. In accordance with a plan to eliminate regional hospitals from the Zone of Interior hospital system, five Army Area and eight Army Air Force Regional Hospitals have been recommended for reduction to station hospital status on 30 June and the balance by the end of September.

Corresponding to the reduction in authorized beds, personnel requirements for the operation of Zone of Interior hospitals, other than Army Air Force, were reduced by 7,500 during May. Personnel assigned to these hospitals dropped by 19,600 during the month. All categories of personnel participated in this decrease. The largest declines were: civilians 10,500; enlisted men 5,900; nurses 2,000. The surplus in officers has been eliminated entirely and the surplus of 16,000 in enlisted men and civilians recorded at the end of April has been reduced to less than 5,400 by the end of May.

Summary:

- a. Patient load and authorized patient capacity of the general and convalescent hospital system continue to decline rapidly.
- b. Waltham Area, Coral Gables and Pasadena Regional Hospitals were redesignated as Murphy, Pratt and McCornack General Hospitals respectively on 15 May 1946.
- c. Considerable revision of the specialized bed structure of the general hospitals was effected during May.
- d. Five Army Area and eight Army Air Force Regional Hospitals have been recommended for change to station hospital status on 30 June and the remainder by 30 September.

HOSPITAL CAPACITY AND PATIENT LOADS, Z/I HOSPITAL



HOSPITALIZATION

HOSPITALIZATION IN THE ZONE OF INTERIOR (Continued)

e. Assigned personnel in Zone of Interior hospitals decreased by more than 19,000 during May.

SUMMARY ASF HOSPITALIZATION IN THE ZONE OF INTERIOR End of May 1946

Type of Hospital	Patient Capacity		Patients Remaining		Beds Occupied	Personnel Shortages ^{c/}		
	Authorized	Effective ^{a/}	Number ^{b/}	Percent of Effective Beds		MC	ANC	Total
Total	94,877	88,325	75,501	85.5	62,338	-546	-97	-5,366
General	63,704	62,829	53,553	85.2	42,319	-337	-37	-2,915
Not Blocked	54,754	53,879	47,284	87.8	36,921	-273	249	502
Blocked ^{d/}	8,950	8,950	6,269	70.0	5,398	-64	-286	-3,417
Convalescent	5,190	5,190	4,565	88.0	3,690	22	-8	322
Not Blocked	3,690	3,690	3,423	92.8	2,689	25	-	803
Blocked ^{d/}	1,500	1,500	1,142	76.1	1,001	-3	-8	-481
Regional	12,079	9,663	9,087	94.0	8,356	-114	-71	-1,296
Station ^{e/}	13,904	10,643	8,296	77.9	7,973	-117	19	-1,477

^{a/} Less debarkation beds and 20 percent dispersion in regional and station hospitals.

^{b/} Data exclude patients in triage at debarkation hospitals.

^{c/} Overages are indicated by a minus sign (-).

^{d/} Hospitals scheduled for closure by 30 June 1946 and blocked for receipt of new patients.

^{e/} Includes hospitals under the Chief of Transportation.

BEDS AUTHORIZED AND PATIENTS REMAINING IN ASF HOSPITALS BY TYPE OF CARE AND TYPE OF HOSPITAL ^{a/} End of May 1946

	Beds Authorized	Patients Remaining				
		Total	General	Convalescent	Regional	Station ^{b/}
Total	93,402	75,501	53,553	4,565	9,087	8,296
General-Convalescent Care	53,057	43,266	38,772	4,494	-	-
Evacuees		32,888	29,127	3,761	-	-
Z/I		10,378	9,645	733	-	-
Regional-Station Care	31,447	26,687	11,563	65	8,006	7,053
Regional	4,974	4,503	2,431	-	2,072	-
Station	26,473	22,184	9,132	65	5,934	7,053
Non-Army	8,898	5,548	3,218	6	1,081	1,243
POW	1,096	900	169	2	255	474
Civilians	1,540	1,888	1,069	3	348	468
Veterans Administration	5,980	2,524	1,794	1	464	265
Other	282	236	186	-	14	36

^{a/} Excludes debarkation beds and patients.

