CONFIDENTIAL

RCC1.950406.011

Regraded Unclassified - DEC 5 1985

MINUTES OF THE MEETING OF THE
ARMED FORCES MEDICAL POLICY COUNCIL
ROOM 3E-869, 17 MARCH 1952, 1330 HOURS

Members Present:

W. Randolph Lovelace II, M.D., Chairman
Melvin A. Casberg, M.D., Vice Chairman
George E. Armstrong, Major General, (MC) USA, Surgeon General, Department of the Army
C. J. Brown, Rear Admiral, (MC) USN, Deputy Surgeon General, Department of the Navy
Dan C. Ogle, Major General, USAF (MC), Deputy Surgeon General, Department of the Air Force
James P. Hollers, D.D.S.
Isidor S. Ravdin, M.D.
Alfred R. Shands, Jr., M.D.
Hilton W. Rose, Captain (MC) USN, Executive Secretary.

Members Absent:

H. Lamont Pugh, Rear Admiral, (MC) USN, Surgeon General, Department of the Navy
Harry G. Armstrong, Major General, USAF (MC), Surgeon General, Department of the Air Force

Present at the invitation of the Council:

Silas B. Hays, Brig.General, (MC) USA, Deputy Surgeon General, USA
Harold H. Twitchell, Brig.General, USAF (MC), Office, Surgeon General US
James O. Gillespie, Brig.General, (MC) USA, AFMPC
Winfred P. Dana, Rear Admiral, (MC) USN, AFMPC
A. H. Schwichtenberg, Brig.General, USAF (MC), AFMPC
John R. Wood, Colonel (MC) USA, Office, Surgeon General, USA
Hugh W. Rowan, Colonel, Office, Chief of the Chemical Corps, USA
Raymond W. Murray, Captain (MC) USN, AFMPC
Harry G. Moseley, Colonel, USAF (MC), AFMPC
William W. Roe, Jr., Colonel, (MC) USA, AFMPC
Sheldon S. Brownton, Colonel, USAF (MC), AFMPC
Thair C. Rich, Colonel, (MC) USA, AFMPC
Frank K. Lawford, Lt Colonel, (MSC) USA, AFMPC
C. J. Simpson, Captain, (MSC) USA, Office, Surgeon General, USA
F. R. Colman, LT (MSC) USN, AFMPC
B. F. Brofft, LTJG (MSC) USN, Office, Surgeon General, USN
Mrs. Dorothy Blondheim, AFMPC
Miss Maxine Gulde, AFMPC

SECURITY INFORMATION

CONFIDENTIAL

Rec'd & sent to Classified Msg. Center for logging-in & sent for by Miss Gould

I. C-2 Briefing. (Agenda Item No. I)

Captain J. F. Clare of G-2 Briefing Section gave a summary of the current international situation for the information of the Council.

II. Present Status of Chemical Warfare in the Armed Forces. (Agenda Item No. II) (Confidential)

Colonel H. W. Rowan, USA, Office of the Chief of the Chemical Corps, discussed the general principles and the strategic and tactical employment of chemical warfare and pointed out the several advantages and disadvantages of this type of warfare. In his remarks he indicated that the strategic employment of chemical warfare could best be effected by incendiary destruction and offensive and defensive smoke screens. Concerning the tactical employment, he emphasized that flame warfare and psychological warfare were of primary consideration. Of the three types of warfare (radiological, biological and chemical warfare), chemical warfare, in his opinion, is the ideal form of warfare and available for use as a supplement to conventional warfare.

Colonel John Wood, Chairman of the Medical Research and Development Board in the Office of the Surgeon General, followed Colonel Rowan's discussion and described the various types of agents utilized in chemical warfare. The following is a brief summary of his talk.

In beginning his discussion Colonel Wood listed the type of war gases as:

ANTI-PERSONNEL WAR GASES

1. Harassing Agents:

   a. Tear Gases
   b. Sternutators

2. Casualty Agents:

   a. Lung Irritants
   b. Systemic Poisons
   c. Vesicants
   d. Nerve Gases

Before discussing the more important gases, Colonel Wood pointed out that the harassing agents are practically out of the gas picture. These two were tear gas and sternutators.

