

U. S. Air Force Oral History Interview

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Maj Gen Richard L. Meiling

25-28 Oct 1982

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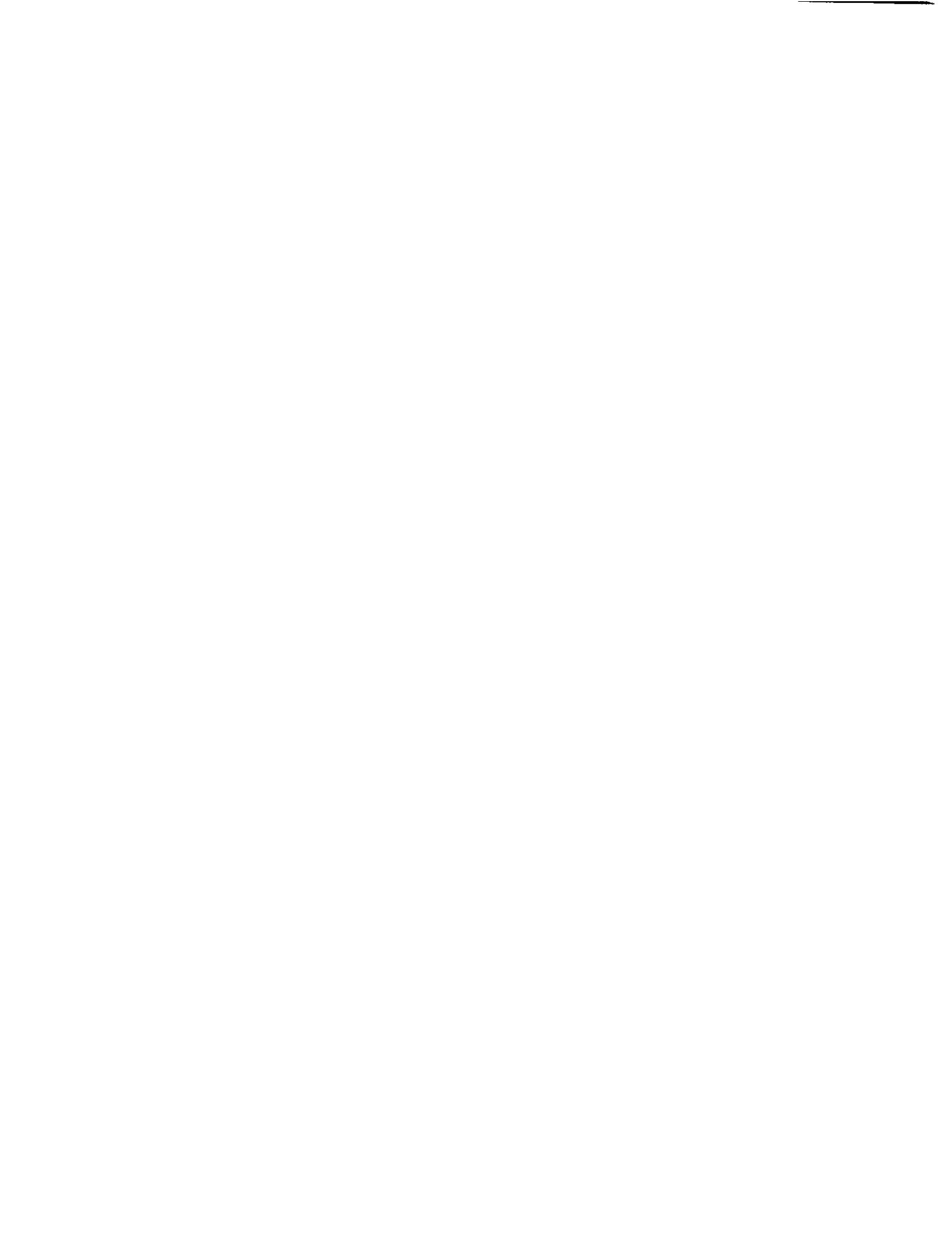


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UNITED STATES AIR FORCE
ORAL HISTORY PROGRAM

Interview
of
Maj Gen Richard L. Meiling

By
Capt Mark C. Cleary

Date: 25-28 October 1982
Location: Maxwell AFB, Alabama

Edited and Transcribed by Beth F. Scott

FOREWORD

One of the oldest and oft-used sources for reconstructing the past is the personal recollections of the individuals who were involved. While of great value, memoirs and oral interviews are primary source documents rather than finished history. The following pages are the personal remembrances of the interviewee and not the official opinion of the US Air Force Historical Program or of the Department of the Air Force. The Air Force has not verified the statements contained herein and does not assume any responsibility for their accuracy.

These pages are a transcript of an oral interview recorded on magnetic tape. Editorial notes and additions made by US Air Force historians have been enclosed in brackets. When feasible, first names, ranks, or titles have been provided. Only minor changes for the sake of clarity were made before the transcript was returned to the interviewee for final editing and approval. Readers must therefore remember that this is a transcript of the spoken, rather than the written, word.

BIOGRAPHICAL SKETCH

Maj General Richard L. Meiling was born in Springfield, Ohio, in 1908 and graduated from high school there in 1926. He received a bachelor of arts degree from Wittenberg College in 1930 and started his medical education at Jefferson Medical College in Philadelphia that same year. Later he transferred to the University of Erlangen, Germany, and completed his medical schooling at the University of Munich, receiving his MD, with honors, in 1937.

Doctor Meiling returned to the United States and interned at Ohio State University Hospital in 1938. During this period, he also received a commission in the US Army Medical Corps Reserve. He started his residency in obstetrics and gynecology at Cleveland City Hospital in 1939 and later completed it at Western Reserve Hospital in 1947. His residency was interrupted in early 1940 when he was the first Reserve medical officer called to active duty from Ohio preliminary to World War II.

In 1942 he attended the US Army Command and Staff School and was assigned to Headquarters Army Air Forces. In this position he helped plan and supervise the worldwide aeromedical evacuation system. In 1944-45 he was sent to Europe as commanding officer of the Strategic Bombing Survey group to evaluate the effects of allied saturation bombing on the civilian population as well as on military targets. He also assisted in the interrogation of top Nazi health authorities and other high-ranking Nazis.

In early 1945 he was assigned to the Legislative Liaison Division of the General Staff and served in this position until January 1946 when he was released from active duty. He then completed his residency training in obstetrics and gynecology and was certified in this specialty in 1947. He entered private

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25-28 October 1982
Taped Interview with Maj Gen Richard L. Meiling
Conducted by Capt Mark C. Cleary
Edited and Transcribed by Beth F. Scott

C: To begin, Doctor Meiling, could you tell me something about your family background?

M: I was born in Springfield, Ohio. Both my father and mother were born in Ohio, my father in Xenia, Ohio, and my mother in Springfield, Ohio. My grandparents on all four sides came from German background. The family names were Rubenstrunk, Hax, Meiling, and Bauer. They began immigrating into the United States as early as 1802. The Bauer family came through Maryland down to Pittsburgh, down the Ohio River to Cincinnati, and up into Xenia and the Springfield area. On the Rubenstrunk/Hax side of the family, the Hax family came from around Mannheim. The Rubenstrunk family came from Huckleswagen and Wuppertal. They came to the United States through New York and Newark, changing the name to Lobenherz, and migrated to Springfield where Grandfather had a large bakery. My Grandfather Meiling's family came from Bavaria by way of the Hanseatic free cities of Germany and Norway to the United States. He was an engineer on the Pennsylvania Railroad.

My father dropped out of high school at the end of the ninth grade for academic reasons. He started as an "engine-wipe" at 50 cents a week. Because he could play the trumpet, he became interested in the band of the Ohio National Guard, which played at funerals and weddings. The Commander of the Ohio Guard in Springfield was a jeweler. He talked my father into coming into his jewelry store as a janitor and playing in the band in the afternoons. Later he sent my father first to the Hamilton Watch Company where father became a watchmaker and then to New York where he studied

I came back home, and there wasn't anything really to do. I worked as an assistant superintendent of a large cemetery.

C: How did you get that job, sir?

M: The superintendent of the cemetery was a close personal friend of the family. We had played in that cemetery. It is a very, very big one, over 3,000 acres, and very hilly. As children we used to coast there. They had a sleigh pulled by horses, and we would hook our sleds on behind the sleigh. It would pull us uphill, and then we would coast down. As I came along in high school, I was given the job of taking care of the stalls for the horses. The superintendent had a couple of cows, and I learned farming there because he had alfalfa and timothy fields that had to be cut and put into the haymow for winter. I got paid one and a half times regular pay for coming in in the mornings and cleaning the stalls and getting the horses ready. I loved the horses. They were a very, very charming part of my life.

As I grew up I went from cutting grass to learning how to operate a gasoline power shovel and learning how to pour concrete and put in curbing. I then went on into surveying and finally secured the position of assistant superintendent where I sold lots and conducted funerals. When I started I got 18 cents an hour. When I left to go overseas, I was getting 45 cents an hour. We worked a 9½-hour day, 6 days a week. Anything over that was time and a half.

My association at Wittenberg led me to know several theological professors from the University of Erlangen, which is a university town just north of Nürnberg. In addition to a university, it had a large military post

set speed records. This particular flier didn't come out of his dive. I deserted my position in the Governor's box and ran over to see what was going on. I noted that his body and the motor of the plane had gone approximately the same distance into the soft ground. The thing that impressed me was that the fliers were back in the race within about an hour. Of course, there were international planes involved. As the Governor went to inspect these various planes, I went with him. It was an era when they were experimenting between biplane and monoplane, between canvas or cloth-covered wings and metal wings and, of course, their shapes and configurations. I became very interested in flying, and I was able to talk my way into the backseat of an airplane that somebody flew. I don't remember who the pilot was, but from then on I was terribly interested in aviation.

When I graduated from high school, I wanted to go to West Point. My parents were very pacifistic in their attitude and would not sign my papers of application to go to either West Point or Annapolis. So I went to Wittenberg, and the first semester I was listed as pretheological at Mother's request. She was going to make a minister out of me. After a semester of Greek, I decided that theology was not for me. In the meantime I became quite interested with the students who were premed, and I transferred into premedicine. I went to the hospital, saw a few operations, and decided that I would take biology and chemistry. It was a more successful academic course for me than had been theology or pretheology. Wittenberg, being a Lutheran school, had a compulsory course in Bible and the life of Christ that we had to take to graduate. So my interest was probably aviation from a curiosity standpoint and medicine as a second career to one that Mother had tried to encourage me

C: In 1932 did you have the feeling that a very, very small minority of the officers were pro-Nazi?

M: A very small number were Nazis. The North Germans and the Bavarians, which are South Germans, were fundamentally conservative. The officers came from the monarchy-supporting group of German society. They weren't politically active in this to any great degree, but in their minds the great times were under the King of Bavaria and the King of Prussia, who later became the Emperor of Germany. The units that I knew best were Bavarian. They were--just as the academicians were--very loyal to the King of Bavaria, who was also by tradition the pretender to the throne of Scotland. The Wittlesbacher family descended from Mary, Queen of Scots. So this relationship between Scotland and Bavaria among the royal families was very close. Two of my best friends were Counts Von Pappenheim, and their great-great-grandfather had been a famous general in the Bavarian forces. Their father had been on the privy council to the King of Bavaria. In 1916-18 he had been the King's aide-de-camp in the military forces. Through their family and their relatives--their mother was a Prussian princess--I learned these people rather well.

When we speak of Nazis today, we have an altogether different connotation than they had at that time. To say somebody was a Nazi in 1932 on was like saying he was a "gangster" in the United States. When I first went to Germany, in Erlangen, in Nürnberg, and other places, they would have political parades. The participants weren't allowed to carry guns or knives, so they carried large heavy keys about 9 inches long that they used to open the door in the wall that protected the garden of their home. The key was on a large leather thong, and they would swing this. In

threw the vegetables and meat all in one place. Later this was to be known as the one-kettle meal or the ein Topf. I made it a point to go to many of the meetings of the Communists, of the Hitler group, of the Stahlhelm to find out what it was all about.

Male students were also very active in dueling on that particular campus. It was forbidden by law, but dueling fraternities existed. Usually twice a week at night, they would have a dueling match between fraternities. It was very interesting. Girl and boy students would go to this particular beer restaurant, and there would be student lookouts a block or two blocks away, all around it, who would whistle if the police were coming. Everybody would sit around and have their beer. The police would come in and walk through, greet people, and walk out. Then the sabers would be brought out again.

(End Tape 1, Side 1)

M: The medical students would sew up the dueling cuts. I became quite interested in this and learned how to put in invisible stitches, what we would call subcutaneous stitches. This made me very popular with two of the fraternities; they wanted me as their dueling surgeon. I remember that the patient could not have any anesthetic. He could have a couple of shots of brandy, but he was not supposed to flinch. If the surgeon put subcuticular stitches in and did it deftly with a small needle, the duelist didn't suffer the pain that he would have if the needle went through the skin and got down into the lower layers. They wore these scars with great pride as it showed manhood. Of course, when Hitler came in, the fraternities were abolished, and the dueling was abolished. This was a side

fortification. The military did not take either our sidearms or our rifles away from us, but they took our spark plugs. We had a little Opel convertible. We spent a week there as their guests, but we weren't allowed to leave. Then they had to send us some 180 miles back to Sofia where it cost us about \$70 to get exit visas and pay for our transgressions and so forth. We came down then into Yugoslavia and Albania. From Albania we came back along the coast there to Dubrovnik, which was later to play an interesting role in my staff life when we lost a plane with nine nurses aboard in Albania. I was monitoring in Washington the rescue of these people. They were behind the German lines, and we had to arrange for them to move almost every night. The partisans, both Tito [Josip Broz] and Mikhailovitch [Draza] forces, got them down near Dubrovnik where British and American patrol boats took them off one at a time.

Having been through this area, when the war did break out, I had a better understanding of what was going on than I would have had entirely from maps. I remember in Bulgaria, during our 1934 visit, there were only 14 miles of paved roadway in the whole country; it ran from the winter castle to the summer castle. There was only one hotel that had inside toilets. We left Bulgaria for Yugoslavia. We crossed no bridges. We forded every stream, or we found a place where there was a ferry barge to take us across. The Shell Oil Company was interested in information about the roadways. We bought our fuel, which was primarily made from potatoes, and we had to readjust our timing and our carburetor, depending on what fuel we could get. We broke a spring, and we had to go to a blacksmith and draw in the sand what we wanted for a new leaf, and he hand forged the thing for us. We had to replace it, so we had to know quite a little bit about the motors and the equipment. Then we got to Split in

very logical for them to air evacuate them because they wouldn't have medical facilities in Spain. Of course, they would have access to aircraft. It would be very easy for them to put their wounded on a Ju-52 and fly them to Munich.

M: Well, General Sperrle [Lt Gen Hugo] was the senior military officer in Spain, and he was a Luftwaffe officer. He had been in command of the district in Munich before he was sent down to Spain. The Germans wanted to give their people, particularly the officers and the senior noncoms [noncommissioned officers], one battle experience and then send them home. They did not want other European powers to know how many troops they had there or how many casualties they were suffering. The trip by boat from Spain through the channel up to Bremen or Cuxhaven or Hamburg was quite lengthy. By using their planes, a chap who was wounded in battle, in a dogfight or in a tank engagement or artillery barrage, could be home 2 days after he had been in battle. Some of the patients had been in Spain less than 4 days, and they were sent home. Later I talked with General Schroeder [Oskar], who was the senior medical officer of the German Air Force. The big thing was to get them home and get them back into their units where they could tell their combat experiences. They could instruct combat problems without having this feeling they had been forgotten at the front. Philosophically it was a great idea. They were in a battle. When they came home they were heroes, and they were decorated. Senior officers came to see them as patients. Most of the conversation was, "How soon can I get back to my unit?"

In the British forces, as well as other European forces, there is also this great attachment to your unit. Sometimes a regiment will be much larger than our division.

down the black stripe. If he could make it, he could return to the social function. If he didn't he retired to his quarters.

I had great fun learning all these things and participating in them and getting to know how they thought. One of the most interesting things for me, I was a guest at the barracks in Nürnberg on the night Röhm [Capt Ernst] and many of the other people were executed. Nürnberg barracks were alerted and within 4 hours marched out to Munich. I was not allowed to leave the Nürnberg barracks for 2 days until the state of martial law was relieved. I was fed well; I had good quarters. But I didn't know what was actually going on except what I could pick up on the German radio or the British broadcasting system. I had no newspapers. It was a very interesting experience. When they came back, they sat around and talked about would they have fired on Germans if the order had been given. They were unanimously of the opinion, "What do you mean, would we have fired? Why certainly. If an order is given, you fire." There was no argument. They might not believe in it, but that was an order. One must appreciate this philosophy of life to understand many of the things that then happened as Hitler increased his power and became very dominant in their activities. One must remember he promised the people only "bread and work." As I said before, they recruited the entire Communist company there in Erlangen by giving them boots and food. They made a point: "We didn't promise you butter; we didn't promise you fruit." The only time we got imported fruit in Germany was at Christmastime, and this was "a gift from Hitler." People could buy oranges, grapefruit, bananas, and pineapple on the market 5 days before Christmas and 5 days after Christmas, and then it disappeared. They had no more. My friends and family in Switzerland sent me

fantastic. One of my sailing friends in Munich was a senior engineer in the German railroad system. We discussed many of these things. I was not a spy, and I didn't know anything about military logistics from that standpoint, but I learned through this movement. Then as they began to build the autobahns, they always built them to support their frontiers. When I later got to Command and Staff School and learned about railheads and waterheads and fuel dumps, this all made a great deal of sense because I could actually associate it with the movement of trains and with the building of the autobahns. When Hitler went across his own borders into Russia and found his railroad rolling stock did not fit the Russian track and vice versa, he encountered difficulties. In France lack of fuel heads to support his penetration of the motorized and the tank forces was limiting. This all gave me a background that wouldn't normally be associated with the study of medicine. The trip through the Balkans was the same thing. I got an idea of what they were doing--actually fighting a war between Yugoslavia and Bulgaria. Regimental size battles were going on, of which nobody was making reports back in Europe or in the United States. It was very interesting. The first time I ever saw a battalion on bicycles was in Yugoslavia. The major in command pulled his saber from his scabbard and raised it up over his head and circled a couple of times. Everybody stopped, folded his bicycle together, put it on his back, and went through the woods. I thought this was fantastic. I thought, "Boy, how can they control that sort of thing?" Well, we soon learned how to do it. But for me, a youngster out of Springfield, Ohio, these were all great experiences.

My friends in Switzerland--I went there primarily to study pathology--said, "Now look, you should go down to the League of Nations, which is in session, and we will arrange through

treat them. The first sulfanilamide, known as prontosil, had just come on the market in 1937. It seemed to help with younger people but didn't do much good with older people. At that time there were 28 known strands of the pneumococcus. For six of those strands, we had a specific serum that we used to treat patients, but it was not overly successful.

As I began my research work, I needed to have permission to work with animals. Hermann Göring, who was the leader of the German Air Force and president of the German Parliament and had many other activities, was the chief minister in charge of all kinds of animals, including the wild animals; he was also in charge of the hunt. I secured permission to go to Berlin and see him, to ask permission to use research animals in my studies. The only thing that he said was, yes, I could have it, yes, he realized I was an American, not a German, but that every 3 months he wanted a report of the progress that we were making. The research work consisted of injecting the animals with one of the strands of the pneumococcus, recovering it from the animal within 18 to 24 hours, and testing it on the laboratory media to determine whether the "vitamin C" had any effect. We began to notice a definite effect, so the professor suggested that not only with animals but with human patients I should see if there was some way we could get them to take vitamin C in their food. We made a complete study of all the foods that reportedly had vitamin C in them, which was ascorbic acid. If we fed the ascorbic acid, we could recover it in the urine and excreta every day. Although we were feeding maybe 900 milligrams of vitamin C, we found that everything but 250 milligrams was excreted daily. On the basis of this, we then tried to find out how we could put it into the daily diet. We found in Scandinavian countries and Germany at the

canned vegetables had to try to prepare what we had prepared in the university hospital kitchens. They succeeded. It became a part of the Göring 4-year economic plan. I mention all this because here I was learning about economics at the national level--politics and military activities, as well as medicine. I think it behooves a good physician to observe the environment in which he is surrounded.

In due time I came home in 1938. I came first to Columbus and then later up to Cleveland. Do you want to ask me any questions about what we have covered?

C: There is a question I would like to ask, sir, concerning the purges of the university system during the time you were there. Was that noticeable, and did it have an effect on the quality of instruction at Erlangen?

M: That's the reason I left Erlangen. The faculty at Erlangen became very responsive to the political party. In Munich, when I transferred there in 1934, it had still a very strong Catholic faculty. Munich and Wurzburg were the two Catholic faculties in Bavaria, and Erlangen was the protestant one. Erlangen transferred very rapidly to a politically dominated medical faculty whereas it took almost till 1938 to change the faculty in Munich. It wasn't a reduction of quality, but it was the introduction of political concepts that bothered one. The men who became professors were still good technical, scientific members, and the patient care was still good. But the real essence of moral and ethical values changed with the introduction of the politically dominated faculty. This was true not only in medicine, it was true in philosophy, and it was true in engineering and in law. Remember Munich was a very, very strong Catholic center. In fact until 1848 it was forbidden for

M: The northern universities particularly. Munich was a holdover. Notwithstanding the fact that the Brown House was there and Hitler was there frequently, Munich still was, as the people say, somewhat the "home of the mountaineer." It is true to this day. If you go to Munich and go into Bavaria, you will find they are great on their culture, but the people, as you talk with them, are simple people. They are not really perturbed about the politics of either their country or the world. They are very perturbed about the politics of their little city or their little village and become very irate if anybody does such a thing as assess a 2-cent tax on their beer. They are probably not exactly what you would call "great minds."

C: As you have indicated, your association with Goring, at least from time to time, was such that it was on a personal basis, and we will probably come back to this later when we talk about the end of World War II. You mentioned the Nürnberg party rallies. Did you actually attend those?

M: I attended five of those rallies.

C: The Leni Riefenstahl movie "The Triumph of the Will," I think, was based on one of those.

M: Yes.

C: Was that as orchestrated as people say? Was it basically set up for the cameras rather than something the cameras recounted as history? Would they do rehearsals several times?

M: There were no rehearsals. The party rallies lasted 9 days. Each day the people that were going to parade arrived

get it out of my soul, because I just couldn't control being swept along by this enthusiasm. I would go down to Switzerland. I had very nice girl friends down there. The Swiss are very anti-German and anti-Italian by nature. The Italian is not quite up to their level of society, and the German they just plain don't like. One of my German friends, an SS [Schutzstaffel (Guard detachment)] officer, was the right guide on the flag. He started out as a lieutenant and ended the war as a brigadier general in the "Adolf Hitler Regiment." That regiment was not a regiment as we think of it. It was a division.

C: Would that be the SS Adolf Hitler?

M: Yes. He would always arrange with some of his police friends to get me a press pass. A press pass was about 9 by 4 inches, and it had your picture on it. If you had that you could have a camera with a telescopic lens. If you didn't you couldn't because they were afraid of telescopic lenses being used to sight guns for assassination and so forth. On numerous occasions I was within 30-50 feet of Mr. Hitler, Goring, Goebbels, and Ribbentrop [Joachim von] on the reviewing stand. In Munich, frequently I would be in the Carlton Tea Room, and Hitler would come in for his afternoon tea--he never drank coffee--and a piece of cake. Before he arrived there would be six or seven secret policemen that would come in and sit down at various tables. It was customary in Europe, if your table wasn't completely occupied, either in a tearoom or at restaurant, to let somebody else come in and sit with you. They would always say may we, but you jolly well let them sit. One would be in the tearoom and suddenly notice six or seven of these lads come in and sit down. Nobody else could come in the

Regiment were very much in evidence. I saw him many times down in Berchtesgaden at the hotel. I also sat two rows behind him at the symphony one night in Munich. He was very charming. At a press reception in Nürnberg to which I was invited, I actually talked with him, shook hands. He wanted to know how long I had been in Germany and did I like it. There were no political questions permitted, and you were instructed to let him direct the conversation. So besides Ribbentrop and Göring and Goebbels, I also had the experience of meeting Hitler.

C: Was his private speaking voice very much like his public speaking voice?

M: No. It was very quiet and modulated. He was an actor, a very, very pronounced actor, Dr. Jekyll and Mr. Hyde. In speaking with him privately, he was almost timid.

C: Did he ask you anything about America?

M: The only thing I recall, he asked me where Ohio was. I tried to explain. He knew about the Great Lakes. That made sense to him. He had a comprehension of where Pittsburgh and Chicago were. Trying to locate Springfield for him in Ohio was a lost effort. Polite, gracious, he talked to me for maybe 4 or 5 minutes. I remember saying, "Herr Hitler, you, I know, want to speak with some of the others, and I appreciate very much having this privilege of speaking to you." He was very gracious.

(End Tape 2, Side 1)

M: Between acts in Europe theater goers parade up and down the lobby. They have food and drink. Hitler was always

you say, "Petrie heil, Petrie dank." Petrie being Saint Peter, the patron of fishermen. They issued an order that everybody was supposed to greet the other with the words "Heil Hitler." Then they came out with an order that you couldn't say, "Heil Hitler, Waidmann heil," because that meant, "We hope you shoot Hitler." (laughter) The stupidity of bureaucracy that had to decide what you could say when you greeted somebody always impressed me as being bureaucracy carried too far.

I enjoyed my years over there. I learned a great deal, not only in medicine but in world affairs, in economic affairs, and in politics. It always amused me to talk with American reporters, many of whom could not speak the German language but who were reporting for various news media here in the United States. They would write about something that I had been present at and seen, and I couldn't tell from what they wrote where they were.

C: Was Howard K. Smith in Berlin?

M: Yes.

C: Did you ever meet him?

M: No.

C: Or read his articles?

M: Yes, I read his articles.

C: What was your impression of his accuracy, sir?

troops the Germans had spies. By the time the Germans got to Trier--and I think it took 5 or 6 days to go the 125 miles from Koblenz down to Trier--the enthusiasm of the German people was beginning to come through as hesitancy, "Does this mean war?" Here we had the troops coming right to the French border. It is only 4 miles outside of Trier till you get to the Luxembourg-French border. These people were not enthusiastic. They weren't shouting in the streets. They were sympathetic, and they were giving the German soldiers flowers and wine. But if you went into the restaurants and listened to their conversation, they were worried, "Now for the first time since 1918, we have German troops in our town. We have French troops in the Maginot Line. What is going to happen?" This did not fit the inquiries we were getting for information. Of course, it was secondhand to me because these boys were correspondents back in Munich and they knew I was in Trier. They thought this was a great thing for me to get them some pictures or tell them about the enthusiasm. I wrote back and told them, "I didn't see it as enthusiasm. I saw it as a great concern of what was going to happen," not that day but within 2 or 3 weeks. I don't think the American press fully appreciated the worry and consternation that the people had, that here they were back in a situation like World War I where their town was on the border, and Metz and Namur are just down the line a little piece. What was going to happen to them? So I was a little skeptical about reporting what they were told versus what had actually happened. I have that same feeling today when I view televised news of Beirut or any other place where we are involved.

C: Sir, I would like to move ahead now. You were commissioned a first lieutenant in the Army Medical Corps in 1938, I believe.

the medical capabilities at Wright-Pat, but it was not a big operation; there were probably less than 3,000 officers and men in the total Air Corps in 1939. It was just beginning to develop. My observation was very interesting; for example, Colonel Baker said, "Now look, you are only here for 2 weeks. You are qualified in gynecology. We have all the officers' wives and the noncommissioned officers' wives lined up for you to do vaginal examinations and breast examinations for cancer. On the military side you are assigned to all-night flying from Monday night till Thursday night. Captain Schwichtenberg and I will take the weekends, and you go on cross countries. Put in a basket leave, and you go anyplace you want to cross country. You know some of the pilots. You get all of your military experience and your flight surgeon's experience on the weekends and during the night flying." I had a sergeant and two orderlies and an ambulance out on the line every night. I would say, 80 percent of all the women that were lined up for appointments were examined. It impressed me that those doctors were really as far advanced in preventive medicine for the dependents as anybody could be at that time. They didn't have elaborate examining rooms. They didn't have elaborate operating rooms. We didn't have anybody to give an anesthetic if we needed to do a biopsy. We got a civilian MD who was a Reserve officer, an anesthesiologist in Dayton, to come out. So my experience was good, that they were thinking ahead, that their facilities were very limited, and they had a very difficult time getting medical supplies sent to an airfield.

C: The facilities in the event of a wartime emergency, of course, would be swamped. They wouldn't have nearly the capacity to deal with the casualties.

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years he recruited a number of aeromedical researchers. Did you know Dr. J. W. Heim?

M: No, I didn't.

C: After the war with Germany was over, we sent in teams to interview some German scientists. I think it was called Project Paper Clip. Were you familiar with that project?

M: Yes.

C: I know Dr. Strughold [Hubertus] was recruited for the Aeromedical Laboratory, and they got others as well. One example was Hans L. Oestreicher, I believe. Could you tell me anything about that?

M: No, I don't think there was any correlation in 1939 when I was at Wright with what was going to happen. In 1939, when I was there, World War II had not yet begun. One did not have the feeling of war being necessarily imminent, although several of the officers did talk to me about my experiences the previous 6 years in Germany and my knowledge of German uniforms, German insignia, and German military organization. Interesting to me, about this same time, I had been asked to speak before some civic groups around Cleveland. The next thing I knew, the FBI [Federal Bureau of Investigation] was investigating me to see if I was a Nazi agent. The "friends" who had asked me to speak in one of the towns there in northern Ohio were the ones that had told the FBI that I had predicted the United States would be involved and there would be a world war. If you had lived in Europe in 1936 and 1937, one couldn't help but feel there was going to be armed conflict, and one couldn't help but feel the United States was going to be involved. When one came back to Ohio

M: That's correct.

C: In regards to that then, did the war interrupt this training, or did you decide to interrupt it yourself?

M: I was ordered to active duty "without my consent" in 1940. That terminated my training in OB-GYN. I was sent to Fort Thomas, Kentucky. I became the officers club officer, motor pool officer, detachment commander, and in the evenings on my own time, I could relieve the "trained surgeon" in obstetrics. But I was not assigned any medical duties because my military spec [specialty] was obstetrics and gynecology, and they didn't need that. Because of my military experience, I learned how to be a club officer. I ran the officers club, I ran the motor pool, and I was detachment commander. In those days detachment commander was the same as a company commander. I had 190 enlisted men under me. I had to meet my payroll. In those days, even though I was a medical officer running the pay table, I had to have a .45 strapped to my hip with a clip in it.

C: They were more concerned with money than the Swiss were some years before.

M: Oh, yes. I learned about trucks and ambulances. I learned that the commanding officer of the post--Fort Thomas is a small place----

(End Tape 2, Side 2)

M: The commanding officer was always quite happy with his motor pool officer if his own car was in good condition and clean. After about 4 months at Fort Thomas, I was very

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are going to write it. This unit was just organized about 10 days ago, and it has neither a T&O nor an equipment list, and it has no training manual. It is down at Camp Jackson, Columbia, South Carolina, and I will see to it that you are sent there within the next day or so. When you get there you report to the Commanding General of I Army Corps."

In due time I arrived at Camp Jackson. It later became Fort Jackson. I Army Corps had the 9th Division, the 8th Division, and the 30th Division, the National Guard unit from Alabama and Georgia, plus corps troops. I found there were no other officers in the 52d Medical Battalion, and the second day I was there, I reported in to the commanding general of the Army corps. He said, "This is great. You are my medical officer." I said, "Sir, I am a first lieutenant. That calls for a full colonel." He said, "Rank has nothing to do with it. You are here. I want you to eat at my mess, and I want you to attend all staff meetings. In the meantime get your battalion together." So the first thing I got was a shipment of a cadre. In those days if a unit was cadred, all the misfits were sent to the new unit. Every man I got had been court-martialed at least twice. I got a second lieutenant, who had never had a day on active duty, as a supply officer. He was in the Medical Service Corps. Then I got telegrams saying that at Camp Upton, Long Island [NY], I would receive 700 men from the Selective Service unit there and I would get 700 men from Fort Niagara [NY], I should be prepared to come and get them. Well, that meant I had to put together my own special train; I had to get food from the Quartermaster Corps; and I had to get ranges, field ranges that used coal, in my baggage car to prepare food.

Jackson. They met us and took us to our new barracks. The wives of the officers who joined the unit had made the beds for each one of these selectees. Our unit was quarantined because we were coming in from that terrible civilian world where there were all sorts of diseases. We fed the selectees at about 11 o'clock in the morning and then told them they could turn in and sleep for 4 or 5 hours and they would stand to for retreat that night. Seven hundred young men out of New York City in that area, and 2 days later the group came down from Fort Niagara. So we had over 1,400 selectees who had never had any military service, and we had 22 of the toughest cadre that you could imagine. We called them acting sergeants. We received 27 Reserve medical officers from the Ohio area about the same time, none of whom had ever been on active duty. I had a medical battalion, and First Army sent word that they were coming down to inspect us. We obviously hadn't progressed to even teaching first aid; we were trying to teach them how to march and get their uniforms on correctly. We wired First Army and suggested that they wait a month for their inspection, which they did.

In the meantime two Regular officers were assigned to the 52d. They were Captain Newton [Lt Col George D.] and Captain Batch [Lt Col Joseph W.]. They, of course, outranked me, and I *dropped from commanding officer to executive officer to adjutant of the battalion.* When the First Army came down a month later, we passed our inspection and were awarded a certificate as being one of the best units in the First Army. With our own money we bought two drums and six bugles. We had our own music corps for the boys to march by. They had a lot of pride. We then went on maneuvers later that summer. In September I was to return to civilian life. Of course, I was the big test for all the

have court-martial charges against them." Dave said, "Well, this chap hasn't. He has a superior record as a field officer. He has been supply officer of the I Army Corps during the maneuvers, and he managed medical supplies scattered all over the Carolinas. He was able to get civilian pharmacies to put perishable drugs in iceboxes in the pharmacy and day and night let us go in and draw on them." We didn't have field iceboxes; we didn't have anything. We went out and asked people to do this because we were the Army. In those days, in the Carolinas and Georgia and Alabama, the Army was well respected, and they were happy to do things for us.

At any rate I was assigned to the Secretary of War's Office and sent to Randolph Field. You can imagine when I got to Randolph Field, I must have had a yellow marker on my file, "Handle with care. He is from the Secretary of War's Office." If you can imagine a first lieutenant in the Medical Corps being assigned from the Secretary of War's Office to school, you have a good idea of what I was up against. Colonel Reinartz [Brig Gen Eugen G.] had just come in as commandant the week before I got there. He had been a medical officer in charge of cadets in 1932 when I had been at Randolph Field. I had written my own orders as Adjutant of the 52d Medical Battalion, and I had given myself 250 miles a day travel, which was legal. That enabled me to go from Carolina up through Columbus, Ohio, and down through New Orleans and finally to Texas. I arrived, and the executive officer, Captain Kernan, said to me, "Lieutenant, you are absent without leave. Furthermore, you can't be paid." I looked at him and said, "Captain, would you like to make a \$5 bet that I am not absent without leave and that the finance numbers on there are correct and that I will be paid?" Reinartz was in the next room, and he heard me betting with his executive officer. He came out and

me on 20 December, and I was assigned to Grenier Field, Manchester, New Hampshire. I got there a day after Christmas. Again I had 24 medical officers, none of whom had been on active duty. There was a Regular Army captain who was in charge of the hospital. He made me chief of the professional services. He said, "Now you organize surgery and medicine and get this place going."

They were sending us troops from the south, and they had never seen snow, and we were having temperatures 20 below zero. We were getting a lot of frostbite cases. We got that all straightened out. I had learned to ski in Europe. I noticed that we were losing fliers in the mountains in Maine, New Hampshire, and Vermont. When we got them out, it was exposure that had caused their deaths. So I asked permission to talk with the state highway patrol up there in New Hampshire. I talked with them and said, "I think we should get these fliers out and into a civilian hospital as soon as they crash." "Well, there are no civilian hospitals." "Well, you have something." In these towns in Vermont and New Hampshire and Maine, they would have a home with maybe 20 beds that the local doctor ran. I set up a deal with the highway patrol for skis and snowshoes to go in after these chaps. From nearly a 100 percent loss, we reduced exposure deaths to less than 20 percent loss, and the fractures we would put in extension until we could get ambulances up to that little hospital and bring them back. So I was having a great time.

I arranged for all our officers to have 1 day a week off for education. We were about an hour and a half drive from Boston, and everybody wanted to go down to Harvard to attend medical clinics and scrounge around and find out what was the latest in medicine. I went up to Dartmouth to ski

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marketplace in New York City to buy meat, fish, and eggs. We had a vet [veterinary] officer, and he and I became good friends. He taught me how to buy down on the market. I would ride in with him, and we would buy four boxcars of spareribs, or we would buy a boxcar of oysters or a boxcar of shrimp or eight boxcars of chickens. I learned what the difference between New York, Chicago, and Kansas cuts were. I also learned that if we ordered a package of 24 chickens we were guaranteed that 22 of them would meet our specifications. All that sort of thing. The vet had an accident, so for 3 weeks I was in charge of all veterinary services--meat inspection, egg handling, and so forth. I turned back ten boxcars of chickens and four boxcars of spareribs. Well, the suppliers weren't going to have any of that. So the next thing General Bradley got was a call from the local Congressman, "Get rid of that Major Meiling." I told General Bradley what the story was. He told Baker. He said, "Give him more responsibility, don't cut him down." I got more responsibility.

It came along to the last part of May. I had taken care of Mrs. Bradley and had checked the general a few times. He was having a few extra rhythmic problems with his heart, and we got that straightened out. He said, "Meiling, I am going to Russia, and you are going with me."

(End Tape 3, Side 1)

M: This was when they were setting up the shuttle from England to bomb Germany, fly to Russia, refuel, bomb Germany, and fly back to England. He said, "We are going to transfer you from the Medical Corps to the Air Corps. As of this afternoon you start wearing Air Corps insignia. You have got to be qualified in the air, so we will make you an

beaches, I had C-47s coming in to pick up the wounded. They were bringing in mountain 75 artillery, shells and equipment. This just caused one hell of an uproar in the faculty. When the game was over, I was ordered to appear before the faculty to explain how I got the idea of flying onto the beaches with military equipment and taking wounded back. I told them about my experiences in Germany during the Spanish War and how the Germans were using transport planes. I cited several military documents written in German, English, and Swedish that I had been able to get through the library. Where did I get the idea about the portable 75 artillery? I said, "It seemed to me that we needed artillery, and I don't know enough about the 155s and the 255s to know whether they are transportable or not. The 75 I know is transportable, and it *could* be used as an antitank gun." They said, "We accept that as a better solution than we had, and you get an A, notwithstanding the fact that you lost your air umbrella for lack of fuel. Incidentally we have orders here for you." The orders read to report to General Arnold [Henry H.], Headquarters, US Army Air Forces. Well, of course, I was going to travel on secret orders, so I supposed my orders to go meant I would probably have to carry a message to General Bradley, who in the meantime had gone to Moscow.

I got to the Pentagon and reported to General Arnold. I had seen a few generals in the meantime, but here was the Chief of the Army Air Forces. He said, "Did you write this script here about air evacuation?" I said, "Yes, sir." "Do you believe it will work the way you said it would?" I said, "Yes, sir." He said, "You actually saw the Germans doing it?" I said, "Yes, sir." He said, "Well, you are going to be assigned to General Grant's office." I said, "But General Arnold, I have secret orders, eyes only." He said, "Who the hell signed them?" I said, "Sir, I am not supposed

offices. We used the same coding for the patients, male and female; their disease; their injury; and where they came from. One thing we didn't know, but Mrs. Roosevelt [Eleanor] informed us shortly thereafter, was that we were to send the evacuees to the nearest hospital to where they came into the service so their families could see them. With the coding we could put all this in. We could correspond with the hospitals in the United States and the overseas hospitals by this coding. To me the thing that made air evacuation really work was not that I was the only regulating officer the Air Force ever had but the fact that we had this code, it was simple, we only had nine classifications, and we could get a report from all the general hospitals or the regional hospitals or station hospitals every 24 hours of what beds they had available. This was to provide us with a real test later on. Four hospital ships were coming back from England and were off the eastern seaboard. The Navy would not let them come through the submarine net at New York, Boston, Philadelphia, or Norfolk. They finally arranged for them to come into the harbor at Savannah. The Troop Carrier Command provided the C-47s. They were located at that time in Fort Wayne [IN]. The 700 patients were taken off those ships where they had been for more than 14 days. The ships had to sail fully lighted with a big green cross on them. The patients were taken off the ships, placed on the C-47s, and distributed within an area of 900 miles around Savannah. This took only 3 days and 3 nights. We knew where to send the planes, and when they landed there was somebody from those hospitals to pick up those patients. Hospital commanders came up with the idea of letting the patients telephone home when they first arrived in the hospital. Because of the war it took 5 days to schedule an ambulance train (special) between Boston and Georgia.

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About this time Dr. Howard Rusk [Brig Gen Howard A.] came to Washington. He was a professor of medicine and believed in getting the patients out of bed--early ambulation and rehabilitation. General Grant had visited at Saint Louis Barracks and seen what Rusk was doing. He was putting convalescent patients in classes where--if they were gunners they were working with machineguns; if they were drivers of motor pool vehicles, they were working with motors. If they were observers they were working with the still pictures and recognition of various kinds of enemy airplanes. Howard was brought to Washington. He had been there about 2 days, and he came in with about 80 pages that he wanted published. He went to General Grant, and General Grant said, "You go down and see Major Meiling." Well, here was Lieutenant Colonel Rusk. He wasn't very happy about going down and seeing Major Meiling. He had never heard of him. He came in and said, "General Grant said to publish this." I said, "Did General Grant say directly to publish it?" "No, but I want it published." I said, "It takes a little time to get a War Department circular prepared. Let me read it over and see what you want. Colonel, a directive from here that is one paragraph long by the time it gets to the field will have an average of 20 pages of endorsements explaining it. So if you start out with 80 or 90 pages here, you are going to have a textbook when you get out to the field." So I rewrote it into 2 paragraphs 12 lines long. It became the directive for rehabilitation in the Army Air Forces and later in the Army overall. It was this that he used then in establishing the rehabilitation center and programs in his civilian life in New York where he was professor of rehabilitation. He is called the international authority on rehabilitation today. In his autobiography he tells about how this Major Meiling cut his masterpiece down to ten lines and it was a success. He said, "It's all in knowing what to

marked vehicle, but according to the Hague Treaty, you cannot put any military equipment on an ambulance. It must be medical. You can put food aboard, yes, but otherwise it is blankets and splints and medicines. If you are pushing forward--for example, when they crossed the Rhine River at Remagen, there was no flow of traffic back. The Air Force put gliders into Germany across the Rhine near Remagen and picked up the patients that couldn't be evacuated because there was no surface means. Had the Germans had the capability at that time to launch an air attack and had these gliders been marked, they would have been a perfect marker for the landing zone. As camouflaged planes they were part of the transportation system. The medical does not and should not, in my opinion, command vehicles, whether they are planes or helicopters or gliders. That should be a command decision, but the staffing and the care of the patients aboard belong to the medical service.