^{b/} Includes hospitals under the Chief of Transportation.

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INDUCTION EXPERIENCE SINCE V-J DAY

With draft legislation currently pending before Congress a brief account of recent induction requirements and experience should aid toward clarification of some of the problems which may arise with respect to literacy and age limitations on inductions. The data in this summary relate, therefore, to the induction experience since V-J Day when some of the induction requirements, namely those for age, literacy and limited service, were altered to meet the changed needs of the armed forces. Since V-J Day there have been practically no changes in the physical and mental standards.

Beginning in September 1945 only registrants within the age limits of 18 through 25 could be inducted and this requirement continued in operation through the middle of May 1946, when a new provision of the Congress prohibited the induction of men who were 18 or 19 years of age. In addition, a directive was published in November 1945 which prohibited the induction of registrants, whether volunteer or non-volunteer, who had three or more children under the age of 18. This directive was further modified in December 1945 by excluding from induction fathers with one or more children and by specifying that only volunteers between the ages of 18 through 24 who had less than three children could be accepted. This limitation with respect to age and induction of fathers brought into the armed forces primarily men in the younger age groups. The registrants of the older age groups either had been in the armed forces and had already been discharged or they belonged primarily to the 4-F registrants among whom the rejection rate upon re-examination has been very high. About 77 percent of the men inducted into the Army in the last three months of 1945 were 18 or 19 years of age. It has been estimated that the average age of the Army inductee during this period was about 19.4 years.

Simultaneously with the age limitation, the induction of illiterates was discontinued. To qualify for general service, registrants had to be able to pass at least the Q-1 or Q-2 mental qualification tests which were prescribed for registrants failing to present satisfactory written or oral evidence of sufficient schooling. Registrants ascertained to be high school graduates and English speaking have been considered acceptable for induction without taking the qualification tests. The passing score on the Q-1 or Q-2 test was fixed as 9, approximately equivalent to a fourth grade education level. Registrants who could qualify for limited service only, had to pass the Classification Test R-1 in addition to the Q-1 or Q-2 test. The passing score on the former test was fixed as 25, approximating an eighth grade education level. This requirement with respect to limited service remained in effect until March 1946. At the present time, the literacy requirements are the same for both general and limited service inductees.

There has been no restriction during this period with respect to the number of limited service registrants to be inducted. Such registrants have been all assigned to the Army, while those qualified for general service have been apportioned to the Army and Navy according to ratios jointly agreed upon by the services each month.

Results of Preinduction Examinations

In conformity with the existing induction procedures 564,000 registrants were forwarded for preinduction examination during the seven-month period from October 1945 through April 1946. About 43 percent of these registrants were rejected in spite of the fact that there was no restriction with respect to induction of limited service personnel. As indicated in the table on the following pages, the registrants sent up for preinduction examinations composed quite a heterogeneous group. About 20 percent of them had been rejected on previous examinations. The existence of such a high proportion of previously rejected registrants is probably the result of the fact that local boards had to resort to a great extent to recalling men who had previously been classified 4-F in order to meet their quotas, the occupationally deferred classes having been almost exhausted. Only about one-third of these previously rejected registrants qualified for induction and these primarily for limited service. Of the registrants not previously examined, consisting mainly of men in the younger age groups, about two-thirds qualified for service.

Causes of Rejection

The table on page 29 presents in detail the causes of rejection for men given preinduction examinations between October 1945 and April 1946. Of each 1,000 registrants forwarded for preinduction examination 145 were rejected for mental reasons, including psychiatric disorders and mental deficiency, 187 registrants because of physical defects, mainly ear, nose, throat and sinus defects, cardiovascular diseases, and musculo-skeletal defects, and 98 for administrative reasons, primarily illiteracy. Since probably not more than six out of every 1,000 registrants who were rejected for administrative reasons were rejected because of moral reasons or for criminal records, about 92 of each thousand registrants were rejected for illiteracy. Adding these rejectees to those rejected by reason of deficient intelligence (48 per 1,000 registrants) it may be seen that about 14 percent of all registrants were rejected for illiteracy and mental deficiency.