In discussing the lung irritants, Colonel Wood said chlorine became obsolete after World War I and chlorpicrin should have as well, for neither are very toxic. However, phosgene, which is a lung irritant, still can do a casualty job but it takes a lot of it, and the casualty effects are delayed for 6 to 18 hours. It is somewhat irritant, has a moderate

characteristic odor, and is fairly easily detected. For that reason troops on the alert with gas masks will not find it much of a threat.

When it comes to systemic poisons, such as arsine, hydrogen cyanide and cyanogen chloride, they too, he said, can be classified as not very effective. Hydrogen cyanide is light and diffusible and, to be effective, concentrations must be built up quickly by "crash-attack" methods or it will disappear faster than you can deliver it on the target. Since gas masks have been improved, it makes the use of cyanogen chloride obsolete.

The vesicants are divided into three distinct types -- arsenical vesicants, nitrogen mustards and sulfur mustards. The arsenical vesicants are wanting in so many respects that they are little used in chemical warfare. On the other hand, of the nitrogen mustards only the ethyl derivative has important chemical warfare possibilities.

The mustard gas, said Colonel Wood, is still the "king of the vesicants" and is certainly one of the most effective chemical warfare agents ever discovered. During World War I, 75 percent of our chemical warfare casualties were caused by it and it produced more casualties in the AEF than all other chemicals combined. The secret of the success of mustard gas lies in its insidiousness for the vast majority of its victims have no idea there is any mustard gas near them. The so-called "horse-radish smell" characteristic of this gas quickly renders the olfactory nerves insensitive to its odor. Liquid mustard on the skin or clothing causes no sensation whatever for hours, but a maximum burn is produced in the first few minutes. It is even painless in the eye for many minutes and complete destruction of vision is inevitable. Its insidiousness is noted too when it is breathed as a vapor for there is not the slightest annoyance until a dosage is received severe enough to cripple vision for weeks or to produce a permanently incapacitating or fatal chemical bronchitis or pneumonia. Again mustard gas is very significantly related to temperature, for as the temperature rises mustard gas becomes more volatile and the concentration of vapor increases. At the same time the sensitivity of the skin to injury by identical doses increases many fold.

When the presence of mustard gas is recognized, continued Colonel Wood, troops have a definite protection against it in the use of the modern gas mask, the permeable protective clothing and a decontaminating ointment. However, decontaminating areas where mustard gas was used may be very difficult, particularly difficult are wooden structures, such as docks. Usually such contaminated wood must be removed, burned and replaced.

Colonel Wood then gave a dissertation on the nerve gases. He stressed the physiological effects after exposure to a nerve gas and the antidote. He pointed out that if the victim can be reached at an early stage intravenous or intramuscular doses of atropine are immediately indicated. It is often possible to reverse the cardiorespiratory effects, such as the strong contraction of the bronchioles and smaller bronchi and later bradycardia. A dose of 2 milligrams of atropine sulfate should be given every few minutes until the cardiorespiratory symptoms are relieved and

SECURITY INFORMATION

dryness of the mouth appears.

Colonel Wood closed by saying "The best answer to the war gas problem still is the prevention of exposure, by whatever means are at hand".

III. Medical Services with Combatant Forces - Medical Enlisted Corps in Army and Air Force. (Agenda Item No. III) (Secret)

In connection with the directive of the Secretary of Defense which recommends the creation of a medical enlisted corps in the Army and Air Force similar to the Hospital Corps of the Navy, the Deputy Surgeon General, in the absence of the Surgeon General of the Army, informed the Council that the only existing problem in classification and assignment of enlisted medical personnel which inspired this directive is in the area of trained medical administrative noncommissioned officers who are given a general administrative military occupational specialty which, after training in a medical specialty, permits their assignment to duties other than medical. He explained that a military occupational specialty for medical administrative noncommissioned officers was being established by the Department of the Army to insure proper assignment of these personnel who would then be under the administrative control of the Surgeon General. He also stated that in view of the foregoing action being taken by the Army, the need for a medical enlisted corps as such would be obviated.

In discussing this problem within the Air Force, the Deputy Surgeon General of the Air Force then explained that the designation of medical military occupational specialties, including a military occupational specialty for medical administrative noncommissioned officers, already existed in the Air Force and therefore it was felt that the intent of the directive of the Secretary of Defense had been complied with. He then recommended that the Council go on record as recognizing such compliance.