I was very sorry when in peacetime the Air Force went to marking the planes as ambulance red cross planes. As long as you are in a peacetime situation, it has a great public appeal. Dependents, particularly babies and mothers, can be transported. In the actual combat activities, just maintaining the paint to keep that airplane white when all the other airplanes are camouflaged is a hell of a load on the overseas commander. He doesn't need that white and red paint. With a hospital ship 2 months' notice of its destination must be announced. It must be fully lighted at all times, and it must have a green cross on a white background. No battle fleet commander wants a hospital ship near him. I don't think in combat in the future any Air Force commander is going to want a white ambulance plane on his combat operation airfield. You can't have independent medical operation airfields. So I would imagine that were we

spent time in learning what the environment is. The average military doctor does not want to be sent to Command and Staff School, he doesn't want to go to the War College, he doesn't want to go to the Industrial War College and learn how he can apply the needs of the medical service into the organizational and operational structure of the parent command.

I am sorry to get off on this, but you hit a key issue.

C: Was there friction between the Army Surgeon General's Office and the Army Service Forces Headquarters over any of the following points? (Captain Cleary hands Dr. Meiling a topics card.)

M: One must go back historically to find out where the Medical Department of the Army was at the time of the issuance of War Department Circular No. 59 of March 1942----

(End Tape 3, Side 2)

M: Let's go back to the history of the Medical Department so we have a background for the environment in which War Department Circular 59, 2 March 1942, established the Army Ground Forces [AGF], the Army Air Forces, and the Services of Supply as three components of the War Department. Up till this time there had been a Quartermaster Corps, Artillery Corps, Infantry Corps, a Medical Department, and everybody coordinated under the Adjutant General. It was a very definite conglomerate with corps chiefs being literally in command and in charge of personnel, training, and so forth. Army military policy goes back to the time of our frontier activities. In fact we could even go back to the historical reference to the first medical directors that the Army had

had developed with the mounted military forces and the foot soldiers. It was very hard to get the Americans to change their basic concepts of military operations. During the period prior to World War I, it is interesting to note that Assistant Surgeon Albert J. Myer, for whom Fort Myer was named, was a signal officer of the Army because he had developed both weather studies and the use of various codes to transfer signals. In 1880 he was named the Chief Signal Officer and head of the Signal Corps. It was under the Signal Corps that the first aviation section was established, and 2d Lt H. H. Arnold was the second Army flier assigned to it. Other medical officers developed the Medical Library and Museum, designed and built Johns Hopkins Hospital, New York City Library, and the Marine hospital system. John S. Billings was in charge of the vital statistics of the US Census Bureau. Leonard Wood [Gen] was a medical officer, who later became Chief of Staff of the United States Army, Governor General of Cuba, and Governor General of the Philippines. He also ran once for the nomination of one of the political parties for President of the United States but was unsuccessful.

F. C. Ainsworth [Maj Gen Fred C.] was a medical officer and became Adjutant General of the United States Army. Trying to construct what was happening after the Spanish-American War in the Medical Department, one finds that the leaders of the medical service were perturbed that in time of emergency the civilians would come in and run the military hospitals. The Medical Department developed the concept of the general hospital. They had Walter Reed [Washington DC]; Fitzsimons [Denver CO]; one in El Paso [William Beaumont General Hospital]; one in San Francisco, Letterman; the one in Panama, Gorgas; and one in Hawaii [Tripler]. If one was fortunate as a medical officer, he was assigned rotation

fell into a second-rate professional classification because they could not be assigned to general hospitals. They were assigned to the airfields. This stimulated the further development of the "flight surgeon" who was responsible for the aeronautical medical problems of the flier. He came literally under the Air Corps, but he belonged to the corps area command. This caused conflict when the Air Corps separated from the corps areas and developed what became the Army Air Forces in 1940. It was then that the Surgeon General tried again to get the medical officers back under the Surgeon General so that he would have complete command of assignment of their duties and what they could do and could not do.

The Surgeons General and their staffs were not knowledgeable of military organization, but they were committed to this concept that regardless of how the Army was organized, they had, as a department or a medical corps, command over the training and personnel as well as the operation of the hospitals assigned to it. It is only reasonable to understand why, like the Navy, they put the greatest stress and their best people in these big hospitals which were under their command. The field forces shifted people from one area to another, to overseas commands, from China, the Philippines, Hawaii, Cuba, Puerto Rico, during the period between the wars. The flight surgeons were sent to the fields in like manner but never given the opportunity to really have hospital duty. They had dispensary duty, small things, maybe an appendectomy, maybe a tonsillectomy. If they had any problems, they had to send the patient to one of the general hospitals. General Magee [Maj Gen James C.], who was Surgeon General when World War II broke out, did not have a very effective staff as was found in England. When the Army got over there, they had a limited medical supply

disease was suddenly coming from. Of course, it was coming from our personnel. If a chap got sick in the Mediterranean, he got on a plane that was going back. He didn't report through medical channels. He tried to get back to Germany where he was assigned before he had to turn himself into the hospital. A feasible medical and sanitation plan must be incorporated at command level when developing a war plan. I don't care whether it is the invasion of France or Beirut or Cairo. You need it right then. As a front develops then you bring your medical sanitation people and the medical corps in, and then you get evac hospitals and surgical hospitals with controlled air evacuation.

This attitude on the part of the Surgeon General was very marked by the development of orders from the Surgeon General back in the time of General Ireland [Maj Gen Merritte W.] who transferred the Medical Section of the Signal Corps back to the SGO. It was necessary for Congress to direct the President to create, by Executive order, a Director of Military Aeronautics and a Bureau of Aircraft Production. When the Director of Military Aeronautics was established, he appointed Major Lyster [Brig Gen Theodore C.] as the Chief Surgeon of the Air Division of the Signal Corps. Later Lyster was to go to Europe as the Chief Surgeon of the Air Service in the Army Expeditionary Force under Pershing [Gen John J.]. The surgeon in the Zone of Communications objected to this and said that Lyster's people had to be under the Surgeon General. All the time this was going on, it became very obvious that there were two classes of medical personnel, those assigned to the field units or the station hospitals and those assigned to the general hospitals. The civilian medical profession recognized the quality of the doctors assigned to the general hospitals;

Marshall personally told me at a later time when we were discussing some of these things, he said he went to see Mr. Roosevelt one morning to give him his normal daily briefing, and he asked that Kenner be appointed Surgeon General. He did not take it through channels. He did not go through the military aide to Roosevelt. Roosevelt said, "Certainly. Do you have the certificate of appointment?" He did, and Roosevelt signed it. General Marshall took it back to his office. About 4 weeks later, after a briefing, Roosevelt said, "Oh, by the way, I want that certificate on General Kenner recalled, and I would like to have General Kirk appointed Surgeon General of the Army." Marshall said, "Yes, Mr. President." He said, "I didn't discuss it with him, I didn't argue with him, I came back to my office, I sent the certificate on Kenner back to the White House, and I issued a directive that General Kirk was never to be given an appointment to see me unless I called for him, that anything he wanted to do with the Chief of Staff, he would do it either through the Commanding General, Somervell [Gen Brehon B.], of SOS, Services of Supply, on whose staff he was a special staff officer, or he would deal with my deputy." At that time it was McNarney [Gen Joseph T.]; later it was Handy [Gen Thomas T.]. "I issued further orders that all medical matters that were referred to me had to be cleared by General Snyder, the Assistant Inspector General." At still a later date, we appointed General Snyder the Inspector General of the United States Army, and he still handled all matters pertaining to medical things overseas. He was the liaison with the War Department.

When General Kirk became Surgeon General, the first day--I was Assistant to the Air Surgeon, General Grant--he sent for General Grant and said words to this effect, "Dave, I want you to become my deputy. I will see to it that you are made a major general, and I want your whole office wiped out and transferred over here." General Grant said, "Norm, under no

dispensaries and elective surgery--regardless of the qualification--could not be performed anyplace except in general hospitals, this drew the line not only between the medical personnel assigned to the Air Force and those of the War Department but also between physicians in civilian life. These were people who had gone in the Air Force voluntarily. They were specialists in neurosurgery or abdominal surgery or thoracic surgery or orthopedic surgery who couldn't practice their specialty, not because they weren't qualified but because they were assigned to an Air Force dispensary. They wasted no time in writing back and telling the people back home what the Army was doing. The American College of Surgeons, the American Medical Association, and the specialty boards then got into this whole thing. General Kirk had been personal surgeon at the time of the removal of the gall bladder of then Secretary of War, Mr. Stimson; they were good friends. In short order, by various means, this controversy got to President Roosevelt, and President Roosevelt, after getting quite a bit of flak from the civilian medical people, found a solution in the report that there was unsatisfactory medical service in England. US Air Force personnel were being sent to British hospitals, and the closest American hospital was several hundred miles from where the airbases were. To relieve this General Hawley [Maj Gen Paul R.], Dr. Cutler, and Dr. Zollinger [Robert M.], who were the chief surgical advisors in the European theater, set up surgical teams to go to these English hospitals and operate on war casualties taken off the returning bombers. They were still in English hospitals, and they were being fed English menus, which were quite different from American menus. The boys were writing home to their mothers, and their mothers were writing to Congressmen. This was all piling up in the White House. So in February 1944 the President appointed Dr. Edward A.

convalescent hospitals, station hospitals, and an air evacuation system with a regulating officer who had the authority of the Chief of Staff to make decisions about how many beds were provided for different types of diseases in these hospitals. The Army was adamant that they would not allow the Air Force to have general hospitals. The Air Force was adamant that they were going to have something, regardless of what they were called, in which medical personnel could perform according to their professional qualifications. I don't remember the details now of how we came up with the word "regional" hospital.

It seemed logical throughout the domestic United States to set up a central hospital to which station hospitals could feed patients. We would not lose them to the Army Ground Forces or the Army Service Forces who were still under the command of the Commanding General of the Army Service Forces. Patients could be sent to the convalescent center, usually attached directly to the regional hospital, and while they were convalescing, they could do their duties; improve their skills, be it military or civilian; learn to be secretaries and learn how to handle typewriters. We didn't have computers in those days, but we had complicated electronic systems. Patients could be moved from one place to another through the regulating officer. So the Commanding General of the Air Force by this War Department Circular 140 got what he wanted--command of his personnel. If somebody was so badly injured that he was going to require 6 months to 24 months of hospital care, he was sent to a general hospital. The Army decided later that they would send patients on to the veterans hospitals.

The Army Air Forces tried its best to get general hospitals overseas. The most we ever got in Italy, as I recall, were

General of the Army, General Kirk, standpoint--we had to have, as he put it, medical officers available just like firemen. "If they sat all day long, that was perfectly all right; firemen do, too." He made that statement before the American Medical Association House of Delegates, and it was one of the best statements for the Air Force Medical Service in which we tried to use the professional skills of medical officers. We utilized it when we were trying to get a separate medical service 4 years later. People say, "How did you get the College of Surgeons and the American Medical Association and Specialty Boards to agree that the Commanding General of the United States Air Force in 1949 should have command of his medical service?" A little side issue on this, Kirk had other problems. He was not popular with many of the commanding generals. For example, he landed in the Philippines, and MacArthur [Gen of the Army Douglas] refused to see him and told him he could not leave the airbase at Clark Field and that he should be on the next plane out. He wouldn't let him visit any of the medical establishments in the Philippines.

General Kirk also went to England, and he and General Hood [Lt Gen Sir Alexander] of the Royal Medical Corps of the British Army had a discussion, and they reached the agreement that the medical services of the three forces should be consolidated and they would work intensely to effect this consolidation so that in each country only one military medical service would obtain. In Britain, as is well known, anything that is policy has to be discussed on the floor of Parliament, and the government takes an official position. After 3 years of inside discussion and a Royal commission and so forth, the Minister of Defense stated to Parliament that so long as there was a command of a service that commander should have command of his own

medical service, including hospitalization. It was used in congressional committee hearings when efforts were made to get a separate Air Force Medical Service, so it was easy to find out what Kirk and Hood were doing because all one need do was follow the pages of Parliament. Kirk later told me one day that, yes, he had discussed this with Hood and that he had discussed the whole thing with General Eisenhower.

In 1949 when I was on the Cooper Committee of the Department of Defense, at the direction of Secretary Forrestal [James V., Secretary of Defense], we held open hearings. The first person to be heard was Secretary Forrestal on the subject of a unified medical service. Why did we hold these hearings? General Eisenhower in 1948 and 1949 was president of Columbia University, but he held a special position. Forrestal had designated him to sit as acting Chairman of the Joint Chiefs. Meetings of the Joint Staff had a prepared agenda which the staffs of the three departments worked out. On 25 February 1949 they had finished the agenda, and General Eisenhower said, "Gentlemen, I have something. We have been going now for 5 weeks, and we haven't agreed on anything, but here is something I am sure we will all agree on. That's a proposal to the Secretary of Defense that he consider the establishment of a single medical service for all three services." Not being an agenda item, he did not call for a vote on it. No one present objected. It was sent to Forrestal, the Secretary of Defense. General Eisenhower delivered this handwritten memo to Secretary Forrestal, demanding formation of a single Department of Defense Medical Service. Then Forrestal told Mr. Cooper [Charles], who was the Deputy for Medical and Health Affairs, to hold hearings on this proposal. That's how it happened that first Forrestal and then Eisenhower appeared at the hearings. The committee decided that I

should be the questioner of Eisenhower. General Hawley was on the committee as well as General Bliss [Maj Gen Raymond W.] and Admiral Swanson [RAdm Clifford A.]. I was a civilian at the time. In fact I was at Ohio State, and I came back for this meeting. I listened to Eisenhower present his idea, and I said to him, "General Eisenhower, isn't that exactly the same plan that General Kirk presented 2 years ago and the same plan that you have presented to the Army?" He said, "Yes." I said, "Well, it was turned down at that time. I wonder what there is about that that you find so good?" He said, "I think medical officers should have their own uniforms. The Director of Medical Services should be on an equal level and sit with the Joint Chiefs when they discuss any medical matters, and he should have equal authority." I said, "What color uniform would you propose?" "Well," he said, "it could be green, or it could be purple. The Medical Corps colors have always been silver and purple. That would make a good uniform." I said, "How would this force function to meet the needs of a division or a corps or an army or a fleet of the Navy or an air force or an air force wing? Who would assign these people?" "Oh, the Reserve doctors coming in could be assigned to those duties." Remember, here is a man who commanded the biggest force the United States ever put together in the field. The other members of the committee started to ask questions, and he said, "Don't ask me these questions; ask General Hawley or General Bliss. They are the ones that gave me this plan." Afterwards he came up to me--I think we were both having dinner that night in the Army Navy Club. He said, "Meiling, why are you so hostile to the Army Medical Department?" I said, "I am not hostile. I served quite a few years in it. I think it has great merit, but I think the Air Force needs its own medical service. I do not think the Veterans Administration is the way to solve the medical needs of the Armed Forces." "Well," Eisenhower stated, "you

have all this duplication of hospitals." I said, "We will get rid of the duplication. You don't have to kill the services to solve a problem that is a command problem. If you have ten hospitals and you only need three, all the commanding officer has to do is say close them." He said, "But think of what Congress"--I said, "It's a command decision. If you are going to think about what Congress is going to say if they no longer have a hospital in their community, we will never solve this problem." (See Appendix B)

Later, when he was SHAPE [Supreme Headquarters Allied Powers Europe] Headquarters, I visited him several times. We had some very interesting discussions, and later when he became President of the United States, he invited me to become an Assistant Secretary in the Cabinet. He did not want me in the Department of Defense [DOD] where I had been, but he wanted me in the Department of Health, Education, and Welfare. I told him that I would not leave Columbus to participate in that and the only thing I would do would be to come back to the Department of Defense. He said, "Did you ever think in a position at Cabinet level you could have more influence than you could when you are responsible for an operation?" I said, "I don't see the Department of Defense responsible for operations. They are policy and programs. The operations are the responsibility of the commanding generals or the commanding admirals." I saw him once after he was out of the White House, and he was complimentary. He thought we were moving forward. He even went so far as to say, "I don't think a single medical service would have served the three forces the way they need to be served," which was quite a significant statement, but he also said, "I don't understand why you can't put Army and veterans hospitals together." I said, "General Eisenhower,

you and General Pershing have been very famous patients at Walter Reed. Would you have been happy in a veterans hospital?" "You are taking it out of context." I said, "No. Would you have been a happy patient, and would you have received the treatment that you received at Walter Reed had you gone to the veterans hospital up on Wisconsin Avenue?" He said, "Let's drop it." So I don't know if I ever convinced him.

I think you need to have a feeling for the manner in which the War Department and the Surgeon General's Office developed general hospitals from 1900 to the present day. In so doing they had an elitist group purely because they were assigned there, not necessarily because they were top in their specialty field. By so doing they caused friction within their own forces; for example, General Kenner and General Hawley are beautiful examples of field soldiers who never commanded and served very little time in general hospitals but who were very knowledgeable field medical officers. I think the same was true, for example, in the Navy. Admiral Swanson who was Surgeon General--well, we can go back further than that. The one preceding him, Vice Adm Ross McIntire was Surgeon General and personal physician to Mr. Roosevelt. He bragged to me that he had never been on a destroyer or a submarine, that that was no place for a "qualified" doctor. The Navy informed me through their command that they were having trouble with snorkel submarines. I said, "I will go and ride one 2 or 3 days, and let's see what the problems are, I would like to take along some specialists." We did. We came back, and Admiral Swanson said to me, "You must be crazy. Why would you want to go down in a 'pig boat'?" That was a nickname for submarines. "It was bad enough when I, as a lieutenant commander, was assigned to a flattop. I am a specialist in

ear, nose, and throat. You need to be the chief of service in a big hospital. Then your civilian confreres will respect you."

After World War II this became even more difficult. The Army, Navy, and the Army Air Forces had given commissions to doctors who had specialty certification from the American boards one and sometimes two ranks higher when they came on active duty than somebody who didn't have his specialty certification. They got more pay; they had more rank. When the veterans hospitals came along in 1946 with their big expansion, the VA just said, "Anybody with board certification gets \$6,000 more a year than anyone who doesn't have it, and for every 10 years of board certification, you get another \$5,000." So in the Army, Navy, and the Army Air Forces, the drive was on to get sent to a residency training program. This was to effect the development of the medical services of the Army Air Forces and the Air Force----

(End Tape 4, Side 2)

M: We were discussing the problem of residency and board certification. We had lieutenant colonels and colonels in 1946 and 1947 being sent to become residents so they could qualify for board certification. Board certification was the end all of everything in professional life in that period of the 1940s and 1950s. The military and the Veterans Administration were giving more money; advanced rank was forthcoming in the military on the basis of board certification. It was amusing to me. In 1948 I first joined Secretary Forrestal's staff as a consultant. I was the only one who had qualified by taking the examinations and was truly board certified. The three Surgeons General

had honorary board certification. I was the only one at top level, and this included the Army, Navy, Air Force, the medical service of the Veterans Administration, and the Surgeon General of the Public Health Service. They had all received honorary board certification. Yet they would argue day in and day out with me why we needed more residencies, not what we were doing to provide service, but why we needed more residencies, why we needed more people in residency training. This was a very difficult time. It was a time when few medical officers wanted to go to Air University [AU], Command and General Staff School, or the Naval War College. That wouldn't lead anyplace. If you wanted to get someplace, you had to be board certified regardless of your rank.

When the Air Force became a separate medical service in 1949, they didn't follow General Grow's plan, but both General Armstrong and his deputy, General Ogle [Maj Gen Dan C.], were very insistent that they have hospitals. By the time Ogle finished his Surgeon General's term, I think, the Air Force had something like 190 hospitals. He issued a directive that in answering the phone medical officers should say, "This is Doctor So-and-so" and not give their rank. By using the term doctor, they would impress the military people that they were professionally qualified and the Air Force military would come to the Air Force hospitals instead of trying to go to general hospitals of the Army. I hate to call it a class distinction, but it was a social distinction of where you were assigned that sort of implied to the nonmedical public that you were a better physician than the other chap who wasn't assigned to the hospital. This reflected in the Army and the Navy and the Air Force the line officer's attitude. He had great faith and great confidence in his flight surgeon because he saw him every

day; he flew with him; any problems he had, medical or otherwise, he could take to him. But when his youngster had a brain tumor or his wife had a gall bladder problem, "Don't you think we ought to send her to one of the Army general hospitals?" This used to irritate the medical officers who were qualified and assigned to hospitals so that the Air Force developed the big hospital at Wright, one at Andrews [AFB MD], and the one at Keesler [AFB MS]. At Kelly [AFB TX], they developed Wilford Hall, et cetera. They never called them general hospitals, but they called them Air Force Medical Centers.

It was a carryover of this problem that developed before World War I and between World War I and World War II that one had to have a special name on the military hospital that indicated he as a physician was better qualified because he was assigned there. Even if one had board qualifications in surgery or something else, if he wasn't assigned to one of the big hospitals where they taught residents, he wasn't quite as good. In civilian life the teaching hospitals were the ones that were connected with universities and had residency training programs. What it cost the American public and the three departments, I have no idea. But the maintenance of residence programs in military hospitals from 1946 on meant that one had to find patients that would keep residents happy. So you had to transfer patients to the building regardless of what it was called--US Naval Hospital, Army General Hospital, Air Force Medical Center. This has caused a lot of problems, and if one doesn't understand this and see it in reflection, he will not understand the friction and the differences of philosophy that existed between the Army Medical Service and the Air Force Medical Service and the Navy Medical Service. I think the best example of that was the Deputy Surgeon General

of the Army, the day that the Air Force Medical Service came in, 1 July, made a bet of \$10 that the new service would fall on its face by 1 January 1950 because they didn't have any general hospitals and no doctors would serve with them if they couldn't serve in a general hospital. He thought the Air Force would get a lot of people that weren't interested in professional advancement. Well, he lost his bet, and the Air Force has maintained a very good quality of medical service. I think they probably stress hospitals today. I think it was wonderful that Gen Paul Myers [Lt Gen Paul W.], Surgeon General, made it possible for everybody in the Air Force Medical Service to find out what their combat assignment would be. I think military physicians were really somewhat taken aback when they found out that Myers' concept of war mobilization was to send Air Force patients to the next available civilian hospital with whom the Air Force has a contract. Mobilize the people in this Air Force hospital to go out with the flying forces and call in the Reserve to take over the Air Force hospital facility. This was quite a shock to many who thought, "God, the Regulars will take all that field work." But I think it is realistic. I don't think we are going to have 3 to 12 months to mobilize. I think we have to work with what we have. It is silly not to utilize the beds and the personnel in large civilian hospitals. By clearing elective surgery, civilian hospitals would have ample beds to take military patients. We might have shortcomings for a month or two about dependents. We might find that obstetrical cases were handled on a 1½- to 2-day term instead of 5 days, but it's a realistic plan that can function.

Germany was particularly interesting to study after the war. I was on the US Strategic Bombing Survey [USSBS] and found

out that they had from the very beginning of their expansion not tried to build big hospitals. Wiesbaden is an exception to the case. They had used one or two floors of existing civilian hospitals, university, county, and city. Then they had gone into the resort areas and taken over resort hotels for convalescent and definitive care. They conserved their medical resources for both civilian and military that way. They saved a tremendous amount of money in the form of buildings. The United States had military hospitals built, so I am the last one to suggest that we tear them down. I do think when it comes to personnel we have to evaluate both sides of the coin--what the military needs and what the civilian sector needs--and divide them accordingly so the situation that existed in the 1940s and 1950s isn't repeated; namely, an attempt for coequal status with the civilian side by having big military hospitals and big military clinics to compete with popular big civilian clinics. The United States developed a program that was not realistic and not the most efficient use of our personnel by both the military and civilian sectors.

C: General Meiling, I would like to proceed along the line of discussion concerning the administration of hospitals. I would like to ask you if during wartime the procurement and distribution of medical supplies--that is, moving from a peacetime to a wartime environment--was any real problem? Exactly how did we mobilize the pharmaceutical companies to provide the types of medical supplies we needed?

M: I think one must keep in mind that in the military you have supplies that have a limited life and you have supplies, like bandages and so forth, that can be stored in proper situations for years. During World War II, the rapid expansion of forces and the movement of forces into the

Pacific and the European theater and the lend-lease demands caught the medical supply procurement literally with their pants down. It was almost disastrous what happened to medical supplies in the North African campaign. Secretary Stimson brought in Mr. Voorhees [Tracy, Chairman of Committee on Health Affairs] to solve the contracting disaster and then go to England and straighten out medical supplies so that the shipment of supplies got to the areas where they were needed. During my term as Assistant to the Secretary of Defense, one of the things that we accomplished in supplies was to have a central medical supply catalog which served all three forces. We also reduced the number of medical supply depots in the continental United States so that the number of perishables and the nonperishables in the supplies were concentrated on the shelves in four different places rather than maybe 20 or 30. I remember in World War II the military was very much interested in the development and the procurement of a vaccine for which one of the large pharmaceutical companies was using horses; they were bleeding the horses. They had about 900 horses. They came in to us and said, "Look, we are matching the problem of producing your vaccine, but we have some problems. We have to dispose of X hundred thousand eggs every day and X tons of manure every day. The egg is innoculated and then incubated, and we can throw it out. The farmers in a radius of about 50 miles of our big plant are willing to come and get these eggs to feed to their pigs, but they don't have any special gasoline ration to supplement their own ration of gasoline. The same thing with manure. We can't haul it away. Can you get us gasoline from the Fuel and Energy Board to support the farmers?" We found out that they finally took a farm field of many acres, and they just took the manure out there and made a compost pile which, after the war, they sold as fertilizer for people's gardens. Here

one of the big problems was not in meeting our demands, it was getting rid of the waste product. These are all things that enter in to medical supplies production. Fundamentally units with tables of organization will be resupplied when they are sent overseas. The resupply will be on a 30-day or a 60-day or a 90-day basis, depending on what classification of medical supplies we have. For example, if you had an X-ray machine in your big hospital, every 90 days you would get a new tube. Assuming that the tube was burnt out or broken, then you would have to have a resupply. This is true with all the expendable equipment in a hospital. But now the Air Force--I am talking about World War II--did not have hospitals. It had dispensaries. All the medical activities were the responsibility of the Army in overseas theaters so that the requisition of medical supplies from the medical supply depot in a given theater was subject to what they had aboard and depended on how these supplies got to them. I can recall several requests that we had. One from the Pacific didn't do with medical supplies, but the chief AAF medical officer wanted whiskey to be given to the crews of the bombers when they came from long overwater missions in because the Navy was doing it. The Medical Department would not buy whiskey except as part of medical supply. General Arnold told us to get the whiskey and get it aboard a boat and get it sent out there. Whiskey, you may recall, was rationed during World War II in the United States. But we succeeded in getting a relatively small freighter filled with whiskey. Because of the complications of this, we had our flight surgeons issue a prescription. When the fliers came back and they were debriefed, they each got a prescription for 2 ounces of whiskey. Many of them didn't want to drink it then; they wanted to wait until they were on crew rest for 3 or 4 days. Then they would go in with five or six of these prescriptions, and they would come

away with a small bottle. It was a great morale builder, but the Army Medical Department objected to this on the grounds that they needed the same kind of morale builder for the infantrymen as they needed for the combat flier. They never were able to get General Arnold's order rescinded, so it was up to us in the Air Surgeon's Office to see that these supplies which normally would have been medical supplies were procured as air supplies.

The problem in 1950 of trying to reduce the size of the medical supply catalog was tremendous. I think we had something like 70,000 items in the medical supply catalog. By the time we had one medical supply catalog put together for the Army, the Air Force, the Navy, and Public Health Service, we had reduced the items that were duplicated previously in the three branches to about 33,000 items in the catalog. That sounds just like a lot of paperwork. And we did get rid of pages. But when you translate that into the supplies that are on the shelf in the central depots, you can see that we reduced the warehouse space tremendously. Now the problem was that in distribution the manufacturer puts it together, and he doesn't want to warehouse it. He wants to get it out of his factory as fast as possible. So you have central medical supply. Those central medical supply depots take care of the Zone of Interior of the United States, the Zone of Communication, and the combat zone. Each of those zones has medical supply depots. When you get to the hospitals, each supply officer feels he is only as good as the items he has on his shelves in warehousing. This goes on down to the station hospitals and to the dispensary, so the user's supplies are depleted by the distance he is from the supplier. Everybody is putting supplies on his shelves so he can "show at inventory that he is doing a good job of maintaining

supplies." The medical services were probably the worst offenders in this that we had in World War II.

Initially, in 1940-41, we had to get rid of a lot of bandages and dressings that had been bought and warehoused for World War I. You would open one, and the waxpaper would crackle, and you would find that the fibers of the bandage would break down. Once we got rid of those and began to get the new supplies in, the manufacturer did a good job. His leadtime was very definitely specified in contracting. The perishables, such as vaccines, narcotics, and controlled items provide additional problems that you don't have in resupply of the Air Force. It wasn't until we established the Office of Medical Services in the Secretary of Defense's Office that we began, one, with a central catalog; two, with a central procurement for all services; and three, when we got into Korea, we were providing medical supply services for some 50 allies that were involved. It was the same thing with surgical instruments.

We weren't the only country that had problems. When I interrogated Dr. Karl Brandt, who was the chief medical officer of the German Government, he had had army, navy, air force, the SS, and the SA [Sturmabteilung (Stormtroopers)] under him as far as medical supplies were concerned. I said to him, "How did you solve them? You didn't have total mobilization, but you certainly had control." He said, "We worked with Dr. Speer, who had charge of the civilian economy of Germany, and we reduced, for example, the number of surgical clamps called hemostats from some 67 types that were available in 1939 to 7 that were available in 1942. The same thing--we had 27," as I recall the conversation, "different types of operating tables. It was reduced to two." The United States didn't get that far until our

medical supply catalog in 1949-50 reduced the number of hemostats, let's say, or the number of different operating room tables that are needed for a mobile unit versus a general hospital or a station hospital. These are problems of logistics that medical officers, if they are going to exercise top command, should learn at the Industrial War College. It is only by understanding the industrial development of your country that one learns how industrial development can support the logistic war effort. In peacetime, procurement of supplies is not much different than in a large community that has joint hospital procurement. For example, let us say there are 11 hospitals, and they all buy through 1 purchasing agent. This means that they order 6 months in advance. They try to maintain a low level of supplies on the shelf and have the supplier send resupplies on a 10- to 30-day period.

(End Tape 5, Side 1)

M: For a facility in the State of Ohio, for example, that is no more than 6 hours' delivery time from any type of medical equipment, one doesn't need to have a 90- or 120-day supply on the shelves in the hospital warehouse. One can order as needed. The factories in peacetime are perfectly willing to gear their production to demand. This is not true in wartime. Unless one understands the capabilities of the industry, whether it is pharmaceutical or instrument or equipment or wool blankets and sheets, as a commander he is at the mercy of what somebody tells him. One has to coordinate his requirements with the overall allocation of a war production board. As I said, suppose one needs fuel so he can haul away waste products at a company that is using thousands and thousands of fresh eggs and a lot of blood from horses in your serum production? What do you do

when you get over into the area of how to produce human blood serum as an alternative to human blood for transfusions? How do you stockpile plasma? Do you stockpile it as liquid, or do you stockpile it as powder that can be reactivated as liquid? Do you find a chemical to take its place? As you think of this, you have to keep in mind that the human blood cell is about 7 micron in diameter, so anything that you manufacture must be within that size, or it won't go through the filtration of both the liver and the kidney. When a national defense blood program is established, one has to deal with the Red Cross. Did you know that there are certain sections of our country which during World War II and during Korea had independent blood bank groups that were not connected with the Red Cross and that we had to deal with them?

To give you an example of how difficult this supply situation is, MacArthur's headquarters in August 1950 sent a cablegram to the Joint Chiefs demanding 500 units of fresh blood to be delivered in Japan every 24 hours. At this time fresh blood has a potential life of 30 days. So what we did was take blood that was gathered on the eastern seaboard and send it to the west. Then the blood that was gathered in the west, we sent by air to Hawaii and then on out to Japan. We never missed a single day of supplying the blood that they wanted. For some reason, MacArthur's headquarters and MacArthur himself would not allow this blood that we were sending out there to be used for American patients. It was all right for the allies and the Koreans, but he bled his own troops to get blood for American patients. MacArthur tried to set up general hospitals in Japan, which were disapproved by my office and the Secretary of Defense's Office because we were more worried that the Russians might hit us either in Turkey or in East Germany, and we did not

want to be totally committed to the Pacific. The Pacific theater went ahead and established two general hospitals in MacArthur's theater, but because they had not been authorized by the War Department, there was no automatic resupply of equipment going to those hospitals.

Nevertheless, the Korean experience is the first time in US military history that medical supply was cited as being far superior to any other supply unit in the theater. It performed a fabulous job. I think one of the reasons was the function of a common medical catalog and a common medical supply depot at Ogden that supplied the Pacific theater. The Navy and the Army and the Air Force could then draw medical supplies at any forward depot because they all fed back to the central control in the western seaboard supply depot. I can't comment on what is prevalent today, but I have every reason to believe the medical supply situation for the three services is geared to a military contingency. Depending on the availability of pharmaceutical companies and supply companies, there wouldn't be an immediate crisis in the civilian economy for medical supplies because the military took everything. I think there would be some shortages over a period of time. But as far as I know, both the civilian sector and the military sector would be able to handle their medical supplies needs.

I would like to mention at this time that in our studies in World War II when we were "selling air evacuation to the General Staff," as differentiated from hospital trains and hospital boats and hospital Army transports, we found that to maintain an individual, officer or man, in an overseas theater took 8 tons of supplies the first 30 days. This was everything. We also found that to maintain a patient in an

overseas theater we required six individuals. Remember you are taking care of this individual around the clock. If you multiply 6 times 30 plus the 1 patient, you find that we are dealing with a sizable logistic load going to the theater to maintain that patient. It behooves the theater commander to have the fewest number of patients in his theater. It reduces his workload; it reduces his logistic tonnage. Airlift is essential in moving patients to United States.

It does provide a problem, and that's in personnel. If this man is pulled back to the United States for hospitalization, will he be fit mentally to go back to combat? The experience we have had in both Korea and Vietnam would indicate that the answer is yes, he will. The British were far ahead of us in World War I and World War II. They provided leave back in England for their fighting forces, whether they were patients or just on leave. After 5 days they turned around and went back to the front. I see no reason why the American soldier wouldn't do the same. You get into the problem of the personnel pipeline. During World War II, it was complicated because we had segregated units. We had to have a personnel pipeline to feed the segregated units as well as the nonsegregated units. Units were not rotated out of the theater, but replacements would be sent in from pools. During the latter part of the spring of 1945, personnel were very short in the European theater because more were beginning to be sent to the Pacific theater, and there was a time when General Eisenhower had them clean out cooks, clerks, and bakers to make infantrymen of them. It was true up front that you didn't have personnel, but if you looked at the total picture, it was a matter of personnel distribution that was lacking in its ability to meet the demands of two or more theaters of war. Today, the social or cultural handicaps from segregated

units do not exist. A single pipeline on personnel and a single pipeline on medical supplies as well as many other things are established. But the big problem, I think, the medical services must keep in mind is that they should reduce their logistic tonnage; airlift is allocated by tons not by items. If you are resupplying a major theater, you use both airlift and sealift with tonnage allocated by a transportation board. If the medical service officer doesn't understand this as well as any other staff officer in dealing with transportation or if he forgets about dealing with individuals when he is talking logistics, he is making a mistake. The individual responsibility as physicians must be maintained. That's our role as humanitarians. But whether it's a patient or whether it's a tent or whether it is a portable hospital, we must think in the terms that the staff used in their logistic planning. This has been one of my interests in the military, to be able to talk the language of the staff, prepare memoranda and endorsements and so forth on memoranda so that we had a mutual understanding of what we were trying to do. You can see why in my thinking the ambulance plane has no place in wartime. I am not saying anything about the ambulance plane in peacetime.

C: What you have pointed up, though, is that it is critical to know how the rest of the staff operates; that is, the rest of the military staff.

M: That's correct.

C: You were in a position in World War II, of course, to have dealings in that area. I think perhaps now would be a marvelous time to discuss those three strands of medical supervision that existed during World War II and how they

interacted in a practical way to support the forces overseas during World War II.

M: Now you are talking about the three strands of medical command. Let's start with the Surgeon General in 1940 when we began to mobilize. He actually commanded the several general hospitals that the Army had.

C: The Surgeon General had control of it.

M: Yes. It is an interesting side that the Gorgas Hospital in Panama charged fees for medical services, whether it was putting a Band-Aid on or taking a gall bladder out, on the basis of your income tax of the previous year if you were a private citizen or tourist. They had a definite segregation problem. Anybody that was in the military was on the "gold" standard, and anybody who was not military was on the silver standard. It's the greatest study in socialized medicine that the United States has ever had. Nobody has really done a good study of that, but that's an aside.

Getting back then to the command, the Surgeon General commanded the general hospitals. Then we were divided into the corps areas. The United States had various corps areas. All station hospitals came under the command of the commanding general of the corps area. The base commanders or the fort commanders or the field commanders were all under the commanding general of the corps area. In addition to this one had the Army organization of aeronautics. The Air Corps, the air divisions, and the Army Air Forces had just come into being under General Arnold in 1940. This was 2 years prior to the time the War Department was reorganized into three components. As Commanding General of the Army Air Forces, Arnold moved the medical section from the air

division and the Air Corps into his headquarters and established a medical section of the headquarters, and this was headed by Gen, then Col, David N. W. Grant, who later became the Air Surgeon. The flight surgeons who were on airfields were under the control of General Arnold through General Grant. On medical policy and hospitalization, they were under control of the commanding general of the corps area. This mixture of these flight surgeons were responsible medically two ways. General Arnold wanted a separate medical service to support the Air Force. The Surgeon General was opposed to the Air Force having anything resembling a separate force. Back in World War I, this was General Ireland. In 1937-38 it was General Reynolds [Maj Gen Charles R.], and then General Magee was the Surgeon General from 1940 to 1943. In 1943 General Kirk, who was bitterly opposed to a separate service, came along. They were opposed to the Air Corps having a medical service just as they were opposed to the Quartermaster Corps or the Cavalry Corps or the Armored Force Corps having a separate medical service. The power that they felt they had in the Medical Department of the Army was complete control and, as far as possible, command of the medical services. They based this on a congressional act which made the Surgeon General of the Army the senior medical advisor to the Secretary of War, not to the Chief of Staff, but to the Secretary of War. Because of this the Surgeon General could personally go to the Secretary of War anytime he wanted to without going through the General Staff or the Chief of Staff.

C: Making the situation far more complicated than it would be otherwise.

M: General Marshall did not deal with the Surgeons General in his period; it's not unusual because here was a special staff officer that was going over his head. In the Navy it was similar because Adm Ross McIntire likewise commanded the large naval hospitals, but he had no command and control throughout the Navy. He could not even go into a Navy dispensary unless requested. For example, at Great Lakes the Navy had 2,000 beds, a big hospital, but it was a "dispensary." He had to get permission from the Navy Bureau Chief who controlled training before he could go in and inspect what was going on in that medical facility. But McIntire not only could go to the Secretary of Navy as his chief medical advisor, but he was the personal physician to Franklin D. Roosevelt. He saw Mr. Roosevelt not once but many times every day. He was the one who developed the civilian advisors in medicine. Dr. James Paullin of Atlanta, Georgia; Dr. Strecker of Philadelphia; Dr. Leahy; and Dr. Winchell Craig [Rear Adm Winchell Mc.] were all responsive to Admiral McIntire. He in turn would go see President Roosevelt and carry the message that the Surgeons General wanted. To say the least this irritated the hell out of the Chief of Staff and the Chief of Naval Operations.

C: It almost sounds like Renaissance Italy politics.

M: Yes. It was. There was friction; there were all sorts of reasons why there was friction. The commanding officers, the line officers--Arnold, Marshall, Somervell, McNarney--all were trying to get the medical under the Staff, the G-1, the G-2, the G-3. Later we had A-1, A-2, A-3, and A-4. But because of this independence, medical officers were not included in war planning. This was war planning as to what the annexes were going to be, the medical annexes for each theater or for each war operation,

and the line staff was not accustomed to asking medical opinion. So usually a major, sometimes a lieutenant colonel, was assigned to be liaison on war planning. There was no medical intelligence because there was nobody in G-2 interested in what the medical people needed. Why is this important medically speaking? If you can tell the capabilities of the oxygen supply in a plane, you can tell what its performance is going to be. I don't care how good the engine is. The human performance is limited by an oxygen supply system, including the mask, if one can obtain and evaluate an oxygen system, one can very rapidly tell the combat people what the capabilities are going to be, the G forces the pilot can take. The Army Air Forces sent one of our people--he was then a lieutenant colonel, Randolph Lovelace [Brig Gen William R. III], who was at the Wright-Patterson Field laboratories--to Sweden. The Army Air Forces provided him penicillin, which was not available worldwide, as an exchange, and he gave a couple of lectures on surgical procedures to the Swedish Academy. When he came home he had a complete oxygen supply system in his luggage from the German Luftwaffe for their then new first jets. This was medical intelligence, but it became Air Force intelligence the minute it got to Wright-Pat, and the human engineering had to dovetail with the aeronautical engineering. This is why it is so important to me that we have people with an MD degree who can talk staff language. I don't care at what level, whether it's human engineering versus mechanical engineering, aeronautical or space engineering, or whether it is talking with A-4 on supplies or on airlift to and from the theater or whether it is talking about the strategy as anticipated to be, in a given program. It's well and good to be the best technical surgeon or the best cardiologist, but if you can't talk with the line staff that is responsible for planning, your whole

program is handicapped. This is what I learned in the Air Force as special assistant and Chief of Plans to General Grant. I had had the experience of providing medical supplies at division and corps level for over a year. I had learned how to compute, for example, the fuel for 6 by 6s to supply a combat group on the move. The medical unit of a combat group has some 6 by 6s which can be requisitioned by the line officer. If you are going to advise him, you have to know how many gallons you use in 24 hours, how many gallons he uses and how many minutes of combat limited by unit supplies.

(End Tape 5, Side 2)

- M: We were talking about the support of ambulances and helicopters to a moving combat unit and how the medical officer must understand supply. Whether it's the waterhead, the fuel head, or the food head, he has to understand supply if he is going to be able to get his people and his equipment into a position to function efficiently. This same thing is true in the Air Force. It becomes even more so as one moves up into staff activities where they are planning overseas theaters or world strategy. There should be somebody in the medical service that is adequately trained to deal with intelligence; it isn't just telling somebody already in place in intelligence what you want. The chances are they won't be medical specialists, so you have to be able to send a message to them and tell them specifically what you want and what alternatives they should look for.
- C: This is an extremely good point. What you are saying really is that the Medical Corps should allow for rotation of officers into assignments where they are exposed to this.

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But if I understand what you are saying, this did not ha
except in exceptional instances.

M: That's true.

C: When it did, of course, it was to our mutual advantage.

M: That's right.

C: But because it didn't do this in the main, it hamstrung the
whole operation. Is that a fair estimate of the situation?

M: That's right. Let me explain even that. When General LeMay
[Curtis E.] was Chief of Staff and even earlier, when he was
Chief of SAC [Strategic Air Command], he wanted doctors in
the hospital to take care of the dependents. He felt if SAC
officers and crewmen knew that back home their families were
being cared for that was the most important morale builder
that he could have. He did not see the wide picture, if you
will, that by sending medical officers to the various staff
colleges they would learn to be very effective at a higher
level. He and I had discussions about this, and it always
came back to the same thing: "Well, dammit, take care of
the wife and the child. You don't need doctors; we can use
MACs [Medical Administrative Corps]. We can use Air Force
officers to tell you people what to do." This is very
typical of senior officers who have been very active combat
fliers or Army combat commanders. When they get to the
senior staff position, it is very hard for them to think
about the broad picture and not be swayed by their own
personal experiences. General Eisenhower felt it was much
more important to have good medical service; he cited what
his son and daughter-in-law needed with their children as
opposed to what we needed--medical officers who went to
staff colleges. It was very hard for General Eisenhower and

General LeMay to see the broad picture that General Arnold saw. All his life General Arnold saw why his medical service had to be something besides doctors to sew up cuts and take out tonsils. He was very, very interested in his medical service responding to command, and it could only respond to command if it understood what the A-1, 2, 3, and 4 were doing and what War Plans was doing. General Spaatz [Carl] and General Vandenberg [Hoyt S.] allowed the Air Force immediately after the war to put assistant air attache medical officers in several of our Embassies overseas to keep track of what both our friends and our enemies or adversaries, potentially, were going to do.