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INDUCTION EXPERIENCE SINCE V-J DAY (Continued)

On the basis of this combined preinduction and induction experience, it might be expected that out of 100 registrants called up for the first time by the local board for the purpose of induction, 60 registrants will be found fit for general or limited service and inducted, while 40 registrants will be rejected as unfit, provided the physical, mental and administrative standards, and the age limits remain as they were prior to 15 May 1946. Since age is one of the most important factors in determining rejection rates, it might be well to recall that about three-fourths of these registrants were under 20 years of age. Changes in age will force greater recourse of the 4-F group, resulting in much higher rejection rates. In addition, most of the 4-F group have irremediable defects, so that only a small proportion of this group could be considered for re-examination.

RESULT OF PREINDUCTION EXAMINATIONS BY CAUSE OF REJECTION

Men Examined From October 1945 Through April 1946

	Number		Rates per 1000 Examined	
	Not Previously Examined	Total <u>a/</u>	Not Previously Examined	Total <u>a/</u>
Result of Examinations: Total	440,159	564,433	1000.0	1000.0
Qualified for General Service	259,051	294,236	588.5	521.3
Qualified for Limited Service	17,943	27,666	40.8	49.0
Rejected	163,165	242,531	370.7	429.7
Distribution of Rejectees by Cause of Rejection				
Mental Defects	51,517	81,929	117.0	145.2
Physical Defects	65,135	105,596	148.0	187.0
Administrative Reasons	46,513	55,006	105.7	97.5
Rejected for Mental Defects by Cause				
Deficient Intelligence	21,090	26,883	47.9	47.6
Psychiatric Disorders	30,427	55,046	69.1	97.6
Psychosis	377	678	0.9	1.2
Psychopathic Personality	10,329	19,576	23.4	34.7
Psychoneurosis	9,887	20,483	22.5	36.3
Other Psychiatric Disorders	9,834	14,309	22.3	25.4
Rejected for Physical Defects by Cause				
Neurological	2,349	4,102	5.3	7.3
Defective Vision	3,471	7,333	7.9	13.0
Eye Defects (Excluding Defective Vision)	2,083	3,504	4.7	6.2
Ear, Nose, Throat and Sinus	7,529	13,608	17.1	24.1
Pulmonary Tuberculosis	1,893	3,101	4.3	5.5
Respiratory (Excluding Pulmonary TB)	2,509	3,870	5.7	6.9
Hypertension	1,638	2,854	3.7	5.1
Cardiovascular (Excluding Hypertension)	7,303	11,870	16.6	21.0
Gastro-Intestinal	659	1,124	1.5	2.0
Genito-urinary	3,905	6,226	8.9	11.0
Syphilis	135	253	0.3	0.4
Hernia	4,098	6,717	9.3	11.9
Flatfoot	3,917	5,775	8.9	10.2
Musculo-skeletal (Excluding Hernia and Flatfoot)	11,423	16,753	26.0	29.7
Other Physical Defects	12,223	18,506	27.8	32.7

a/ Includes registrants previously examined and registrants not previously examined.