Further discussion indicated that the Council members were in agreement that the establishment of a medical administrative noncommissioned officer designation, in addition to the presently established medical designations, should constitute compliance with the directive of the Secretary of Defense. They accordingly approved a proposal that a statement be prepared for the Secretary of Defense enunciating the Council's views and that this statement be coordinated with the Surgeons General of the Army and the Air Force prior to submission.

IV. Uniform Policy for Promotion of Medical Service Officers from 1st LT to Captain and From LTJG to LT. (Agenda Item No. IV)

The Deputy Surgeon General of the Army invited the Council's attention to the discrepancies that exist in the eligibility requirements for promotion of officers of the Medical Corps, Dental Corps and Veterinary Corps, from 1st Lt to Captain (LTJG to LT). For example, he pointed out that at the present time the following time-in-grade minimal requirements are effective for promotion of Medical Corps officers in the three services:

[redacted]

Army - 16 months
Navy - 24 months
Air Force - 12 months

The inequitable promotion policy as reflected in the above has been normally a source of criticism in the Armed Forces and especially since Public Law 779 (Doctor Draft Act) has been in effect. These inequities have resulted in a serious morale and recruitment factor in the Army and Navy and unless they are eliminated will result in further morale and recruitment problems.

Discussion of this problem revealed that the medical services do not establish promotional criteria. They are established in the personnel branches of their respective military departments. The problem therefore becomes involved with the overall promotion policy in each of the three services. In view of the foregoing the Council approved the following motion made by Dr. Rovdin:

> "Resolved, that it is the opinion of this Council that it would be highly desirable to have a definite policy for temporary promotion of 1st Lieutenants of the Medical Corps, Dental Corps and Veterinary Corps and Lieutenants (J.G.), Medical Corps and Dental Corps, and be it further resolved that, since the matter concerns others than the personnel here designated, it be brought to the attention of the appropriate agencies of the Department of Defense with the hope that an equitable solution be found for what now poses a serious morale problem in the Medical Department of the Army and the Bureau of Medicine and Surgery of the Navy."

V. Dental Service for Air Force Personnel in the Pentagon. (Agenda Item No. V)

General Ogle informed the Council that it had come to the attention of the Surgeon General of the Air Force that there are inadequate dental facilities in the Pentagon to handle the Air Force military personnel assigned thereto. At present all dental treatment in the Pentagon is being furnished by the U. S. Army General Dispensary. In an effort to minimize the problem, the Surgeon General of the Air Force suggested to the Air Staff that all Air Force personnel in the Pentagon be denied service in the Army General Dispensary and that an expanded dental clinic be created at Bolling Air Force Base, to which activity Air Force personnel could go. The Air Staff objected to this proposal for the reason that it would mean excessive time spent by Air Force personnel away from their jobs. As an alternative the Air Staff suggested establishment of a Bolling Air Force Base Subclinic in the Pentagon.

Further discussion revealed that the problem posed was not entirely a policy decision for the Council to make. However, it was agreed that the Chairman of the Council would prepare a memorandum to the Secretaries of the Army and the Air Force to inform them of the Council's recognition of the inadequacy of dental facilities in the Pentagon. It was further agreed that the memorandum would recommend that the problem be resolved by increasing space available in the Pentagon in a manner satisfactory to both departments.

VI. Uniform Release Program for Priority II Registrants. (Agenda Item No. VI)

On 17 December 1951, at the joint meeting of the Council and the Health Resources Advisory Committee, the Chairman of the latter Committee recommended that a uniform release policy for Priority II registrants be established, based upon length of prior service. As a result of the foregoing recommendation a study was conducted by representatives of the medical services of the three military departments, the Selective Service, and the Office of the Assistant Secretary of Defense (Manpower and Personnel). Based upon information obtained at a meeting of the foregoing representatives, the group recommended the following solution to the problem:

"That the Assistant Secretary of Defense (Manpower and Personnel) be requested to conduct a study to provide a uniform release policy for Priority II medical, dental and veterinary registrants or Priority II type reserve officers involuntarily called to active duty with recommended limitations as follows:

(1) That a minimum of 12 months of service be required of those called to duty.