When the critical period came of not having enough doctors on duty, things like intelligence and planning and staff schools were put aside, and everybody was too important to spare. They had to take care of not only sick military personnel but the dependents and the retired people. If you go through the justification for hospitals and the justification for personnel, you will find that in congressional hearings these were things that were stressed; namely, the care of the wife and the children. Probably not so much in your time, but at that time SAC was rotating units on a 3-month basis. They would go out to Guam, or they would go over to Europe. The crews were away from their home base for 3 months at a time. Socially we had many problems. We had a very, very high divorce rate in our combat crews; I am sure your own experience in the missile groups bears this out. So the commanding generals were going to solve morale problems, and they should have; that was part of their responsibility. But they weren't listening to the people who could advise them on the long-range obligation of the medical service as well as the current day-to-day responsibility.

The average doctor coming in the service wants to work in the hospital. It's the exception who will accept an assignment voluntarily to a staff school, because he will say, "What is this going to do to my medical career?" I think the medical service needs to have the same emphasis on the staff schools a medical officer has attended to get flag promotion when the time comes as well as his proficiency in his medical specialty. In other words, as a military medical man, we have to assume that he started out with a sound medical professional background. If he is going to come up the line, then he has to have some military experience. Unfortunately, if the doctor becomes very skilled, his only chance of financial remuneration is advanced rank. So after 20 years he will take a look and say, "Well, if I go out I will be in this financial bracket very shortly because of my profession. If I stay in I have got to learn a second occupation, namely, military, to be advanced to rank so I can get financial reward." These two things work against each other at a time when they should be compatible. I think it requires great leadership in both the line and the medical to find the compatibility that is needed.

C: Another facet of medicine, of course, is the mobile surgical hospital system that the service maintains in wartime and that has been popularized recently on television and the movies. If we look at the one end of the spectrum to see medical officers going to Command and Staff School, wouldn't we also look at the operational aspects of the mobile surgical hospital as being an experience that more officers assigned to the Surgeon General's Office be exposed to?

M: I think that is quite true. The Air Force has over the years developed the best transportable hospital of the

services. They have one now that has no supporting poles, and that gives you complete freedom of movement inside. It has air-conditioning, and it can be transported. Again on the airlift problem, it takes 20 tons of "lift" to transport it. It can only go where the Air Force has already located a field and is functioning because it needs electricity and water and sewerage and things like that. So if the Air Force engineers have the base laid out and equipped and functioning, you can bring a portable hospital in very rapidly. Working in that portable hospital is something that, I think, every Air Force doctor, dentist, and nurse should have some experience. Individuals don't go on alert, go down to the apron, get aboard a plane, land, and find they have this beautiful camouflaged portable hospital there and they don't know how it functions. In other words how do you maintain a sterile area in the operating room? How do you maintain the temperature and humidity in the recovery room? I don't expect the doctors to do the repair, but they should understand how it functions so that the sergeants and the airmen that come along can do a proper job. They have somebody who knows what he wants and can tell them how to adjust. The doctor doesn't have to do the physical part of it, but he has to understand.

C: Very much like the combat crews in missile capsules may know the general features of their equipment and know how to report malfunctions. It is almost like a hospital weapon system, you might say, where you have the general knowledge of that system.

M: You mentioned something that is very difficult for doctors to understand, and that is the "systems" concept of the Air Force. Every weapon and every vehicle that the Air Force

has is part of a system. It is very difficult for doctors to understand that when the designers start the system starts and one goes through the design and then through the appropriations for a model and then builds up a model. You are still pushing along in the system, and a given plane might be 12 or 15 years in a system. They see it on the apron, or they see it in the air. It is a plane. They don't understand what went into it. They don't understand the weaponry and the electronics that have to be fed into the central system from an electronic system or a weapon system or a navigation system. It is so difficult to get people to understand this.

C: Almost as difficult as field commanders that have a problem in seeing that the medical support of their system is part of their system as well.

M: That's correct. That is very well stated. You asked me about mobile or MASH [mobile Army surgical hospital] hospitals. During World War II, surgical hospitals. evac hospitals were semimobile. Evac hospitals were normally set up to handle 200 patients a day. In many instances they handled a great deal more. They were such that you could tear them down and move them in at least 2 days. They could be in tents, or they could go into buildings. It wasn't until we got into Korea that they began to think in terms of mobile units, later called MASH units that have been so well publicized by the television series. The big thing is to get the patient back from where he was wounded. This was done by litter carriers, by jeeps with litters strapped to them, and finally by the various types of helicopters that came in.

The first time I know of that we ever used choppers was in the Myitkyina activity in Burma when "Flip Corkin" [Col Philip G. Cochran] and "Johnny" Alison's [Maj Gen John R.] command landed behind the Japanese lines. Sikorsky had a chopper that could be put into a DC-4, take the blades off and transport it over. Mostly gliders were used for that activity. Gliders were also used at the Rhine crossing at Remagen. Everything was going forward. First the Remagen bridge and then the engineers bridge; everything was moving forward. The wounded that were up forward couldn't be brought back over the roads. That was the first time they used the gliders in actual combat on a pickup basis. They went in and loaded patients in the gliders and then came by with a C-47. They had cables stretched between two stakes that looked like fishing poles, and the C-47 picked up the cable with a hook and towed the glider back. It really impressed the medical officers of the Communications Zone and the Zone of Interior that there was something to finding out how to get the wounded out of a pocket that had only access roads into it. Staff officers began to think in three-dimensional space instead of purely surface area. Of course, today that has been advanced greatly by the use of choppers by the Marines and by the Army and by the Air Force. Aside from the mobile medical unit at an airfield or airbase where you have no buildings, I don't think the mobile evacuation or surgical medical hospital or unit is going to be used in the next war. As you well know we always fight the next war on the experience of the last war instead of anticipating something new. So maybe they will come up with something new. To me the key factor is get the patient back as far as he needs to go for definitive care. If that means bringing him all the way back to the Zone of Interior, do it. In Korea, for the first time, patients arrived in American Zone of Interior hospitals that were 36

hours away from combat. One didn't try to permanently fix fractures. Fractures were immobilized for the trip, but the fractures were not definitively cared for until the patients were back here in the Zone of Interior. The problem with abdominal wounds and chest wounds was much the same. The real definitive care came after they got back to the Zone of Interior. Wounds of the head and brain wounds were handled the same way.

I do not visualize large hospitals of any of the three services being located in the theater of operations.

C: There is the question, highly speculative of course, that if war develops to a point where permanent facilities are targets, a force that has to fight behind enemy lines for an extended period of time may not have the luxury of sending their wounded back to some permanent facility on their side of the line. There are no stable lines because combat units maneuver. They may be required to repair the people on the move. As I say it is highly theoretical at this point, but in such a scenario wouldn't a mobile surgical hospital be absolutely critical to the well-being of that unit?

M: Now you are assuming that a command decision has been made that that commander is responsible for noneffectives.

C: Can we develop a capability where we can become responsible for noneffectives?

M: I am sure we can, but at what cost? At what cost to his effectiveness in his primary mission? I can't visualize on a three-dimensional basis that you couldn't evacuate his noneffectives easier than you could fly in a mobile hospital with its personnel and maintain its resupply. Remember this noneffective is using up your supply lift, and the sooner

you get that demand on your resources out of there, the more effective you are going to be in accomplishing your primary mission.

C: War planners in NATO [North Atlantic Treaty Organization] talk more and more about working with forces in place and drawing from prepositioned materials. Reliance on seaborne resupply, for example, is not something that commanders want to think about in the first 3 or 4 weeks of such a war. The change in tactics, I think, is suggesting that we are moving to a position of self-sustaining forces, and we perhaps are a little more capable than the Soviets in that regard. I guess that is what I am getting at, the idea that there may be such a large conflict that dependable supply from the United States would be cut off and the sheer Pandemonium, the sheer chaos that was going on in the European theater, might be such that it would be good to have a surgical capability with each division size force. Is that capability possible?

M: I don't think there is any question about being able to have that size medical unit with a combat command. On the other hand you raise the question of NATO. I was in the Office of the Department of Defense when NATO was created, the military force, and one of the medical problems was that it was all right to fight together, it was all right to use equipment made in the United States or made in England, but if one gets sick or is wounded, he wishes to be sent to his own military hospital rather than to a Danish hospital or a Dutch hospital. He wants to be sent to an American hospital. In the European Common Market, all doctors are licensed to practice medicine in the Common Market. I happen to have a license to practice medicine in Germany. So now I have a license to practice medicine in any of the

countries of the Common Market. The irony of the thing is that in the United States I only have a license to practice medicine in the State of Ohio. (laughter) Forty-nine other states require that I get a new license to practice in their states, unless I am in the military, and then I can practice anyplace. We still have the hangup that we have to have American medical facilities and personnel for American wounded. The English have to have them for English wounded.

We have a long way to go. We started on supplies, interchange of supplies, and our common medical supply catalog is most helpful in telling them what they can get from us. They can adapt to this on the limitation of what their national industry can produce for them, but we haven't gotten around to the point of saying, "Okay, those doctors are all right; our people can go there." Let me show you the irony of that. In the Air Force hospital at Wiesbaden or Bitburg--we could go on down the list--or the Army hospitals, there are German civilian doctors, there are Dutch civilian doctors, and there are Belgian civilian doctors working in the out-patient service. There are civilians, non-US civilians, working in all our hospitals. In the European theater we have become more acclimated to foreign doctors taking care of people in American uniforms. We haven't been nearly that successful out in Japan. In Turkey and in Greece, we use civilian natives to supplement our medical facilities. Whether in the next foreseeable decade we will get to the point that we don't have to have a stamp "America" on the medical facility that is supporting an American division or not, I don't know. It involves the question of command responsibility for the commanding officer of a unit. Remember his doctors are there to advise him, but he has command of his medical service. So how much the 30-year "occupation" of Europe will have changed our

concepts at the planning level, I don't know. I think the fact that in all of our staff colleges we have a large number of foreign staff officers makes it possible for us to think in terms of joint planning. I don't mean that it is being done today, but I mean it has potential. This in turn will be a potential with the military medical services. There is more exchange of top medical talent----

(End Tape 6, Side 1)

M: Unification of medical services under NATO to support national units and others. To go back to the Korean experience, we had some 50 different nations involved in the Korean war. Most Americans think that was all fought by American troops, but we had units from Ethiopia, Turkey, Greece, France, and Iran. They were out there, and we had Swedish medical units. I remember the Swedes said they would be very happy to send a surgical unit. They would expect the United States to provide enlisted personnel and nursing "sisters," and each Swedish officer would need one batman to take care of his uniform and his leather and get his bed made and have tea for him and things like that. I said, "Gentlemen, I am very sorry, but we can't provide that. We don't provide it for our own troops, and you would never find an American soldier that was going to wait on a Swedish officer." Then they wanted all Swedish surgical instruments, and each one of their surgeons was to be authorized to take 400 pounds of surgical instruments with him. There is no question that the Stille Company of Sweden makes superb surgical instruments. All of us enjoy using Stille. But for them to have Swedish instruments out there meant a new supply line to keep them coming. Because of the political and diplomatic ramifications, we had to give them permission to take 400 pounds of Swedish Stille instruments

out to Korea. When they couldn't be resupplied, they found out that the American instruments worked quite adequately. I have talked with them since, some of them that I got to know, and they said, "You know, you make some instruments that we don't, and we have begun to use them." It was the same thing, they had a blood substitute, which had a high molecular value, and they wanted that rather than our blood plasma which they felt caused hepatitis. I never received any complaint from any American unit or individual who was treated by Swedish doctors in Swedish uniforms. I understand--I have no personal experience in this--that the UN [United Nations] forces in Lebanon are interusing available medical personnel. There is no reason why they shouldn't. But the best medical facility in Lebanon is the American University Medical School and Hospital right in western Beirut. It has always been staffed--it was established back in 1880, I think--and has been supported by American contributions. HEW [Health, Education, and Welfare] actually built the present university hospital in the 1950s over in Beirut when the big hospital building program was going on in the United States, the so-called Hill-Burton law. There wasn't much publicity, but a \$30 million hospital was built in Beirut. It was an American hospital, an American university, and had an American staff. It's a wonderful experience to see because chiefs of staff at Hopkins or Michigan or Harvard go over for 3 years and run those departments. Almost the entire Mediterranean likes to send their younger specialists to the American hospital there in Beirut. How much this is going to influence our planners from having dealt with NATO and UN combined forces of what we need in the way of mobile surgical hospitals for combat units can only be speculated. I think it would be a nice thing to hear discussed over at the Air University, particularly at the War College where

some of the officers used to say, "What do you over at the hospital know about the staff? Are they really top people? We have residents training at our hospital at my command, and I have learned that where residents are being trained it is just like in civilian life, you have the best." Well, the medical staff here at Maxwell Field has always been very high-class and very good professionals. But here were commanding officers; they were generals. I came here to the course, and they were asking about the quality of the professional man in a station hospital on this base. Is that going to influence his planning when he starts thinking about a combat situation? It may, I don't know.

C: There is something that we have been on for the last couple of minutes that brings a question to mind. Are you saying that we really ought to look at Europe and other fields of operation on the basis of interoperability rather than standardization along American lines?

M: I don't think there is any question about that.

C: And further that we should guard against the big hospital mentality which could lead to some shortfalls when we get in a combat situation where we really need mobile facilities.

M: Right.

C: How would you go about that, sir? In your visits to USAFE [United States Air Forces in Europe], PACAF [Pacific Air Forces], and Alaskan Air Command [AAC], you had an opportunity to see medical facilities in all of those locations and in a variety of years. If you compare the early 1950s to your last tour to USAFE in 1968, would you say that we have progressed along that route, or is it

pretty much the same as it was in the early 1950s when you first arrived there?

M: We have not progressed because we haven't had combat to push us into it. We have had simulated combat in our maneuvers. It is my understanding from friends of mine who are in the European theater that there is more utilization of German military medical facilities by Americans in the maneuver areas than there ever has been before. To what degree this is taking place and how it is affecting planning, I have no idea. I would hope that our prepositioning of tanks and artillery and so forth certainly doesn't require prepositioning of large hospitals. I think we could take a page out of the German war experience. They utilized the civilian medical facilities by designating a ward or a floor as a military hospital rather than building a big military hospital. To be very factual every foreign military medical officer that I have talked to is extremely jealous of the beautiful big hospitals we have, but do they have a true military requirement?

C: Yet they are much more flexible, and in terms of practicality they would be much more effective during a wartime situation.

M: Not only that, but their military medical people don't get wed to the idea that their military career is a big hospital. Let me tell you about the Swedes and the Swiss. They have total military service; everybody has to serve. I think the largest military hospital that the Swedes have is 28 beds, but if they send a man or woman to a civilian hospital, the doctor who takes care of that patient immediately is under reserve military service and responsible for the proper military medical history of that individual until he is discharged back to his unit. So both

the military medical sergeants and the military medical officers are responsible for this soldier in their military capacity while doing their civilian job.

C: That shows a tremendous amount of flexibility.

M: Yes. The chief medical officer of the Swedish Air Force goes to his office at 6:30 in the morning. He works until 11. Then he has lunch, and in the afternoon he has his private civilian practice, and he does his surgery in the civilian hospital in the afternoon. But in the morning he is on military status. The Swiss are the same way. The Swiss have no military hospitals. If a Swiss soldier or airman is injured, he is sent to the Swiss hospital, and here again, the Swiss reserve medical officers are available, and they take care of him and all his military papers. If they foul up his papers, this comes back on their military record. If, for example, he develops tuberculosis, they send him to the civilian hospital, and a diagnosis is made. He is not carried on the military roll, but he is immediately transferred to the civilian program, what we call MEDICAID [Medical Aid], and he is given full treatment as a ward of the state, not as a military man, regardless of his rank. He is finally sent to reconvalescence. They are so flexible on this that they find it very difficult to understand our tremendous hospital-medical setup that goes with our forces whether they are Army, Navy, or Air Force.

C: The whole question of what we expect of doctors, I think, also leads to another issue, one that I wanted to save toward the end of the interview, but I think it would be more appropriate here. That is the question of retaining the good doctors that we have whether they are in a large

hospital setup or assigned to other duties, maintaining them to a point where they have become effective for an entire career. There is, of course, a very real profit motive on the outside, but I thought you might want to comment on what we could do to retain more excellent doctors in the services.

M: I wish I could answer your question. It is something that has plagued us over the years, and I think we have all spent a great deal of time on it. As dean of medicine at Ohio State, I was very proud that every graduating class had graduates that entered the Army, Navy, or Air Force service. We had seminars in which we discussed the advantages of military life not only with the young doctor but with his wife or his fiancée. The average civilian has a certain amount of awe about the military and what is going to happen in military life. I think one of the things that is necessary to maintain doctors is to keep their wives happy. This is true in civilian life as well as in the military. Wives in the military have a tendency to assume the rank of their husbands. This can be very discouraging to the wife of a young captain in the Medical Corps. She has a fear of being told to do something or not do something or being told she has to participate in certain social functions. The graduates of the Military Academies learn a great deal about the social responsibilities of their families, as well as their own, as they go through the cadet schools. There is nothing comparable to this with the medical officers. Medical school has a full curriculum in itself without trying to handle social graces and things like this. One thing that I found in recruiting for the services, the wives were impressed that there was the equivalent of a country club in the officers club. There was usually a golf course on an airbase. On many of the airbases, there was an

opportunity for horseback riding. There were nurseries, and there were babysitting opportunities that they didn't have in civilian life. What were the things that they worried about? The cultural things--where would they ever get a chance to go to the theater? Where would they get a chance to go to the symphony? Where would they get a chance to go to the opera? This is quite a sales point in trying to get a doctor to locate in a smaller community. If they are an hour or two from a metropolitan area, you can sell that metropolitan area, its arts and culture. How do you do it in the military? Well, of course, you have to admit that if you get sent overseas to Germany or England you have all the opportunity in the world, but if you get sent up to Montana, it isn't very productive of the arts and culture, and you have to switch over to skiing and hunting and fishing, which may attract the husband more than the wife.

C: It may conflict with both of their self-images.

M: Yes, no question about that. We try to explain military social life to the couple as a family and their children. The base is important as most doctors get quarters on the base because they have to be available "24 hours a day." They get to a point that they have to live within a social structure that is fundamentally based on military discipline. The fire marshal comes in and looks at the house. The security people come around with their dogs and check the outside and may on occasion come inside. You have to have a pass to get in and out of the gate. You have to show a pass to go into the base commissary or into the base exchange. The prices at the exchange aren't that much better than they are at discount houses. The commissary is fine if you have five children, but how do you break down some of the units? The airbase commissaries have done

better than the Army, I think, on this in stocking individual breakfast foods and specialty foods. One of my associates goes over to Wright-Pat every month, and he will bring back \$200 worth of food from the commissary. They are accustomed to the big cans and the big packages, and they know what they want in meat and so forth. It is just he and his wife. She is the daughter of an Air Force general, and he was 29 years on active duty, the last part as a colonel. When I had these younger people, I tried to get this couple and six others to talk with them and tell what they did and how they lived and their activities with the church. "How could you be interested if you had a different denomination in the pulpit every time the chaplain changed?" Well, they explained this to them. These are some of the things that more consideration must be given to recruiting.

You then get them aboard, and they want to strive for their residency. They get their residency, and they get board certification. Now they don't want to be sent to the military medical center; they don't want to be sent to school. The only thing they want is five or six prepaid trips to medical conventions each year, which have to be justified in the military as educational procedures. Many commanding officers require them to report what they did, said, and heard. If they are civilians they don't have to report to anybody when they come back from a medical meeting. This may irritate them a little bit. If they are in civilian life in a hospital or group practice, the firm always pays for the wife to go along. Well, the military doesn't. I have always felt you could use Reserve officers to better advantage by having programs in which you discussed the pros and cons of military life and why you can still be a physician when you put on the uniform of a military man or military woman. I have always felt there

could be an increased recruitment of female physicians in branches such as pediatrics, obstetrics, anesthesiology, and X-ray so that other slots could be made available for personnel in surgery and medicine.

C: Then you feel we really should train more Reserve physicians?

M: I think very definitely you should have a recruitment of Reserves. This is a very, very difficult situation because you bring the Reserve on and the average hospital commander says, "Fine, you are assigned to medicine or surgery," whatever your specialty is. He spends 2 weeks a year on active duty, and he sees practically no military life. He wears a uniform and salutes, goes through that, but he doesn't participate in the actual military side of the force that he is with.

C: If the Swiss and the Swedes, for example, have no problem making the transition from military to civilian using their reserve system, isn't there something we can learn from that system to allow for longer Reserve periods to ensure that military life experiences are included in those 2 weeks or 3 weeks or 4 weeks? Can we encourage former flight surgeons, once their initial 8-year obligation is up, to maintain their Reserve status so that we can call on them in case of emergency?

M: Your number one problem is to show a doctor that he isn't going to be called up willy-nilly because we get involved in some sort of a situation like the Marines over in Lebanon right now [1982]. When the MD leaves his civilian post, there is nobody making a salary for him. It is not like leaving a company that says, "We will support you as long as

you are called to active duty, and there will be a job here for you when you come back." When the doctor or the lawyer or dentist is called up to active duty, the income that he is accustomed to back home and his private clientele cease. He thinks twice before he decides that he will proceed as a Reserve officer. I think the educational training program of the Reserves should be oriented not to teach him surgery or medicine but should be oriented to the military. I would say 95 percent of it should be military orientation. We had six former Air Force officers and two Navy in my office when I was vice president and dean at the College of Medicine. We kept a world map under curtains, and we had all the things that we could pick up in the paper and magazines. We had a situation map, and every 2 or 3 days, we would have coffee and talk about what was going on in the world. We found that the Reserve officers would come and listen to us and say, "Why the hell don't we have that in our unit? Why do we have to have stupid things? Why don't we have something that is interesting?" I think the creative imagination of the people who are responsible for Reserve programs and education has to be tapped from a medical standpoint of, "What possible responsibility is this man going to have?" If he is a mobilization assignee, he knows where he is going, and he can spend time working on that position. But there is a very limited number of mobilization assignees, so how do you get Reserve officers interested in the force? How do you get them interested in the blue uniform as differentiated from the green uniform? What really motivates them? Sure, if you stay with it long enough, you can get a retirement program, but that isn't of great incentive to the average physician that you might recruit. So you have to find out why he likes to come on active duty.

(End Tape 6, Side 2)

M: We are talking about the problem of recruiting and retaining Reserves and the problems that this causes, particularly for physicians. I am told it is much easier to recruit Reserve nurses and Reserve medical service personnel than it is to recruit physicians at the present time. Of course, you go back to the 1960s, and there was nothing popular about the military service, particularly in the academic world. It was very difficult to maintain interest. My experience at that time was that we were still able in our college to recruit for all three services as differentiated from recruiting for public health. Our people weren't very interested in public health. Two of the other schools in Ohio recruited very well for public health but very poorly for the military. People used to joke that I, as dean, ordered them to be interested. You have to be interested yourself. The chap in charge of the Naval Recruiting Office was a very skilled cardiologist. I used to provide him my office and conference room for his meetings with the medical students. I was able to get the Surgeon General of the Army as well as the Air Force to come and speak to the students. So out of 200 graduating seniors, we usually had 16 to 18 that went on military duty. It can be done, but you must be creative and use your imagination to tie the military to the things that they are interested in, including their families.

C: So the emphasis on military training is a must certainly. Would you think bonuses to keep doctors in would be effective in the long run? I am saying past the 8-year point. Say we take a student through ROTC. He goes to medical school at Uncle Sam's expense, and 8 years later he has fulfilled his obligation. He can now leave the service.

Would bonuses, to your way of reasoning, as well as the retirement attract such an individual?

M: The bonus was originally used because you could only provide financial remuneration by rank. The bonus is the answer to maintaining the same promotion structure for medical personnel that you have for the line personnel. I would have to say the bonus is a definite inducement. I don't think it is a be-all and end-all, because if a person wants to get out and take the civilian route, it's a long, hard day. The average military doctor puts in maybe 40 hours a week, and the average civilian doctor puts in something like 70 to 75 hours a week. So the remuneration versus free time and recreation becomes very difficult. As an example, the officers club equivalent in civilian life is a considerable outlay in initiation fees and dues. The availability of athletic facilities, such as golf and horseback riding, is very expensive in civilian life. The bigger the community, the more expensive it is. These things become stimuli to a person that is wavering. I think a doctor who wants the military and can find, as they did in the old days, hobbies, whether it is studying insects or studying animals or studying libraries or being interested in other things, has more free time for that if he wants to take it in the military. The demands on his time are not as heavy so he has a more relaxed life. You are finding that civilian doctors are beginning to change. They are cutting down the number of hours they are working, they are taking time off, and they are away from their practice. They don't have that compulsive desire to be there all the time or that they have to have a bigger house than the chap down the street or that they have to have more cars. That is no longer the big driving force that it was in the last two decades. I know one doctor who works 4 months and takes a month off, works 4

months and takes a month off. He and his wife have been to South America. They got intrigued, and they went to New Guinea. They wanted to see what the Pacific war in New Guinea was like, so they went upcountry and saw the aborigines and the former man eater tribes. They have been to China; they have been to Japan. He just flatly states, plans his whole office like this, that he will work 4 months and then he will take a month off. He spends 1 month each year in Florida reading and swimming. They have a condominium that they lease. It is surprising how many books of world affairs and things like that he will cover in 30 days on the beach. They get up, go swimming, come back and have breakfast, and he stretches out and reads, and she reads. They are not antisocial; they lead a quite active social life at home. This is the sort of thing that I am seeing in the younger doctors coming on that I didn't see in my generation.

C: The question I have then, Doctor, is whether this new lifestyle is any less antipathetic to the military lifestyle than the earlier form? We talk about the acquisitiveness of the last two decades, and certainly doctors on the outside would have a better opportunity to achieve the good things in life, but would this relaxed lifestyle be any less antipathetic to the regimentation, as they see it from the outside, of the military? The fact that someone else is telling you where you are going to go next year, telling you when you are going to get up, and of course, the business of uniforms?

M: I can't answer that. I see some trends that would indicate that to achieve the lifestyle they want they would be willing to accept the limitations of military discipline. The concept of retirement is just beginning to infiltrate

the medical profession. Doctors were like lawyers; they never retired. They might slow down, but they didn't retire. Today I am seeing a large number of doctors in independent practice and in group practice and in hospitals and universities taking retirement at 65 and refusing to renew their license so that they can say if somebody calls, "I am sorry I can't see you because I am not licensed." I look back 20 years, and I didn't know anybody that did that. I look today, and I know 50 percent of the people my age are not doing anything in medicine. They are totally retired, and I think they are aging more rapidly than those of us who maintain some activities. Some of them play a lot of golf, and some of them do a lot of fishing. But I think one needs to have some mental stimulation, I would say daily. One only gets stimulated when he has some some administrative responsibility. You can say, "Well, I can sit in a library and read." Yes, that's delightful, but that isn't the stimulation of administrative responsibility, whether it's running your own office or running a big hospital or running a medical school.

C: You are saying decisionmaking is an important part.

M: Extremely so. When I retired that was the hardest thing to get used to, that I didn't have decisionmaking every hour on the hour. I have learned to live with it. I am very happy that I have been able to keep up other activities.

C: While we are still on the subject of doctors coming into the military or staying in the military, do you feel the Medical Corps has traditionally gotten its fair share of promotions, starting from World War II onward?

M: Let's go at it from a military standpoint. Promotion meant increased responsibility. One's promotion files were part of the personnel program. In the medical field promotion was primarily a means by which a doctor received monetary remuneration. This provides some very difficult problems for the military because it can't make doctors all colonels. To the professional man an individual may be president of a bank or a four-star general, but the doctor already sees himself as being on an equal footing with those types of individuals in civilian and military life. Professionally he is equal to them; therefore, he should have the opportunity to have financial remuneration of an equivalent capability. The military doctor would not be happier if all of his colleagues were colonels because he wouldn't fit into the lifestyle and the social pecking order in a military environment. I don't think there is anyway to solve this problem.

C: It seems to me, though, that traditionally because of the scarcity of doctors willing to stay beyond a certain term in service they have by self-elimination promoted those who have stayed on. I am not saying that is good or bad, I am simply saying those people who were in service long enough to be considered for colonel were such a small number to begin with that you never wound up with a situation of all chiefs and no Indians. You would find, for example, more combat commanders wanting to stay to colonel; therefore, there would be more senior captains and more senior majors bucking for promotion. Promotions seem to be a big thing for us. Is it a big thing for the doctors? You are telling me no probably because the ones that do decide to stay are successful in getting promoted.

M: I think promotion is a big thing in any part of the military environment. The fact that the line comes in as second lieutenants and the medical as captains causes some of the problem right in the beginning. Originally, if you go far enough back, the doctors had no rank. They were called assistant surgeons and surgeons. There have been proposals that I have seen in personnel board studies to take the rank away from everybody but line officers. I think your recruiting would be zeroed in right then. I don't think it is possible in a military environment to deny rank to all eligible components. Nurses were not given commissions until World War II, but they had rank without commissions. I listened in World War II to all the comments about how women should not be allowed to command men, they should only be allowed to command women. Today there are generals in the line; there are captains in the Navy commanding men. I don't know what will happen if they go into combat, how this is going to work. We have only recently had lieutenant generals in the medical service. General Eisenhower in 1949 recommended that we have four-star medical directors of the medical service. I am not sure that is a solution to the problem. I think if you join the military, you have to live by the terms and the perimeters that surround military life. You shouldn't have too many special considerations given you because you have a PhD or an MD unless you can perform in your military capacity.

C: Do you think branch rivalry extends to the Medical Corps as well?

M: Of course, I think the concept of the esprit de corps and rivalry of a nature that breeds efficiency is very healthy. I think part of a good commanding officer is to stimulate the branches under him to compete for excellence. This

builds morale. It is the same basis of why we have good football teams at certain universities. It has a lot to do with maintaining student and alumni interests in the parent unit. I think this is true in the military.

C: In that respect has there been sufficient recognition of some of the great accomplishments of our research medical men?

M: No, I don't think so. I think if one looks back at the accomplishments and the heroism of medical men, it was recognized more prior to World War I than it has been since World War I. The work on yellow fever, malaria, in the Panama Canal, in Cuba, and in the Philippines got great recognition. If you were to ask the average Air Force medical officer about General Grow or General Grant, they probably wouldn't be able to tell you what they did. They wouldn't know that General Grow was the one who developed body armor for bomber crews. He developed the electrically heated glove. There has been, just as we have today, no historical section involved with the medical service of the Air Force. The Air Force wouldn't be flying if it weren't for human engineering. Medical has been placed in a position of, "Over there on the hill is the hospital." What makes it possible for us to function down here on the flight line hasn't been dramatized.

C: How men can stay alive above 20,000 feet, for example.

M: Yes. And how one can take G forces, what went into the development of the ejection seat. Randy Lovelace jumped from 40,000 feet. We never did determine what happened, but he lost his gloves, he had his hand frostbitten, and he was unconscious when he landed and had a dislocated shoulder.

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Because of the problem associated with that, Boynton [Lt Col Melbourne W.], who was also in the equipment laboratory at Wright-Pat, went up with two parachutes. He had done a great deal of work. He was an expert swimmer and had been on the American Olympic team before he went to medical school. He had developed a method of inflating and getting into the raft after you hit the water, getting rid of your parachute. He demonstrated from actual parachute jumps into the Gulf of Mexico how it should be done. Having looked at the films on Randy Lovelace, he determined that when you came out above 40,000 feet it was very important what you did with regard to your parachute, how much free-fall you should have, what happened to your oxygen mask and so forth. He went up and jumped, and neither one of his chutes opened, and he was killed. First Lieutenant Schick was wounded at Pearl Harbor. He came in with the B-17s from California right in the middle of the second Japanese attack. He picked up a machinegun bullet, but he continued to work all that day on the field, treating wounded, and working in the aid station. About 10 o'clock they said, "Let's fix your wound." They took him in, and he died from aspiration because the person who gave the anesthetic didn't know how to clear his airway. Schick and I were together at Randolph Field on Wednesday, and Thursday morning he was gone. Monday morning Reinartz announced that he was dead. It caused quite a reaction among those doctors. They were all studying to be flight surgeons. We were all going to combat units. We had all watched the blackout of San Antonio. We were all cognizant that when we left we were going to be assigned to combat units, but we didn't think of it in terms that we might get killed. Here was Lieutenant Schick, a classmate, already dead, and we had only been in the war 1 day. I think there was a general reevaluation of what we were doing. We had all volunteered. There wasn't anybody

in the class that wanted to transfer to the Army, and there wasn't anybody who didn't want to go to a combat unit. Several of us--I was one--were sent to a hospital. When I left they had you fill out for personnel what you would like, and everyone of us put in for combat units. That was where the action was going to be. We had had hospitals back in civilian life.

It demonstrated, I think, how you suddenly become attached to your own service, your own squad, your own unit. What makes the strength of a command is this "belonging" to your group, whether it is the Air Force or your wing or group or squadron.

C: Recognition also is a very important part of this.

M: Oh, certainly. I have talked this over with Mrs. "Pat" Bragg who has served with many of the Surgeons General of the Air Force. She is in the Surgeon General's Office. She handles congressional liaison. What history there is up there is in her office. She is a wonderful person, and she has known the military and medical leaders over this period as well as anybody. She is a very, very understanding person as well as knowledgeable about the medical services and their problems. One can imagine handling White House and congressional correspondence would keep her busy 24 hours a day, but she does all sorts of other things, public relations and speech-writing and so forth. I am a very great admirer of Pat Bragg.

(End Tape 7, Side 1)

M: What has been started by Dr. Kohn [Richard H.] and General Myers and General Bralliar [Lt Gen Max B.] to try to revive the historical record of the medical service, as differentiated from clinical and research activities, will bear fruit. I think it is needed. Before everything is lost I think it needs to get started. It is my understanding that they have asked for an allotment of one military and two civilians effective next fiscal year into what is Pat's office. Of course, she wants extra personnel herself for her job before she takes on this new project, and I can understand that. I think there is enough pressure and interest that something will be accomplished.

I wrote a long letter about a year and a half ago saying that the Air Force Medical Service ought to be better represented in the Air Force Museum at Wright-Pat. While it was authorized by Congress and it is staffed by Air Force personnel, it has a private board of trustees that makes all the decisions. The museum is fundamentally interested in physical objects. They *don't* want pictures; they want airplanes. They have all the airplanes you could think of. They still have a lot in storage that haven't been put together. General Myers and I went out there and had a discussion with the director of the museum. He promised that they were going to do something, but he said to me, "What kind of instruments can we show? We have oxygen masks, and we have oxygen systems, but what did the medical have in the way of instruments that we can display? They will tell the picture." I spent 3 months mulling that over in my mind. How do we get across to the director of the museum that you don't sell the work of the medical service by some physical object, that the medical service is more than a physical object? As I said to him, "Some way you should capture human engineering with aeronautical

engineering without use of a physical object." Well, he appointed three people on his staff to come up with a static display of some kind to represent the medical service. He has uniforms of the flight nurses and their insignia, and he has some old posters of nurses from World War I. I live close by and frequently go over. On any given day there may be 5,000 to 6,000 schoolchildren going through that museum, 7 days a week. Every day, you will find people from six or seven foreign countries; you can pick them out either by language or dress. Other visitors are military, Reserve officers, students, ROTC. There really isn't anything there to tell the tale of the medical service, which, as the story goes, started when Arnold got an insect in his eye and they came to the conclusion they should have goggles. Arnold had Lt John Kelly, a medical officer, assigned to the flying field at College Park, Maryland. What about the medical services as an ongoing system to sustain the personnel?

C: Or something simple like shoulder restraints to keep people from bashing their brains out on the cockpit dash.

M: That's right. And what did we do about the design of the helmet, and how did we counteract the oval face shield that was a part of it with the convexity of the canopy?

C: To prevent distortion.

M: They had terrible distortion in the beginning. These are things that had to be dealt with or you couldn't be flying-- you couldn't even be in space unless the physiologist and the cardiologist came up with some human engineering answers. I don't want to put a model of a hospital in that museum; I want to show that this is something peculiar unto aeronautics. I hope that I will live long enough to see

that accomplished. I am not saying that it ought to be at the Smithsonian, which is a beautiful example of museum architecture, but someplace besides Brooks Field [TX], there ought to be some record of the medical service, in my opinion. People should know their contributions.

C: Would profiles of some of the pioneers and giants in aeromedicine, do you think, be more to the point than these physical artifacts? As you say goggles and shoulder restraints and so forth don't tell you all of the thinking that went into that. Perhaps profiles of the men that helped design these things would. Something as simple as little cameo pictures of these individuals together with a description of what they innovated.

M: It might well be.

C: This seems to come clear to me in the oral histories that I have read of Campbell [Col Paul A.] and Armstrong and others that there is a lot that is not talked about that is absolutely critical to this development, and the only way it can be displayed is as ideas that came to fruition and, of course, saved many, many lives.

M: Incidentally, when you interviewed Campbell, had he suffered a stroke then?

C: I don't recall for sure, sir. I was just using it as a research document. It seems to me it was something less than 100 pages in length. I believe Dr. Hasdorff [James C.] interviewed him.

M: I visited in 1981 with Paul and his wife out in La Jolla [CA]. A member of my family lives out there.

C: As I recall the interview took place in 1975 or 1976.

M: Oh, then he was still all right. After he had his stroke, he had a very acute recall of the war years and their development. He was one of my instructors when I was at flight surgeon's school. He was a captain. We got very well acquainted, our wives got acquainted, and we kept up this. He then became assistant military attache in London, and we visited there several times. When we were out in California the last time, last year, Paul and I sat together, and he couldn't tell you where he was yesterday or what he had had for breakfast, but once you stimulated him to talking about his experiences during the war, the research problems, the training problems, and his work in intelligence, it was just fantastic. Unfortunately he had a second stroke at Christmastime this past year and passed on. I thoroughly enjoyed just sitting and talking to him because he had this fantastic recall. He kept saying, "Now, Dick, why don't you move here, and then we could talk every day." (laughter) "I don't see why you want to stay in that cold climate up there in Ohio. You and Betty ought to come out here and enjoy California. Better yet, we ought to both go back to San Antonio." He wanted so much to go back to San Antonio.

C: When you mentioned World War II experiences, I do have a couple of questions from that era. In January 1945 you commanded the Morale Division of the Strategic Bombing Survey of Europe. Were your findings much different from the earlier estimates done by the British in 1943 on the effects of strategic air attacks on German towns? These are

the points, sort of a points synopsis, of their findings in March 1943. (Captain Cleary hands Dr. Meiling a note card of points.) I imagine you will probably want to take issue with one or more of them since they were preliminary findings and perhaps not all that objective.

M: Our division, called the Morale Division, was divided into a military and civilian study. As you know there was the Petroleum Division, and there was the Economic Division, et cetera. The Strategic Bombing Survey was directly responsible to the Secretary of War. The direct liaison was through Mr. Lovett [Robert A.], who was the Assistant Secretary of War in charge of aeronautical activities during World War II. He had been a Navy pilot in World War I in England. Mr. Lovett later became Mr. Stimson's assistant in charge of aeronautics. Mr. Forrestal, who had been Secretary of the Navy and then the first Secretary of Defense, and Mr. Eberstadt [Ferdinand], who was the head of the National Defense Study for the Hoover Commission and had been head of the Munitions Board--all were associated in financial institutions in New York and were very close personal friends. It was very interesting to see how they approached problems.

Getting back to the US Strategic Bombing Survey, it had a board of trustees, all civilians--a chairman, Franklin D'Olier, and a vice chairman, Paul A. Nitze. It had a military commander, and each one of the subdivisions had a military man responsible for administration. Morale was my division. A member of the board, Dr. Rensus Lickert, who was professor at the University of Michigan and had the famous Lickert polling surveys on all sorts of activities both before World War II and afterwards, represented social studies. He put together the concept of polling and

interviewing civilians first in England and then in France and Belgium and finally in Germany. We had 92 PhDs with assimilated rank as our personnel. They all could speak four languages. They all had some specialty in sociology. My military staff had all been with the Air Force in various capacities. One officer had been in the Myitkyina campaign. One had been in Russia during the shuttle bombing as the senior medical officer out there. We attacked both the civilian side from what happened to disease and sickness and hospitalization and the military side from what happened to morale as related back to bombing. We got to Europe in January 1945. My senior officers all went to a British study group in interrogation. The fundamental of what they taught us was, never ask a question that can be answered yes or no and always play to the man's ego, particularly if he was a high-ranking officer or a minister in the government. Let him tell how he would have run the show if it had been his responsibility. Then out of that you could find out how he got along with his confreres and colleagues and superiors. It was well worthwhile, and I think it helped in our interrogations when we first went into Germany.

When we got to England, we found that it was top secret that we had actually bombed cities; the British Government felt that their people politically would not favorably tolerate the bombing of civilians. We were, therefore, extremely careful how we functioned in England. One of the most amusing things occurred when I wanted to find out what happened to the women who were evacuated from London for obstetrical reasons. Most of the pregnant women were sent to the country. So I was given a card and picked up at the corner by bus. There was a midwife in charge of the bus, and there were all these pregnant women. She looked at my card, and it was authentic. She looked at my uniform, and

she said, "And what in the bloody hell is a Yank doing as an obstetrical patient?" I told her I was a doctor of obstetrics and I wanted to see how wonderfully they did things. I was evacuated first by bus and then by rail. We arrived, and we were received by some women at a little village railroad station. We were shown into the freight office, and there they had slices of bread and baked beans lined up in military rows. That was our tea. We had to have our own ration cards for tea and coffee and sugar and meat. So we got through this staging, and all these good country ladies who were receiving us were telling the obstetrical patient, "Now don't worry, child. You are in good shape." Then we were taken to various country estates that had been turned into obstetrical receiving hospitals. Each would have maybe 30 or 40 obstetrical cases. They had midwives who did the deliveries, and then one of the professors of obstetrics from the university would have maybe 15 to 25 of these homes that he was responsible for. If any difficulty developed he was called. I ate with the patients. It was cold as could be, I thought, but they thought, compared with what they had left in London, it was very comfortable. We all had heavy overcoats and mufflers on. They were from all walks of life and all economic classes. It was practically impossible to have an obstetrical delivery in London during the war years. They had to go out. This was true of all the big towns, and it proved to be true in Germany.

I talked with the mistress of the mansion, and she had retained two rooms. Her husband was on duty in North Africa and had been gone for 2 years but was due home within a few weeks. She was quite worried because she wanted an additional two rooms when he came home and the midwife wasn't about to give her any of her own rooms. They were

using all her china; they were using all her linens and so forth as her part in the war effort. In talking with these people, you got a direct reaction to the bombing. What did the bombing do to them? The obstetrical patient usually got to one of these delivery homes 4 weeks before she was due. She stayed until she had the baby, and then she stayed another 4 weeks before she was permitted to go back to London with her baby. They were not private rooms, but they would have anywhere from six to ten in a single room. They each had a bed and a small drawer in which they could have their private belongings. They all ate the same food, and they all had to contribute their rations for their sugar, for their tea, and for their meat and eggs. Because they were obstetrical, they got an extra ration of meat per week, and they got two eggs per week. They were very unhappy. They didn't like the country; they wanted to be able to go around the corner to the pub and have a beer, or they wanted to go around the corner to a flick, and here they were out in the country. There was nothing they could do but take a walk. This was true in almost every one of these homes that I went into. The patients were very unhappy, and it was all because of the bombing. Some of them would talk about, "Well, if we didn't bomb them, they wouldn't bomb us." Others were very, very patriotic: "We can take anything the Germans want to give us."