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INDUCTION EXPERIENCE SINCE V-J DAY (Continued)

Final Results

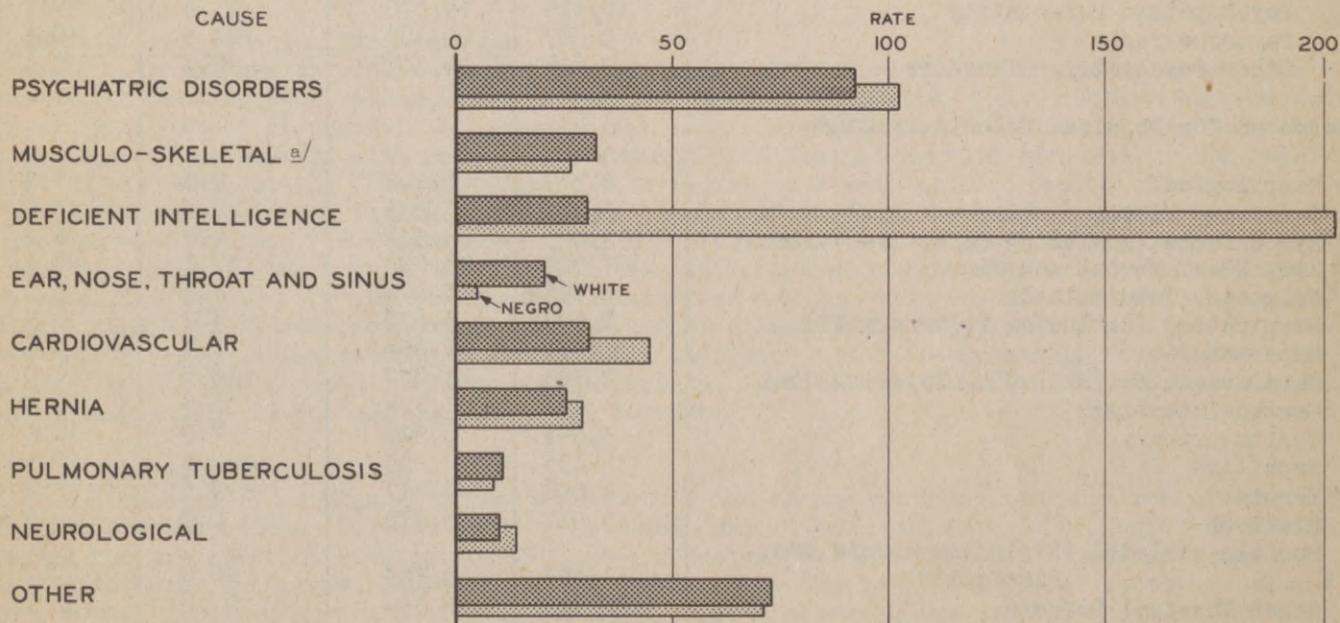
As may be seen from the table below, 272,400 registrants were forwarded for induction during this seven-month period: 236,400 of them, or 87 percent, were found fit for general or limited service and were inducted into the armed forces, and 36,000 or 13.2 percent, were rejected. The inductees were distributed to the armed forces in the following manner: 199,200 were assigned to the Army and 8,100 to the Navy. About 14.6 percent of those inducted into the Army were for limited service only.

EXAMINATIONS AND REJECTIONS OF REGISTRANTS BY PREVIOUS EXAMINATION STATUS

October 1945 Through April 1946

Previous Examination Status	Number of Examinations	Rejections	
		Number	Percent
Preinduction Examinations			
TOTAL	564,433	242,531	43.0
Not previously examined	440,159	163,165	37.1
Previously examined			
Total	124,274	79,366	63.9
Rejected previously	111,329	76,133	68.4
Accepted previously	12,945	3,233	25.0
Induction Examinations			
TOTAL	272,380	35,977	13.2
Not previously examined	19,149	7,518	39.3
Rejected previously	12,263	4,221	34.4
Acceptable previously			
Total	240,968	24,238	10.0
Reporting for physical inspection	171,737	9,170	5.3
Reporting for complete re-examination	69,231	15,068	21.8

RESULTS OF PREINDUCTION EXAMINATIONS BY CAUSE OF REJECTION RATES PER THOUSAND SELECTEES EXAMINED, OCTOBER 1945-APRIL 1946



^{a/} Excluding hernia and flatfoot.

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