(2) That credit be provided toward release above 12 months of service in such a manner that:

(a) Those who have served less than 6 months subsequent to release from an ASTP or V-12 program or deferral from service to pursue a professional program be required to serve 24 months (as modified by Sec. 1 (x), Public Law 51, 82nd Congress).

(b) Those who have served 6 months or more subsequent to release from an ASTP or V-12 program or deferral from service to pursue a professional education, be called to active duty for a period between 12 months and 24 months depending upon their length of prior service, permitting those with the most prior service to be released first."

The Council approved the recommendation outlined above.

VII. Proposed Directive - Coordination of Medical Research in the Military Departments. (Agenda Item No. VII).

Pursuant to previous Council approval of a statement of policy concerning conduct of research in the medical and health fields, a proposed Department of Defense directive to implement the foregoing policy was submitted for approval. The Council approved the following proposed directive as submitted, substituting in paragraph III C thereof "Medical Sciences Committee of the Research and Development Board" for "respective Surgeons General". This directive will be submitted to all interested departments and agencies for coordination prior to publication.

"I. PURPOSE

The purpose of this directive is to establish the responsibility for professional guidance and evaluation of all medical research and research having medical implications performed in the Military Establishment.

II. AUTHORITY

This directive is issued pursuant to the authority assigned the Armed Forces Medical Policy Council by Secretary of Defense memorandum dated 9 January 1951, subject, "Establishment of the Armed Forces Medical Policy Council" and its attached directive.

III. APPLICABILITY

A. Responsibility for research initiated and conducted by the medical services in the Medical and Health fields shall be vested in the Surgeon General of the Military Department concerned.

B. Research having implications affecting the medical and health fields which is initiated and conducted by agencies of a military department other than the medical services shall be coordinated with the office of the cognizant Surgeon General to insure qualified medical guidance and evaluation.

C. Liaison between the Medical Sciences Committee of the Research and Development Board and the Armed Forces Medical Policy Council shall be maintained for the purpose of insuring accurate information to all interested parties on the status and progress of research in the medical and health fields and research having medical implications carried on in the Defense Establishment."

VIII. Educational, Training and Citizenship Criteria for acceptance of Commissioned Medical Corps Officers in the Armed Forces. (Agenda Item No. VIII) (Confidential)

The Council was informed that the present educational and training standards for the commissioning of medical corps officers in the three military departments are at variance in certain respects. For example, the Surgeons General of the Navy and the Air Force will only commission graduates of Class A medical schools. The Surgeon General of the Army also commissions graduates of Class A medical schools, and in addition graduates of Class B medical schools when the applicant has completed at least one year of internship in a hospital approved by the American Medical Association and the American Hospital Association and has successfully passed an examination for license to practice medicine in one of the 48 states. With respect to commissioning of graduates of foreign medical schools, there are

the following differences:

a. The Surgeon General of the Navy requires United States citizenship for a period of 10 years.

b. The Surgeon General of the Air Force requires a United States citizenship.

c. The Surgeon General of the Army requires first citizenship papers.

In view of the foregoing, the Council approved a recommendation to establish an Ad Hoc Committee to study and recommend uniform minimal standards of education and citizenship for commissioning of medical corps officers in the three military departments.

IX. Present Status of the Blood Program. (Agenda Item No. IX)

The Council approved in principle a report on the present status of the blood program which set forth developments in that area to date. The report submitted was for the purpose of informing the Council of the events which sequentially have occurred in the implementation of the Executive Order of the President which requires the Office of Defense Mobilization to integrate and coordinate all interested agencies in the blood field into a single National Blood Program. The report further presented the evaluation of the present Department of Defense stockpile of blood plasma and the operational requirements for whole blood and blood derivatives for the remainder of FY 1952 and for FY 1953.

X. Approval of Blood Program for FY 1953. (Agenda Item No. X)

General Schwichtenberg requested Council approval of a proposed letter to the Chairman of the Health Resources Advisory Committee which set forth the current Department of Defense views relating to modification of plans for a war reserve stockpile of a fully acceptable plasma. In addition the letter referred to certain budgetary recommendations in light of information that the Bureau of the Budget has established an allocation of funds for the Department of Defense and the Federal Civil Defense Administration for procurement of whole blood, blood derivatives and plasma expanders. This allocation is not entirely acceptable to the Department of Defense, in view of the possible infectious nature of the presently available plasma, and the necessity of providing an acceptable plasma in the amount of the first increment previously approved. The Council approved the proposed letter with the exception of a statement contained therein relating to an assumption that a new method of processing acceptable blood fractions would be approved between September and December 1952. Following coordination with the Munitions Board, the letter is to be forwarded to Dr. Rusk.