I then spent some time with a professor from the University of London at his quarters. Then I went to another home of a lord and lady. The good lord and lady had taken the evacuees very seriously, and for every baby that was born, he deposited a pound to start a bank account for that child. He was in his late seventies, but he kept a big situation board. He had been a captain in the service. On that situation board he had every obstetrical case listed, what time they delivered and everything else. The morale in that

home was much higher than any other because the lord visited them every day and he talked with them. He taught them how to play bridge; he taught them how to play chess. So they were doing something.

We went to another that had evacuees' children, children up to the age of 15. The lady there was very unhappy. She said, "Those little urchins came in and took my goldfish and dropped him down the toilet, and nothing happened"--it was one of these pull toilets. "So then they took my Peke [Pekingese] and dropped him down. With that I made an official complaint." (laughter) I was getting an idea of how various civilian elements, both in the metropolitan areas and out in the country, were responding after 4½ years of bombing. We were evaluating the British unbeknownst to their authorities by this method because we couldn't set up interviews the way we would do when we got into enemy towns. We noticed that over a period of 4 years eclampsia or preeclampsia of obstetrical patients disappeared. Everybody had the idea that it was because of their diet or it was because they had very little sugar or it was because they all ate at the same time and, therefore, there was no chance for this renovascular disease to develop in the obstetrical patient. When we got to Germany, we found the same thing was true.

We also found that after the first year there were practically no psychiatric cases in the obstetrical group. They didn't develop hysteria; they didn't develop minor psychoses that you would expect to find in a small percentage of a normal obstetrical group.

We then began to see about contagious diseases--the sewerage. The water lines were broken, gas lines, and we

found that instead of going up contagious diseases were on a downward curve. After a bombing they would stay down for 6 months if there was no additional bombing of the area, and then they would begin gradually to come up. The question was, why? The intense heat generated by the bombing, the release of natural gas in the pipes killed all the rats and mice and cats and dogs that would spread disease. This was something that we didn't fully appreciate until we had gotten into this survey quite deeply and were in Germany.

With regard to air attacks, you have to remember that there was no other way from 1940 to 1944 for the British to have combat contact with the Germans in Europe. Many people belittle what the strategic bombing did, but it built morale for the British and the Americans because they were doing something to the Germans. Now you get over to the Germans, and you ask yourself, "What did this bombing do to them?" It obviously destroyed factories; it destroyed homes, transportation, and municipal works.

C: There was a great difference, I think, between the number of civilian casualties in Germany and in Britain because of the size of the bombing. I think at the end of the war it was estimated something like 800,000 German civilians had lost their lives to bombing. At least that's the figure I have heard. If we compare that with the casualty losses in Britain, something around 50,000 during the Battle of Britain and so forth, and then look at the ratios of the population, obviously strategic bombing had almost a tenfold greater effect in terms of damage and destruction to Germany than to Britain. Did it, therefore, have a greater impact on German morale?

(End Tape 7, Side 2)

M: We can look at the bombing of Hamburg--five days and six nights--at which time there were said to be 185,000 casualties, of which most were dead. When we went back and tried to establish records, we came up with 75,000 dead. We could not verify, nor could we increase or decrease the 185,000 casualties. It is interesting to note that the heat was so great that the building blocks, 4- or 5-foot square building blocks, actually burned. Because of this fire storm in the center of town, there was no oxygen, and a great deal of carbon monoxide was generated. We actually opened bomb shelters that had never been opened after the bombing and found people dead but sitting in their benches or chairs around the walls with their clothes intact. We had pictures that we got from the Germans that showed individuals literally cremated on the streets of Hamburg from this intense heat. Here again we found that after the bombing of Hamburg the population began to flow back, and within 30 days of that bombing attack, Hamburg was using industrial electricity at an equivalent rate of what they had been using 10 days before the bombing. The factories were set up in the open, and the production lines were in the open.

How was this possible? The only place you could get food or clothing was at the factory. So to live you had to come back to work. This was true in England as well as in Germany. In England you got a special ration card for clothing and food as a gift from the King. In Germany you got it as a gift from the Fuhrer, Hitler. The only place there was any heat was in the movies, or flicks as they called them. In the evening you went there to get warm before you went back to what was left of your home to sleep. So you had a circle. To eat you had to work. To get clothing you had to work. To stay warm you had to go where the

propaganda machine was working; namely, the movies. People say, "Why didn't they revolt?" They were caught in this. If you can't eat and you can't be clothed and you can't get warm unless you do it according to the way the government says, your political desires are not as high as they might be if you had a partial solution to your problem. Medically speaking, the actual development--and these were good responsible professors of psychiatry and so forth--saw a marked decrease in the psychiatric casualties. Again the preeclampsia and the eclampsia of obstetrics were almost zero in Germany, particularly in the metropolitan areas where they had bombed or where they had evacuated. Out in the country on the farms and so forth, we did find records--and I actually saw and delivered a patient with eclampsia. She was a farm girl about 19, and she had a full-blown case of eclampsia which I treated very primitively. I drew 500 CCs of blood off, and that pulled her pressure down. It apparently got her kidneys going again. After two such treatments and 10 hours of waiting, she had a normal baby and made a good recovery. I went back several times to see her after the war.

You asked if there was a breakdown in morale, which the British said there wasn't any. We found none in 1945.

C: They did, however, say that even the party loyal by 1943 were beginning to have some doubts about Hitler's leadership. Did that seem to be borne out by what you saw?

M: Yes, but remember the war was almost over or was over when we were questioning, and they had lost. They had to blame somebody. They wanted to impress the American interrogators that they were never Nazis, they were Germans, but they weren't Nazis. We went down to the city hall and looked up

ration cards, and we decided who was a Nazi and who wasn't by the priority and the number of rations they got. Some of the loudest protesters had the greatest ration cards. They were still in shock when we got there. They were very much afraid, and they couldn't understand why we were allowing the Russians to come in. They had a great fear of the Russians, and rightly so. The Russians treated them very, very badly, but they had treated the Russians badly. It was really more than that. You mix East and West, and the ethical and moral standards of the Slavs are different than that of the Anglo-Saxons. You ask the people, "Well, what did you think about the bombing?" Almost universally they said they wouldn't have gone into the bomb shelters unless the police forced them to. They had great fear of the bomb shelters. The government had spent tremendous resources on these bomb shelters. When the United States bombed the dams above Frankfurt and above Koblenz, at Frankfurt and Mainz particularly, they flooded the underground hospitals and the underground bomb shelters, and the patients and the people down there were fatalities of drowning. In the heart of the city, wherever they were underground, there was great fatality, as I say, from carbon monoxide and natural gas and lack of oxygen. In Hamburg they built high-rise--they would be 20-stories tall--bomb shelters so they could get the air that was still available for ventilation. The Allies, Americans and British, after 1945 tried to blow them up, and they weren't successful. As recently as 2 years ago, I went by, and they are still using them as apartment houses. If you want to see the effect of double blast doors and triple entries and so forth that we later incorporated into the Atomic Energy Commission shelters, you will find them in those original bomb shelters that they built in the Hamburg-Bremen area.

With regard to the effectiveness of their evacuation, they were very effective because they had the mountain areas that they could send children and women and expectant mothers to for care and feeding and so forth. They still had a considerable amount of garden produce that they could grow.

C: I noticed this last point that was made in that 1943 report. It would seem if there was anything that was wishful thinking in the report it was the fact that they thought the Bavarians would crack whereas the Prussians would not. Of course, part of that was tied to the fact that most of the British bombing up until 1943 had been in the Ruhr area and along the Rhine.

M: I think you have to go back to World War I to find out why the British felt this. The Bavarian military under King Rupprecht wouldn't fight unless they got their beer every day. (laughter) The Bavarian soldier is somewhat stubborn. He doesn't respond to his officers' and his noncommissioned officers' orders without questioning them. The Prussian or the North German follows without question. If you put that together with a large evacuation population of elderly people and females and children, the morale to continue battle or wage war is not as great nationally as you will find in the industrial communities. The farmer, whether he is French, German, English, or American, is not a belligerent soul when it comes to national policy. He doesn't respond with such great patriotism that he has to see his country achieve great results. Remember Bavaria was the weakest part of the Hitler movement, although it was headquartered in Munich and was the site of many of their great activities--the Hitler headquarters, the so-called Brown House was built in Munich. The art gallery of Hitler was built in Munich. The Parteitag in Nurnberg was Bavarian, but blind followership

was not to be found at any level or even among the uniformed forces in Bavaria. You found that in north Germany and also found it in the highly industrialized Rhine and Ruhr Valleys where you had a lot of coal mines and so forth around Essen, Dusseldorf, and places like that.

You must also keep in mind that after Casablanca there was coordination of bomb targets, and the staff established a miniature Germany composed of cities, industries, and transportation. There were 50 cities in that target folder, and they maintained that if you destroyed the 50 cities you would destroy Germany. The Americans were committed to daylight bombing and the British to night bombing, and of course, lots of times the target they thought they were going to bomb was already burning because crews had not arrived over their own target when they dumped the bombs. There was no desire on anybody's part, as far as I knew, to bring bombs back to England. I went on two bombing missions to find out what it was like when I was over there.

C: The devastation was widespread, though.

M: Oh, yes, tremendous, but we did a lot of agricultural bombing, too.

C: And plowing the fields a little deeper than anticipated.
(laughter)

M: It was unbelievable. When we got there and found that 5 miles outside of town they had bombed heavily, then we tried to reconstruct it. Well, what was the pattern of the anti-aircraft units? Obviously many of the bombardiers were willing to get rid of their bombs and turn for home rather than penetrate the anti-aircraft fire.

- C: It is, of course, also true, sir, that if the lead bombardier was off everybody bombed on him.
- M: That's right.
- C: If they made a mistake, they made a big mistake. It wasn't just a matter of scattering bombs all over the place.
- M: I will mention Darmstadt as a typical example. It was not one of the cities that was selected for destruction even though it had a very large pharmaceutical industry. By accident somebody dropped bombs on the railroad station, and by coincidence, in the freight yards, there were two ammunition trains. By the time everybody had flown over it for 24 hours and added a few bombs, there was very little left. In fact, when we got to Darmstadt, we had to use blades on our armored vehicle to get a pathway for a jeep to go through. Even in four-wheel drive, it wouldn't go through. The same was true in Nurnberg; the same was true in Munich. To get rid of the rubble and get the streets cleared, they just pushed all the rubble into the planned and partially excavated subway of Munich. It wasn't until the recent Olympic games that they excavated all the old subway and got the new subway going. In Stuttgart they made two mountains outside of the city. They are really not hills; they are big mountains of rubble. They are now suburbs of the town with very delightful homes on them; they were put there to get rid of the rubble in town.
- C: I understand that's the way cities in ancient civilizations were built over many hundreds of years. You would have one city above another, above another. Some of these things that look like hills are tells, really just communities with a past.

M: With regard to your question, was there medical care to keep the people going, yes, there was. They had lots of sulfanilamides but no penicillin. In 1944-45 they were down to where they scrubbed with fat and sand put together in operating rooms in many hospitals, both military and otherwise. They had no soap. They had alcohol, but they had no ether. I am talking about in 1944-45. By the middle of November 1944, they had no intravenous fluids, except in one or two instances where we found hospitals still had them. The bombing in Hamburg and the bombing in Hoechst destroyed a great part of the pharmaceutical industry. The long period of bombing, 4½ years, seemed to have a deadening effect on the people. They accepted it; it was a way of life.

C: Stoic.

M: Yes. There wasn't anyplace else to go. Everybody tried to get their children evacuated. The Germans had proposed to the Allies that Friedrichshafen and Constance on Lake Constance bordering Switzerland be declared open cities. They could concentrate patients and the elderly there, and there would be no bombing. They also asked that Emden and Flensburg on the Danish border be declared open cities. All of the reports--and I have never been able to find a written report on it--that I have heard implied that Franklin D. Roosevelt was the one that said we would never give them open cities. Churchill [Sir Winston] had asked Roosevelt that they give them open cities. He wanted open cities in England. Roosevelt said, "Under no circumstances." Unfortunately the Americans bombed two Swiss towns near Schaffhausen, causing rather sizable destruction. There was a feeling at that time that this had been directed by Roosevelt to show that he wasn't going to tolerate open

cities. I think the facts of the case were that the navigator got lost and he saw Lake Constance and he matched it for one of the land points that he was looking for and they dropped bombs on the Swiss of Schaffhausen. We obviously paid quite heavily to everybody who was hurt or killed, their estates, and we also rebuilt the town after the war.

It's interesting to me to note that the Swiss used their lakes as shelters for fuel and for food. They built large tanks like you would find at a filling station and sunk them into the mountain lakes. Lake Thun, Lake Zurich, Lake Lucerne, all had these areas where they had gasoline that they took out of the crippled B-24s and B-17s that landed in Switzerland. They did the same thing with whatever wheat and grain they could get. It was perfect temperature. They were very, very reticent to take evacuees from Germany or France unless they were definitely Swiss families. The Swiss had their sources of food supplies, and they were very limited, but they had a great deal of milk and butter and cream and things like that. They had cheese. They were able to limit the slaughter of their cattle, so by not increasing their population, they did very well. We had a tremendous mission in Zurich and in Bern that was part of the OSS [Office of Strategic Services], and it was headed by Dulles [Allen].

The Swiss had an agreement, for example, that the internees that came in as prisoners from B-24s and B-17s--we had a big camp at Gstaad in the mountains--were allowed to take the train into Bern and go to the university as long as they gave their word they wouldn't try to escape. If they escaped and were caught--and most of them were--then they were military prisoners, and they were put at hard labor.

There was a great deal of misunderstanding about the Swiss using both German and American military prisoners to build one of their best mountain passes, Susten Pass, during the war. It took them 5 years to build it, but they did it with this labor from individuals who had tried to escape. If it were arranged that prisoners were to escape--the English and the Americans were one unit the Italians and the Germans were the other--an equal number had to go over the border to their own area by prearrangement--then the Swiss didn't interfere; they let them go. In trying to find out from Germans who sent their children to Swiss families the effect of bombing on their children, you found that the children had no understanding of the bombing until they came back and saw the destroyed towns.

After one served 2 years in the German Army or the German Air Force, he could become eligible for a semester at the university. Females were mobilized the same as males in Germany. The only way one could get to the university after 1942 was by way of compulsory defense service. Most of the people then wanted to go to the small towns like Tubingen and Erlangen, which were not bombed but had good universities. The academic group, when we questioned them in 1945, was very realistic that they had been misled by Hitler because they saw an easy solution to unemployment and their economic difficulties. Even the academic group felt President Roosevelt was a Jew and, therefore, all this terrible bombing that the Americans did had some relationship with the Hitler anti-Jewish activity. Everyplace that we went and talked to people, they emphasized that after the bombing the only way they could get anything to eat or get warm was to go to work. Bombed cities, until we began to specialize in trying to find and destroy electric plants, were back in production within 30

days, sometimes earlier. The production was, based on electric power consumed, equal to what it had been a month before the bombing.

C: Was your conclusion that if we went after specific targets like hydroelectric facilities and synthetic oil refineries and refineries in general we were probably doing as much as could be done to eliminate industry, but if we just carpet bombed cities, we really wouldn't be very effective? If this is true it tends to totally contradict what the British thought all along, that by bombing cities the collateral effects of destroying industry would be enough to warrant this additional expenditure.

M: I think the issue here is: are we trying to destroy the enemy or are we trying to maintain our own morale at a time that we are trying to build to eventually destroy the enemy?

(End Tape 8, Side 1)

(Tape 8, Side 2 not recorded)

C: If you had not had the bombing offensive?

M: If we had not had the bombing offensive during the period 1940-45, the allied civilian population would not have had something to hang onto that we were doing something to hurt the enemy. It was a great psychological morale builder for our own people--American, British, and French. On the other hand what we were doing to Germany was of greater propaganda value by carpet bombing towns than by pinpointing rail centers and knocking out locomotives. More effective bombing was the knocking out of locomotives and the transformers and the hydroelectric plants and the fuel

plants. The effect of that was at least 6 weeks off on the receiving end whereas the bombing of the cities was instantaneous. So one had target selection groups trying to figure out what they were supposed to do. My only criticism of them is that they didn't take a look at what German bombing did in England. I think the Otis Elevator Company in London is a great example. They were bombed some 70 times, and they were still effective until the last bombing which knocked out their electric plant. That type of information was rapidly generated and sent after we had taken a look at Germany to change the bombing in the Far East. I don't think the last word has been written on bombing as an effective war instrument. I think the people that would like to show it was inhumane will show that it was ineffective. The people that believe the cavalry should still be maintained and the horse carts will say, "Well, bombing didn't do anything." Bombing did a great deal to both sides besides destruction. This was quite evident to us. We surveyed civilians both in the rural areas and in the metropolitan areas to try to find the difference. The rural areas would say, "Oh, those poor people in town." But it was just sort of a reaction, "Gee, I am sorry your wife is sick." In the metropolitan areas where they had taken great destruction, the first thing they wanted to say was, "You know we are only allowed one room. We had a big house, or we had a big apartment. We are only allowed one room now, and we have to cook and eat and sleep in it." Well, that persisted for several years after the war was over. It was more inconvenience than a real fear of the bombing. The civilian population responded to bombing very much like the military responds to artillery fire and machinegun fire. You expect it, and pretty soon you get used to it. You don't ever like it, but you get used to it.

With the German military the bombing had a different morale effect. As we went through various military units, we found that they censored reports of bombing from certain towns because they had a predominant number of individuals in that military unit from that town. Men who went home on leave found that the life of the civilian was much, much more difficult and worse than even the units that were on the Russian front. I have talked with a number of German officers and enlisted men in the years since when they were not influenced by trying to create an impression. They said, "You know, we had more fear about what was happening to our families from bombing than we did of the Russian offensive. Bombing is terrible." What it does--I am quoting now--to the soldier or the officer who knows that an area is being bombed because he hears it being broadcast on the German radio or on BBC [British Broadcasting Corporation]--he begins to worry about what has happened to his family. The actual bombardment of the ground forces did not seem to have any more effect on the Germans than it did on the Americans. They both bitched about the fact that their own forces bombed them and the Air Force didn't have any idea where they were bombing. The Americans frequently cited the killing of General McNair [Lesley J.] and of General Roosevelt [Brig Gen Theodore, Jr.] by bombs falling too close to the advancing line in France. When you asked them about strategic bombing as we thought of it, "Did you have a feeling that bombing the mills and the factories back home was terrible?" "Only as it affected my family who were in that city."

Social life in Berlin among the ranking military officers and the ministries in Munich, even in Frankfurt, continued through Christmas 1944. The custom of celebrating on the 24th and then having the 25th and the 26th as the first and

second holiday was observed. They were not able to bake cakes because the flour they were getting had 20 to 30 percent sawdust in it. Out in the country they were able to have cakes for Christmas. So moralewise one has to weigh strategic bombing as what it does for his people versus what it does to the enemy. If select targets are used, I am sure strategic bombing would have a 6-week to 6-month very derogatory effect on the economy of a country, but I don't think bombing the towns willy-nilly has that much effect. One of the interesting things that I got into with both General Goring and Dr. Brandt when we interrogated them was the fact that by 1942 they had selected committees to plan for the rebuilding of Germany. After the Hamburg bombing of August 1943, it became very active, and they had architects planning what the hospitals would be and how the universities and the housing would be built. We recovered, in the Strategic Bombing Survey, volumes of plans for the rebuilding of Germany, which gives you another approach to how the enemy responded to our intensive bombing. They responded by having anticipatory planning at higher levels.

(Interruption)

M: To clarify what we say here about anticipatory planning, it reflected that as early as 1941-42 when the Germans began planning and making designs and industrial programs for replacement hospitals and schools and universities they were thinking they were going to be victorious. As the war went on, they realized that they might not be victorious but they might have a stalemate. They still weren't at that time thinking of being defeated. They began planning how they were going to rebuild the cities, how they would rebuild the medical facilities and how they would adapt by governmental order the same things they were doing in the wartime. In

other words there wouldn't be 20 different kinds of aspirin; there would be one kind. There wouldn't be 20 kinds of surgical clamps, but there might be only 5 kinds instead of 40 or 50. There wouldn't be 30 competing companies building medical equipment. There might only be two or three. They had serious architectural designs. Some of the drawings that we found were 2½ by 4½ feet in size. They were true architectural designs. Some of them we found were coordinated by both Dr. Brandt, who was the senior medical officer under Hitler for military affairs and by Dr. Speer, who was the master planner.

By 1944 we received the impression from discussions in 1945 with many of these German leaders that seriously they didn't think they were going to win the war. They thought they were going to be able somehow to prevent their enemies from coming into Germany. They didn't anticipate that they would collapse inside Germany. Of course, it was Eisenhower's intention to force the collapse of Germany within Germany. Unfortunately the Russian approach was to destroy Germany. If you remember, the Secretary of Treasury of the United States, Mr. Morgenthau [Henry, Jr.], wanted to make a rural country out of Germany after the war and have nothing but agricultural activity. The fact that this would create a tremendous political and economic vacuum in the center of a mass of nations didn't seem to affect the planning at President Roosevelt's level until really late in 1944. Then there was a complete reversal in memoranda about planning the type of occupational government we were going to have and how we were going to feed the Germans. We hadn't at that point thought, as far as I can determine from reading, about denazification. That was something that came much, much later. I have never been able to understand the principle that established denazification because, while the

British and French ascribed to it, they didn't follow through on it the way the Americans did.

C: Sir, there is a point concerning denazification that you might be able to confirm or deny. General Clay [Lucius D.] received a National Security Council order that said, "You will not hire any Nazis in critical positions on your staff." He said, "Well, the most experienced people that we have here in administration are former Nazis. So to heck with you, I am going to go ahead and hire them." And he went ahead and hired them totally contrary to the directive he had received from the Security Council.

M: I think that is true. I think it was true in all areas over there. I think Mr. Murphy [Robert], who represented the State Department on General Eisenhower's staff, was probably the most realistic diplomat that we had over there. He understood better than others. The political aspects of the Roosevelt regime versus the political aspects of the Truman [President Harry S.] regime are very, very interesting. Mr. Truman was Mr. Roosevelt's choice for political reasons. Truman was not taken into Roosevelt's confidence when he became Vice President, but he knew a great deal about the military situation because he had been chairman of the Senate committee on contracts and industrial programs. He probably knew more about the industrial development of our war effort than any other single man. When he became President he was faced with two things. One, he had Roosevelt's published plans of what we were going to do, both domestically and foreign, and two, if he were to win an election, he had to establish himself as the Democratic leader. One of the most phenomenal things in American political history is that without a revolution and without an upheaval he got rid of everybody that Roosevelt

had appointed--every Cabinet and sub-Cabinet member, even down to the Public Health Surgeon General--before he went into his political election campaign for his reelection in 1948.

C: Did that have a profound effect on the Medical Corps, more specifically in the area that you would get involved in with Eberstadt in 1948-49?

M: It did, yes. It did quite a bit because the people that were responsible to Truman were receptive to new ideas and to Truman's idea of a Department of Defense while the people who were responsive to Mr. Roosevelt were very much for the status quo. This played a very important role for us in the time we were planning and hoping for a separate medical service. One of the key people was Dr. Rusk, who was a personal friend and had been a personal physician to Mr. Truman. We used to say Howard could go in the back door of the White House without an appointment anytime he wanted to, and you could float a balloon over there by getting Howard to go in and talk to some of the people. Howard Rusk could also arrange for you to talk with people like "Matt" Connelly [Matthew] who was the confidential secretary of the President's. The Army dental general, Brig Gen Louis H. Renfrow, was also very close to Mr. Truman from his Kansas City days. He was very favorably inclined toward the Air Force versus the Army although he held his commission in the Army. The military aide, Maj Gen Harry B. Vaughan, and the naval aide to Truman were likewise inclined to listen to the Air Force problem more readily than they were to the status quo being pushed by the Army.

You must remember at this same time, 1947-49--and we will get into it a little bit later--that the Navy was proposing

that they take over all the hospitalization of the Air Force. As General Grow was to say, "We jumped from the frying pan, which is the general hospital of the Army, into the fire of the Navy, and we still don't have anything." So the Army and the Navy were competing for who was going to have the extra beds that belonged to the Air Force. Neither one of them wanted the beds assigned to the tactical units. They wanted the beds which were over and above tactical or station hospital or dispensary level. They wanted the general hospitals. All this did play a role in the political activities that occurred in Mr. Truman's Presidency.

C: At this time you were in the Legislative Liaison [L&L] Division of the General Staff. So the stage is really set for this big struggle that is going to go on, I think, throughout 1945 at least. In August 1945 you worked with the Senate Armed Services Committee on demobilization and postwar force structure. So both of these things are actually being thrashed out at this time, aren't they? You have the demobilization of a pretty sizable medical service, and at the same time you are trying to hold onto assets so that they aren't thrown into either the Army camp or the Navy camp?

M: That is true. Let's go back. When Arnold, in 1943, established a postwar planning group in his headquarters, I was assigned as the medical member of the subcommittee of the postwar Air Force. I learned such interesting things as the total tax basis that the United States was going to have 10 years after the end of the war. I learned about the gross national product and the gross national debt, because these were all being considered in whether the United States could support a 250-group Air Force. They used the air

group as the unit in planning. It didn't make any difference whether it was bomber, fighter, or transport; it was the group that was the planning unit. You must understand this--when it came to getting a separate force, the Air Force leaders were literally prepared to take only the apron and the runways. They were prepared to give up the hangars and the rest of the field if they could get independence for everything that came on that apron and flew away or landed on the runway. So the use of a group as a unit of planning was very logical. They then debated whether they would have 50 or 52 wings. They later went to the wing planning unit in lieu of the group because a wing could have fighters, bombers, and transports in it, and a wing had to have a headquarters, so that meant they had to have a field. If the Air Force had the field, then everything on the field belonged to them. This all came up over a period of months as the staff planned to live within the tax dollars that could be found under what was then considered both Republican and Democratic economic programs.

I was sent to the Strategic Bombing Survey in November 1944. There I learned all sorts of interesting problems of national economics and national products and population shifts and the demography of populations of the areas that were going to be surveyed. The survey studied the British Government because, as I said earlier, bombing was discussed only in camera in the Parliament. It was never made public. That the survey was even allowed to organize on British soil took an act of the top Minister of the British Government. We had to agree that anything we put together would have top security so it wouldn't get back to the British press and the British people.

When I was sent back to the United States from the bombing survey, I had acquired a sufficient number of points to be relieved as a Reserve officer. Reserve officers gathered points for their months of service and overseas duty. I think I needed something like 56, and I had something like 200. When I went in to see General Arnold and General Grant, I was told that even though I had the points there was a clause that if you were essential to the national defense effort you couldn't go home. I had asked not to go to Japan with the bombing survey. There were many reasons why I wasn't interested in going to Japan. I was fundamentally interested in getting back and completing my training for obstetrics and gynecology and getting my boards.

C: That would be at Western Reserve University?

M: Yes. In August 1945 General Arnold said, "You are just the person I need. Senator Hatch [Carl A., Dem-NM] of the Armed Services Committee wants two advisors to help him with the problem of demobilization and particularly military demobilization of medical people. I have selected Mr.---then Lt Col---"Robert Wagner [Col Robert F.]," who later became mayor of New York City, "from the JAG [Judge Advocate General] and you from the medical service, and you have had experience with the planning board for postwar Air Force programs, so you can represent two areas. You will be placed as a legislative liaison officer over there without your medical caduceus. You don't have to answer to the War Department Medical Service or the Surgeon General's Office."

There were 50,000 medical officers on active duty in the Army, Navy, and the Army Air Forces. They all wanted to go home; their communities all wanted them. Congress was being

overwhelmed with requests to bring them home. Senator Hatch wanted good advice because the Surgeon General, Dr. Kirk, had recommended that the Army general hospitals be used to hospitalize the patients, the wounded and the sick, of the forces rather than turn them over to the Veterans Administration.

(End Tape Tape 9, Side 1)

M: Senator Hatch wanted good concrete reasons why this was not sound, and we were able to give it to him. Later President Truman designated General Bradley to be the Director of the Veterans Affairs, and General Hawley who had been the surgeon for Eisenhower and ComZ [Communications Zone] of Europe to be the chief medical officer. It was relatively easy to show that the Veterans Administration expansion would relieve the military of a nondefense role and still provide medical care for the returning wounded soldier. It was a feeling of the General Staff that occupation in Japan and occupation in Germany, Italy, the Philippines, et cetera was going to be a difficult problem and anything that gave them relief by assigning it to another agency was sound. So we recommended to Senator Hatch that any patient that was going to need more than 6 weeks care should be transferred to the Veterans Administration. We consulted with Hawley about whether he was going to have sufficient personnel to do this. He said, "Yes, because every medical school in the country is going to be named a consultant source to take care of the veterans. This will help their education and their research program, and it will provide a recruitment program for us." Many medical schools eventually got a veterans hospital, in which a professor of surgery was paid by the Veterans Administration for 50 percent to 70 percent of his time; he was paid by the university medical

faculty for the remainder of his time. The civilian specialist had adequate personnel and patients in both his civilian hospital and his veterans hospital for training, so he could have a good training program. HEW later decided that research money would be granted to both the veterans hospitals and the civilian hospitals. The military medical force returned to a level in which their military problems in the two theaters postwar were controlled. The civilian doctors returned to the civilian sector at an early date. Obviously I was not very popular with the Surgeon General of the Army or the Surgeon General of the Navy for these recommendations, which came into force when Mr. Truman, Mr. Hatch, and General Marshall approved them. That's all it took to make them work.

I said to Senator Hatch one morning, "Colonel Wagner and I have been talking about the fact that we eventually want to return to civilian life. He has a very good law practice, and I would like to get back to academic teaching and my specialty." He said, "You mean both of you men are Reserve officers?" I said, "Yes." He said, "Had General Arnold or General Marshall told me you were, I wouldn't have accepted you. Now that I have had you and found out that both of you have a better understanding of what was going on than anybody they might have sent to try to influence me, I am glad they did. What is this about your wanting to go home?" I explained to him that both of us had requested it. He said, "What happens?" I said, "Normally we would have to go to a demob [demobilization] center, and it would take us 6 weeks to get out of the service. But as a JAG officer, he can handle the legal papers, and as a medical officer I can handle our discharge physicals. If you were to call General Ulio [Maj Gen James A.], who was the Adjutant General of the Army, "I would imagine we could be out of here within

the day." So we called Wagner in, and he said practically the same thing that I had said. He picked up the phone, had his secretary get General Ulio on the phone, and as you can imagine, the chairman of the Armed Services Committee had no trouble talking with generals at any level, or admirals. Ulio said, "Yes, they can do that. If they bring the papers over, it will take us about 20 minutes. Do they each know how much leave they have coming?" It so happened that each of us had 4 months. We had never taken leave while we were on military service, so we had the maximum that you possibly could get.

Then I went over and told General Grant and General Arnold that I was going home, that my orders were being published, and that I hoped to be in the Reserve and I would come down anytime they wanted me but I wanted to get my professional status established as I would be recognized by my profession. They were very, very understanding, only sorry that I hadn't come to them first, but they understood. Each of them asked me to personally respond to telephone calls. I stayed an extra day in Washington, and General Grow came in from the Pacific theater. He was to take over General Grant's position. He insisted on having lunch with me. He didn't want to do it in the Pentagon, so we went over to the Army-Navy Club. He said, "Richard, there is only one thing. You have to promise that you will respond even to being called back to active duty for a period of time if I need you in planning for the postwar Air Force." I said, "General Grow, I will be delighted to do it." This was November 1945, and he was planning the postwar Air Force and a medical service which could not come into being until the National Defense Act was changed, and that wasn't changed until 1947-49

I went home on a Sunday, and Monday morning I was in the operating room for the first time in several years, qualifying for my specialty. In the early part of 1947, I got my specialty boards. I had then everything I really needed. I could go government, academic, or private. I wanted to clear this so that you understood why I was over at Legislative and Liaison and what we did. By the first of January 1946, 29,000 physicians had been sent to demobilization centers to be sent home.

- C: In retrospect would you say that demobilization went pretty smoothly?
- M: Very smoothly. I think the only question you have to bring up is, why did General Eisenhower in Europe, as one of his first acts after the surrender in May, say that we would not stand any formations? The troops didn't have to stand anything but a pay formation. You couldn't have formation for meals; you couldn't have retreat or review. Patton [Gen George S.] didn't pay any attention to that. The Third Army went right ahead. This demoralization of a fighting force was unbelievable to see. By August they couldn't even march in a straight line.
- C: I remember reading that some of the remote outposts that we had up in Alaska, especially in one particular instance, demobilized so quickly that a couple of weeks later when a spotter plane went up to check over the field there was still laundry in the washing machines. They had turned off the appliances, I think, but there were still meals sitting on top of the stove.
- M: They just left.

- C: Picked up, climbed on a plane, and left. They left their uniforms hanging on the clothes line. That was it. That's your demobilization in Alaska.
- M: Not only Eisenhower but Stimson in the War Department did not understand the need to prepare the people of the United States for why we still needed a disciplined military even if the shooting war was over, but the war wasn't over. We still had some problems, but they were so afraid, or they were so hindered from telling who the potential enemy would be that we couldn't talk about what might happen to us with Russia. The only thing was, let's get out, get home, and let's get back to work and with mother and the children forget all about our responsible approach to demobilization as well as to a responsible approach to future mobilization. Our response to mobilization was equally erratic. It wasn't a phased program, and we didn't have a phased program with objectives. The result was we suddenly had a collapse of essential military services. Demobilization went all right, but the result of it was a collapse of essential units. We were still calling draftees in, but we were sending everybody else home. It takes time to make a draftee or a selectee into a trained individual in a fighting unit. It was the same thing with the Navy. Only they didn't bring planes home and salvage them; they just pushed them overboard. The flattops got rid of them, and then they didn't have a repair problem.

We Americans are a peculiar people. We will drive our head through a concrete wall and turn right around and pet a rabbit or a squirrel or a chicken and be very childish about it. It is probably going to take us another century to mature.

This is reflected in the media when they haven't anything to write about. The war is over, so let's write about why we shouldn't have an army. Let's write that all the generals are bums. Let's get rid of all this hero worship. Let's don't salute. The Military Law Commission, which was headed by General Doolittle [James H.], probably did as much disservice as anything by rewriting military law so that you couldn't have the stern, strict courts-martial that you once had. I don't think General Doolittle meant it. I don't think at the time he saw this as a collapse of discipline, which eventually got so far as to have soldiers pull pins and roll grenades into an officers club in both the European and the Pacific theaters. They couldn't be punished for doing something like that; it was a misdemeanor. Under the old law you could have taken them out and executed them. I think we lost a great deal in the change of military law in the enthusiasm to become a civilian society again. I think General Eisenhower very definitely contributed when he ordered no formations. I remember I had a soldier who had been in Europe just 6 weeks and had had no combat, and he was assigned to our outfit. He got drunk and shot a German woman. I brought him up for a general court-martial. That didn't come under USSBS [United States Strategic Bombing Survey]. We couldn't have courts-martial. We had to turn all that sort of thing over to SHAPE. They sent him home and released him. I had another one who got a little bit tipsy, and he decided to drive down a sidewalk in Darmstadt, and he hit some seven different people. Two of them were displaced persons, and the others were German. He was transferred to the stockade of the Army unit there, and he was sent home. No charges were filed. He was just sent home and got out of the service. Those were personal things that I had, and I know that there were many, many others. This breakdown in military discipline--it wasn't a

breakdown; it was a planned reduction--is one of the sad, sad tales of American military forces. We aren't all heroes, and we aren't all good Christians, and we aren't all good boys. We misbehave, but when you misbehave in the guise of the military force, it should be punished because you are there under a very peculiar moral situation. As long as the war is going on, it's legal to shoot and kill. Once the war is over, it becomes murder.

C: The mistreatment of civilians even in wartime is not condoned.

M: That's right. That is one of the weak spots, as I see it, after World War II, this loss of military discipline. I admired Patton because the Third Army didn't follow the directives from Eisenhower's headquarters. They were still polishing their leather and pressing their uniforms and meeting formations and marching and having retreat and reveille and playing the "Star-Spangled Banner." It was a military outfit. When they relieved Patton of his command and sent him to this paper-clip organization up in Bad Nauheim, I think they broke his spirit as much as the accident which broke his neck contributed to his demise. He wasn't capable of readjusting to an undisciplined military life. He could readjust to a military disciplined life in peacetime but not to an undisciplined military life.

This was the environment when General Grow took over. As I say I went home. General Grow and his staff, General Armstrong, General Ogle, General Benson [Maj Gen Otis O., Jr.], General Twitchell [Maj Gen Harold H.], Colonel Love [Brig Gen Albert G.], General Cook [Brig Gen William F.], and Col Hayden W. Withers were all very important people in planning and working with the Air Staff as the plans went

ahead for the National Defense Act of 1947. I continued my status as a Reserve officer. I succeeded in influencing the American Medical Association--and it wasn't hard to do--that they should have a committee on national security. With 50,000 doctors in the Armed Forces during the latter part of the war, it was only natural that many of them didn't do anything. They sat. This caused great resentment when they came home. When Kirk said they were like firemen, they, almost as a unit, became antimilitary. They had had good friends in the service; some of them had good experiences, but they didn't want this to ever happen again. The way to prevent it from happening is to have a council on national security that is going to pass on what the military can do with medical people and what the civilians will have as their fair share. For better or for worse, I was selected a member of the committee and made their secretary. We had hearings at which we had people like General Kirk, General Grant, General Grow, Admiral Swanson, and others appear. We wanted to know what their program was going to be for the Reserves. We suddenly became aware how sincere General Kirk was in pushing for a single medical service. At this particular time President Truman was talking about national health insurance. So the overwhelming majority of the profession saw the problem presented by Kirk of a single military service as part of the Government takeover of all doctors and medical services and national health insurance. It wasn't difficult to get the doctors stirred up. Formal resolutions on Government medical services were brought to the house of delegates. The executive council approved them and then authorized the AMA [American Medical Association] to send representatives to appear before any and all committees of Congress that were discussing health matters whether they were civilian or military.

On that council we had some people that had held relatively high rank. Rear Adm Winchell Craig [Winchell Mc.] was professor and head of neurosurgery at the Mayo Clinic. He had been on the Surgeon General's staff of the Navy. Dr. James Sargent, a very famous urologist, had been a captain in the United States Navy. Dr. Howard Diehl had been the AMA consultant in the Surgeon General's Office of the Army in charge of personnel and procurement of doctors by selective service. Dr. Diehl was dean at Minnesota and had been on the Personnel Advisory Board of the Manpower Committee for allocation of personnel to industry and to agriculture and to academics and to the military. Then there was Col Peron Long, who was professor of preventive medicine at Hopkins, and he had been a senior staff officer first in North Africa on tropical medicine and then in Europe. He served as the senior staff officer on the sanitation and care of prisoners of war, both in Italy and Germany. Dr. James Paullin, who I said had been president of the American Medical Association and a personal physician to Franklin D. Roosevelt. All these people--we met almost once a month during 1946, 1947, and 1948--when pooled, had a tremendous background of what happened in the two services. They all had positive ideas of how it should have been run. I think this is characteristic of physicians. They can give you a positive answer on anybody else's problems. Sometimes they have a little trouble on their own. We are born independent, and we live independent. We have to make decisions. I used to hear this complaint from General Arnold and his staff that there wasn't a flight surgeon who didn't think he could run a better combat unit than anybody else in the Air Force. They often talked about weather, and that irritated line officers. (laughter) But it never stopped them from talking.

I remember General Glenn [Brig Gen Charles R.], who was a medical officer. He would just go marching into the Chief of Weather's Office and tell him what he thought was wrong with the weather reports. Or he would go into Personnel, or he would go into War Plans. Finally General Grant had to say, "Now look, 'Charlie,' either you are going to shut up, or you are going to get out of Washington. I don't want to hurt you, but I can't have all these complaints coming in about how you are disrupting other people's staffs." We weren't a bunch of angels by any means.

Getting back to the AMA activity, the Army, the Navy, and the Air Force were perfectly willing to play ball with this committee in more ways than one as long as we were interested in projecting what they wanted. About this time the Surgeon General of the Army developed a private society called the National Consultants of the Surgeon General of the Army. Anyone who had been a consultant was eligible for membership. Don't ask me why, but somebody proposed me, and I was elected to membership in that group, too. General Kirk was trying to sell this group on the idea that we only needed one medical service because a patient is a patient and he has the same kind of appendicitis in the Navy or the Army or the Air Force and you don't need all these medical services. Only lieutenants and captains should be assigned to combat roles. All senior medical officers ought to be assigned in hospitals. There was public support for this. It was allegedly going to save a lot of money if there would be but one medical service. They would only be taking care of patients. Among the political planners of the medical profession, there was this great fear of a strong government medical service that would dominate everything in the USA health programs.

(End Tape 9, Side 2)

M: The result was that the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American College of Obstetrics and Gynecology found it very easy to take a position with the Council on National Security of the AMA as supporting the concept that all things being equal each of the services, as long as they were separate services, should have its own medical service. On the other hand they supported the concept of a unified medical supply catalog and a unified medical supply support system, depot system; they supported a national medical library rather than each of the services having a library. The concept of sanitation and so forth was to be a responsibility of each of the commands. The result was that each of the civilian groups recommended that we make this medical service responsive to individual commands as long as the commands were independent. In other words, if you abolished the Army, Navy, Air Force, and Marines and had just one thing, a so-called national defense force with interchangeable assignments, then you could have a national defense medical service. So when you read these resolutions, keep this in mind as to what was going on. The civilian medical profession on one hand did not want a national medical service. They didn't want a national health service, compulsory or voluntary. On the other hand the Surgeon General of the Army wanted to increase the size of his hospital program. The Navy wanted independence, and the medical officers assigned to the Air Force, as well as the senior line officers of the Air Force, wanted a medical service responsible to their command.

From this General Grow, who was then the Air Surgeon, had his planning group, that I have mentioned before, at all

levels. Their work was phenomenal. General Grow said that they would not take any statement to Congress that I had not seen; I was the one who would coordinate with civilian medicine what the Air Force wanted and what they were doing. There were hearings before various committees of Congress, and various people wrote public articles, and the media found it a happy day to see the differences of opinion.

One morning I was sitting in my office in Columbus, Ohio, and I got a telephone call from former President Hoover [Herbert C.] saying that while he had never met me he was sure that he had read quite a little bit about me and both he and President Truman would like to talk to me the next day concerning my joining the Hoover Commission in their activities. I agreed to come to Washington, and I met both President Hoover and President Truman. Mr. Eberstadt was the chairman of the Hoover Commission Committee on National Security Organization, which Truman had appointed to advise him on the reorganization of the executive branch of government. Mr. Eberstadt, Mr. Hoover, nor President Truman were satisfied with the activities of a medical advisory group that was studying Government medicine. That group was headed by Mr. Voorhees, who had been on active duty with the Army to straighten out their medical supply and contract problems back in World War II. Associated with him were some very well-known medical figures--Dr. De Bakey [Michael E.], a heart surgeon down in Texas; and Dr. Churchill, professor of surgery at Harvard, to name two of the people. They were more interested in the central hospital system that was developing along the lines of the Veterans Administration. As I said, General Bradley was heading the veterans; General Hawley was on this group. At the same time that there was this Voorhees committee, Secretary of Defense Forrestal established an advisory group

to him composed of Major General Hawley, the Surgeons General of the Army and the Navy, and the Air Surgeon. They were to advise him on the problems of the current military medical services. Mr. Eberstadt had heard Voorhees, and he had heard Hawley. For reasons which I never found out, he decided that he didn't feel comfortable with either one of those committees, and he wanted an advisor to him. He named Dr. Howard Rusk and myself as his medical advisors on national security. Dr. Rusk, unfortunately, had a commitment to spend the next 4 months in Europe. It, therefore, devolved on me to go to Washington on Sunday night and spend all day Monday with Mr. Eberstadt. Then Monday evening we would have a dinner, which Mr. Eberstadt hosted, at the Carlton Hotel. Frequently Mr. "Barney" Baruch [Bernard M.] was there. General Marshall came. Secretary of State Acheson [Dean G.] would be there; Mrs. Hobby [Oveta C.], who was later to be the head of HEW; Nelson A. Rockefeller; and Hanson W. Baldwin, the military correspondent of the New York Times, were frequent guests. It was a very stylized Monday night dinner at which I received an education in international and national politics as well as economics because Eberstadt was a very successful international banker. He would frequently have Forrestal and Lovett there, and you could soon see that they were not only close personal friends but they were very close professional associates.

One of the interesting things about this was that we would be allowed two cocktails and then we would go into dinner. During dinner, there would be no wine or liquor served. After the plates had been removed, Mr. Eberstadt would start out with a question, and it was tossed around the room. My special duty was to watch Mr. Baruch. If Mr. Baruch turned off his hearing aid, I was to kick Mr. Eberstadt under the

table, and he would then address a question directly to Baruch to get him back into the discussions. These were not only interesting people but they were powerful people in international affairs. The opportunity for a young physician to sit there week after week and listen and be asked questions by them was not only thrilling but it was very educational.

Finally Mr. Eberstadt asked me to set up hearings for his group to listen to civilian and military leaders expound what they thought the medical services of the national defense forces should be. These were conducted in some length. Then we prepared memoranda. At about the same time, November 1948, Mr. Forrestal became dissatisfied with the Hawley group, and he appointed Mr. Charles Cooper, then executive vice president of AT&T [American Telephone and Telegraph Company], to be his Deputy Secretary of Defense in Charge of Medical and Health Affairs. He in turn had an advisory committee composed of civilians to advise Forrestal on what the medical services should be. I was appointed by Forrestal to this committee. So here I was on the civilian committee, the AMA; the committee of the Hoover Commission; and Forrestal's committee all attacking the same problem.

It soon became my responsibility to write the memos and arrange the interviews and develop staff studies from which we could establish certain position lines and then move into a phased development in the program. One didn't try to solve the whole problem at once. One tried to develop a phase line and then another phase line and then consolidate and move forward to another phase line. This was new to civilians, both medical and nonmedical, but it seemed a logical approach. Of course, success is what spells its effectiveness.

At the same time I was advisor, as a Reserve officer, to General Grow. He became somewhat imbued with the idea that I was the perfect bridge in all of this negotiation and that the Air Medical Service should do nothing that would confuse the issue without my knowing it.

C: Sir, you were the only one in that position, weren't you? You were the only one that was on all these committees?

M: I was the only one. It was not difficult to prepare a resolution or a memo for Eberstadt which became known then as the Eberstadt Committee Report. This document showed that we needed three medical services and, at the Department of Defense level, we should have a coordinating office. Everybody wanted to be at the Secretary of Defense level. There was no opposition to this in the military. But they all had different ideas of what they were going to do when they got up there.

At the end of February, 25 February 1949, General Eisenhower, who was acting as Chairman of the Joint Chiefs--he was at this time president of Columbia University and, of course, very closely connected with Mr. Cooper, who was president of the College of Physicians and Surgeons Hospital associated with Columbia--appeared before the Cooper committee to testify on why he thought we ought to have a single independent medical service to serve all three branches of the service. In the meantime, you will recall in 1947, the Air Force was established. It's very unusual to think back then, but at 11 o'clock in the morning, there was no Department of Defense, no Secretary, no staff. Because of the threat of invasion of Germany through Poland by Russia--General Vandenberg as head of the CIA [Central Intelligence Agency] reported this to President Truman--

President Truman, who was at sea on the Missouri coming back from South America, ordered Forrestal, who had been confirmed as the new Secretary of Defense, to take office. They had wanted to wait until 11 November to have it on Veterans Day. Instead, at the end of September, Forrestal took office. At 11:00 you had nothing; at 11:02 you had a Secretary; at 11:05 you had three Assistant Secretaries--McNeil [W. J.] in Finance; Leva [Marx] in Law; and Ohly [John H.], Executive Administration. By 11:20 they actually had a file cabinet and a duplicating machine moved into the office; it belonged to the Department of Defense. One was dealing with a new organization. It could establish its own precedence and traditions. In November 1948 Forrestal established the Cooper Committee, and he said, "I want each of you to bring to me ideas about how the Department of Defense should develop. Would you prepare a short memo?" I talked with both Leva and Ohly, and they said, "Well, why don't you just prepare a staff memo? He is accustomed to receiving those from the military forces, and it will be a great deal easier for him to go through it than if you write a letter." So that's how I wrote the staff memo proposing a separate medical service for the Air Force, complete with hospitals and all our field forces. The Secretary of Defense was to issue a directive that air evacuation would be the primary mode of moving patients. We didn't eliminate at that time hospital ships and hospital trains in the theater, between theaters, or between theaters and home, but we did say the primary mode would be air evacuation. This would be assigned to the Air Force.

C: If I am not mistaken, sir, the Army also had some hospital ships. It was largely an Army bailiwick that you were talking about reducing.

M: That's correct.

C: I imagine the Army had something to say about that.

M: Many times, many times. (laughter) Now the question was, would the Air Force accept this responsibility without asking for additional planes? The answer was no. They had agreed on a division of forces that gave them so many planes; when they got those planes, air evacuation was not part of their duty assignment. They wanted to know the tonnage involved in air evacuation and how frequently they would do that, and then they would tell you how many new cargo planes they wanted to do it. We had many go-arounds between General Vandenberg, General Norstad [Lauris], General Swofford [Lt Gen Ralph P., Jr.], and myself about what this requirement for planes would mean. The Navy would want an equal supply of planes. I said, "No, the Secretary of Defense should give these planes to the Air Force." But then the fleet air arm came in and said, "If it is all going to be air evacuation, we need planes for the fleet air arm to move patients." You can see how in trying to establish a medical service, you get into the problems of political allocation of tonnage, political allocation of wings, models of planes, and adaptability to the other services.

Came this meeting that Eisenhower had with the Joint Chiefs the last of February--and it might be noted that the Joint Chiefs had not agreed to anything over a period of 6 or 7 months at any meeting that Eisenhower presided over. He was very desirous of having something that they could agree on.

C: He liked unanimous decisions, as I understand it?

M: Yes. He wanted a unanimous consensus. It was customary to have the agenda from the Chairman's office a week in advance so that each of the three services were properly briefed as to what was involved in the agenda program. When they met that afternoon, they didn't agree on the agenda programs, and he finally said, "Well, gentlemen, there is one thing I know you will all agree with, and that is the need to have integrated medical services." Nobody objected. It wasn't real clear that he knew what he was proposing. At any rate, that afternoon, 25 February 1949, he sent a handwritten report over to the Secretary of Defense. Jack Ohly called me at home in Columbus and said, "We have a piece of paper that you should see. Can you fly down this weekend and take a look at it?" I did, and he said, "How do you think Mr. Forrestal should handle this?" I said, "Jack, the only thing to do is give it to the Cooper Committee and let them see what they come up with." I was a member of the Cooper Committee, and as I recall it was 5 March that we had our first hearing. Secretary Forrestal was the first witness, and General Eisenhower was the second witness. Then we heard the Air Surgeon and each of the two Surgeons General. Then we heard Mr. Voorhees, and then we heard General Hawley. By the 20th Mr. Cooper said, "I think we have come to a conclusion. Who is going to prepare the paper?" Jack Ohly, who was sitting in on the meetings, as well as Mr. Leva, said, "If Dick can spend a day here, we can get an official paper out for the Secretary." So I spent the following day, and we wrote the memo for the Secretary in which we answered the proposal that General Eisenhower submitted to Forrestal. Incidentally the paper we had prepared for Mr. Eberstadt was completed and approved, and it arrived on the Secretary of Defense's desk within hours of the time that the Cooper Committee report arrived. This made it very easy for Assistant Secretary Ohly who was in

charge of administration, and it made it easy for Marx Leva to do the legal background of what this would entail. Both memos proposed that the three services should each have a medical service. It should be headed by a Surgeon General who was a military officer. Further that the Department of Defense should have a medical director who was on the staff of the Secretary of Defense and he should be a civilian. The development of that office was left then to the Secretary of Defense and his staff. He would decide how many people he would have and what they would do, but primarily the new office would be responsible for policies and programs. The Navy took the position that he would be a super Surgeon General imposed on the three Surgeons General, that he would be sort of a Chief Surgeon General, and he would control all the hospitals. They proposed a table of organization with 95 officers to be assigned to the staff to run all the military hospitals. The Air Force position was that he should see to the equal distribution of supplies, equipment, and facilities and he should ensure equal distribution and purchase of equipment and a common catalog. The Army came up with a common catalog, but they did not foresee the Department of Defense doing it; they saw the Department of Defense assigning the Army to procure all medical supplies for the three services and running the supply distribution system.

There was very little difference in the Cooper and Eberstadt reports. Forrestal had that paper for almost a week, and he called me and asked if I would come down, which I did. This was convenient because Rickenbacker Field was then Lockbourne Air Force Base [OH], and I could get a plane. The pilot was very happy to fly me down in about an hour. I would get there, and we would meet in the evenings. After we finished I could get in the plane and be back to

take care of my civilian medical practice the next morning. Forrestal said he would approve this, and we talked about it. I was to return in 10 days. In the meantime Forrestal resigned, and Secretary Johnson [Louis A.] came in. Leva and Ohly and McNeil were continued as Assistant Secretaries of Defense, and they recommended to Johnson, whom I did not know at that time, that he ask Cooper and me to come in and brief him on what had evolved. In about 5 minutes of briefing, he said, "Well, I understand this whole problem"----

(End Tape 10, Side 1)

M: Prepare the directives for the Secretary of Air Force and Chief of Staff of the Air Force to establish the Medical Service of the Air Force and the position of Surgeon General of the Air Force." It sounds like, the way I have told it, that it was a great "I" in this, but the tremendous work was done by all these staff officers in General Grow's staff. General Armstrong, General Ogle, General Benson, General Twitchell, General Schwichtenberg, General Cook, and General Kennard [Brig Gen William J.] were working constantly with the Air Staff and the War Department staff, preparing statements for presentation before congressional committees and answering memoranda, keeping it coordinated so that we never lost track of what we were after; namely, an Air Force Medical Service. We were very fortunate that "Tooey" Spaatz was no longer Chief of Staff, so his agreements with General Eisenhower, Chief of Staff of the Army, were no longer binding on the people who assumed the role of Chief of Staff; namely, General Vandenberg. We were also very fortunate that Secretary Symington [W. Stuart, Secretary of the Air Force] was very enthusiastic as the first Secretary of the Air Force in having a medical service of the Air

Force. The Secretary's Office, the Chief of Staff's Office, Air Plans, Air War Plans, the Surgeon General's Office, the A-1 personnel, A-3, and A-4 were all working together. Qualified medical officers who had staff experience worked with the Air Staff on these various things and kept track of the requirements or the requests from Congress and from the Senate on details. It could never have been accomplished if it hadn't been for the superior staff work that General Grow's office provided and his ability to hold all the reins in his hand at one time and prevent frustration taking over. Prevent vindictive accusations against staff officers over in the War Department or in the Surgeon General's Office from influencing what we were trying to accomplish. He also was in the position that he could decide where he would compromise, and I was in a position that I could influence the understanding of the compromise at the level that policy was being determined.

Well and good, I was very happy. I was then a colonel in the Army Air Forces Medical Service; to wit, in the Army Medical Corps. Now we were going to have an Air Force, and I was going to be transferred. It became very discouraging suddenly to me to find out that some of the officers that I had worked with, medical officers and so forth, didn't want to transfer from the Army to the Air Force. They felt like many others that the medical service of the Air Force couldn't succeed, it didn't have qualified people to take over big hospitals. The Army was going to continue to provide general hospital care until the Air Force could build up; 54 percent of all the Air Force patients were in Army hospitals; 100 percent of all the Air Force medical personnel to be interns and residents were in Army facilities. The Navy was trying to take over. A few of my colleagues looked it over, and they didn't see that this was necessarily a great opportunity.

C: Would this include the flight surgeons at the dispensaries?

M: Yes, even those. The Army was beginning to feel it was going to have its own aviation section, so there was a place for Army flight surgeons even this early in the game, though it really didn't come into being until a little bit later. So several of the key officers that I thought would break out a bottle of champagne stayed with the Army. That had an influence on the younger officers that had looked up to these chaps. I was at Atlantic City at the American Medical Association meeting, and we had had a meeting of the Council on National Security. We felt really quite well that things were coming along. Mr. Johnson had appointed Dr. Allen [Raymond], who was an MD and president of Washington University, to come on as Director of Medical Services. Mrs. Meiling and I were out on the Boardwalk, and some people stopped us and said, "They are paging you at the hotel. They have a serious emergency call for you." We went back to the hotel, and I took the call. It was from the White House. Matt Connelly said, "Mr. Johnson and President Truman want to see you at 9 o'clock in the morning. We have set up a plane to pick you up at 5 AM in Atlantic City." I said, "What do they want of me? What's going on?" "Well, I can't tell you over the telephone, but you be prepared to accept the top medical position in the Department of Defense." I thought, "Well, Allen's got that. Why would they remove him before he had even taken office?" So we walked along the Boardwalk and discussed it. Finally she said, "You make up your own mind. Whether you stay home or you go to Washington, the family will go with you." The next day I flew down to Washington, and Johnson met me in the outer room of the President's suite in the White House. He said, "The board of trustees of Washington University has refused to give Dr. Allen a leave of absence."

I have talked it over with the Cooper Committee, and with the exception of you, they are unanimous that you should take over. I have told Mr. Truman that you should take over. Don't tell me what you are going to do; you tell him." So we were shown in to see President Truman, and he had a folder going back to my recommendation to Forrestal about how the medical services should be drawn up and what they should do. He said, "Did you write this?" I said, "Yes, sir." He said, "Do you believe in it?" I said, "Yes, sir." He said, "Then you are the only person who really knows how to put it together and make it work. I am, therefore, asking you to come aboard as an assistant to Secretary Johnson. He has already made the recommendation." I said, "But Mr. President, I come from a county in Ohio where I didn't know there were Democrats until I was in high school. I thought there were only Republicans." He laughed and said, "I like to know why people become Democrats and Republicans, and I can see that is a very logical order." I said, "But Mr. President"--and he said, "Now look, we looked you up completely before we brought you in here. We know all about you. You don't have to support my medical program. You get this medical program of the Department of Defense going, and you get the Air Force Medical Service so it can support the Air Force. If I don't hear a hell of a lot of complaints about what you are doing, you are not doing a good job. We will expect you on 1 July at 9 o'clock in the morning to be sworn in as Director of Medical Services and Assistant to the Secretary of Defense." He turned and said, "Louis, how did I do?" Mr. Johnson said, "Mr. President, you had me sold. I didn't see how Dr. Meiling could say anything." I said, "But I wouldn't like to lose my position at Ohio State." He said, "Who is the president out there?" I said, "Dr. Howard Bevis." "Oh," he said, "Judge Bevis. He is an old Democrat." He turned to

his secretary and said, "Get President Bevis on the phone." He took the phone and said, "President Bevis, this is President Truman. I have a young man here in my office by the name of Dr. Meiling. He is one of your junior professors out there. I have convinced him that he owes his country a duty, and he says that he has to have your permission otherwise he would have to resign. I wish you would put him on an extended leave of absence of several years so he can go back there." Bevis said, "May I speak with Meiling?" "Sure." So here I was in the President's office talking with Bevis. He said, "Do you want to do it?" I said, "Yes, sir, I do." He said, "Well, then there is no problem. You can have a 2-year leave of absence, and the board can extend it later." With that I officially became the first assistant--because we didn't want people to think the first director, Allen, had been kicked out. For 2 months I was the assistant director but actually ran the show, and we sent Dr. Allen and the Surgeons General to Berlin and to Europe on a trip to inspect things. He had never seen field medicine.

When he came back we had organized. The Navy had proposed this tremendous big staff, and everything this Director of Medical Service was going to do was by command. They had proposed Rear Admiral Boone [Vice Adm Joel] to be the executive to the civilian director. Boone had been the Presidential physician to both Hoover and Coolidge [President Calvin] and also one of the assistants under Harding [President Warren G.]. He was very well decorated and had the Medal of Honor for his service with the Marine Corps in France. To make a very simple story short, he planned to take over my position. Boone couldn't tolerate the idea that an upstart brigadier general of this new Air Force was going to run things and he a senior Navy officer

was going to be an executive. In due time I had to get rid of him. When I informed him that he was relieved, his first action was to call in the Marine guard in the Pentagon and post an armed guard over his desk and post another armed guard over his file cabinet. Then he marched off to see Secretary Matthews [Francis P.] of the Navy. I marched down to see Secretary Johnson. I said, "Are those files and that desk Government property?" "Yes, they are." "What do we do?" He said, "You call Marx Leva and let Leva go down and arbitrate the thing. Don't you touch it." By 11 o'clock Admiral Boone had been over on the Hill and had a hearing with the congressional committee on Armed Services. The fat was really in the fire. The evening papers had headlines, "Meiling fires Medal of Honor winner." Time and Newsweek had stories about how Meiling fired the senior admiral. When they came to interview me, I had sense enough to say, "No comment." Under my picture in Time, there is a nice quote, a crisp "No comment."

The Surgeon General of the Navy, Swanson, was the next one that decided he was going to take over my job. President Truman did not reappoint him. One day I went over for a briefing with Johnson, and I said, "Mr. President, I am afraid you are hearing too much about me." He said, "Everything I hear is good. Everybody says that you are tough, and then when I find out what you are doing, you are a great guy." I said, "Mr. President, I apologize for causing you trouble, but you told me to get this thing straightened out." All the fighting that took place then in the first 6 months that I was in the Department of Defense was Navy and Army against me, which gave the Air Force breathing room, if you will, without having to fight their sister services every time they turned around. By December I was convinced that the Air Force Medical Service was

definitely going to survive. General Armstrong had succeeded General Grow as Surgeon General. General Armstrong used the same people and the same program that Grow had fostered to get the Air Force going, and they began to prepare requests for hospitals on Air Force bases and the replacement of cantonment-type buildings with brick and mortar structures.

C: Do you think you were selected not only because of your pivotal position but precisely because as a brigadier general you would be a greater diversion for the Navy? These admirals senior to you would be a little bent out of shape that they couldn't displace you and take over whereas if they had encountered a more senior Air Force officer then perhaps they would not have been diverted as much? I am trying to determine whether there was a little bit of mental chess going on here that involved having a believable diversion and if your rank was part of that as well.

M: I didn't get my rank until September, and I had been appointed in June. I was the first Reserve officer and Rusk was the second to receive the flag rank in the new Air Force Medical Service. I don't think that had anything to do with it, really. I think the fact that Forrestal, Eberstadt, and Cooper all knew me personally was the deciding factor. They had had experience with me, and their recommendations to Truman carried a lot of weight. I think it wouldn't have mattered whether I had ever been in the Reserves. The fact that I was a Reserve officer was played down in public releases. It was the same thing; Ohly, Leva, and McNeil had all been Navy officers in World War II, and they were the only three Assistant Secretaries of Defense at that time. Forrestal had been the Secretary of Navy and before that the Assistant Secretary of Navy when Knox [Frank] was Secretary

of the Navy. It was practically impossible to touch anybody for an executive position that didn't have previous military associations.

C: Was the alignment, though, of the Navy as you portray it significant, at least in people's minds, in terms of policy decisions and the way they would react to those policy decisions? Did the Navy tend to be naturally antagonistic to you as an Air Force officer?

M: Much of the senior leadership in the Navy was anti-Department of Defense. They tolerated it when they found they couldn't beat Truman in Congress, that there was going to be a National Defense Act and there was going to be a Department of Defense. Let me show you what happened in Korea. In the summer of 1950, we had a need for approximately 1,200 medical officers in the expanding Air Force and Army. We had ASTP [Army Specialized Training Program] medical officers who had received deferment to go to medical school and who had never served a day of service and some who had only served 6 months. I proposed to General Marshall, when he became Secretary of Defense in September 1950, that we call these Reserve medical officers to duty and that the Secretary of Defense assign them in their own uniform to serve with the Air Force and the Army. The Navy didn't need additional people at this particular time. Marshall took me to see Truman, and I explained what we were talking about. Truman could make sound decisions very rapidly. He said, "Do you have the papers, and where do I sign?" Matt Connelly brought the papers that we had prepared; he had put them in language that he wanted for the White House, calling these officers to duty subject to assignment in the services where the Department of Defense determined they were needed. The Navy, because this was the

first time anybody had called officers of one branch to do service in another branch, filed an official protest. Their JAG took it up with the legal counsel of both the Senate Armed Services Committee and the Attorney General of the Army. It took about 48 hours to get the reply back that the President had that authority and he had exercised it. They would call up these Navy Reserve doctors who had never had any active duty service.

C: It sounds to me as though both the Army and the Navy as traditional services not only were anti-Department of Defense but also dragged their feet on flexible tours of officers in duties that would not be traditionally Navy or Army positions. You didn't have that background, quite the contrary. You were recognized as being flexible enough to work with study groups and committees, and you would not show the same sort of sectarianism of tradition. Do you think, again, the fact that you had that background and the fact that you were open to the progress of the Department of Defense was a sizable factor?

M: Yes. I think the fact that I was part of the Eberstadt group and the Hoover Commission played a big role, because it was there that they developed the National Security Act and made it possible to develop the Department of Defense and revise the National Security Act of 1947 which had established the Department of Defense and the three services. I have always felt my experience with the Eberstadt group was a big influence with Forrestal and then later with Johnson and with Mr. Truman in appointing me Assistant to the Secretary of Defense.

C: Am I correct in assuming that during this period of time you went out to the Eniwetok tests in the Pacific?

M: I went out to the Eniwetok tests in 1951. Several members of the Joint Staff of the Joint Chiefs, myself and the military attaches from the White House, flew out to Eniwetok together. I am trying to think exactly how that happened. At the time we had set it up to go, it was based entirely on the dates of prospective bomb drops. In the meantime General MacArthur was relieved of his command and was proceeding home. We were ordered to go to Hawaii and meet him. We flew out to Hawaii in a "Connie" [Constellation, C-69], and we all got off the plane in civilian clothes because we were going to keep the press from knowing we were there. While we were housed at VIP quarters of the Navy, we spent most of our time in recreation over on the far side of the island away from Honolulu. We had to wait 5 days for MacArthur to arrive. We got word that he had left Tokyo. We expected to hear from him at Wake where they were going to refuel and again at Johnston Island. They refueled at Wake, but they missed Johnston Island. They missed it by quite a piece, so about 10 o'clock at night when we had heard nothing and nobody--the Navy, the Army, or the Air Force--had picked up any SOS call or anything, we had to call the White House to say we were here but we didn't know where MacArthur was. About midnight they picked up the plane by radio. They were 460 miles north of Johnston Island, navigational error. They were coming on in; they arrived about 1:15. They were all dressed in summer uniforms--I was in civilian clothes--to greet him. He sent word that he would see us at 6 o'clock in the morning at Admiral Radford's [Arthur W.] quarters. Admiral Radford was then the Pacific Fleet Commander and the theater commander.

(End Tape 10, Side 2)

M: We were given word that MacArthur would not see us, having arrived about 1 o'clock in the morning, until 6 o'clock at Admiral Radford's quarters. The next morning we were duly called by Marine orderlies and taken to Admiral Radford's headquarters. Right on the dot of 6 o'clock in the morning--there were some 12 of us--in came General MacArthur and his chief of staff, General Sutherland [Lt Gen Richard K.]. Two of the officers in our group had served with him in the Pacific, and there were cordial greetings. I was the last one to be presented, and he said, "Oh, Meiling, you are the one that kept me from having general hospitals in Japan." I said, "Yes, General MacArthur, and you are the one that requested blood and have never used it." So I guess we were both equal. (laughter) He said, "I hope you get on out to Japan to see what's going on. By the way are you assigned to Marshall's headquarters?" I said, "Yes. I am Assistant to Secretary Marshall." He said, "Very interesting, very interesting. Well, you do not have an understanding of the Pacific theater. If you had you would have allowed us to have our general hospitals." I said, "General MacArthur, has there been any problem with air evacuation from your theater back to the United States?" "None that I know of." I said, "Then I am satisfied that we made a proper decision." He said, "Let's have breakfast."

We had breakfast, and it was a great social gathering of friends from the military service, Admiral Radford and his staff. We all reported back to Defense and the White House that we had met him and that there had been no difficulty except Vice Admiral Davis [Adm Donald C.], who was secretary of the joint staff, put in, "Meiling and MacArthur differed on general hospitals and on air evacuation. Meiling won." (laughter) It always amused me. Admiral Davis was a delightful person and a great personal friend. There was

always this tendency to needle among the services. We were instructed to stay at Honolulu until MacArthur was actually in the air. As a result we had 3 more days in Honolulu where we swam and enjoyed the beach on the far side of the island. General MacArthur received an honorary degree from the university and addressed the people and so forth prior to his departure for San Francisco.

When he left, we were already on the runway with our motors revved. We took off about a half minute after he was wheels up. We went on to Eniwetok. They had postponed the bomb drop because they wanted us to see it. They had three scheduled. The first one was to be a static, and the next two were to be visual drops. We went to Eniwetok, and after 3 days of briefings and so forth, the weather was considered perfect for the static drop. We had the first static drop then early in the morning. We were on the atoll about, I would say, 18 miles, as the crow flew, from the static drop area. Immediately after the drop the senior medical officer and I took off in torpedo boats to go to the static area, which was down the lagoon. I would say it took us more than 20 minutes to get to the bomb drop area after we had seen the bomb explode. As we came in to the dock which was still standing--it was a wooden dock, and it was not on fire, and it didn't show any charring--the water was literally covered with dead fish bottom up, and they all had evidence of burns. The second torpedo boat was alongside us, and it was taking specimens to take back to the laboratory. The only protection we had was our fatigue uniforms and leggings so that we didn't get dust from the beach into our pant legs. We all were wearing surgical masks because of the dust. We spent about 4 hours looking at the blast damage and the animals that had been in set cages. We then reembarked and went back to our barracks where we had Geiger counters go

over us. We all showed a great deal of radioactivity. We stripped and took a cold shower right there on the docks so we wouldn't contaminate the rest of the camp area. The radioactivity with one shower was reduced maybe 70 percent as indicated by the Geiger counters. We took a second and a third one and then checked, and we were down to about 10 percent. At this time I noticed that around my genitalia I was getting a larger reaction on the Geiger counter, and I said, "Why is that?" This black soldier that was in charge of the shower baths said, "General, sir, I bet you wore some of those new nylon shorts." Well, I had, and that had collected little droplets of radioactive moisture that got on the hair. I soaped down, and the Geiger counter was negative all over. I soaped my hair, and it was negative. Several of the officers had taken hot showers as opposed to cold seawater showers; their reduction was a little bit more rapid than ours. The radiation was on our clothing and so forth--we just threw them in the big washtubs they had there--came out after one rinsing and they were clear as far as the Geiger counters were concerned.

That afternoon the generals and admirals that were observers wanted to go in. But two of them weren't very enthusiastic about it. I had been there, and at lunch I told them what had happened. I said, "I think we should all wear the canvas booties to cover our trousers as we go through the sand. When we get there, we will put you in a track vehicle, and you won't have to get out on the sand or anything. You can see everything. If you want to get out, you can, but I think it's worth going through." They all went along, and there was one four-star general, who had been decorated three times for bravery, who just couldn't bring himself to get out of the tracked vehicle. We got over to where the dogs were, and he wanted to see how the

burns had been accomplished, because the windows to the dogs and to the pigs and rabbits were all controlled like swords fitting together. They were electronically timed with the blast, so we knew how much exposure each animal had received. The group with the Atomic Energy Commission, the military group, had actually raised the dogs on the atoll to get rid of genetic disturbances if possible. So they were all third and fourth generations of dogs that had been raised out there. It was a fascinating experience to me because when I had been at Hiroshima and Nagasaki I was impressed by the devastation there versus the devastation in Hamburg and in Cologne. Here we were on an atoll, and the only buildings that had been built to test and the materials and the animals and so forth were at issue. Otherwise it was just a flat atoll the way it had been before we got there. I was impressed with the fact that after the bomb goes off that area would not be denied to the enemy as originally thought. So I wrote a memo to the Joint Staff saying this should be further explored.

We then moved up to within 5 miles of the bomb center for the next blast. The thing that surprised me was that there was no shaking of the earth like there is in a heavy artillery barrage. You have the noise, you have the mushroom cloud and the fireball above it, but you don't have the fire storm that we saw in the bombing of cities with heavy conventional bombs.

Later, as a Reserve officer, the Air Force sent me to Nevada Flats, and I saw several bomb drops there. We were within, I would say, 4 miles of bomb center, and we could watch the plane coming over. That is an experience that I just don't particularly care to repeat. I have great faith in navigation and flying, but when you think the plane was at

10,000 feet and I was out here just 4 miles, maybe 4½, which is the actual distance on some runways--we had armored vehicles. We had all kinds of trenches, and we actually had Marines and Infantry in some of the trenches, all with protective clothing and protective goggles. I reemphasized the fact that the dropping of the bomb was to me very similar to the use of chemical warfare in World War I. It had a very explosive effect on our military thinking, and yet afterwards, to the best of my knowledge, chemical warfare has never been used as a decisive military weapon anyplace in the world since World War I. I stuck my neck way out by saying, "I don't believe the atomic bomb will ever be dropped in normal warfare; there are other ways of achieving a result." I didn't say used; I said dropped. That has haunted me greatly, but you, as a missileman, can assure me that missiles will take the place of any dropping.

I also went to see the Air Force demonstrate retrobombing, where you take off and climb to the top of your hyperbole and let your bomb go over your shoulder. I am not sure that the advantage of the H-bomb is so great that we need to be concerned by all the public and media hysteria with it at the present time. It might, however, have a political influence in Congress as to what we do with offensive weapons to provide a sound military defense. For this and other reasons, I think it is very essential that the medical service keep a limited number of medical officers so well acquainted that they can appear before Congress and give good medical answers to the questions that are being proposed by civilian medical authorities who have never seen a bomb exploded.

C: This, of course, becomes increasingly difficult since there hasn't been any atmospheric testing since the early 1960s.

M: That's right. Well, shall we call it quits for today and tomorrow afternoon get going again?

C: Yes, let's begin again tomorrow.

(Interruption)

C: General Meiling, while we are on the subject of nuclear issues, atmospheric testing and so forth, was there any change in medical evacuation exercises in the 1950s that would allow for the enormous changes in casualties that would be anticipated in a major nuclear war?

M: I think you assume that war plans of the three services were anticipating these huge casualty lists. Really it was Civil Defense that was anticipating it and using the threat of these enormous casualties to continue the civil defense program and to stockpile water and food, bandages, and so forth all over the United States. I don't recall at any time that there was serious consideration given at military level that we were going to have all these casualties to the point that the excess numbers of casualties would prevent the military from performing their duty as a defense force and as an offensive force once we were engaged with the enemy. There are many hypothetical questions propounded in the media, but I do not personally recall at any time that we made changes in hospital or evacuation programs or even the procurement of whole blood and blood plasma, blood plasma being something at that time that we could store, or dried globulin which we could store. Civil Defense had some fantastic figures of what they would need and what would happen if any city were hit the way Nagasaki or Hiroshima were hit. But if we go back and take a look at what the Japanese did in those cities after they had been hit or you

take a look at what happened in Germany at Hamburg, which was probably the biggest city area that was bombed at any one time, six nights and five days of continual bombing, or Cologne or Nurnberg, hospitalization and transportation resolved itself around the ability of the available health service to triage their patients. By triaging patients they attended to those who "had a possibility of living" whereas those that they forcefully decided were not subject to possible recovery were shifted over into a special area. I might say that is the concept, as I understand it, of the military medical services of the three forces today. Even at the level of the portable flyaway hospital there will be triage officers, and those triage officers will have to fight down their personal and professional priorities and channel their activities and their available resources to those that have a chance of recovery. More than that I am not in a position to talk because I have never been privy to any planning by the military that would assume responsibility for all "casualties in the advent of a nuclear incident." We did have, and still do have as far as I know, plans in case the Air Force has a nuclear incident with a takeoff or landing of a plane that has nuclear arms aboard. I have never been privileged to hear anybody in a responsible position talk about financing the military to take care of huge civilian casualties. If they are not responsible financially for this, they can't have the reserves of equipment. So this is a civil defense problem rather than a military problem.

C: Could we conclude generally, though, that much of the *medical* help in a general nuclear war would have to be self-help because of the lack of resources?

- M: Not only a lack of resources but the distribution of available resources. Self-help for the medical centers and the fire departments as well as for the sewerage and waterplants that would of necessity have to be improvised will be at a local level at least in the first 3 or 4 days.
- C: You mentioned during the break, sir, that you wanted to add something to the record concerning the Eniwetok tests, that General Kenney [George C.] and others had been at that test with you.
- M: Yes. General Kenney and General Cannon were the Air Force officers that were in the party that came from Washington. Of course, General Kenney had served as the senior air officer for MacArthur for several years during World War II, and they were very good friends. This had a very good effect on our visit with MacArthur at Honolulu. When we got to Eniwetok, there was a very definite bull session by these senior officers, vice admirals and lieutenant generals and full generals, of what had happened that caused President Truman and Secretary of Defense Marshall and Secretary of State Acheson to unite on the removal of MacArthur as the commanding officer of American forces in Korea and senior military commander of all the United Nations forces in the Korean conflict and to replace General MacArthur with General Ridgway [Matthew B.]. The comments, of course, went back to the reason President Roosevelt called General MacArthur back to active duty in 1941. He was serving as the commanding officer on leave status from the United States Army; he was, therefore, commanding officer of the Philippine military forces. Early in 1941 President Roosevelt had called him back to active duty. You must recall that General MacArthur went to the Philippines when he retired as Chief of Staff; he had not been home for

approximately 7 years. It was quite noticeable to all of us that he did not understand or agree with the concept of the three forces of the War Department that were to come into being in 1942; namely, the Services of Supply, the Army Ground Forces, and the Army Air Forces. He did not agree with the concepts that the Joint Staff and the Joint Chiefs had full command over everything. He still believed in the concept that had been prevalent in World War I: the theater commander was absolutely independent and responsible only to the commander in chief; namely, the President of the United States. He foresaw himself in many of his actions as being the replica of General Pershing, who had commanded the American Expeditionary Force in Europe. That recalls the fact that General MacArthur was a division commander under Pershing, General Marshall was Pershing's top aide, something like an executive officer, and General Patton was one of the senior aides. So the conflicts that were to arise later in the war are often attributed by columnists and writers of history as the personal difficulties that had existed back in the days when they were all under Pershing. Actually it was very difficult--and Kenney pointed out how difficult it was--for MacArthur and his staff to recognize the change that took place and under which he had to serve during World War II.

(End Tape 11, Side 1)

M: The command that prevailed in World War II and that we discussed very openly by these officers. For example, Vice Admiral Davis had been in the Pacific as a senior naval commander during World War II. Kenney had been in the Pacific as the senior air officer under MacArthur. Cannon had been one of the senior officers in the European theater. For me it was an experience almost like studying for a PhD.

It was like going to a seminar every time we sat down to a meal--seminars on organization of defense forces and of combat forces. It was very similar to the fabulous education I received from the Eberstadt Committee on world finance, world politics, national defense in the United States and the philosophy in which the State Department and the Defense Department had to integrate their activities. I also had a similar experience when I was assigned to the postwar Air Force board that General Arnold set up in 1944. We discussed and studied the taxation basis, the taxation yield, and the national product upon which the future Air Force would be built. It was conceived in 1944 as being independent. All officers, not only the line officers but the medical officers, would have to understand these things if we were to live under budgetary controls established by the executive branch of the Government and divide resources properly among the three departments in the Department of Defense.

Eniwetok was naturally a great experience with the use of nuclear weapons, but it was also a great educational experience to have these seminars each day for some 15 days that we were at Eniwetok.

C: During this time, was there any speculation as to the outcome of the French involvement in Indochina?

M: At this time, no. The French involvement was so complicated--remember President Roosevelt was committed long before World War II started to the abolition of colonial empires--British, French, Dutch, German, Italian.

C: And of course, the Portuguese.

- M: Yes. After World War II the State Department was still committed to the dissolution of colonial empires. Here was France trying to reestablish itself as a world power through its colonial empires. France didn't receive a very sympathetic ear at a high level of the United States Government. This was reflected then down among those of us who were special staff officers in the various fields of activity.
- C: If we can move ahead then, before I ask you any questions concerning your 1958-68 activities as first a member and then chairman of the Air Reserve Forces for the Medical Advisory Council, is there anything that you would like to add to this particular period of time, the early 1950s?
- M: In the early 1950s each of the Surgeons General--that was General Grow, General Armstrong, Major General Ogle, General Bohannon [Lt Gen Richard L.], and General Niess [Maj Gen Oliver K.]--all appointed me as a mobilization assignee to the Office of the Surgeon General. My title varied from Assistant Surgeon General to consultant in anticipatory planning. I say that because fundamentally I was interested in war planning with the medical service. You can imagine, as a Reserve flag officer, for me to come on duty meant that I succeeded whoever was there in command of a hospital or a unit because of my rank. By using me as a consultant, I could move into overseas commands without taking anybody's place. The same thing in the United States. I could go to a headquarters of SAC or a headquarters of Air Defense, and there was never any question of my assuming medical command, nor was there any question that the officer who was assigned there was in command. He did not control me, and I did not control him. I was more or less a consultant sent out as a special officer from the Surgeon General's Office. Also,

having had top clearance of the highest quality as Assistant Secretary of Defense, which is higher than top secret, the Air Force could maintain my clearance and update it every year or more frequently. I arranged for an officer in the Surgeon General's Office to handle my clearance. It was never sent out to me in Columbus because I didn't have a locked safe and I didn't want to go through all the problems of who saw it when it was in my office. So I would frequently, sometimes two or three times a month, fly down to Washington for a couple of hours just to be briefed or attend briefings or to get my security clearance papers for things I needed to know. The result was that when I visited overseas commands I was always invited by the commanding general to attend his briefing any day that I was there. This brought me up-to-date and current with what would normally be called war plans but which were really operational directives and operational responsibilities. Much more emphasis on the line officer's responsibilities than on the medical officer. Many times the medical officers weren't cleared and couldn't attend the briefings. This is not unusual, because when I was Assistant Secretary of Defense, the Surgeon General of the Navy and the Surgeon General of the Army could not be cleared for certain types of security. The Surgeon General of the Air Force, however, was cleared for all types of security except Presidential. You learn to live with it when a problem comes up, what you can discuss in front of those who are cleared and what you can't discuss in front of those who are not cleared. Anybody who is in the military high command knows that there are various reasons why even senior special staff officers cannot be cleared for certain types of security. So it was no problem for me when I was sent to overseas commands where I couldn't have the surgeon accompany me to a briefing of the commanding general. It made me feel that back in

headquarters--and I made recommendations several times--we should spend some time getting our senior medical officers who had command responsibilities cleared for all types of security so that they could participate in the planning of various contingencies. I still think that is very essential.

C: Turning to your position first as member and then as chairman of the Air Reserve Forces Medical Advisory Council, was reserve augmentation of active duty aeromedical evacuation resources in time of war a critical issue?

M: All matters were critical issues because we were having difficulty recruiting Reserve officers--medical, dentists, nurses, biological specialists, financial types who might become medical administrative corps. It was felt having a Reserve policy board with a Reserve officer on full-time active duty responsible in the Surgeon General's Office and a second officer at Gunter Air Force Base [AL] responsible for Reserve activities we would be able to recruit better. The Surgeon General noted that we recruited new graduates and members of the faculty at Ohio State better than probably any other medical school in the country. So it was probably just logical in his thinking--I never asked him why he did it--that I should be the chairman. I was the ranking officer of the Reserve. The only other Reserve officer at that time who had two stars was Dr. Wallace Graham [Maj Gen Wallace H.], who had been physician to President Truman and his family and was a surgeon in Kansas City. I am trying to think if we had any brigadier generals at that time, and we did. We had two at that time in the Reserves, so there were two slots for two-star generals in the Medical Reserve and two slots for brigadier generals. Our recruitment problem was primarily at the level of a field officer, major or

above, because the commitment of a chap who is independently practicing medicine is very great. He volunteers to agree that when the flag goes up he will leave everything at home and come on active duty. He is literally deserting his patients. He is deserting his family. He is stopping his level of income which affects both the nurses and the secretaries in his office and his own family the day he comes on active duty. If he comes on active duty, he is going to have to have two households, the one where he was, where his office is, and the household where he is assigned to active duty. These are problems that are very difficult to sell. To the Reserve officer who comes on and is a weekend warrior and gets to fly, there is some special remuneration. He gets to fly, and he wouldn't be able to do this--he wouldn't have electronic and weather equipment for his private plane. But when I try to sell this program to the doctor, what do I have to offer him? I realize that President Kennedy [John F.] said, "Don't ask what we can do for you; let's find out what you can do for your country." If there is a patriotic cause or a crisis, that's one thing, but when it is simple economics, even for a 2-week tour of duty, it is another thing. It is very difficult to get the average physician to come aboard. He had a take-home pay income back in the 1950s between \$70,000 and \$90,000 a year. Suddenly he is going to be reduced in his income, but the expenses of his office and his home in the civilian sector will still go on. His patients fear that he will go away and leave them so they try to find somebody else to go to. It's a very difficult problem, much more difficult in the Medical Corps recruitment than in any other.

C: Really, the business of having Reserve personnel for aeromedical evacuation is just a sidelight of that. If we don't have the doctors to begin with, it is kind of ridiculous to even talk about evacuation.

- M: It makes a good selling point, particularly when an air evac plane can be brought in every 3 or 4 months to have demonstrations and television and local newspapers get pictures. We have air evac ambulance planes essentially for propaganda. Militarily there is no reason for them. Propagandawise there is every reason in the world to have air evac planes--in peacetime.
- C: Was the general feeling in the 1950s that if we were to have adequate medical care in a war emergency we would literally have to go back to the old tried and true procedure of drafting doctors?
- M: I don't think that has ever been changed. The actual number of doctors who were drafted was small. I can remember five cases where doctors were brought on duty as enlisted men because they didn't volunteer. The threat of bringing them on active duty is very great. In each of those five cases, they went to Federal court and lost at the level of the Supreme Court their contention that they were losing their civil rights because they were being forced to come on duty as enlisted men when they were entitled to a commission. I think it was very fortunate for the forces that we never weakened on that. If a physician had to be drafted, then he had to go through basic training the same as any other enlisted man. It was only after he had demonstrated his goodwill that he could apply for a commission as a medical officer.
- C: Jumping ahead a little bit, you conducted a special study for the Surgeon General between 1965 and 1967. What were your conclusions on medical education and medical services in the Systems Command, if we can use this then to contrast findings in the 1960s with what was generally true in the 1950s?