XI. Report of Inspection Trip to Korea and Japan. (Agenda Item No. XI) (Restricted)

General George Armstrong reported on his recent inspection trip to Korea for the information of the Council. The itinerary of the inspection party, with few exceptions, covered all major medical installations in the front line medical service. In addition, certain medical installations in the rear echelon of the 8th Army were inspected. In Pusan they inspected the ROK Hospital, the Danish Hospital Ship "Jutlandia", the Swedish Red Cross Hospital, and the Prisoner of War Hospital, in addition to U. S. Army medical installations there.

General Armstrong's observations of the front line medical service dealt primarily with the problems of cold injury, the potential recurrences of epidemic hemorrhagic fever and the employment of medical personnel during the current inactivity of combat forces. In connection with cold injury he stated that all possible measures have been announciated and are being vigorously pursued to reduce such injury to the maximum extent consistent with current military operations. The number of cold injuries to date among U. S. troops has been approximately 700 contrasted with approximately 4400 at the same time last winter. He pointed out that more than 200 of the above mentioned total of 700 cases occurred in two isolated instances of company action. The number of cold injuries among Marine Corps personnel has been negligible. This is due primarily to the fact that all Marine Corps personnel have been equipped with the new cold weather boot. While the Army has not been completely equipped as yet, 50,000 new boots had just arrived and all Army personnel will soon be equipped with them. In connection with the evacuation of cold injury cases, he stated that one officer is stationed on the East and West side of the front to act in a consultant capacity regarding treatment and disposition of such cases. All cold injury casualties evacuated to Japan are sent to Osaka Army Hospital.

Regarding epidemic hemorrhagic fever, General Armstrong continued by stating that the disease, because it is seasonal, is expected to reappear in April and that a team is now being set up in Japan to study it.

At the time of his inspection, medical personnel were handling only about 50 percent of their normal work load. He reported their morale was high and that the high morale was due to the establishment of a local medical society and smaller similar groups for the exchange of medical information plus the relaxed policy concerning emergency admission of civilian cases. He felt that the professional experience to be gained by increased admission of civilian cases far outweighed any disadvantages.

In closing, General Armstrong paid tribute to the outstanding work being done at the Prisoner of War Hospital in Pusan. This hospital, consisting of two U. S. Army field hospitals combined, continues to have a very high census (7600 patients) among which are many amputees. Because of the desire of the patients to receive the excellent medical care offered, their morale is high and no security problem exists. The amputee

rehabilitation program at this hospital was especially noteworthy as was the establishment in Pusan of a children's hospital by two U. S. officers, both acting on a volunteer basis.

XII. Establishment of Armed Forces Medical Library. (Agenda Item No. XII)

The Chairman of the Council invited attention to the Department of Defense directive which established the Armed Forces Medical Library. He stated that publication of the directive culminated a great deal of work by all concerned for a very worthy cause and that the only action remaining was to resolve certain budgetary problems.

XIII. Litter Carrying Capacity of New Aircraft. (Off Agenda)

The Chairman of the Council reported that as a result of a recent visit to the Beechcraft Aircraft Company in Wichita, Kansas, he had noted that the specifications for the new Twin Bonanza aircraft being produced for the Army did not provide for standard litter carrying capacity. General George Armstrong stated that this problem was being investigated to insure that corrective measures are taken.

XIV. Approval of Standard Designs for Permanent Hospitals. (Off Agenda)

Brigadier General H. H. Twitchell, USAF (MC), informed the Council that on 13 March 1952 the Air Force, in the course of formal Budget Bureau hearings on the Public Works Program for Fiscal Year 1953, was asked for a complete financial history of each medical construction item programmed since 30 June 1950. This was requested by the Bureau of the Budget in order to present a fully coordinated picture of all Air Force Public Works expenditures since 30 June 1950, to clarify requirements for the various individual items and to insure the presentation to the Congress of only those items of highest priority. He continued by stating that inasmuch as the plans for construction of 75/150, 100/200 and 150/300 bed permanent hospitals programmed for Fiscal Year 1952 had not received formal Council approval, and since they constituted a part of the overall review requested by the Bureau of the Budget, emergency Council approval was required at this time in order to permit the Air Force to meet the deadline set for the review. These plans exceed the total square footage or the per bed square footage established by the Hospital Branch, Bureau of the Budget, and they have not received formal concurrence of the Munitions Board. However, they do have the verbal approval of the cognizant Munitions Board Task Group and formal approval will be granted as soon as the coordinating signatures of all concerned are obtained.