M: The big reason for this study was the fact that to maintain graduate medical education in military hospitals required a distribution of disease and injury factors that was not always available. Certain specialties were very limited. Likewise we were promising these young doctors that if they took a residency and then came on active duty they would be called in their own specialty. This wasn't what the Armed Forces needed, a group of specialists that could not be used for other things. There was great dissatisfaction--for example, neurosurgeons were assigned to the outpatient service, particularly at night. They objected to this. They were there to do spinal cord and brain operations. Orthopedic surgeons felt the same way. They were there to do bone operations. We oversubscribed to our residency program projected 4 or 5 years ahead as to how many of these specialists in each category we would need to call to active duty. When we didn't call them to active duty, then the other doctors--the internists, the cardiologists, the pediatricians--all objected to the fact that we weren't calling people to active duty who were in the high income bracket, and they were being called to active duty because we were taking care of "dependents." These were problems that were very serious with the Reserve forces and with the regular duty people--how to control the training of specialists who would then serve in Air Force hospitals, how to assign these people and still stay under the military law that said if your military occupational spec showed that you were malassigned, after 4 months you were to be relieved.

The juggling between overseas theaters and the Zone of Interior was coming along. At this time the Air Force was just coming into its own with "Air Force medical centers," which had residency and educational programs. Everybody wanted to get a free ride at a good salary to be a resident.

The point was if we educated them in civilian hospitals rather than military they had no feeling of belonging. It was the same thing if you sent Air Force people to Navy or Army hospitals--they stuck out like a sore thumb even when they had to put their uniforms on. They had no inborn esprit de corps for their parent service. As a medical educator and dean of the College of Medicine at Ohio State, the Air Force Surgeons General--Armstrong, Ogle, Niess, Bohannon, Pletcher [Lt Gen Kenneth E.], and Patterson [Lt Gen Robert A.]--all used me as their advisor. I held positions in the Association of Medical Schools where I could represent the military thinking in some of the things that were being decided as to the requirements for training and the certification for training.

C: Do you feel the School of Aerospace Medicine received the funding it needed for its programs? Were certain areas curtailed unfairly due to the lack of funds in light of what you are saying concerning this maldistribution of talent?

M: Philosophically any medical academic unit should have patient care, research, and education. To talk about the School of Aerospace Medicine, the funding gets down to how much we are going to put into education, how much we are going to put into patient care, and how much we are going to put into research. By what the name implies, there should be a weighing of research funds and support at the Aerospace Medical School. On the other hand it's a military school, and the academic program has to be both military medical and medical scientific. So when one talks about the funding, it's very difficult to differentiate between necessary research for the future and research in the military and medical programs of the current operation. Command surgeons want preeminence for the military and medical operations.

The research people want to be free to go into various fields, sometimes duplicate other Government agencies, but project that ahead to what they are going to need 10 or 15 years from now. This becomes very difficult when we have a budget for the next 2 years and research people want to spend money for the next 15 years. This is true in all branches of the military, and it isn't just medical.

At what point is research necessary? From a Government standpoint medical research was financed and supported by, at that time, the Health, Education, and Welfare Department. They got the money to support research. They did not want to give this money to the military. They did not want to give this money to the Veterans Administration. So the military and the Veterans Administration were going into Congress under defense budgets asking for research money, which sometimes was confused with the research money that they had been asked to appropriate for HEW and the civilian sector. Whether one was doing clinical research or basic research, the same held true. Basic research is sometimes very hard to define as how it fits into a systems concept in the military force and how it fits into daily operations. Clinical research can fit into daily operations, but one has a hard time justifying it because it duplicates the clinical research of the civilian sector or the public health service. To answer your question, were they hurt by lack of funds, I think the present political situation in which the President is trying to get the military back into a financial program that will support the goals of our international life indicates that in earlier periods we weren't getting enough money. If you didn't get your promotion and you didn't get a pay increase, you would probably agree with me.

C: There are a couple of minor questions that I want to ask. One is concerning Cold Dove, which was the special plan published in August 1967 for the emergency augmentation of medical personnel with Reserve forces. There was a chance to exercise that after the Tet offensive in February 1968. Would you care to comment on that, first as a concept and then in actual practice?

M: I had no responsibility for that. I think it would be wrong for me to comment because I didn't have responsibility, and I wasn't in a position to spend time learning why it was developed, what its goals were, and how effective they were in achieving these goals. So I would like to pass that one.

C: All right, sir. You took some courses at the Air War College in 1966. Could you evaluate those courses from the point of view of a student looking at it as a competent course of instruction and the courses you took at Sandia [Base NM], Cape Kennedy [FL], Vandenberg [AFB CA], and Patrick [AFB FL]?

(End Tape 11, Side 2)

M: I thought the courses at the Air War College that were given for general officers of the Reserve were exceptionally good. We were briefed by top intelligence officers as to the current situation and what was projected in international relations. We were briefed by operational officers as to what we could anticipate in new systems and new dogma. We were not only briefed by senior commanders and the Chief of Staff, we usually had a briefing team with us for 2 days from each of the major commands, such as TAC [Tactical Air Command], SAC, Air Defense, as well as the European and the Far East commands. In 2 weeks you were brought up-to-date

so that if you continued your own reading in this you had the opportunity to continually know where you and your unit were going to fit into war plans. I rated this very highly, and I think the other generals that came to it--many of us came repeatedly. I remember General Doolittle, who was then a lieutenant general in the Reserves, said, "This is the best way that has ever been conceived to update one in his military career." I felt that way. I certainly did not have the military background that General Doolittle did as a theater air commander.

With regard to the courses at Sandia, Kennedy, Vandenberg, and Patrick, we were given likewise superior instruction in nuclear weapons, in missiles, and we actually visited the silos and other things that go with this type of military operation. We learned the hazards of escaping nitrogen in the silo, of escaping fuel, of rupturing the skin of the missile and so forth, so I would say it was very important for all of us who were Reserve but had senior rank and senior administrative positions. I don't recall any briefing that was given us at any of these places that wasn't technically and militarily of the highest quality. The exhibits, the observations, and so forth were superior.

At places like SAC Headquarters and at Air Defense Headquarters and later during our visits to command posts, several of us were given mobilization designee slots at the command post. Through briefings and through limited maneuvers, we were able to visualize how we would function if that command post were activated and we were sitting in a specific chair. I think you fully appreciate that a command post is only as good as the teamwork therein. We had an opportunity to handle electronic equipment that we would necessarily be handling every minute every hour if we

were suddenly called to active duty. Our opportunity to see what the Navy and the Army were doing with command posts was excellent. The interservice staff officers that we met through these courses gave us a very good understanding of concepts and nomenclature to understand each other when we tried to communicate. I think these were very, very beneficial, and I am still disappointed that command post exercises are no longer conducted because of lack of funds. I don't think one can assume that people are suddenly in a couple of hours going to be able to take over and function in a command post if they have had no previous temporary duty with it.

C: Before I ask my final questions, as we discussed during the break, there are a couple of items that you would like added to the transcript at the appropriate points. The first of these, I think, would have to do with an amplification of the controversies that we talked about in 1942. The conflict between the Surgeon General and the Air Surgeon was not necessarily just those small portions that you discussed, but it involved something larger than that. I believe you illustrated it by your experience with Twentieth Air Force.

M: My experience with Twentieth Air Force was much later in 1944. When General Arnold was made Commanding General of the Twentieth Air Force, he had, at Marshall's request, in 1941 been made one of the members of the Joint Chiefs although he was under Marshall's command. He was a coequal on all the Joint Chiefs' activities and later on the Combined Staffs when England had representation. How was he to command a unit that normally would be sent to bases in a specific theater? His concept of the Twentieth Air Force was that it was worldwide; therefore, he did not want his Twentieth Air Force bases under the control of the theater

commanders. He didn't even want the theater commanders to make decisions as to target selection. The order establishing the Twentieth Air Force and General Arnold as commanding general was so broad that it said "everything" was under his command. General Grant was named Surgeon of the Twentieth Air Force. A-1, A-2, A-3, A-4 of the Air Force were then named A-1, -2, -3, and -4 of the Twentieth Air Force. Operationally, as the wings were established, they reported back to Twentieth Air Force rear headquarters, which was Headquarters of the Army Air Forces. General Grant recommended to General Arnold that I be appointed the Assistant Surgeon of the Twentieth Air Force rear headquarters. Col Harold H. Twitchell was a medical officer assigned in forward headquarters. Colonel Benson was assigned to one of the wings, the first wing that went into India, the China-India-Burma area. We developed a staff study for General Arnold as Commanding General of the Twentieth Air Force showing why he should have numbered station hospitals attached to the bases and not under the command of the theater commander. Remember at this time, there were nine corps areas in the United States, and their surgeons were responsible for "hospitalization in the corps area." The theater commanders and the district commanders were responsible for hospitalization in their area. Suddenly by using the command vehicle of the Twentieth Air Force, one had the possibility of circumventing medically this command organization and putting the Air Force medical services under the Commanding General of the Twentieth Air Force outside the continental United States. General Arnold approved; the Commanding General of the Army Service Forces disapproved; theater commanders disapproved. It never came to actually a turndown at the War Department staff level; that would have sent it to General Marshall. But General Arnold saw to it that we shipped equipment to maintain

enlarged dispensaries with the base units of the Twentieth Air Force, which in reality were the same as numbered station hospitals. They just didn't have a number, and they weren't called station hospitals. They were called Twentieth Air Force Medical Facilities.

Let's go back a little bit to the situation in 1940-41-42. The Surgeon General was General Magee. He did not understand fully what the War Department was planning in the way of reorganization. When the Army Air Forces were established in 1941, he continued to talk of it as the Army Air Corps and the Army Air Division, the concept that had prevailed in the Army and the War Department, that one had corps--Artillery Corps, Infantry Corps, Armored Force Corps, Quartermaster Corps, and the Medical Corps. This involved a great number of things. As we went into the full spirit of mobilization and then Pearl Harbor occurred, the War Department came up with War Department Circular 59, 2 March 1942, designating three components of the War Department. The Army Ground Forces were responsible for all training of ground forces. Under the Army Ground Forces, there were four armies established. These were later to be shipped to overseas theaters. The Army Air Forces had all the aeronautical activities, and the Services of Supply, which later became the Army Service Forces, provided all the support for the other two agencies. They did the purchasing, they had control of transportation, and they assumed that they had control of hospitalization and evacuation. They set up a separate medical division within the Army Service Forces. So suddenly the Surgeon General, although he was a special staff officer to the Commanding General of the Army Service Forces, found that he had duplicating divisions under Col William Wilson's [Brig Gen William L.] Medical Corps with regard to procurement of

supplies, storage of supplies, distribution of supplies, hospitals, patient transportation, and medical regulating officers. The Surgeon General did not accept this as anything he had to comply with. He found it difficult even to coordinate with it.

The Army Ground Forces began likewise to develop a separate office for medical personnel and medical training. Immediately a conflict developed between the responsibility of training of the ground forces and training responsibility of the Army Service Forces. The Air Force maintained they had their own responsibility for training. So it wasn't just a difference of philosophy between the Army Air Forces medical officers and the Surgeon General's Office; it involved almost the entire War Department. Because of this we had the appointment of Mr. Tracy Voorhees, a New York lawyer, who was commissioned a colonel in the office of the JAG and assigned responsibility for legal contracting affairs of the Surgeon General and the Medical Department. Because most of the legal affairs involved contracts for supplies and equipment, he became an authority on all medical supplies and equipment. It became evident in 1942 that a shortage of equipment existed that was needed for overseas. The Surgeon General said the reason they didn't have equipment was because the White House was demanding that they meet lend-lease requirements--litters for Yugoslavia, medical supplies for China, et cetera. Everything that you could possibly think of was depleting the war supplies prior to our entry into the war. The Army Surgeon General advised that there was a great possibility of epidemics during mobilization because of the crowded barracks. He sent many a memorandum all the way up to General Marshall that one couldn't mobilize this fast because you couldn't put so many people into a single room in the barracks. He got into difficulties with the Public

Health Service over venereal disease, not only how to prevent it but how to treat it. He got into difficulties with civil defense because he was planning in case of bombing of the United States to take over hotels and make hospitals out of them. In the opinion of the Director of the Civil Defense, this was a civil defense responsibility and not a military responsibility. He had a lot of trouble with personnel recruitment. The lay public would write their Congressman that Dr. So-and-so was being taken out of their community and they didn't have any other doctor. So Congress was involved. The Surgeon General failed to make adequate provision for the recruitment of female MDs, Negro MDs, osteopaths, and chiropractors. Each of these groups was using the public media. The result was that the Army Service Forces decided that they should have "an investigation within the Army Service Forces of the Medical Department." General Somervell, the commanding general, went to the Secretary of War. This was in September 1942, prior to the North African invasion. The Secretary of War appointed a committee chaired by Colonel Wadhams [Sanford H.] and had one other retired Medical Corps officer, Colonel Keller [William]. They had the dean of Tulane, the professor of surgery from Washington University, the dean of Johns Hopkins, and several other civilian doctors and one dentist and Mr. Covington Gill, who was a War Department consultant and who in the preceding 6 months had been extremely critical of the failures of the Department of Army to provide adequate medical plans to meet mobilization. This group heard many military, civilian, and medical leaders. They finally came up about the end of November with a report, and there were 95 things that they recommended be done.

It soon became evident that the Army Service Forces wanted to get rid of the personage of General Magee. They had a candidate to be the new Surgeon General. They didn't know that General Marshall had a candidate, and they didn't know that Secretary of War Stimson had a candidate. The result of all this was a considerable reorganization of the medical services within the total War Department. That involved the Army Air Forces, the Army Service Forces and the Army Ground Forces. When you realize that all these things were going on, the friction between the Air Surgeon and the Surgeon General was just one of the numerous aggravations. The Army was attacking the Army Surgeon General staff. Of course, the result was when General Magee's time was up in early 1943 General Kirk was appointed the new Surgeon General. He took issue with the Wadhams Committee report, and he immediately attacked. This is my personal opinion. It is my impression that he took the position that he couldn't attack the Commanding General of the Army Service Forces because he was a special staff officer. So the thing to do was attack and try to destroy and absorb the Army Air Forces medical services. The result was that, I think, most people still today recall this as General Kirk trying to eliminate General Grant. Various things happened, such as a War Department directive saying that a surgeon couldn't do surgery if he were assigned to a building that had the words "station hospital" on it and he was in the Army Air Forces. It didn't make any difference about his personnel, about his professional training, about his capabilities. It was what building was he assigned to? This then led to what we have already described about President Roosevelt's getting involved personally in this difficulty and sending Dr. Strecker with General Grant and General Kirk to England to investigate what had been reported as the lack of adequate medical care of the airmen and the aircrews of the United

States Army Air Forces assigned in England; namely, the Eighth Air Force.

It was then while they were gone that the deputy chief of staff to General Marshall assigned General Kenner for the Army and myself for the Air Force to write a War Department directive, which later became Circular 140, providing definitions of what the Air Force could have; namely, they couldn't have general hospitals, but they could have an Army Air Forces regional hospital. They could staff a regional hospital to do anything that a general hospital could do. They could have convalescent hospitals, which could take large numbers of patients and particularly patients back from overseas, and they had station hospitals, and they had air evac hospitals. We still did not have official permission to have facilities in overseas theaters, but the Air Transport Command [ATC] had hospitals assigned to them, and they were supplied and reequipped because they were handling patients moving on the Air Transport Command routes worldwide. Twentieth Air Force had facilities that were in named dispensaries but were the equivalent of regional hospitals as far as their staffing was concerned. If the reader understands that this was not two men having a professional fight affecting the war effort but really a difference of philosophy in which the Surgeon General and his staff--in the words of General Lutes [Lt Gen LeRoy], who was Chief of Staff of the Army Service Forces, "They never understood the organization of the Army into three components. They never understood the role of the War Department General Staff. They never understood how they could be part of war planning and prepare the annexes for war plans." He felt in his various statements that the medical officers assigned to General Magee were so fixed in their ways that they couldn't even imagine how a new organization would function.

C: You felt that was a fair assessment?

M: Yes, I think it was. I very definitely think it was. You can argue the pros or cons of all the arguments we used that the flight surgeon was the only one who could decide whether a flier was sick or psychiatrically impaired. We used the flight surgeon as a vehicle to gain what we hoped to be a command decision in which the Army Air Forces had its own medical service.

(End Tape 12, Side 1)

C: Another question to be added, as appropriate to the transcript, was concerning your impressions of the high-ranking Nazi officials you interrogated at the end of the war.

M: Unless one has been there, it is very difficult to visualize what happened at the end of the war. I am talking about from 1 May 1945 onward. The German Government and German leaders, both military and civilian, if there was such a thing as civilian, were scattered over Germany. Some had gone up to Emden where Admiral Dönitz [Karl] established the continuation of the Reich. Under Hitler it was the Third Reich, and for maybe 6 days, there was a Fourth Reich. Others like Göring had gone to Berchtesgaden. Others were actually in Berlin up to the time Hitler committed suicide, which I think was 27 or 28 April.

C: The Goebbels family principally among them.

M: Yes. Himmler [Heinrich] was found near Hannover, and he committed suicide by taking cyanide within an hour of the time he was captured by the British. They began to pull

these people together, depending on the level of their authority, in two camps, one near Bad Nauheim, which was called Dustbin, and one in Monheim, Luxembourg, at a health resort. It was called Ashcan. Monheim was something like Sulphur Springs, a big hotel, gracious gardens, fountains, the waters for cure which were so popular in Europe. They moved a combat infantry group and an MP [military police] unit in there. They took out all the windows in the hotel; they took out all the mirrors. When a prisoner was brought in, he had to put his glasses on a big dining room table in the main lobby, and a tape was put down with his name on it. This was wonderful for the prisoners because then they knew who else was there. Everybody had their glasses lined up. Don't ask me what the Americans thought when they figured this one out. It was claimed the prisoners might attempt suicide by cutting a blood vessel.

This whole health resort was then surrounded by two high-wire fences with enough space between them to drive a jeep. At each corner there were three tanks. Then outside there was another ring of tanks. The prisoners all ate in the same dining room, the same food; they were not allowed to wear their insignia, but they could wear their uniforms. There isn't anything, in my opinion, that causes a person to lose confidence in himself more than to be suddenly deprived of his responsibility. We would see people like Streicher [Julius], who was the Jew baiter of the Nazi Party from Nürnberg. He would stand on the terrace or on the porch, and he would give speeches. He would throw up his hands like the crowds were calling him. The rest of them all said, "Well, he was crazy when he was in office, and he is crazy now."

C: He felt it his responsibility to continue that role.

M: Yes. Göring was a very interesting character. I had known Göring early in my student career in 1932 in Erlangen, and then in Munich in 1936, I had gotten permission from Göring to do medical research utilizing animals. I had known him early on as a typical fighter pilot, cavalry type, hail-fellow-well-met, everything is wonderful today, tomorrow will take care of itself. As you may recall, when he came to power, he built a memorial home called Karinhall for his Swedish wife. He robbed France and Italy of all types of art treasures. He had some of them in his lavish homes in Prussia and also down in Berchtesgaden in Bavaria. But he also had some mines in which we found truckload after truckload of art objects, which he and his staff just apparently gathered to be doing something. They didn't display them. They were very careful that there wasn't any moisture in the mine. He used the best mining engineers to provide these hideaway places. He was greatly overweight, and he arrived at Ashcan with an aide, a major, and with an orderly, who was a sergeant. The sergeant was carrying his medical case. That medical case had seven upright areas, and in each one of the seven compartments, there was a little drawer for each hour of the 24, beautifully made, inlaid, and in these were the medicines that he was supposed to take, including those of an addictive form. Within 3 days of the time he came to Ashcan, they had started to wean him off his medications. The further he proceeded on therapy, the better he was, the clearer he was, the more positive he was, the more he emphasized the fact that he was a German, that he was a Prussian Army officer in World War I, that he had the highest decoration that the Kaiser could give. He was abusive in his comments in questioning of some of his top staff officers in the Luftwaffe.

C: Did he have anything to say about Milch [Field Marshal Erhard]?

M: Yes. He made the statement to one of the American interrogators that Milch was half Jew so why should they blame me for what happened to the Jews I protected? It seems that Milch *did* have a grandmother that was half Jewish. Richtofen [Wolfram von] and some of the others that he talked about were just amateurs compared with what he did. Remember his real power was Minister President of the Reichstag. He was also Minister President of Prussia, which is a much higher title than a governor of one of our states, but it functions as the same thing. Prussia was a much more organized bureaucracy than any of the other German states, like Bavaria or Saxony or Wurtemberg. When he was brought in to me for interrogation and I had planned a 2-day session, he came in--he was in his field marshal uniform of the Luftwaffe.

C: It was a light-blue uniform, I believe.

M: Light blue with white facings and large white stripes down the outside pant leg. He was brought in by the guards. I had an American sergeant with me who was supposed to act as my interpreter. I was wearing no insignia of any kind. I had on wool khaki military shirt and trousers. He came in the door and stopped in front of my desk. The sergeant said to him, "The prisoner will give his name, rank, serial number, and the last position he held on active duty." Göring drew himself up, looked at me and said in German, "Doctor, the last time you and I met, we didn't need an interpreter. Do we really need an interpreter today?" Well, my cover was blown. My sergeant didn't know that I had had anything to do with Germany in the period 1932 to 1938 when

I was there in medical school. He didn't know that I knew Göring; he didn't know that I knew several of the other prisoners that we were going to have. We had Mr. Göring sit down, and the two of us withdrew. I explained to him that he could sit in on it but he wouldn't ask the questions, I would ask the questions. He said to me, "You know, Colonel, I am worried about something. I meant to tell you. All these interrogation rooms are wired, and we have the feeling that somehow the Russian and French interrogators have compromised several of our interrogation rooms; I think this one is compromised. I think you would do better to take him out into the garden and sit in front of one of the fountains, because to the best of my knowledge, there is no way to pick up a voice with falling water in the background." Well, that was great with me.

We took him out, and he and I sat there in very comfortable chairs and we talked. Very little direct questioning as I have said. We were taught not to ask a question that could be answered by a yes or no. I tried my level best to get him to talk about what he would do if he were to be in a position such as he had held before or had anticipated he would hold as the successor to Hitler. What were his plans? It was at this time that we found out through both Göring and Speer there was a very definite plan for postwar Germany. We found out that Dr. Karl Brandt was planning new hospitals and new medical faculties to meet the needs of the bombed out areas. We found that housing programs were well along and developed. As long as Göring was talking about what he the patriotic German would do, we had no difficulty in having a flow of conversation. My sergeant was taking a lot of this down in shorthand, and I was making notations. We broke every hour, and I would have the guards take our prisoners to the toilet; I would go to the toilets. We

offered them coffee or tea. Göring would not drink from the cup of tea that was brought to him or the cup of coffee until I took the cup that he had and put it over at my place and put mine in front of him. Then he would drink. He was very suspicious. He was extremely positive that we were going to fight Russia. It came out directly and indirectly over 2 days of questioning. I would say that by the time he had been off drugs for almost 15 days, he was very coherent about what he thought the problems were going to be in the future.

When we talked to him about the members of what we Americans called the Nazi Party, which was the Hitler Party, he had very little respect for them. I had been requested not to ask him about the execution of Röhm and the others in 1934 because the interrogators that were coming in to find out what they could do about the Nürnberg trials did not want that subject discussed under medical affairs, and I thought that was a reasonable answer. He was polite. I asked him if there was anything that I could do for him. That was one of the things we frequently used, because these people had not had any telephone contact or personal contact with their families. He told me where I would find Mrs. Göring, and he said if I would be so good as to just tell her that he was alive, that he was still a good German, and nobody would ever change him from that, why, he would be appreciative. I assured him we would try our best to find her and if we did we would see that she got the message, which we, incidentally, did. We did that with many of our prisoners, both military and political. So much for Göring.

Ribbentrop, who was the Foreign Minister, was arrogant to the point that I concluded from my discussions with him that he was intensely afraid. He brought out several times that

Mussolini had his son-in-law, Ciano [Count Galeazzo], executed. I thought he had great fear. He was to be interviewed by the Russians, and he tried to find out from me what the Russians would do; would they be allowed to torture him? He was the only German prisoner that mentioned that, that he expected the Russians to try to torture him. Would the English and the Americans allow that to happen?

The Russians did not interrogate during the day. They liked to interrogate from about 6 o'clock in the evening until midnight. Then they wanted to have a full dinner served for them, and they wanted company, and they thought we should provide American women officers to dance with them, to drink with them, to eat with them, and they thought people like myself should stay up and have dinner. I didn't, and this was very impolite. The thing that interested me most was that the Russians would ask every one of my prisoners who I was. Had they known me before? What questions was I asking? Several times the prisoners did not tell the truth about what I was asking, and the Russians said, "We know what he said; we know what you were asked." It gave you insight into what we were dealing with with the Russians. In the private conversations we found the Russians thought the idea of the trials that occurred at Nürnberg a year later were so much propaganda for the Americans and that they had no meaning. The British were not too enthusiastic, and the French were not enthusiastic at all about what would happen out of the Nürnberg trials or trials of that type.

I had General Schroeder, the senior medical officer of the Luftwaffe, who was also president of the German Red Cross and who had studied and taken his PhD at what was then Western Reserve Medical Faculty in the 1930s. He was a charming gentleman, a very talented professional man. He

was very ashamed to admit any knowledge of the cold water experiments in which concentration camp people were used as animal experiments. He did admit that they had sent a message to the SS doctors at the concentration camps that they would like to know how long a flier could be in the water before he became unconscious due to cold. And yes they did take that information and put it into the construction of their flotation jackets to keep the head and the base of the neck out of the water. That information we had gotten through other sources and was used out at the clothing and equipment lab at Wright-Pat during the war to design our own flotation collars.

Handloser [Gen Siegfried], who was the senior medical officer of the German Army, was a very correct 65-year-old Prussian officer. He asked if he could have his monocle while we were interrogating him. I said, "Certainly you can have your monocle." It was very interesting. When he got his monocle and he could see and he had a pencil and paper and could write things down, he became much more cooperative and really participated in the questioning.

Admiral Dönitz was another typical Prussian officer of the Navy. He was gracious, correct, always emphasizing that he was a German not a Nazi, that he was not a member of the party, but yes he did go to party functions, and yes the party had made it possible to rebuild the German Navy and the German Submarine Corps. On medical matters he almost invariably, even with regard to submarines, referred that to his chief medical officer. He said, "He is someplace in camp." And he was. We had him up at Dustbin rather than at Ashcan, and he did provide us with a lot of information that we wanted about the pressurization in submarines.

Karl Brandt, who was the senior medical officer of all Germany, held his commission in the SS. When I had been a student in Munich, he had been an assistant professor of surgery specializing in hand surgery. He was very, very talented. I watched him operate many times. He left Munich and went to Essen where he became chief of surgery in the big hospital for mine workers. During 1933, he became engaged to a young woman, who later became his wife, and she was a champion German swimmer, held all the German records in swimming. She was invited to go to Hitler's home in Berchtesgaden for tea. She asked if she could bring her fiance because they were on a vacation in the Bavarian Alps. They went to tea, and while they were at tea, a message came in to Mr. Hitler saying that his adjutant and bodyguard, Lieutenant Brückner [Wilhelm], of the SS had been in a serious accident at a nearby town called Traunstein and they didn't expect him to live; there was no qualified surgeon there to take care of him, what should they do? Brandt said to Mr. Hitler, "I would be very happy to go and see if there is anything I can do." He did, and he operated on Brückner and saved his life. Mr. Hitler and Brückner and all the others were very appreciative of this. They decided that when Hitler traveled in his special train, or airplane as the case might be, but mostly in the train, he needed to have a personal physician, what the Germans called a Begleitartz. The only way that they could do this was to give him rank in the SS. Brandt was not a member of the party at this time. He counterproposed that he was willing to become Hitler's physician, but he didn't want to sit around and do nothing. So his roommate in medical school was also in the Hamburg area, and they had a third one--and I can't think of their names right now. They were all good surgeons and all specialists. They made the agreement that when Hitler left Berlin, for example, to go to Cologne one

of these doctors would go with him and when he got there the other doctor would go on to maybe Munich. So one of the three was always with him. They advanced in the SS. They took their military training because they were in what was called the Waffen SS, and they came up the ladder rather rapidly from that position next to Hitler even before the war started. On the way into Vienna, Brandt was with Hitler. It was very interesting to hear him tell about the mechanical breakdowns and how the Germans went into Vienna with a very, very small unit of armed forces, because the armed forces couldn't keep up with the movement.

C: The tanks were breaking down along the road to Vienna.

M: Yes. He also told me that when they went into Vienna and later when they went into Czechoslovakia they had no medical supplies and they had to go into the civilian drugstores to get medical supplies. He said that he did not even have medical supplies for Hitler's train at that time. By the time they went into Poland, though, that had all changed.

(End Tape 12, Side 2)

M: We were talking about interviews with General Brandt, who was the top medical officer of all Germany and a Waffen SS general. In talking about the campaigns in Poland, he felt the Germans had learned from their experiences going into Vienna, going into Prague, and their experiences in the Spanish War. He had been in Spain during the Spanish War. He and I talked at some length about the air evacuation of military patients from Spain to Germany, and he remembered distinctly--at least he said he did--my assignment to the surgical wards where these patients came in to the university hospital in Munich. I asked him about Russia

particularly. He said, "The one thing is, don't underestimate them. Their equipment is about the same style as you would have found here in Germany in 1903, 1908. Their X-ray tubes on their X-ray machines are exposed; therefore, the operator of the machine is exposed to radiation. But you will find their X-ray plates are as good in detail as anything we have. We found no new drugs of any kind in any of the Russian hospitals, military or civilian, that we overran." He stressed the fact that although he thought one should respect them one shouldn't fear them the way the Germans at home did. He said, "The other thing is, don't ever trust them, whether they are doctors or whether they are scientists or whether they are military people. They do not have the same attitude toward what is truth and what isn't truth that the Anglo-Saxon has." We concluded then by having him take a typewriter to his room, and he typed up some 95 pages of plans of how to reorganize German medical facilities and sectors after the war. He sent me to two architects in Hamburg who had the actual planning and design papers. I went to see his wife. They had no children. As a matter of identification, I talked to her about their dog. He had told me certain things that only he and his wife knew about the dog. This was the identification for her that anything I asked of her she was to try to help me find, and she did. She led me to several places and to several people that I wanted later to interrogate. I felt my interview with Karl Brandt was perhaps the highlight of all my interrogations. It was sound; it lasted quite sometime, and I gave him typewriter and paper and got the commandant's permission for him to work at night putting this together in his own words. Again, the same thing the British had taught me, get the prisoner who has been a very important person to again have some responsibility, and he will give you a lot of information that you would never get by questioning.

One evening I came back to my quarters, and I found two Russian female doctors in my room. I asked them in German what the hell they were doing in my quarters, and they said they were having menstrual cramps and they were sure that I as a doctor would have medicine. I said, "What makes you think I am a doctor?" "Oh, we have gotten that from the German prisoners that you have been talking to. We know all about you." I said, "That's interesting. Did the prisoners actually tell you who I was and what I was?" "Oh, we know you are a lieutenant colonel. We know that you are an American doctor. We think it would be very nice if you joined us this evening for dinner, and maybe we could do something after." I had never been propositioned quite so openly by people in uniform. At any rate it bore out more than anything else my feeling that in dealing with the Russians you had to take your position and not compromise in any way because any kind of a compromise they could work with you they would exploit.

We had other prisoners. I had Schacht [Hjalmar], the Minister of Finance, at my headquarters down on Lake Starnberg. I had Pastor Niemoller [Martin], who was the Protestant clergyman who opposed Hitler in Berlin before the war began as well as after the war. We had a wonderful opportunity to explore with these people in their language what they thought and what had happened to mislead an entire nation into what seemed to be a recognizable disaster before it happened. Several things were said; namely, "Mr. Hitler solved unemployment. He gave us the autobahn. We had a return to respectability. Our military forces were again recognized. It was an honor to be a member of the military." I said, "But what about all of the negative sides? How do you justify the concentration camps?" In discussing it with them, they said that the concentration

camps were factories. The only way a prisoner in a concentration camp at the lower level--there were five classes of prisoners in the concentration camp--the only way he could eat was to go to work. If he got sick and couldn't go to work, he starved to death or became so debilitated that he died. The inmates were a means by which they could solve their need for workers. They utilized slave labor--French, Russian, Polish, and then when they could no longer supply food and things like that, the first people to be cut off were the people that should have been fed at the factories. The factories were shut down because there was no way to get raw material in. It was an interesting approach to a horrible situation. If you saw the end result of the prisoners in the concentration camps being released, it wasn't hard to visualize how this came about and what happened to the entire system. This doesn't excuse the policy they had of exterminating Jews. The Jews were only a part of the concentration camps. Niemoller had been 22 weeks in a concentration camp. Schacht had been in a concentration camp for 14 days. They had no contact with the factory or with the Jews or with the criminal element. I talked with some other prisoners that had been at Dachau, which is outside Munich. They had separate quarters, and they had no contact with the mass of prisoners that were in the lower three categories. It is hard to be objective. We are talking 30-odd years after the fact. It's hard to come up with political answers of what motivated this sort of behavior on the part of people who went to church every Sunday, as part of their family life. It is true that the SS, and particularly the Waffen SS, did not go to church. Yet I was the best man in 1937 at the wedding of a Reserve SS officer, and the other attendants were all in black uniform. It was a Catholic church, and it belonged to the bridegroom as part of his castle. The Catholics allowed

the wedding and then reconsecrated the altar and church when it was all over. As best man I was responsible for dealing with the Catholic priest of the village. The bride gave a sizable financial gift to the Catholic nuns who ran the day care center in the village for the women who went out and worked in the fields. I arranged all of that. The Catholic parishioners in the village all turned out for the wedding. It was a high point and a regular parade, if you will. We civilians were in frock coats and striped trousers and so forth.

So in trying to understand them, sometimes we got a little bit astray from what they had contributed in air evacuation. They told about the evacuation of patients by the Russians. Later General Eisenhower was to tell me about his experience with Zhukov [Marshal Georgi K.] when he demanded that Zhukov turn over American prisoners to the American forces. Zhukov said to him through an interpreter, "We don't keep track of anybody until they get to be a major. If a soldier doesn't have his paybook, he can't get paid. A soldier who is a prisoner is of no value to you. Why are you so interested in getting your prisoners of war back? Why don't you just forget them?" Eisenhower said, "I really realized for the first time that their philosophy of life was so different from ours that it probably would never be possible to carry on normal relationships with the Russians." This was a great change from when he saw the Russians as our best ally, because they kept a front going.

That's about all I can say about my interrogations and activities with the United States Strategic Bombing Survey in Germany and in the prisoner-of-war camps we had. I was actually asked by Mr. Murphy if I would not join the American prosecution for the Nürnberg trials. I sent a

cable to a family friend, Senator Robert Taft [Rep-OH], and he suggested that I not participate in this because if they were guilty then their own country should try them. If it was a military crime, the military should try them and execute them, but to have a big show of judicial force based on laws that were passed after the crime was something that he did not think I as a doctor should be involved in. I am very grateful to him because I today feel the Nurnberg trials were not one of the great positive acts of the United States.

Brandt was executed by the Americans. He was not executed by the Tribunal. He went to his death in the prison at Landsberg in Bavaria. He was asked if he had anything to say, and he said, "Yes. I want it clearly understood that I am German, that my country may have been wrong, but it is still my country." They put the mask on him and dropped him through, and he was dead. I don't think Karl Brandt should have been executed. I think he could have contributed greatly to medical science. Most of the things that he did were under Hitler's orders. I realize there are a great many questions about whether the individual has the right to question a military command that he doesn't agree with. In other armies I don't think you would get very far if you did it. In our Army I think your career would be terminated sooner or later after you made that kind of criticism of a direct command. It's well and good to talk about it in the press where you don't have the responsibility for decision. But it's an academic question when it gets down to the reality. If you are in the military, you follow military law. Let's quit for tonight.

C: All right, sir.

(Interruption)

C: I would like to ask my last two questions, sir. They are pretty broad based, and you can answer them in any way. Could you tell me about the leaders of prominence who influenced your career?

M: Starting by seniority, of course, I would think General Marshall. In the days I spent as a young staff officer in the Army Air Forces, I had contact with him. Then in 1950 when he became Secretary of Defense and president of the American Red Cross, I was his Assistant for Medical and Health Affairs, and I was also chairman of the Armed Forces Medical Policy Board. Sometimes there would be four or five conferences a day with General Marshall, and sometimes there might be a day that I didn't see him at all. The so-called squawk box on my desk was the method by which he would curtly say, "Meiling, are you present?" And I would say, "Yes, sir." "I would like to see you." His office was four doors away from my office. Quite by coincidence, when I came aboard in the Office of Secretary of Defense, General Eisenhower was leaving to become SHAPE Commander. For unknown reasons I was assigned General Eisenhower's suite. It was an office, a kitchen, a shower, an office for an aide, and an office for a secretary. So the 2½ years that I was in the Pentagon, I had luxurious office space, and as a member of the Secretary's mess, I met practically all the important military and civilian leaders that came to the Secretary because I usually would see them at our mess.

After Korea started we had to be present about 3 o'clock in the morning so that we could make radio contact with MacArthur's headquarters or the Far East Headquarters in Japan. Weather conditions made it practically impossible

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for us to carry on voice communication with Japan after about a quarter of 5 each morning. From midnight until 2 o'clock, we had static, but from 2 o'clock on we had easy access. The Secretary came in usually at 7 o'clock in the morning. He was briefed on the previous 24 hours, and at 9 o'clock in the morning, he had a briefing that he gave to the President of the United States. He would take along staff officers to present specific specialized programs. So I was with General Marshall many times in the White House for these briefings. The President requested that I be part of his Sunday television program each week in which he answered to the people. I had the anchor position, depending on how much time was left, of telling about the medical affairs in the name of the President as Commander in Chief. Sometimes I would have 3 minutes, and sometimes I might have 12 minutes. We began to put together our program about 1 o'clock in the afternoon on Sunday, and we didn't come on the air until 5 eastern standard time. To watch an off-stage director extending his hands or closing his hands to tell you how much time you were going to have and then drawing his hand across his throat to tell you that you were off the air--many times on Monday mornings at the briefings, both General Marshall and the President would ask more detailed questions of what we were talking about and where we were getting our information. It was sort of like providing the bibliographic background of your story. General Marshall was to me one of the great Americans and certainly the greatest American that I ever knew.

I was a great admirer of President Truman, but I didn't have the relationship with Truman on a day-to-day working basis; I was reporting. With General Marshall, I was working. For example, I would prepare a letter for him to sign as president of the American Red Cross telling us what we could

have in the defense force in the way of globulin or blood plasma or whole blood. Then I would prepare his reply as Secretary of Defense. I would go in to him, and he would look at me and say, "Which one of these letters do I sign first?" To me he was, indeed, a great leader. He wasn't flamboyant like his personal friend Patton. He wasn't the open political mover and shaker that Pershing was. He wasn't an Eisenhower trying for consensus. He could give a direct command, and there would be no questions, but he would always try to find out both sides of the question before he made a decision. These were not prolonged. He rarely deferred a decision more than 2 or 3 days. Usually you got his decision in a matter of minutes. He was always interested in your family. He always had time to ask how your family was. My father died while I was on duty in that office, and a more understanding person than Marshall you couldn't have known. So I had a great deal of admiration for Marshall as a man, as a military leader, as a statesman, and as a great American.

I would mention Gen Joseph McNarney, who was Marshall's deputy when he was Chief of Staff and then became one of his military deputies when Marshall became Secretary of Defense. Joe McNarney was a flier's flier. He was often referred to as the "hatchet man" for General Marshall, but I found him to be extremely fair, extremely loyal, and a very sincere American citizen. He was a no-nonsense military man, as was Marshall. If you had a proposal, it could be 80 pages long, but they would only read what you had on the first page, and you had better present the problem and the alternatives and your recommendation on that first page, or the staff study came back to you. You could have appendices. They taught you very definitely to use anticipatory planning and brevity because they had busy days to read all the papers that came

across their desk. I had trouble with my own staff, getting them to consolidate staff studies so that they could go.

In the medical group General Grow was a very wise and considerate person but also a strong military officer. He did not assume that he knew everything about medicine. He utilized his staff. He picked competent staffs. He could plan as well as any military man I ever knew. Gen David N. W. Grant, who was the Air Surgeon during the war years, was my immediate superior. I first came to him as an assistant plans officer and later became chief of planning and intelligence in his office. Finally I became his special assistant. I also was his assistant in the Twentieth Air Force. He was a very definite fatherly type to me and my family.

(End Tape 13, Side 1)

M: We are talking about my flight overseas accompanying Mr. Hopkins and several other VIPs. General Grant came down to the airport. My wife and 3-year-old son were there, and he picked up my son and took him aboard the airplane and showed him where we were going to sit and then took him up to the cockpit and showed him the instrument panel and let him touch the rudder bar. When we had taken off and General Grant had left, the Secret Service came up to my wife as she prepared to leave and wanted to know what she was doing there and did she know who was on the plane and did she have clearance to be on the apron of the National Airport. She didn't know where we were going. She knew that I was going overseas. One officer said to her, "Lady, you sure are a trusting soul. When do you expect to see your husband back?" She said, "When he gets back. He frequently takes off. I don't know where he is going or when he is coming

back, but that's part of his job." Dave Grant and his family were very kind to my family. I was a very great admirer of his. He taught me a great deal about relationship with the Air Staff and relationship with the Army War Department, as well as maintaining relationship with the civilian sector and with the legislative branch and the White House.

I would mention General Arnold. I did not have a close contact with Arnold. He knew me by name, and he knew where I was in the pecking order. He frequently complimented me through General Grant for the brief and concise reports that I gave at his daily briefings about what was going on. I was given 4 minutes to tell him the medical activities that should be of interest to him around the world on a 24-hour basis. I am sure after listening to me talk here, you wonder how I ever got my 4 minutes in, but it was excellent training. He was a man who could make a decision. I remember his deputy, General Timberlake [Lt Gen Patrick W.]. General Arnold--I was along, and I can't recall if there was anybody else--we were here at Maxwell Field overnight. The next morning we left orders that we were going to take off at 7 o'clock. That meant wheels up to General Arnold. So we got down there. It was about 6:35. Everybody was there except the Deputy Chief of Staff. Arnold said, "Let's go." I mentioned to him that General Timberlake had not arrived yet, that we weren't supposed to be wheels up until 7 o'clock. He looked at me and said, "Meiling, I said let's go; let's go." So we got aboard the plane, and he took over the controls of the plane. We took off, and we just cleared the base when the tower said, "You are to come back. General Timberlake is here on the apron." He said, "Tell Timberlake if he doesn't know how to fly now, it's time he learned. We will see him over in Louisiana." In due time

we landed in Louisiana, and about 30 minutes later General Timberlake arrived. He was sort of red-faced. Arnold wouldn't even discuss it; he thought it was a great joke. (laughter) Again, you see a commanding officer who had a sense of humor. Even in the most serious times--and the reason I was flying with him--we maintained a 24-hour medical alert on General Arnold after his first coronary. President Roosevelt did not want to change leaders during a critical period of the war, and he suggested that if a doctor traveled with General Arnold 24 hours a day--not one but usually three if we were going to be gone any period of time--nothing could happen and it would be much better than trying to explain to the public why the man had been relieved from the top command. Remember, although he did not by congressional edict have the position of a member of the Joint Chiefs, by invitation of General Marshall and the approval of President Roosevelt, General Arnold had equal position in the Joint Chiefs and in the Combined Chiefs with Admiral King [Fleet Adm Ernest J.] of the Navy and General Marshall of the Army. Arnold, to me, was the essence of a strong military commander. After he retired he became the Game and Wildlife Director of the State of California, and he took great pleasure in arranging for ranches in California that had large ponds or lakes to be well stocked. Then he would go by and fish to see if they were handling the stock very well. I have heard many of the ranchers say when he came the first thing he did was inspect the place and then he just dropped the mantle of government and became hail-fellow-well-met, and they fished and talked and had a few libations, and everything was very enjoyable.

There were two medical officers that influenced my life a great deal. One was at that time Capt, later Col, David Liston. I met him first in the 7th Medical Battalion of the

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5th Division at Fort McClellan, Alabama, in 1940. He had just graduated from Command and General Staff School at Leavenworth. He taught me a great deal about staff work and about command work and where they came together. He later became Assistant for Medical Affairs in the Secretary of War's Office under Mr. Stimson. Then he was the chief of staff to General Hawley, who was the theater surgeon for General Eisenhower in Europe. He was actually assigned in General Lee's [Robert M.] headquarters which was the Communications Zone of the European theater. He was a very, very polished gentleman. He was a graduate of Harvard Medical School, and he had the New England accent to make one think he had grown up in England. With all of that you found that he was a tough, thorough military commander as well as a talented physician.

Another one was Col Cadmus Baker. When I first met him, he was a lieutenant colonel. I served on his staff at First Air Force in the Eastern Defense Command as his assistant. My first experience with him was at Wright-Patterson Air Force Base, which was then both Wright Field and Patterson. They were divided. But the medical staff covered both of them. He influenced me, probably as much as anybody, to maintain my Reserve status, and he tried very hard to get me to become a member of the Regular corps of the medical service. He also encouraged me to take the flight surgeon's course by correspondence; it took me 2 years, which was considered normal for the time. When I finally got transferred from the Army Ground Forces, I Army Corps to the Secretary of War's Office to go to Randolph Field, he followed through to be sure that I was assigned in his area. My first assignment was at Grenier Field in Manchester, New Hampshire, and he saw to it in a very few weeks that I was down at Mitchel Field [NY] at headquarters. That, of

course, was what gave me the opportunity to associate with Gen Follett Bradley, who was Commanding General of the First Air Force in the Eastern Defense Command.

Later they sent me to Command and General Staff School, which had shortened their course from 2 years to 4 months. Later it was shortened to 6 weeks and was just staff; it wasn't command. I was in the last course of the combined staff and command course. Baker was to me a very quiet retiring person with a keen insight into all aspects of the problem, a man who could deal with his superiors in a manner of great loyalty without presenting the impression that he was trying to gain favors or special privileges.

Those are the people I think of right now who influenced me. In the civilian line of military, of course, Mr. Ferdinand Eberstadt gave me the opportunity to serve with him and be part of his seminars each week where I learned about government, about international finance, about tax bases and things like that. Mr. Robert Lovett, who was the Deputy Secretary of Defense and had been the Assistant Secretary of War for Air during World War II, was a brilliant mind, a very cordial person, and underneath it a very rigid decisionmaker who had the capability of seeing that his decisions were carried out without giving the impression that he was looking over your shoulder.

President Truman I must mention, because as a rock-rib Republican, I went there to his staff as a somewhat skeptical person. He impressed me with one thing that has stayed with me. That was if you expect loyalty to come up you had better send loyalty down from the top. He was very, very considerate. He knew of your sacrifices. I remember when I left office, he sent word that I was to come to his office at

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9 o'clock in the morning. He was flying to his mother's sickbed at 11. So I was there promptly at 9. As I was shown into his Oval Office, his first question was, "Dr. Meiling, where is Mrs. Meiling?" I said, "I am terribly sorry; I did not know that she was invited." He said, "I made it clear," and he called his secretary and said, "Why wasn't Mrs. Meiling invited?" She said, "This is a military matter, and I don't think anybody here in the staff knew that she was invited. Just a minute, I will get my notes." She said, "Well, it's my mistake; you did say that you expected Mrs. Meiling." He turned to his appointment secretary, Matt Connelly, and said, "Why in the hell did we order the orchids if we weren't going to have Mrs. Meiling here?" He gave me a very beautiful bouquet of three orchids for my wife with instructions that I was to present them to her with a message from Mrs. Truman and himself that they wanted her to know they appreciated her sacrifices in giving up her home in Ohio and coming to Washington for 2½ years and they would be following us to see the advancement of our career in academic medicine which I was going back to. General Marshall was present. In the car going back, he said, "You know, Doctor, I am going to watch and see that you do that just as the President directed." As we were going out the door of the President's office, he called to me and said, "If I didn't have that takeoff for 11 o'clock, I would send a limousine to get Mrs. Meiling so I could give those flowers to her because I want her to know that's the equivalent of a Presidential decoration."

I never went to Mr. Truman with a problem that when he understood he didn't come up with a decision that you could live with. When he made a decision, it was final. In dealing with the military, you found that the experience he had had as a commanding officer of a field artillery battery

in France weighed very much in how he reacted. I think one of the reasons that he didn't get along too well with many of the Navy personnel and the Marines was that they sort of belittled his military experience in Europe as a field artillery battery commander. He had had many days and weeks under heavy fire during the various offensives. If you were cognizant of this and let him know that you appreciated that he had had field command and he understood taking care of troops as well as, in this case, their horses and their equipment, he understood the problem of being at the end of the logistic line. Newspapers have commented very derogatorily, I think, about his remarks about admirals and generals and why he wanted to get rid of the Marine Corps. Most of it was off the cuff and said at a time of considerable stress. Any military problem that I know of he had he faced up to directly. I was, of course, privy to his removal of General MacArthur. I am prejudiced; I don't think MacArthur should have ever been called back to active duty in 1941.

I did not have a very close relationship with General Eisenhower. I told you I would tell you about an experience I had. I was a member of the World Health Organization delegation to which Senator Wagner from New York and Senator Richard Nixon [President Richard M.] from California were also members. Mrs. Roosevelt was a member. It was over the weekend when Mr. Nixon was to arrive, and the staff at the American consulate in Geneva had planned a vacation in the mountains. I volunteered to meet the plane with Mr. Nixon, which I did. I asked him if he had eaten on the plane, and he said no, they had had nothing from the time they left London. So I said, "Where would you like to eat?" He said, "I don't like rich French food." I said, "Would you settle for some German food? I know a German restaurant in this

Swiss town where they speak only French." So I took him to dinner. I noticed he was putting down in his notebook the cost of each item that we ate. When we got through he said, "We are going dutch because we are both on travel allowance from the same source; namely, the United States Treasury. I have no Swiss money, and I suppose at this hour of the night I can't get money changed. When we get back to the United States, I will give you a check for everything you have laid out for me." After about a week I got a message that I was to go to Fontainebleau to see General Eisenhower on some military matters. I told Mr. Nixon I was leaving the next morning, and he said, "Do you suppose I could go with you?" I said, "I will have to ask General Eisenhower if he will invite you. I know several of his staff officers rather personally; I will call them." I called, and I was scheduled to be at Fontainebleau in time for breakfast with Eisenhower at 7 o'clock. I talked with General Snyder, who was then special assistant to General Eisenhower at SHAPE. This was the same Snyder who had been the deputy and then later the Inspector General of the Army under General Marshall. He said he would have to talk with the General. So pretty soon General Gruenther [Alfred M.], who was chief of staff to Eisenhower, got on the telephone and said, "Yes, you can come, but come at 9 o'clock, not for breakfast, after the general has been briefed, and we will see how everything is progressing." We had a plane come down from Wiesbaden and pick us up and fly us over to Fontainebleau. We were at the headquarters by 8 o'clock and were shown in. As we were going in, Mr. Nixon said, "This will be the first time I have ever met General Eisenhower. Don't let me interfere with your business." Of course, I wasn't about to talk military business in front of a Senator. So we went in, and General Eisenhower was very courteous and cordial. He asked about the political activities that Senator Nixon

was observing. At that time there was no indication publicly that Nixon was going to run for office, but he was in his third year of the Senate. Eisenhower asked who he thought would probably be the American nominee. After Nixon said there were several, including one from California, Eisenhower turned to me and said, "What do you think?" I said, "General, you know I am from Ohio, and Senator Taft, who is a family friend, is definitely going to be nominated, and I think he is going to win." He said, "Does President Truman know that you are participating in political propaganda?" I said, "Not only does he know it, I have personally discussed the possibilities of Mr. Taft with him, and he knows how I feel about it, and he warmly supports my having an opinion. He has never asked me to participate in any of his political activities, and inasmuch as he is not going to run, he never will." He said, "I am really surprised that you would make the statement you just made." I said, "Well, General, that's the way I see it." When I got back to Washington, I was taken by General Marshall to President Truman's office. The first thing he asked me was about taking Nixon to see Eisenhower. I explained how it happened, and he said, "Well, that seems very reasonable to me. What did they talk about?" I tried to repeat the conversation. He said, "What did Eisenhower ask you?" I said, "He asked me who I thought was going to be the Republican nominee, and I told him Robert Taft, the Senator from Ohio. He and Mr. Nixon did not agree with me. Nevertheless, I made my statement." Truman turned to General Marshall and said, "Everybody comes back and tells me that General Eisenhower is getting ready to run for President. They all have the same report." General Marshall said, "I concur that everybody that has come through the headquarters with any national level business has been asked similar questions by both Nixon and Eisenhower." In due

time Eisenhower won the nomination and became President. After he became President, he asked me to come to Washington and wanted me to consider becoming an assistant to Mrs. Hobby in Health, Education, and Welfare. This was a position that Nelson Rockefeller currently held but was vacating because he wanted to go back to New York and become governor. I spent 10 days in Washington and decided there was nothing I could do in the complex organization of HEW that was a challenge or was rewarding.

So I stayed in Columbus. Several advisory committees became available to me, and I took those. I saw both Nixon and Eisenhower several times, and then when Nixon became President, he asked if I was at all interested in coming into Government at the level of Health, Education, and Welfare. I told him, as I told Eisenhower, that I would only come back to the Department of Defense as there were several things I felt we had started that had been in limbo that I would like to see organized.

This is what I look at as I look at the people that influenced my career, people that I had respect for as leaders. What was the last question?

C: The high point of your career.

M: I think the high point of my career has to be the day that Secretary Johnson told me that he would approve the reports establishing medical services of equal authority for each of the three military services.

(End Tape 13, Side 2)

M: We are talking about the high point of my career. I still think it was the day that Secretary Johnson made his decision that we were going to have a separate but equal medical service for the Air Force and that we were going to have a Surgeon General and that the Air Force Medical Service would be independent and coequal with the Army and the Navy.

The greatest military thrill that I received was on the day of my retirement. The Chief of Staff of the Air Force had a ceremony in his office in which I was given the Distinguished Service Medal of the Air Force, being only the second or third Air Force Reserve officer to receive such a military honor.

In actual flying activities, I think, the biggest thrill I had was sitting in the pilot's seat of a B-36 at 40,000 feet. At that time the B-36 was the vehicle to deliver the nuclear weapons. In the copilot's seat was General Ramey [Lt Gen Roger M.]. The Surgeon General was sitting in the navigator's seat. That was General Armstrong. To have a vehicle such as the B-36 in your hands was quite a thrill, quite a thrill. I have flown in the B-52, and I have flown in the B-47, and you know, if you were an extra passenger in the B-47, there was no way you could get out. There were ejection seats for the crew, but there was no way that anybody else could get out. In refueling I think you think about those things.

With the Navy the biggest thrill I had was as a medical consultant on their submarines, and I spent a week with the Atlantic fleet. They gave me the honorary title of Commodore of the Atlantic Fleet Submarine Division. In my office for many years, I had my commission as a colonel in

the Army, a major general in the Air Force, and a commodore in the Atlantic Fleet Submarine Division. So I have had quite a few interesting experiences.

I think another delightful experience was the number of retired officers that I could recruit to come with me to Ohio State and be on my staff, both in teaching and administration, so that we developed many medical programs that had a military background. We had a reputation in the United States in the years that I headed Ohio State as the only medical school that never had a project turned down when we applied for funds, and they sent site visitors. We prepared for those site visitors over weeks, and the last 2 days we had dry runs in which I watched the stop clock to see that nobody went over their allocated 2 to 3 minutes. The program progressed; it was impressive to lay medical people who had never had staff experience, but to us it was just a repetition of what we had done on military duty. I think the thrill of putting together a program at Ohio State of \$150 million worth of buildings, a third of which came from the State of Ohio and two-thirds from the Federal Government, the ability to get an aviation space medical program in an academic environment at Ohio State, and to get submarine and underwater medicine involved at Ohio State was rewarding.

Naturally being elected to top office in medical societies is always rewarding. But I still look back on the day that Secretary Johnson said we were going to have a separate medical service. This was in May 1949. I remember picking up the telephone and calling General Grow. He naturally was extremely enthusiastic. I said to him, "General Grow, both of us must remember that your staff"--particularly Colonel Withers; Colonel Cook, later General Cook; Colonel Kennard; Colonel Schwichtenberg--"did the hard work of the planning.

You and I had the pleasure of presenting it. Whatever you do in the first orders of the day as the first Surgeon General of the Air Force, and I know you will, remember those people who worked 10 and 12 hours a day late into the night to get statistical material and research other material that we could present to military and congressional and lay committees and councils that really resulted in recognition of what the Air Force could and would do."

At this point I would like to mention that my son, Capt George R. L. Meiling, received his commission in the United States Air Force. He met his wife, Capt Margaret Ludy Meiling, who was an officer in the United States Air Force in Europe. The Chief of Staff gave me the authority and privilege of pinning a decoration on my son. He earned it for duties over and beyond his activities as a medical administrative officer. I don't anticipate living to see my grandsons in the Air Force, but I hope if they choose a military career anyplace along the line they will choose the Air Force.

My wife, Ann Elizabeth Lucas, married 21 June 1940, has been a very, very staunch, loyal supporter of the Air Force, and fortunately she takes things personally. She felt very keenly when General Kirk not only threatened but prepared court-martial charges against me for things I was doing, such as with Jacqueline Cochran [Lt Col] when we bought cloth for flight nurse and WASP [Women's Airforce Service Pilots] uniforms. In those days the only agency that could provide uniforms for the nurses or other people was the Quartermaster Corps. We bought this for flying clothing and had it made up under a contract at the Research Laboratory for Clothing and Equipment at Wright-Pat. This involved over a million dollars' worth of cloth and tailoring. We thought they were very, very nice uniforms.

We had a little trouble. The nurses thought they should have drop seats in their pants, and the flying girls wanted zippered fronts because of the relief tubes that were available aboard planes. That was one command decision that I didn't have to go above my own office to authorize. We put zippers up the front. I never heard a nurse complain about it after we taught the tailors how to make them so they were neat and formfitting. They had always said when they wore male slacks they weren't very becoming. They soon found that these uniforms were becoming, and they used them, and they are recorded as flight nurses' uniforms rather than flying suits. We justified them as "flying suits," and the Chief of the Nurse Corps and the Surgeon General of the Army were bound and determined that we were going to adhere to Medical Department rules and regulations about clothing. General Arnold just stepped in said, "This is my command. These are my units, and they will wear what I tell them to wear." That pleased my wife, but she could never bring herself to be very pleasant to the Surgeon General of the Army or members of that staff even in later years. She knew them quite well, and we often met them at medical meetings. She still was so loyal to the Air Force. She used to argue with some of my friends who said, "You have to be fair with the Army Surgeon General. He was only doing his job." She said, "Yes, but he was extremely nasty to my husband." (laughter)

I would like to say that what we have gone over in the last several days is naturally my recollections after some 30 years, refreshed by some of the available documents, but it wasn't my doing, it was the fact that we had a very loyal and energetic and ambitious, creative staff. Staff work, as President Truman said, "Loyalty must go down if it is to come up." I think anybody who tries to tell history without

recognizing who made it is doing a disservice to the long hours of the staff. I recall a story about Ludendorff [Gen Erich F. W.] and Hindenberg coming back to active duty and being sent to the Russian front in 1914. General Hoffmann [Max] was chief of staff, and he was preparing the plans. He was asked how many alternative plans he had for the Battle of the Masurian Lakes. The battle later became known as the Battle of Tannenberg, which the Germans won by decisively defeating the Russians with less than 7 days' preparation. Hoffmann said, "We submitted 29 alternative plans for General Ludendorff and General Hindenberg." "What would you have done if they had turned them down?" He said, "We would have drawn up 29 more plans and submitted them the next day." I mention this because that is the attitude a staff officer must have. Even though he is frustrated, he must not show it; he must always drive ahead with new plans. This was and is so essential at the top level of the Surgeon General's Office. He can be positive about his professional medical opinions, but he must be flexible and meet the demands in war planning and contingency planning that are constantly under revision and constantly being updated. It means the medical annex must be updated even if you have to do it all over again 5 days later.

C: On behalf of the Office of Air Force History and the Oral History Division, I thank you for a very enjoyable and informative interview.

M: Thank you.

(End Oral History Interview #1353)

APPENDIX A

ADDITIONAL REMARKS ON FRICTION BETWEEN ARMY AND
AIR FORCE MEDICAL SERVICES

I want to add a little bit to one area in my interview. It has to do with the differences between the Army Medical Service and the Air Force Medical Service. Too often one thought it was primarily a battle between doctors and didn't realize the importance of the difference of opinion between the War Staff and the Surgeon General's Office and his staff with the United States Army. After the reorganization of the Army into the Army Air Forces, the Army Service Forces, and the Army Ground Forces, the Surgeon General was placed as a special staff officer to the Commanding General of the Army Service Forces. The Medical Service assigned to the Army Air Forces was like everything else assigned there, it was directly under the Commanding General, General Arnold.

The Surgeon General's staff labored under a great deal of difficulty by not understanding the reorganization and those who did understand it not accepting it because they felt the Surgeon General of the Army was a medical advisor to the Secretary of War, in this case Mr. Stimson. They did not object to the reorganization at the time but continued to function much as they had prior to March 1942. This caused a great deal of friction within the staff. Over in the Army Service Forces, they had a Department of Hospitalization and Transportation that controlled hospital construction and the problems associated with personnel for the hospitals. In the spring of 1942, there was a great deal of friction. The Surgeon General, Major General Magee, tried several times to abolish the Medical Service of the Air Force. This was in conflict with the Army Air Forces concept of command. They did not believe the Surgeon General could exercise command within the Army Air Forces. This was a very strong point.

At this same time, the spring of 1942, the Army was receiving a great deal of criticism. They weren't able to get medical

supplies. What medical supplies they had were being literally confiscated by Mr. Harry Hopkins, who was the Special Assistant to President Roosevelt for the lend-lease program. This diversion of medical supplies was not only to France and England, but it was medical supplies--litters, blankets, drugs--to China, Yugoslavia, and wherever we had lend-lease. This had not been planned in either appropriations or war plans. The result was that the Medical Department was unable to meet the demands of mobilization. Another area that generated a great deal of controversy in the hospital system was the quota of 5 beds per 100 troops in station hospitals. In dispensaries they would have from 2 to 3 beds per 100. Then in the general hospitals, they had 3 beds per 100 troop strength. Then forces went overseas, and they duplicated in each of the theaters the beds for the station hospitals and the beds for the general hospitals. At that time the War Department did not have a policy with regard to the length of time casualties, either sick or wounded, stayed in an overseas theater. Using the formulas that were developed in World War I, the theater staff was considering 180 days to be the minimum that a patient would remain in their theater. This caused a great deal of friction because of the housing that was needed, the barracks that were being built and the Surgeon General's Office desire to make leases for resort hotels. This the civil defense people objected to because they felt the hotels were to be used for civil defense hospitals. On top of that the people in the Surgeon General's Office did not understand contracting. Contracting was more legal than it was medical, so they had friction with the various medical supply companies, those that made instruments. For example, one of the big jewelry companies switched from making knives and forks to making surgical instruments. They wanted to write contracts the way they would for any other bid article, but the Medical Department did not subscribe to that.

In the meantime General Marshall was quite upset because the Surgeon General insisted on using the same square footage per man in the barracks that they had found necessary during the flu epidemic in 1917 and 1918. This assumed that the troops were going to be in the United States forever. It didn't consider the troops being sent overseas to the various theaters. So this was a housing situation that caused General Marshall great concern. In addition to that the White House was concerned because the Medical Department was making no provisions for Negro physicians or Negro nurses or Negro dentists, no provisions for women physicians, and no provisions for osteopaths. This was causing quite a bit of political turmoil in the country, reflected through Congress up to the White House.

Gen Brehon Somervell, who was the Commanding General of the Army Service Forces--it had been changed from the Services of Supply to the Army Service Forces--was very disgusted with the staff of the Surgeon General. He had built up within his own special staff a hospital, a transportation, and a medical supply section. They were in direct conflict with the desires of the Surgeon General of the Army. All this time there was also the desire of the Surgeon General of the Army to eliminate the Medical Services of the Air Force and put them directly under his own command. General Arnold, as Commanding General of the Army Air Forces, was not about to have General Somervell, Commanding General of the Army Service Forces, control his medical personnel or activities, nor was he about to have General Magee, the Surgeon General, telling him what he could do and what he couldn't do. In August 1942 General Lutes, who was chief of staff to General Somervell, drew up a program of investigating the Medical Department. It was thought at that time it would be handled entirely within the Services of Supply or the Army Service Forces. When Somervell got it he talked it

over with General Marshall, and they decided that instead of doing it within the Service Forces they would appoint a committee composed of two retired medical officers, and on the advice of 2 of the retired Surgeons General they would select 11 medical people--physicians, hospital administrators, and industrialists. At that point the Secretary of War got into it. This committee later was known as the Wadhams Committee because Col Sanford Wadhams--Medical Corps, Army, retired--was made chairman. They did not consult with the Surgeon General. He did not know anything about this until it was announced in the papers. This committee met during September, October, and into November 1942. When they reported back they did not provide the Surgeon General, General Magee, with a copy of their report. In fact he didn't get any part of the report until February 1943. This report indicated 95 areas in which the Surgeon General could effect correction of deficiencies. The report also recommended the abolition of the Medical Services of the Army Air Forces. They had not interviewed General Arnold or General Timberlake or General McNarney who were senior officers of the Army Air Forces. They had come to these conclusions on their own. They did send a copy of this recommendation to the General Staff, who sent it to General McNarney, who then sent it to General Arnold. At that point General Grant, who was the Air Surgeon in charge of the Medical Services of the Army Air Forces, was given it for preparation of a reply.

The reason I go into all this is that the friction was not just between General Grant and General Magee and General Kirk and General Grant. It was not purely between medical air and medical ground, Service Forces versus the Air Force; it was a basic difference of philosophy involving the War Department staff who had designed the reorganization and the Surgeon General's staff who did not believe in the reorganization but still believed in the concept of the Army corps system--

Artillery, Infantry, Quartermaster, and the Medical--and were trying to turn the clock back, if you will, so that they functioned as they had in World War I, as direct advisors to Secretary Stimson.

In the meantime Somervell had made it very clear that he did not want Magee reappointed as Surgeon General. His time was up in May 1943. That's when they got into the problem with Major General Kenner's being brought from Africa, where he was Eisenhower's chief medical officer, and then the politics involved with the civilian medical profession, the involvement of the Secretary of War, Mr. Stimson. Everybody was picking somebody to be the Surgeon General. It so happened that President Roosevelt was involved in this through his personal physician who was the Surgeon General of the United States Navy, Vice Adm Ross McIntire. The nonmilitary recommended then Maj Gen Norman Kirk, who was at that time in command of the general hospital at Grand Rapids--I think it was called Percy General Hospital--and who was a qualified and certified orthopedic surgeon and a general surgeon. He had in previous times operated on Secretary of the War Stimson. So Stimson recommended that General Kirk be named Surgeon General, and Marshall withdrew his candidate, General Kenner. Roosevelt then agreed to the appointment of Kirk.

Kirk's first assignment was to go over the Wadhams Committee report and their recommendations. You can imagine a committee report with 95 different recommendations. Kirk came up with the idea that he would reorganize the Medical Department according to his own concepts, not according to the Wadhams Committee.

APPENDIX B

ADDITIONAL REMARKS ON GEN DWIGHT D. EISENHOWER,
THE COOPER COMMITTEE, AND HEARINGS ON A DEFENSE
MEDICAL SERVICE

General Eisenhower became involved in the establishment of medical services of the three services. When Mr. Forrestal became Secretary of Defense, we had what was called the National Military Establishment, not really a command organization but a policy and program organization. The Chiefs of Staff and Chief of Naval Operations formed the Joint Chiefs, but they had no Chairman from 1947 to 1949. Outside influences were putting pressure on Secretary Forrestal to do something about the medical services. The Air Force Medical Service was being provided by the Army Medical Service because of an agreement between General Spaatz and General Eisenhower that there would be a 2-year hiatus between the establishment of the Department of Defense and the National Military Establishment and the decision of what they would do with the supporting units--Chaplains, Quartermaster Corps, Engineer Corps, and the Medical.

Mr. Forrestal appointed a committee headed by retired Gen Paul Hawley of the Army Medical Corps and the two Surgeons General and the Air Surgeon. Notwithstanding whatever they recommended, it had to go back to their parent department for implementation because the medical people did not have authority to speak for their independent departments. This committee had many subcommittees, and they studied innumerable problems from medical supplies to medical publications to hospitals and so forth, but there was never any action taken.

In November 1948 Forrestal decided to abolish this so-called Hawley Committee, and he appointed Mr. Proctor Cooper, who was then vice president of American Telephone and Telegraph and also chairman of the board of the large hospital known as the College of Physicians and Surgeons Hospital of Columbia University, to head up within Mr. Forrestal's office the medical and health planning. To advise Mr. Cooper he selected some nine physicians

and one dentist. This became known as the Cooper Committee. The Cooper Committee then replaced the Hawley Committee, and the Hawley Committee turned over all their material to the Cooper Committee. The Cooper Committee was made up entirely of civilians. The Surgeons General of the Army and the Navy and the Air Surgeon sat in as observers.

While all this was going on, the Hoover Commission had two committees. One was headed by Mr. Voorhees, a lawyer who had been in the Surgeon General's Office in charge of the Division of Control and Supplies during World War II, and composed of very famous and important medical people from around the United States. A second group was headed by Mr. Eberstadt, who during World War II had been the head of war production. Mr. Eberstadt appointed Dr. Howard Rusk and myself, Dr. Meiling, as his medical advisors. The American Medical Association had a group of civilian doctors known as the Council on National Medical Affairs. The American College of Surgeons had a study group. So there was a little bit of everything involved in deciding what kind of medical service the Department of Defense would eventually have.

General Eisenhower was retired and serving as president of Columbia University. Mr. Truman and Mr. Forrestal asked him to be the acting chairman of the Joint Chiefs of Staff, which he accepted on a temporary basis. For several months he had been unable to get an agenda item approved or passed by the Joint Chiefs. On 25 February, after the agenda items had been discussed at the meeting of the Joint Staff, he said, "Well, this is not an agenda item but is something I feel all of us concur in. Because it isn't an agenda item, it will not be called for a vote. I propose that we have a single, independent medical service of the Department of Defense and that the director or super Surgeon General of this new defense medical

service have equal rank with the members of the Joint Staff." Nobody objected, and according to the record, General Eisenhower personally wrote a memorandum in his own hand and took it that afternoon over to Secretary Forrestal, saying that the Joint Staff had no objection to the formation of a single military medical service in the Department of Defense. Secretary Forrestal then called on his two assistants--John Ohly, Assistant Secretary for Administration, and Marx Leva, Assistant Secretary for Legal Counsel. They called me and asked what I thought Mr. Forrestal should do with it, and I suggested that it be turned over to Mr. Cooper and his committee. Remember I sat on that committee. This was done, and on 5 March the Cooper Committee began hearings in which various medical leaders and military leaders, starting with the Secretary of Defense, appeared and expressed their opinions of what should be done. At the end of the hearings--they were 20 days in duration--25 March the Cooper Committee recommended to Secretary Forrestal that each of the military services needed their own military medical service but that a policy and program office should be established in the Office of the Secretary of Defense. The director of that office was to be a civilian. About the same time that this happened, the memorandum from Mr. Eberstadt through former President Hoover, the Hoover Commission, had arrived at Forrestal's office, and it proposed almost identically the same thing. The American Medical Association sent a letter to Secretary Forrestal proposing almost the same thing, too.

Mr. Forrestal retired several days after these memos hit his desk, and Mr. Louis Johnson was appointed Secretary of Defense. Mr. Johnson, Mr. Ohly, Mr. Leva, Mr. Cooper, and I met in Mr. Johnson's office, and we explained what the problem was, and then Mr. Johnson said, "It's fine. Prepare a memorandum to establish in my staff an assistant to the Secretary of Defense

for medical and health affairs and have the Secretary of the Air Force and the Chief of Staff of the Air Force prepare proper orders to establish an Air Force Medical Service effective 1 July 1949." This handwritten memorandum that Eisenhower had taken over to Secretary Forrestal was often considered to be the stimulus that solved the medical problems as they were then considered.

I was very disappointed personally in General Eisenhower's ideas that all the hospitals would be run by the Regulars of this Department of Defense Medical Service and all the combat medical services would be performed by Reserve officers called to duty. This was General Eisenhower, who had commanded the largest American fighting force in history, proposing that it wasn't important to have a well-organized military medical force, it was only important to have well-organized military hospitals. This represents the thinking that often we found in the staff, of hospitals being more important than medical services. The concept of sending patients back to continental United States if they required more than 20 days of hospitalization was difficult to present and have officers agree to because they were wed to this concept of hospitals and hospitals and hospitals in overseas theaters and back in the United States.

I think the Vietnam and Korean experiences, as well as our experience in the Middle East, have shown that it is more important to fly a patient back as fast as possible to get definitive care in the United States, to reduce the logistic airlift or sealift load to support the people required to maintain that patient in an overseas theater. I think in the context that I have mentioned, it comes to about six individuals to maintain one patient overseas. Each individual requires 2 tons for the first 30 days he is in the theater. At any rate, when General Eisenhower became President Eisenhower, he

did not change the concept of the medical services as they existed.

APPENDIX C

MAJ GEN RICHARD L. MEILING'S MANUSCRIPT,

"THE U.S. AIR FORCE MEDICAL SERVICE"

THE UNITED STATES AIR FORCE MEDICAL SERVICE

TUMULTUOUS YEARS OF HERITAGE AND HISTORY

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"If men could learn from history, what lessons
it might teach! But passion and party blind our eyes,
and the light which experience gives us is as a lantern
on the stern, which shines only on the waves behind us."

Samual Taylor Coleridge
1782 - 1834

"Time goes, you say alas - Time stays, we go."

Henry Austin Dobson

It is said that in every hawser, rope or line of the English Royal Navy one will find, intertwined, a thin red thread representing the continuity through the centuries of this Royal Service. In the United States Air Force Medical Service, one must trace two lines of historical significance; one, the military medical services; and the second, the military aeronautical services.

In these reflections, no effort will be made to re-tell the advances of research, clinical breakthroughs, human engineering, etc., each of which was and is important. The emphasis will be on organization, administration, environment, political and economic contingencies, and leadership. The "thread" of American military medicine shall be first explored preparatory to establishing a basis for the aeronautical services.

The germs of the reformation era (1450-1600) were circulating in Spain, Portugal, England, France, Austria, Germany, Italy and Holland. Politically, what we today call "The Middle East" was, by blocking commercial land travel between China, India, and Europe, creating interest in an alternative sea route between the areas.

The interest of King Ferdinand of Spain in a new sea route to India, etc., and Queen Isabella's desire "to propagate the faith" (Roman Catholic Church) caused these two Spanish sovereigns to support Christopher Columbus of Genoa (Italy) in 1492 on his voyage to what became the Western Hemisphere. Accompanying Columbus, on August 3, 1492, were three Spanish physicians (surgeons); one on each of the three ships--Santa Maria, Nina, and Pinta as they sailed from Palos. These ships each carried cannon so it seems only correct to refer to the three (Maestre Juan Sanchez, Maestre Alonzo of Moguer, and Maestre Diego) physicians as the basic foundation of European (discovery or military) medical services into the Western Hemisphere. (ADMIRAL OF THE OCEAN SEA, Samuel Eliot Morrison, Little Brown & Co., Boston 1946)

A full century passed before the first English physician arrived on the American shores (Chespian Bay in the country of Virginiae) in 1603. He was Henry Kenton, fleet surgeon to Capt. Gilbert of the London Company. Kenton and his landing party were ambushed and killed by the savages as they came ashore, giving their lives for crown, colonization, and the London Company. (AESCULAPIUS COMES TO THE COLONIES, Maurice Bear Gordon, Ventnor Publishers, Inc., New York 1949)

The difficulties between the English Parliament, the Crown, and the American colonies was of a political and economic origin. The mother country attempted to control commerce from and to the colonies by various Navigation Acts at a time when smuggling was a way of life between England and the continent.

In 1775, General George Washington was selected by the First Continental Congress to lead the colonial forces near Boston in an attempt to win a compromise on taxation and limitation of colonial expansion to the west. On July 27, 1775, the First Continental Congress, at the request of General Washington, appointed Dr. Church of Boston as Director General of Hospitals.

It should be understood that each company or regiment brought its own medical personnel when joining forces with the colonial force (army). Likewise, even Washington maintained English military traditions within his command, such as proposing "A toast: To Our Majesty, King George III" before each evening meal at his officers mess. This was discontinued after July 4, 1776. Dr. Church, like his fellow Bostonians, had social interrelations with many British officers from the better families of England. In October 1775, Dr. Church was accused of "corresponding with the enemy" and "bound over" to Congress for investigation. Congress, in May 1776, substantiated no charges and released him from military service.

Dr. John Morgan (on October 17, 1775) from Philadelphia (where he helped found what is now the University of Pennsylvania School of Medicine, 1766) was appointed Director of Hospitals to succeed Dr. Church. (The almost "mania" for hospital control which began at this time permeates the thinking of some military medical leaders of the United States Armed Forces even today.)

The political firebrands of 1775-76 prevailed over the conservative colonists who wished only to remain loyal to the King under more liberal tax control and economic freedom of trade. On July 4, 1776, the Second Continental Congress passed the Declaration of Independence. Of the 56 signers of this Declaration, six worked, or had worked, in the field of medicine:

Josiah Bartlett	-	New Hampshire
Lyman Hall	-	Georgia
Benjamin Rush	-	Pennsylvania
George Taylor	-	Pennsylvania
Matthew Thornton	-	New Hampshire
Oliver Wolcott	-	Connecticut

George Taylor, the owner of an iron furnace in Pennsylvania, on July 20, 1776, was selected to replace a Pennsylvania delegate who opposed separation from England. Taylor had studied and was apprenticed in medicine before he became a "munition" industrialist. Many authors only cite five physician signers (omitting Taylor). The document finally was signed as of January 17, 1777 although in the United States today, July 4, 1776 is celebrated as the national holiday.

The role of the physician as a concerned citizen willing to be charged, and tried, for treason if his cause should fail was well established.

Congress, in September 1775, appointed Dr. Stringer to be Director of Hospitals and Chief Physician to the Northern Department under General Schuyler. In July 1776, Congress appointed Dr. William Shippen of Philadelphia as "chief physician" to a "flying camp" of 10,000 men.

Dr. Stringer was disappointed in his request for help and supplies from Dr. Morgan. Both Stringer and Morgan held Congressional appointments as directors of hospitals in their respective armies of General Schuyler and General Washington. Stringer appealed personally to Congress in Philadelphia.

In January 1777, Congress responded by dismissing both Dr. Stringer and Dr. Morgan.

Congress decided, in April 1777, to reorganize the "hospitals." Dr. Shippen (of the flying camp) was then appointed Director General of Hospitals. Dr. Benjamin Rush (signer of the Declaration of Independence) was appointed by Congress to be Physician General and Surgeon General of Washington's Army.

Differences between Dr. Shippen and Dr. Rush had their origin in Philadelphia's medical affairs and they were carried over into the military with each making charges against the other. In January 1778, Dr. Rush was involved in correspondence with Patrick Henry, a Virginia representative to Congress, advocating the dismissal of General Washington. Rush resigned, but continued his charges against Dr. Shippen.

Dr. Morgan continued his attack on Dr. Shippen. Dr. Morgan had been removed from office and was charged, and then acquitted, by Congress. In August 1780, Shippen was tried and acquitted by Congress, but in January 1781, Shippen resigned from the Army.

Dr. John Cochran of Virginia succeeded Dr. Shippen and remained Director General of Hospitals until 1783 when he was mustered out of the service.

Baron von Steuben (a German volunteer) serving as Quartermaster and Inspector General under Washington, in 1780 drew up the first Army regulations to be approved by Congress on "Treatment of the Sick." (It is worthy of note that General George Marshall, during WW II, appointed Brigadier General Howard Snyder, M.C., as Inspector General of the U.S. Army. It was from him that Marshall received advice on medical affairs after Major General N. Kirk had been appointed Surgeon General by President Roosevelt.)

On April 21, 1818, an order was published establishing the Medical Department of the U.S. Army to be headed by the Surgeon General. This Congressional legislation, reorganizing the staff departments of the Army, including the Medical Department, is recognized as the founding of the U.S. Army Medical Corps. (Reference: THE ARMY MEDICAL DEPARTMENT 1775-1818, Mary C. Gillett, U.S. Army Center for Military History, Washington, DC 1981)

Friction involving the military, legislative, civilian medical leaders, executive branch of government, civilian medical contracts, and military medical leaders was a continuing factor as our nation developed on the eastern seaboard, the Mississippi Valley, and the western frontier during the 19th century.

The anticipated wars with France, England, and the fighting with frontier Indians and the Mexican War were not well organized or planned. Thus, medical services were, likewise, limited, poorly organized, and supported with few funds.

In the War between the States (Civil War 1860-65), Surgeon General Hammond and the Medical Director of the Army of the Potomac, Dr. Letterman, developed plans for the evacuation of patients, involving horse vehicles, trains, river boats, field hospitals and general hospitals, which under battle conditions were most acceptable.

Secretary of War Stanton, however, brought courtmartial charges against Surgeon General Hammond for alleged misconduct involving contracts with civilian medical suppliers and civilian General Hospital owners. Hammond was tried, convicted, and dismissed from the Army in August 1865. Ten years later, in 1875, Dr. Hammond requested the Senate and House to investigate his case. The findings and sentence of the courtmartial were annulled and Hammond was restored to the "retired list" as a Brigadier General.

Dr. Letterman, fearing that Dr. Hammond's enemies would successfully force him out of the military service, resigned his commission in January 1864.

The ill-conceived Spanish-American War (April-August 1898) was also a semi-disaster for the poorly prepared, and provided for, Army Medical Service. After the war was concluded, the President appointed the "Dodge Commission" to

investigate the conduct of the War Department, including the Medical Department.

Recommendations of this Commission included, but were not limited to:

1. Lack of sanitation; failure of inspection;
2. The Medical Department, due to contractual methods of operation, was not able to support the war effort;
3. The need for a reserve corps of women nurses;
4. In time of war, proper volunteer hospital corps were needed;
5. A year's supply of medical supplies and equipment, etc., four times the actual strength of peace time force should be maintained.

The demobilization of the Volunteer Army of the Spanish-American War did not include all the general hospitals. In fact, eight were retained: these were Presido (Letterman) San Francisco, California; Fort Sam Houston, San Antonio, Texas; Sternberg Hospital, Manila, P.I.; Tripler General, Honolulu, Department of Hawaii; Beaumont Hospital, El Paso, Texas; Army and Navy Hospital, Hot Springs, Arkansas; Walter Reed, Tacoma Park, D.C.; and Fitzsimmons General Hospital, Denver, Colorado.

To these general hospitals were sent, not only officers and the enlisted men patients, but their dependents. These and other general hospitals were placed under the (military and medical) command of the Surgeon General. Most other medical facilities were under military command, of district, corps areas, armies, and departments. (A similar situation prevailed in the Navy in which the Surgeon General of the Navy, as Chief of the Bureau of Medicine, exercised command control of the "Navy" hospitals whereas command control of Navy dispensaries, some of which might have more than 1000 beds, were under the fleet, other bureaus, etc., as well as other naval medical facilities.)

In understanding the heritage and history of military medical services, the division of the Army Medical Services into (1) general hospitals; and (2) other hospitals (Station, Base, Fort, etc.) and all ancillary medical activities involved

prestige and pride which at times clashed with the military command structure. Medical officers were poorly prepared to participate in war planning or in contracting for medical supplies and equipment, or in distribution of patients.

All was not dismal in the period 1775 to 1900; a few medical officers participated with outstanding records. They were leaders in the study of plant life, geology, botany, geography, physiology, and infectious disease. The frontier military life could be very boring unless the individual pursued his own hobbies.

On the plus side, the following military medical officers were renowned in non-medical activities:

- HOLTON, SAMUEL - President of Congress, 1780
- LEE, ARTHUR - Ambassador to France, 1776
- THOMAS, JOHN - Succeeded General Montgomery (on his death at Quebec) in command of the Canadian Expedition
- McHENRY, JAMES - Secretary of War under Washington and Adams
- LOWELL, JOSEPH - First Surgeon General 1819. Ordered medical officers not only to keep medical reports but daily records of temperature, winds, weather, and rainfall at each station
- COUES, ELLIOTT - Secretary of the U.S. Geological and Geographic Survey
- BILLING, JOHN S. - Founded U.S. Army Medical Library and Museum (Now the National Medical Library); New York Library System; Designed John Hopkins University Hospital; Developed the Vital Statistical Division of the U.S. Census Bureau.
- AINSWORTH, FRED C. - The Adjutant General, U.S. Army, 1904-08
- WOOD, LEONARD - Chief of Staff, U.S. Army, 1910-1914
- MYER, ALBERT J. - Signal Officer of the Army, 1860; Chief Signal Officer of the Signal Corps, 1880

The above is a limited list of military physicians who accepted the challenge of ancillary duties and became famous.

Now it is time to introduce the continuity in the heritage of military medicine, and the new thread of aeronautical military service. These two threads will be interwoven into the continuing history of the United States Air Force Medical Service as it develops.

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H I S T O R Y

An American physician, John Jeffries, with a French balloonist, M. Blanchard, made what was probably the first balloon flight to study, "the properties of the upper atmosphere." Jeffries was the first American to fly (in a balloon) and the first to publish a book on aeronautical subjects. (Today he is honored by the physician award--begun in 1940--of the Institute of Aeronautical Sciences for the greatest contribution to aviation in the field of medicine. This is an annual award.)

As for the airplane, it was George Peacock of England who demonstrated in 1840 a "man lifting kite." Stringfellow and Henson, also of England, in 1842 produced a model of a small, 10 foot wing span, self-propelled, power driven, heavier than air machine. Dr. Samuel Langley in the United States developed steam driven, heavier than air model planes, one of which flew a distance of 4200 feet in 1896.

It remained for Wilbur and Orville Wright (Dayton, Ohio) to develop an airplane and power plant of their own design, which would carry a pilot. On December 17, 1903, Orville Wright, as pilot, took off at Kitty Hawk, North Carolina, and flew 120 feet in approximately 12 seconds.

Four years later, in 1907, the Aeronautical Division of the Signal Corps, U.S. Army, was established. This is the same Signal Corps whose beginnings might be traced to the action of the first Surgeon General (Lovell) who ordered the military physicians to maintain and report weather conditions, temperature,

rain and snowfall at their respective stations beginning in 1819. Assistant Surgeon Albert J. Myer (for whom Ft. Myer, Virginia, is named) became Chief Signal Officer of the U.S. Army in 1860. The weather, etc., reporting of the Medical Department was transferred to the weather section of the Chief of Signal Corps in 1870. When this office became a separate designated Signal Corps (department) in 1881, Dr. A. J. Myer, M.C., now a brigadier general, was named its commanding general.

Thus, the intertwining of medicine and the Signal Corps is followed in 1907 by the intertwining of the Signal Corps and military aviation.