In view of the foregoing, the Council approved the plans as presented for construction of the permanent hospitals of sizes 75/150, 100/200 and 150/300 beds.

HILTON W. ROSE
Captain, (MC) USN
Executive Secretary

ITEM FOR AGENDA

SUBJECT: Consideration of Policy Relative to Conduct of Research in Medical and Health Fields by Department of Defense and the Three Military Departments

1. The Council unanimously approved the following recommendation in connection with subject item.

> "As a matter of policy, research in the medical and health fields conducted by a military department shall be under the auspices of and be evaluated by the Surgeon General of the respective department concerned.
>
> "Research relating to the medical and health fields, when conducted by any agency of a military department not a part of the medical services of that department will be presented to the office of the cognizant Surgeon General for his information so that necessary coordination and evaluation may be effected."

2. The above declaration on the part of the Council establishes the policy of the Council in these two fields, namely, research in the medical and health fields and research initiated outside the medical services, not primarily concerned with the medical and health fields but which has medical implications.

3. Pursuant to the authority vested in the Council by Secretary of Defense memorandum of 2 January 1951 establishing the Armed Forces Medical Policy Council and its implementary directive, the Council is authorized to issue directives in the name of the Secretary of Defense to implement the policies and decisions of the Council within its jurisdiction and to supervise their execution.

4. The above subjects are within the jurisdictional responsibility of the Council. It is charged with providing broad basic plans, policies and programs within its jurisdiction (which is the medical and health fields) as will provide guidance to other Department of Defense agencies. In addition, the Council is directed to

> "Develop basic medical and health policies for the Department of Defense in collaboration with appropriate agencies and departments.
>
> "Review medical and health policies, plans and programs of each of the military departments with respect to

(a) Conformity with approved policies

(b) Adequacy when unilaterally developed

(c) Consistency between the policies unilaterally developed.

"Review the medical and health aspects of broad policies, plans, and programs which other defense agencies (such as Joint Chiefs of Staff, Munitions Board, Research and Development Board, Personnel Policy Board, Civilian Components Policy Board) are responsible for establishing, advising the Secretary of Defense of substantial differences of opinion on specific medical and health aspects of any given policy, plan or program and recommend appropriate action."

5. In order that the policy decision of the Council in this matter be officially established it is recommended that the Council approve the proposed directive (attached), following which it will be coordinated with all interested agencies prior to its promulgation over the signature of the Chairman, Armed Forces Medical Policy Council.

F. C. GREAVES
Rear Admiral, (MC) USN
Chief, Military Affairs Coordination Division

Attachment

PROPOSED DIRECTIVE

TITLE: Medical and Health

SUBTITLE: Medical Research and Research Having Medical Implications

I. PURPOSE

The purpose of this directive is to establish the responsibility for professional guidance and evaluation of all medical research and research having medical implications performed in the Military Establishment.

II. AUTHORITY

This directive is issued pursuant to the authority assigned the Armed Forces Medical Policy Council by Secretary of Defense memorandum dated 2 January 1951, subject, "Establishment of the Armed Forces Medical Policy Council" and its attached directive.

III. APPLICABILITY

A. Responsibility for research initiated and conducted by the medical services in the Medical and Health fields shall be vested in the Surgeon General of the Military Department concerned.

B. Research having implications affecting the medical and health fields which is initiated and conducted by agencies of a military department other than the medical services shall be coordinated with the office of the cognizant Surgeon General to insure qualified medical guidance and evaluation.

C. Liaison between the respective Surgeons General and the Armed Forces Medical Policy Council shall be maintained for the purpose of insuring accurate information to all interested parties on the status and progress of research in the medical and health fields and research having medical implications carried on in the Defense Establishment.