President Theodore Roosevelt and his Secretary of War, Howard Taft, appreciating the political difficulties of obtaining a Congressional appropriation to purchase a military airplane for the Aeronautical Section of the Signal Corps, collaborated to use White House funds to secure, in 1908, the first military (Wright Brothers) airplane without Congressional consideration or approval.

Lt. Frank Lahm (later Major General) in 1906 won the first Gordon Bennett balloon race. For allegedly taking the wife of a brother officer in an airplane ride, Lahm in 1911 was relieved of flying duties and returned to cavalry duty.

Lt. Henry H. Arnold (later the Air Forces only five-star general and Commanding General U.S. Army Air Forces in WW II) volunteered for aeronautical duty in 1911. Arnold was the son of a prominent Ardmore, Pennsylvania physician (former cavalry officer) and graduate of West Point, Class of 1907. He was hoping, as a result of his superior polo playing and general horsemanship at West Point, to be assigned to the cavalry. Such was not his fate. He was commissioned in the Infantry and sent to Ft. McKinley, Philippine Islands. He freely expressed himself in regard to his distaste of the infantry. He was detailed to a "mapping program" with a Captain Cowan of the Engineer Corps. This program included Luzon Valley and Corregidor and he soon learned the Japanese were making similar maps for military purposes and methodically, and almost openly, making war plans.

Arnold, after a two-year tour in the Philippines, was assigned with the 29th Infantry at Governors Island, New York. Here he saw both Orville Wright and Glen Curtiss (representing their respective airplane companies) who used Governors Island as the first New York "airport." He also attended the "First International Air Meet" ever held in America (Belmont Park).

Captain Cowan had returned to Washington and suggested that Arnold might be interested in transferring to the Signal Corps in order to learn to fly. Arnold, in April 1911, sent through channels to the Adjutant General, U.S. Army, a request for transfer to the Signal Corps for aeronautical duty.

War Department Special Order 95, Par. 10, dated 21 April 1911, ordered Second Lt. Henry H. Arnold, 29th Infantry; and Second Lt. Thomas De W. Milling, 15th Cavalry, to proceed to Dayton, Ohio, for the purpose of undergoing a course of instruction in operating the Wright airplane.

It was here at Simms Station, near Dayton, that Arnold and Milling learned all about construction and maintenance of the plane as well as how to fly.

As a result of a Navy flying instructor (Lt. Billing) being thrown out of a plane and being killed at sea, his passenger, Lt. John Towers (later in WW II Admiral Towers) survived the accident and developed the first safety seat belt. Milling and 2nd Lt. Jake Fickel (later Major General Fickel) improved upon Tower's safety seat belt for Army planes. Arnold and Towers became friends throughout their respective military and naval careers.

While coming in to land at Simms Station, an insect struck Arnold in his eye causing serious and painful injury. Henceforth, all flyers wore goggles. An accident to another flyer, which caused his head to scrape along in the dirt when his plane flipped over, resulted in the adoption of the flying helmet. These three safety devices were the forerunner of many which were later to be developed.

At San Antonio, Texas, Lt. Benny Foulis (later Major General) became the first Correspondence School pilot in history.

Arnold and Milling were sent to College Park, Maryland, to establish the Signal Corps Aviation School and the first regular Army air base. Included at this base was an emergency hospital tent staffed by Lt. John P. Kelley, Medical Corps, who according to Arnold, was probably the first "Flight Surgeon" in history.

Medical literature on the subject of aeronautics was very limited, there being only 11 papers published in 1911 on various medical aspects of flying.

The U. S. War Department on 2 February 1912 published its first instructions concerning the physical examination of candidates for aviation duty. It was prepared by the Office of the Surgeon General at the request of the Chief of the Signal Corps.

Congress recognized the high fatality record of the flyers and authorized a "35% bonus of the flyer's base pay" at the end of 1912. This was followed on March 2, 1913 by Congressional action to legalize "flight pay."

While flying a reconnaissance mission at Ft. Riley, Kansas, Arnold had a near fatal experience (a stall) which caused him to state to his commanding officer, "I will not get in any machine." He was transferred to "desk duty" in Washington at the Signal Corps headquarters. On April 10, 1913 he was promoted to First Lieutenant.

H.R.5304 which called for an independent Air Corps (the first of many such legislative proposals in the next 40 years) was being heard before the Committee on Military Affairs. General Scriven, the Chief Signal Corps Officer; Captain Billy Mitchell, then a Signal Corps officer on duty with the War Department General Staff; Lt. Milling; and Lt. Arnold all testified against the proposal. Arnold was to hear of this through the many years of his military career. The reason for this opposition was lack of experienced staff and command officers.

General Leonard Wood (a physician), Chief of Staff, after the hearing had Arnold in for an informal chat about flying duty for married officers and the

question of lieutenants being assigned duty in Washington. Arnold requested transfer to the infantry.

He was married in September 1913 and took his bride to Ft. McKinley, Philippine Islands, where he joined the 13th Infantry. By coincidence, the Arnolds moved into quarters next to a senior 1st Lieutenant, George C. Marshall, and his sick wife. Marshall and Arnold developed a deep respect for each other's military talents as well as a lifetime personal friendship. This was to benefit not only the military forces, but our nation during WW II when Marshall was Chief of Staff of the Army and Arnold, Commanding General of the Army Air Forces. They served together on the "Joint Chiefs of Staff" (U.S.) and the "Combined Chiefs of Staff" (U.S. and Great Britain) during WW II.

Army regulations dated 1913, par. 191 provided exemption of aviation schools and installations from department commanders. Congress appropriated funds for the Signal Corps to construct 40-bed small hospitals at each flying school as part of the Aviation Section of the Signal Corps.

Congress, in the early 20th century, had enacted legislation affecting not only the military but the military medical programs as well. Of importance was the creation in 1903 of the War Department General Staff. In 1906 a Medical Reserve Corps was formed from which later developed the Officers Reserve Corps for all branches. In 1911 Congress enacted a law against discrimination for the military in uniform (soldiers in uniform were at times refused admission to theaters, hotels, and places of entertainment). The National Defense Act of 1916 restructured the army and it gave the President authority to establish corps and armies and set the national defense on a tripod, consisting of the Regular Army, the National Guard (which could be drafted into the Federal service), and the Officer Reserve Corps, as well as an Enlisted Reserve. Also in this act was a provision for a Council of National Defense to supervise and coordinate industrial resources for national defense.

The War (WW I) in Europe, which started on August 4, 1914, was dividing the United States into three camps--the isolationists, the pro-German, and the pro-Allied (French and British) groups.

The United States, responding to Mexican guerrilla attacks along the Mexican border, had finally responded resulting in U.S. armed intervention. The Secretary of War, Newton Baker, sent Colonel John J. Pershing (later General Pershing) with an expeditionary force of 12,000 into Mexico to capture and destroy the Mexican guerrilla leader Pancho Villa. Villa was not captured but the U.S. Army had a "field training school" of immense importance as preparation for entry into WW I on April 6, 1917 on the side of the Allies. This Mexican expedition involved hospitals, medical supplies, field sanitation, patient evacuation, and organized field medical services.

Wings Over Bordea; Stacey K. Hinkle.

For the Air Section of the Signal Corps the First Aero Squadron, as a combat unit, was organized in 1915. Under command of Captain Benny Foulis (later Major General Foulis) this squadron was led into Mexico in support of General Pershing. No pilots were lost but all the planes (eight) of this squadron were destroyed due to the elements and mechanical problems.

During 1912-16, medical interest in selection of flying candidates was stimulated by the Surgeon General and the Chief of the Signal Corps. In 1916 a board consisting of one medical corps officer and two signal corps officers was appointed to examine and determine the fitness of flying candidates. Lt. Col. (later Brigadier General) Theodore Charles Lyster, M.C. was head of this board. Lyster was assisted in this military aviation program by Major William H. Wilmer, M.C.; Major I. H. Jones, M.C.; and Captain Ralph H. Goldthwaite, M.C. In May 1917 this board established standards known as "AG0609" form which was used throughout WWI. At about this time, the British were developing the "Care of Flyer" program to reduce military aeronautical fatalities which were exceedingly high.

1917 - 1919

In September 1917 Colonel Lyster was named (first) Chief Surgeon, Aviation Section, Signal Corps. Lyster is almost universally acclaimed "the father of aviation medicine." War Department Special Order No. 113, dated October 18, 1917 officially established the Aeronautical Medical Research Board "to investigate all conditions affecting the physical efficiency of pilots--to provide suitable apparatus for the supply of oxygen--and to act as a standing organization for instruction in the physiological requirements of aviators". Thus was really born military aviation medicine.

Under Colonel Wilme, M.P., the aviation medical laboratory at Mineola, Long Island, developed an extensive research program.

On September 17, 1917, the Air Division of the Signal Corps was organized into six sections, one of which was the medical. In January 1918 the Medical Section (Department) of the Air Division was established with responsibility for all medical personnel, medical supplies, and equipment furnished for the use of the Aviation Section of the Signal Corps. The War Department staff, notwithstanding the disapproval of the Surgeon General and the Chief Signal Officer, transferred the medical service from Signal Corps to the Surgeon General's staff effective 11 May 1918.

In October 1917, Lyster was sent to France as head of a medical mission to the American Expeditionary Forces. Here he was appointed Chief Surgeon, Air Service. The Chief Surgeon, Headquarters Line of Communication, strenuously objected to having a Chief Surgeon of the Air Service and one month later it was abolished.

On returning to the United States, Lyster and Jones designed a program to train "flight surgeons" at the Mineola Laboratory. By June 1918, the school was

functioning and in August, 34 officers (flight surgeons) were sent to the AEF at the request of Gen. J. J. Pershing. They arrived at Issoudin, France, on September 2, 1918, and were slowly assigned to aviation training schools and combat squadrons.

At this point, it is proper to review the expansion of the Air Service. Colonel Mitchell had learned to fly, and in 1916 was second in command of the Air Service. He enticed Captain Arnold to return to the Air Service after Arnold's return from his tour in the Philippines. Arnold reestablished his flying status. At the time the United States declared war on Germany, Arnold was returning to Washington from special duty in the Panama Canal Zone. He, like all other aviation officers, wished immediate service in France, but the staff felt he could contribute more in Washington. The aircraft industry was a conglomerate of confusion during 1917-1919. A division of Military Aeronautics and a co-equal Division of Aircraft Production were finally placed under Second Assistant Secretary of War and Director of Service, Ryan, in August 1918.

Mitchell, Milling, Foulis, Spaatz (later Commanding General in WW II of the U.S. Strategic Army Air Force and the First Chief of Staff of the U.S. Air Force) and Gorrell were interested in "strategical bombing". They spent time with the British Royal Flying Corps Commander, Trenchard, and with Colonel Douhet of the Italian Royal Air Force, and Italian bomber builder, Count Caproni, each of whom believed aerial bombardment of the industrial heartland of the enemy would win the war. The U.S. General Staff opposed this concept. By late September, 1918, during the Meuse-Argonne (now General) Mitchell, in conjunction with the British RAF tried out his concept of strategic bombardment. He assembled 200 bombers of the U.S. Forces in one mission, followed by British bombers in a joint mission, which delivered 79 tons of explosives. This was 50 percent of the total tonnage dropped by the AEF Air Service during the entire WW I. Mitchell also prepared a plan for airborne infantry to attack behind the German lines in the fall of 1918. This, too, was opposed by the Army.

Arnold, now Assistant to the Director of the Aeronautical Division, Signal Corps, was learning the hard way to mobilize the aircraft and airplane motor industry for the United States war effort. In collaboration with Charles Kettering (inventor and manufacturer) then President of Delco, and working with Sperry Company and Ford Company, they developed a pilotless bomb, "the bug" (forerunner of the German V1 and V2 buzz bombs of WWII) which Arnold took to France in October 1918, only to have the Armistice on November 11, 1918 end further development of the intended strategic bombing.

The war over, the demobilization and the adverse attitude of Secretary of War Newton and the War Department was limiting the Air Service, its personnel, equipment, and facilities.

Various boards, commissions, and Congressional committees considered the aviation question (air power). Among these investigative activities were the following: the Crowell (Assistant Secretary of War) Board; the LaGuardia Board; the Lassiter (Assistant Secretary of War) Board; the Perkins (Congressional) Board; the Morrow (Dwight Morrow and J. P. Morgan, Partner) Board (President Coolidge appointed this group); the Howell Board; and the Baker Board (appointed after the difficulties and numerous fatal accidents resulting from the highly "political" decision to order the Air Corps to fly the airmail in planes designed for combat, not air mail bags, in 1934.

In 1925 the "Curry Bill" advocated "a separate Air Service". General Mitchell strongly pushed for an independent "air service". He publicly accused President Coolidge, the Secretary of War, and the War Department General Staff of "neglect" bordering on treason. He was courtmartialled on charges filed by President Coolidge, convicted and resigned from the service. General Patrick advocated a "separate air force" and the Patrick Bill was introduced in Congress. In July 1926, the Air Corps Act was a "compromise legislation" relieving the

Signal Corps of aeronautical responsibility and establishing The Air Corps. Colonel Davis, Chief of the Medical Service of the Air Corps, recommended the development of air ambulances. At this time, GHQ Air Force was established in 1935 in an attempt on the part of the War Department to divide the Air Corps into two components although General McArthur, Chief of Staff, had been a supporter of a "combat air force". Attempts were made by Surgeon General (Reynolds) and his successor, Major General James C. Magee, to take the Medical Section from the Air Corps and place it in the Office of the Surgeon General.

General Arnold, Chief of Air Corps, did not object to the Surgeon General having an Aviation Medical Division as long as it did not duplicate the Medical Division of the Air Corps. Further, he specified that the School of Aviation Medicine at Randolph Field, Texas, and the Aero Medical Research Laboratory at Wright Field, Ohio, must remain under the control of the Chief of the Air Corps.

Arnold appointed a board to advise him of the "whole flight surgeon problem" in the Air Corps. Lt. Colonel David N. W. Grant (later Major General and The Air Surgeon), Acting Chief of the Air Corps, Medical Division, served as chairman, with Lt. Colonel Malcolm C. Grow (later Major General, The Air Surgeon and the First Surgeon General USAF), and Lt. Colonel Fabian L. Pratt, M.C. This Board was charged with "justifying the existence of flight surgeons". Arnold was irritated by the action of Lt. Col. Reinartz, M.C., the flight surgeon in Hawaii, in grounding all his pilots on a flight from California to the Philippines. The pilots had celebrated somewhat intensely. Arnold overruled Reinartz.

The Surgeon General Magee, on learning of Arnold's action appointing this Board, immediately carried the case of the Medical Division, Air Corps, to the War Department G3, who, in turn, asked General Arnold to reconsider. Arnold merely asked his board to prepare an answer to the W.D. G-3.

While this was in progress, the expansion of the Air Corps was in progress.

The War Department on 20 June 1941 established the "Army Air Forces," and command and control of all stations, air bases, units, personnel, installations was placed under the C.G. of the Army Air Forces.

This should have ended the Surgeon General's desire to take over aviation medicine, but unfortunately it did not.

Colonel Grant was designated "The Air Surgeon" and assigned to Headquarters Army Air Forces in October 1941.

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WORLD WAR II

Although the "infamous" Pearl Harbor attack by the Japanese on December 7, 1941, precipitated the U. S. official entry into WW II, the Executive Branch of government had been directing such action and preparing for arming the defense forces of the British and French as well as the United States for a period of time even preceding actual hostilities, which began with German invasion of Poland on September 1, 1939.

General Marshall became Chief of Staff, U.S. Army in 1939. General Arnold became Commanding General, U.S. Army Air Forces in 1941, and Colonel David N.W. Grant became The Air Surgeon. Each had progressed through the various military schools--Marshall through Infantry School, Command and General Staff School, and War College; Arnold through Industrial War College and Command and General Staff School; Grant, a specialist in obstetrics and gynecology, had graduated from the School of Aviation Medicine and from the Air Corps Tactical School.

The War Department reorganized under W.D. Circular No. 59, dated March 2, 1942, into three major divisions:

1. Army Air Forces
2. Army Ground Forces
3. Service of Supply (later the Army Service Forces).

The Commanding General of the Army Air Forces on March 9, 1942, charged The Air Surgeon with the operation of the Medical Department (Service) under command and control of the C.G. of the Army Air Forces.

The Surgeon General, U.S. Army, was incorporated into the Special Staff of the Services of Supply under the Commanding General, Lt. Gen. Sommerville of the Services of Supply (later the Army Service Forces).

The AAF concept of its combat mission was that of an "air weapons system" with no limitations such as "Theater of Operations", "Zone of Interior", and "Communications Zone". Ground officers, including Lt. General Leslie McNare (C.G. Army Ground Forces), continued to view the airplane as they thought of the tank, merely as a special weapon of the infantry--queen of the Army fighting forces. The stress of a global war revealed the fundamentally different concepts of the Air Force mission on the part of not only line and staff officers, but medical officers and planners.

The Surgeon General operated (command) a hospital system which, in the Zone of Interior, included general and station hospitals (some exceptions) with their galaxy of medical and surgical specialists (memories of the "hospital directors" in 1776-84).

The Air Force medical service began with the flyer, often on the flying line and in the air and thence, if necessary, in air base station hospitals. The Air Surgeon, as senior medical advisor and special staff officer to the C.G. AAF had access to air war plans and inasmuch as General Arnold was also a member of the Joint Chiefs of Staff, the Air Surgeon was able to consider medical programs and requirements for the strategic mission in global combat.

The Surgeon General and his staff had neglected to successfully present their concepts to the W.D. planners who designed the W.D. Reorganization Plan and, hence, SOS considered the medical program as one of "production" (as were all other military supplies) groups involving hospitals, equipment, pharmaceutical plants, etc. The SGO's planners estimates, based on WW I fixed battle fronts, of sick and wounded, translated into hospital beds and medical personnel for care, treatment, evacuation, etc., was somewhat critically evaluated at the level of General Marshall. At this level, construction planning for military housing was in competition with the "four" level hospital planning.

Recruitment of physicians by the Surgeon General's staff, in collaboration with the "Procurement and Assignment Agency" (civilian) for the Army, Navy, and Public Health Service and the civilian and industrial needs of the nation (established in 1941) was limited. In April and May of 1942, AAF began direct recruitment with authorization of the Army Adjutant General. At the same time, the Secretary of War and Military Personnel Division, SOS, recognized the need to streamline the processing of physical examinations of applicants for duty with AAF.

Within the AAF, medical service provisions were made to accept dentists, veterinarians, nurses, hospital dietitians, physical therapists, aviation physiologists and aviation psychologists.

The Surgeon General's staff experienced serious difficulties in contracting for medical and pharmaceutical supplies, etc., so that a lawyer, Mr. Tracy Voorhees, was induced to take a commission as Lt. Col. Judge Advocate General Corps to advise as to the organization of the contracting, procurement, storage, and disposition of medical supplies and equipment. The unplanned "Lend-Lease" demands for medical supplies vastly aggravated the supply problem. The invasion of North Africa (November 1942) had shown that medical supplies were so lacking that Colonel Malcolm Grow, Surgeon AAF Europe, arranged for all AAF medical personnel to carry 90 lbs. of unit medical supplies per person at the time of the landing. No other medical supplies were available during D + 7 days for the AAF units.

Lt. Col. Voorhees, A.J., was assigned as Chief of the Surgeon General's Control Division for the remainder of WW II. Mr. Edward Reynolds, President of Columbia Gas & Electric Company, was appointed Special Assistant to the Surgeon General for procurement of medical supplies. Thus, civilian expertise was able to solve the supply problem.

In September 1942, the Secretary of War (Stimson) and the Chief of Staff (Marshall), appointed a special committee (at the instigation of the C.G., Lt. General Brehon B. Somerville, Army Services Forces) headed by Col. Sanford Watkins, M.C. (retired) to review the Army Medical Department and SGO Office. Public criticism of several of the Medical Department's programs further stimulated an investigation. The venereal disease problem, the control of prostitution around military bases, etc., involved the U.S. Public Health Service and the military medical service. Discrimination against women doctors, negro doctors, osteopathic physicians, and chiropractors was protested by interested groups. The "yellow jaundice epidemic" traced to yellow fever vaccine supplied by the Rockefeller Foundation was highly publicized. The SGO's recommendations on military barracks at a time of housing shortages had vexed General Marshall.

The so-called "Wadhams" Committee had one other officer, Col. William Keller, M.C. (retired), and civilians as follow:

Dr. Musser	-	Tulane University
Dr. Graham	-	Washington University
Dr. Ruggles	-	Providence, R.I.
Dr. Robinson	-	University of Maryland Dental School
Dr. Hamilton	-	Supt., New Haven Hospital
Dr. Dublin	-	
Dr. Weed	-	Dir., Medical School, Johns Hopkins
Mr. Gill	-	Consultant to the War Department (economist and statistician)

The Surgeon General was not consulted on the appointments, establishment, or charge to the committee.

This committee, after extensively involving witnesses for the military, military and naval medicine, Public Health Service, civilian medicine, filed its report with Lt. General Somerville, on November 24, 1942, with 98 recommendations, of which 85 were within the jurisdiction of the Surgeon General to effect. He, however, was first given a copy of the report on or about February 25, 1943. One recommendation was to abolish the Medical Service of the U.S. Army Air Force.

In March 1943, Surgeon General Magee wrote C.G. SOS that AAF was duplicating hospitals and depriving the Army of scarce medical and surgical specialists.

The real battle within the medical groups was, once again as in previous wars, a question of "hospitals", particularly general hospitals, and who would exercise command.

Brigadier General Hawley was Chief Surgeon, Communication Zone in England. He strenuously objected to The Air Surgeon sending medical supplies by Army Air Force cargo planes to the Air Force stations in Europe. He claimed it was unfair to favor air personnel although Air Force personnel were the only U.S. forces engaging the enemy in the winter of 1942-43 from England.

The U.S. bombers returning from raids over the continent would land at RAF bases with not only damaged planes, but wounded airmen. It was sometimes 200 to 250 miles to the nearest U.S. hospital at Exeter (36th U.S. Station Hospital, England). Lt. Col. Herbert Wright, a board-certified surgeon and urologist serving on the Chief Surgeon's staff of the Eighth Air Force, proposed to General Hawley the procurement of buildings adjacent to an RAF medical facility at Truro, the nearest facility to AAF combat bases, and the assignment of USAAF surgical specialists to staff the facility to care for wounded Eighth Air Force personnel.

Colonel Cutler (Professor of Surgery at Harvard), the U.S. Surgical Consultant in Europe, and General Hawley turned down Colonel Wright's proposal. In its place they sent a surgical team commanded by Major (later Colonel) Robert Zollinger (also from the Harvard group) from the 5th U.S. General Hospital (Salisbury) to the Royal Cornwall Infirmary at Truro.

Colonel Grow, Eighth Air Force, felt the use of U.S.A. surgical teams (two surgeons, one operating room nurse, four ward nurses, and necessary mobile equipment) might erroneously suggest to the British that their medical services were inferior. Hence, the Cutler teams were shortly discontinued.

General Marshall, Chief of Staff, had appointed Major Gen. Howard Mc C. Snyder, M.C. as Assistant to the Inspector General to act in General Marshall's words,

as the "eyes and ears" for the Chief of Staff, and medical matters were cleared through him at the Chief of Staff level.

During early 1943, the AAF presented justifications for AAF rehabilitation and convalescent centers. The AAF designated the Coral Gables Biltmore (Hotel) and the Miami Biltmore (Hotel) and exempted them from corps area control and placed them under The Air Surgeon.

G I, W.D., Chief of Staff and Secretary of War, approved establishment of eight AAF convalescent centers in September 1943.

During 1942, the transport of sick and wounded by air was begun. In September 1942 the Chief of Staff informed all theater and base commanders that air evacuation to the U.S. would be carried out by the Air Transport Command of the AAF. By January 1943 the "Medical Plan for Air Evacuation" was formalized. Troop carrier units would bring patients to Air Transport Command bases and thence to the United States. The North Atlantic Wing, ATC, controlled medical activities, including the 310th Station Hospital at Gander, Newfoundland. Thus, the AAF had its first (defacto) overseas hospital.

The Air Surgeon's office established in Hq. USAAF the position of "AAF Air Evacuation Officer." Lt. Col. Richard L. Meiling, M.C. (later Major General USAF and Assistant to the Secretary of Defense for health and medical matters) was the first and only officer to have this title. He was at that time the only medical officer of the AAF to have graduated from U.S. Army Command and General Staff School. Meiling established a "coded" reporting system (11 categories of patients and 11 categories of beds) in which patients from overseas were matched daily with available beds in U.S. Hospitals and convalescent centers.

Meiling was further responsible for staff studies and plans in collaboration with the Air Staff to convert all transport planes to a capability of carrying

patients. Nurses were provided uniforms by the Quartermaster Corps. (Dark blue blouses and light blue skirts). He succeeded in arranging for the AAF to develop, procure, and issue a "Flight Nurse Flying Suit," much to the disapproval of the Surgeon General and the Chief of the Nurse Corps, who threatened courtmartial procedures. General Arnold settled this matter as a "command decision."

The Air Medical Regulating Office collaborated almost hourly with the Evacuation and Hospital Branch of the staff of the C.G. Army Services Forces, which also operated a (surface) Medical Regulatory Office.

In May 1943, Major General Norman Kirk, was selected by President Roosevelt, as a result of strong civilian medical pressure, to be Surgeon General, Army Service Force, succeeding Major General McGee. General Marshall had originally selected Brig. General Edward Kenner, then Chief Medical Officer on the staff of General Eisenhower in North Africa. Roosevelt had agreed to Kenner's appointment, but two weeks later changed his mind in response to political pressure, and asked that Kirk be named.

General Marshall issued verbal orders that General Kirk was not welcome in his office and official medical matters would be handled by his deputy, Lt. Gen. McNarney (AAF) and Major Gen. Snyder (MC), Assistant Inspector General.

General Kirk, shortly after taking office as Surgeon General, proposed that Grant become Deputy Surgeon General (and to sweeten the pill, that Grant be promoted to Major General). Further, he proposed that all AAF medical services be centralized in the Office of the Surgeon General. Grant refused this proposal, reported the matter to General Arnold, and requested overseas assignment. The C.G. AAF made it clear that no staff officer (The Surgeon General) of the C.G., ASF, was going to usurp the command responsibilities of General Arnold. Shortly thereafter, Grant was promoted to Major General, making him equal in rank to Major General Kirk.

General Kirk was next to instigate a different approach, namely, in July 1943, he had published W.D. Circular No. 165, "Elective Surgery" which was defined in such a manner that it could only be performed in general hospitals. Further, all specialists with the AAF would be declared surplus and transferred to the ASF. This was followed by W.D. Circular 304 in September, 1943, which, in effect, reduced Air Force Station hospitals to dispensaries.

War Department Circular No. 12, 1944, reestablished Army Air Force hospitals in the Zone of Interior and permitted elective surgery within the capabilities of the medical staff available. C.G. AAF had once again established his "command" responsibility and a medical specialist staff officer (SGO) of the ASF was again the loser in the military organization, the executive branch of government, the civilian medical profession, and before the public.

Colonel (later Brigadier General) A. H. Schwichtenberg, a flight surgeon, was designated as "Liaison Officer" between the Air Surgeon's Office and the Surgeon General's Office--an extremely difficult assignment, but well executed in the medical turmoil.

The AAF in The Pacific, China Burma-India Theaters were complaining about loss of man days when patients were sent to ASF facilities.

In Sicily, General Hospitals were assigned (not placed under command) to the Air Force when Army ground forces moved into Italy, but from England complaints reached the Secretary of War and the President that AAF personnel were not receiving equivalent medical care to that provided by the RAF. It was established that the complaints were not inspired by the Air Surgeon's staff or by General Grant.

President Roosevelt decided to intervene. He appointed Dr. Edward A. Stecker, Professor of Psychiatry at the University of Pennsylvania (he was consultant to the Navy and the AAF), Major General Kirk, the Surgeon General,

and Major General Grant, The Air Surgeon, to go to England. Dr. Stecker was to serve as chairman. It should be noted that Dr. Stecker was a friend of the then Surgeon General of the Navy, Vice Admiral Ross T. McIntire, who was also the White House physician. Roosevelt had not, until after his appointment of these three physicians, consulted General Marshall who, as Chief of Staff, was concerned that a controversy involving "staff officers" should be brought to the attention of the President.

On arriving in England, the board was confronted primarily with aircrew problems of health and morale in the Combined Bomber Offensive preceding the planned invasion of France. General Spaatz, C.G., U.S. Strategic Air Forces and Lt. General J. H. Doolittle, C.G., Eighth Air Force, "expressed their opinion" that the medical interests of the Air Forces, because of their highly-specialized problems would best be served by a separate medical establishment. This was indeed excellent "line" support of the AAF position of a separate medical service under command of the C.G. AAF rather than under the Surgeon General who was a special staff officer of the C.G. Army Service Forces.

The fact that "D-Day" for the European Invasion was less than one month away weighed heavily on General Grant and he reluctantly agreed to allow the majority of the Board's recommendations, namely, that the current medical system in England would remain in force and this would be the official report to the President.

General Marshall had taken action on the day the "Board" (four days after appointment) departed for England. He appointed Brig. General Kenner to represent the Surgeon General (and the Army Service Force) and Lt. Colonel Meiling (now Special Assistant to the Air Surgeon) to represent The Air Surgeon and the AAF as an "ad hoc" committee, without a chairman, to prepare a W.D. circular to resolve the friction between the competing medical military groups.

W.D. Circular 140 was published on April 11, 1944, as a result of the work of these two officers. The provisions of this W.D. Circular 140 pertained to only the continental United States. The AAF received authorization for "station hospitals" and "regional hospitals," professionally staffed to care for patients. The ASF was authorized to have "station," "regional," and "general" hospitals. Both AAF and ASF were authorized convalescent centers. Patients being returned from overseas could be sent to either general or convalescent hospitals. The C.G., AAF was charged with responsibility of all "air" transportation of patients with the necessary medical personnel required for this function.

The Army concept that combat wounded should be hospitalized separately from trainees was continued, but the Air Force concept that all patients could be cared for in the same medical facility was recognized. Air Force flight surgeons and medical administrative officers (non-medical) were assigned to ASF general hospitals to advise the hospital commanding officers as to the disposition, assignment and separation of Air Force personnel.

In the 1944-45 period, differences between projected hospital needs between the WDGS-G4, the CG ASF, and the ASF Surgeon General over the need for general hospital beds became very heated. The SGO, perhaps looking forward to the end of hostilities and his desire to retain patients and retain control of war wounded rather than transfer them to the Veterans Hospital system proposed construction of more general hospitals. The AAF countered by proposing better utilization of available beds in station, regional and convalescent hospitals. In December, 1944, at the time of the "Bulge" battle, the European Theater surgeon (Major General Hawley) was forced to empty the theater's general hospitals of patients who had been retained in England for long-term definitive care (against W.D. directives). At the same time, many battle casualties arrived

at AF Base, Mitchell Field, New York, within 72 hours of being wounded. The full meaning of hospital programs overseas and global air evacuation was dawning on military as well as medical planners. The build-up of large overseas hospital complexes was giving way to the concept of utilization of air evacuation, with assigned "air lift tonnage" allocation from the Joint Chiefs to replace the use of hospital ships, medical sections of military sea transports, hospital trains, etc. Medical officers wanted "air ambulances" with the "Red Cross" insigne (all vehicles with the Red Cross belong to the Army Medical Department) but the few medical officers who understood staff and logistic procedures (air lift tonnage assignments) were to prevail in planning for overseas operations. Every military patient required an average of six military personnel to support him at a time when each military individual required approximately one and one-half tons of logistic support per thirty-day period.

As Special Assistant to the Air Surgeon, Lt. Colonel Meiling was ordered to serve on subcommittees of both the U.S. Joint Staff and the Combined U.S. and British (Air, Army, and Navy) Staff. He was also the only medical officer assigned to AAF Post War Planning Group. Additional medical officers were being sent to the Command and General Staff school, etc., for staff training.

In January 1945, the Surgeon General requested 70,000 additional general hospital beds. The Army Service Force staff, the War Department staff, the President's (national) Hospital Board, the AAF staff, etc., were all involved in continuing discussion and, finally, the Inspector General, Major General Howard Snyder, M.C., recommended to the Chief of Staff (Marshall) that regional hospitals, both AAF and ASF, could and should be utilized to care for overseas returnees. No additional hospitals were constructed. The ASF medical regulating officer refused to participate in the assignment of patients arriving at Mitchell Field from Europe to regional and convalescent hospitals. This was corrected and no military patient suffered from lack of adequate air evacuation and hospital care.

The rehabilitation program in AAF hospitals had been conceived by Lt. Colonel (later Brigadier General) Howard Rusk, M.C. He was brought to the staff of the Air Surgeon and directed the physical medicine and rehabilitation AAF program, which was recognized and copied world-wide, and was the foundation for the Post-War civilian program in which Dr. Rusk became the international leader.

In April 1944, the Twentieth Air Force, composed of B-29 planes) was established with C.G. Arnold reporting to the Joint Chiefs. Rear headquarters was in Washington with Major Grant as Surgeon and Lt. Colonel Meiling as "Assistant Surgeon" (all in addition to their principal assignments to Hdq.USAAF). The first combat base for this strategic air unit was in India, then China, then Tinian, Guam, etc. The operations covered three and sometimes four "theaters." The medical support and logistic problem was a new concept in military medicine, as well as in military dogma.

The question before the Air staff was whether to request a separate Air Force medical service in the Zone of Interior and all theaters (the Air Force Commanding Generals in all theaters had requested in the strongest demands for the Air Force Medical Service) or merely control over hospitalization of XX Air Force Command world-wide. General Marshall was against overseas AF hospitals. General Arnold refused to press General Marshall for what his overseas commanders and XX Air Force Wing commanders desired.

During 1944-45, the North Atlantic and South Atlantic Wings of the Air Transport Command were notified that the ASF station hospitals were being withdrawn, including logistic support (rations, automatic re-supply of clothing, medical supplies, etc.) would be as an "exception" to the Air Force Dispensaries on the eight air transport command bases. They could not be called station hospitals because only ASF could command "hospitals" outside the Zone of Interior.

The Surgeon General, in early 1945, still not accepting the War Department reorganization of March 1942, submitted a memorandum to the Secretary of War attempting to regain the pre-1942 position of the Surgeon General. After months of staff meetings involving the War Department General Staff, ASF staff, AAF staff, Surgeon General's Staff, and The Air Surgeon's staff, the Secretary of War approved W.D. Circular 120. Little or nothing had been changed by this *directive*, but the drive for a "medical service" co-equal to the three military components (Air, Army, and Navy) had begun.

No attempt in the above comments has been made to tell the story of aviation medical research, psychological testing, the dental corps, the veterinary corps, the nurse corps. Mention must be made of the 13 flight nurses lost behind the lines in Albania in November 1943. These brave nurses, putting into application the survival techniques learned at Air Evacuation School, moved almost daily with the non-communist rebels (Micalovitz) through both the Tito (communist) controlled area and the German-held area to the coast and were evacuated by a British motor boat January 9, 1944. Three nurses were lost for weeks but they, too, found their way to Twelfth Air Hq. in Italy (March 25, 1944).

Likewise, the heroic deeds of Lt. Colonel (later Brigadier General) Randolph Lovelace, M.C., and Major Melvin W. Boyton, M.C., in making parachute jumps to demonstrate the feasibility of escaping from a plane at high altitude (40,000 feet). Boyton was killed when his "chutes" failed to open.

Then, too, we should not fail to mention First Lt. Schick, M.C., AAF, who was killed at Pearl Harbor. He had arrived with his B-17 Bomb Squadron (flying from California) during the second Japanese raid on Sunday morning, December 7, 1941.

In June 1945 (between V-E Day and V-J Day) there were, in the Zone of the Interior, 4619 medical corps officers on duty with the AAF serving 1,135,000

troops, or a ratio of 4.06 per 1000 troops. The AGF and ASF had 14,515 Medical Corps officers serving 1,749,556 troops for a ratio of 8.3 (M.C.s) per 1000 troops.

In reviewing the 1939-45 period, one is alarmed to learn of the man hours and man days spent studying, preparing staff documents, answering staff proposals, and learning to interpret directives to the advantage of one or another military organization. Nonetheless, the *fantastic care of sick, wounded, injured*, in the U. S. military forces surpassed all previous world military activities. The AAF lead in world-wide medical activities involving global air transportation of patients, early ambulation of post-operative patients, rehabilitation, and physical medicine, aviation protective equipment, oxygen systems, body armor (against low velocity missiles) heated gloves and clothing, etc.

The basic cause of the differences between medical plans organization and operations must be traced to General Magee and his staff in the 1939-42 period. First, their planning was based on the 1917-18 static warfare, second, they did not and would not recognize the role of air power as a military force (this applies to many WD, ASF, AGF, and theater commanders staff officers) and third, they did not cooperate in 1941 with WD planners preparing the War Department Reorganization effected March 1942. This lack of cooperation resulted in lack of understanding and, if you will, ignorance of the organization of the new combat and logistic forces which were to be the U.S. Army of 1942-45. Frustration on both sides led to faulty and, in many instances, total lack of communications. Man, being human, personalities, rivalry, jealousy, and personal animosities seeped into what should have been cooperative support of the war effort.

Now we enter the Post-War Effort.

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POST WAR YEARS 1945-1949

President Truman (as a senator) had served as Chairman of the Senate Committee on National Defense during WWII, as well as on the Appropriations and the Military Affairs committees. He sent to Congress, in December 1945, a message recommending the reorganization of the armed services into a single Department of Defense. The Administration Bill was introduced finally in February 1947 and passed into law in July 1947. This was the National Security Act of 1947, which provided the coordination of three co-equal military services--Air, Army, and Navy--thus the U.S. Air Force and a Department of Air Force came into legal being in September 1947.

General Marshall had been succeeded by General Eisenhower as Chief of Staff of the Army, and General Arnold had been succeeded by General Spaatz as C.G., AAF. Spaatz and Eisenhower had been senior commanders in the Mediterranean (North Africa and Sicily) and in the European Theater. Major General Malcolm Grow, who had served as Chief Surgeon, U.S. Strategic Air Force on General Spaatz's staff in Europe and in the final months in the Pacific War, succeeded Major General David N. W. Grant, who retired as the Air Surgeon, AAF, November 1945.

General Eisenhower and General Spaatz had a "personal" understanding in reaching consensus on "unification" that a period of two years would be provided to effect the transfer of personnel, services, and activities. Included was the statement, "chaplains and medical personnel will remain with the Army, and general hospitals for the Army and Air Force will be operated by the Army". Thus, development of intern and resident training programs, reserve medical personnel, etc., were denied the Air Force for this two-year period.

During 1946-48, the British Government was considering a proposal for the "amalgamation of military medical services". A royal commission and the Minister

of Defense established the government's position as follows: "Each military service requires a medical service responsive to the command of the parent service." Parliament approved this position.

It seems that General Hood, Director General of the (British) Royal Army Medical Corps had a "personal" understanding with Major General Norman Kirk, Surgeon General, Army Service Forces, U.S.A., that they would each seek in their own respective countries "amalgamated military medical services."

In November 1947, the new Secretary of Defense (J. Forrestal) and the Secretary of Air, Army, and Navy, considered the question, "should a single Armed Forces medical and hospital service be established." In January 1948, Secretary Forrestal named a committee on Medical and Hospital Services of the Armed Services composed of The Air Surgeon, Air Force (Grow); Surgeon General, Army (Bliss); Surgeon General, Navy (Swanson); and Major General Hawley, U.S.A., M.C., retired as Chairman, and Rear Admiral (later Vice Admiral) Joel T. Boone, M.C., as Secretary. This "Hawley Committee" amassed volumes of statistics and medical staff studies, but did not prove effective as the respective members did not have decision authority to represent their respective services.

The American Medical Association adopted the following position in 1946-48: "So long as three co-equal military services existed, it is necessary that each exercise 'command responsibility' for its supporting medical service, but that common medical services and facilities (medical supply catalogues, medical supply depots, medical libraries, air evacuation, etc.) should be unified and consolidated." The Council on National Emergency Services, of which Dr. Meiling (then at Ohio State University) was secretary, had developed this "position statement".

The Air Force Association, formed to serve air power in a manner similar to the Navy League, and dedicated to civilian support for the Air Force, in September 1947 held its first convention meet in Columbus, Ohio. Dr. H. Rusk,

Dr. Cortez Enloe, and Dr. Richard Meiling prepared and submitted a resolution "strongly advocating the need for the U. S. Air Force to have a medical service solely responsive to the Air Force command." This was the first resolution to be adopted by the Air Force Association and demonstrated civilian support for a United States Air Force Medical Service.

The first Hoover Commission, on Reorganization of the Executive Branch of the Government, was appointed by President Truman and chaired by former President, Herbert Hoover. Within this Commission was a Committee on Health Affairs, whose Chairman, Mr. Tracy Voorhees, had been a colonel in the Judge Advocate General's Corps, assigned as Chief of the Control Division of the Surgeon General's Office in the ASF during WWII.

A Committee on National Security Affairs of the Hoover Commission was chaired by Mr. Ferdinand Eberstadt, a New York banker and financier. Eberstadt had headed the Munitions Board during WWII. Mr. Eberstadt appointed Dr. Meiling and Dr. Rusk as his military medical advisors with the concurrence of President Hoover and President Truman. It should be noted that Dr. Rusk and Dr. Enloe were from Missouri and each was a family friend and frequent visitor to President Truman.

The "understanding" of General Eisenhower, who had been succeeded by General Bradley and General Spaatz, who had been succeeded by General Vandenberg, was now no longer felt to be "binding" by the U.S. Air Force.

Secretary of the Air Force, Stuart Symington, and Chief of Staff, Vandenberg, were concerned about an Air Force medical service. Secretary of Defense, Forrestal, disbanded the Hawley Board as being of limited effectiveness and appointed, in December 1948, a Department of Defense Medical Advisory Committee of all civilian medical leaders, each of whom had served in military capacities during WWII. This committee was chaired by Deputy Secretary of Defense, Charles P. Cooper, former vice president of the American Telephone & Telegraph Company, and Chairman of the

Board of Trustees of the Presbyterian Hospital of New York. The committee became generally known as "The Cooper Committee."

Secretary of Defense, working closely with Mr. Eberstadt, President Truman, and President Hoover had asked Dr. Meiling, Dr. James Hollers, and Dr. Rusk to serve on the "Cooper Committee," which they did.

General Eisenhower was, at this time, President of Columbia University and Secretary Forrestal had asked him to serve as "Acting Chairman" at each weekly meeting of the "Joint Chiefs of Staff," (Air-Vandenberg; Army-Bradley; and Navy-Adm. Louis E. Denfeld).

By prior agreement, only "agenda" items could be considered and voted upon by the Joint Chiefs of Staff, but on February 25, 1949, Eisenhower, frustrated over several months of obtaining no decision or consensus on agenda items, introduced a non-agenda item proposing the "amalgamation and unification of the Armed Forces Medical Services." The chiefs did not vote on this because it was a non-agenda item. Eisenhower, in a personal hand-written memo, forwarded this item to the Secretary of Defense.

The Secretary of Defense assigned this to Mr. Cooper and his committee. Mr. Cooper, in turn, assigned Dr. Meiling, who with Assistant Secretary of Defense, John Ohly, and Assistant Secretary of Defense, Mark Leva, arranged hearings to begin March 5 and continue through March 20, 1949.

The Eberstadt report recommended "the need for coordination (policy and program) of common services in health and medical affairs under the Secretary of Defense and medical services under command control in each of the military services." The Voorhees Committee reported "it is basic that the Armed Forces have a supporting medical service subject to military control."

On March 28, 1949, the Secretary of Defense resigned and Secretary of Defense, Louis Johnson, was appointed to succeed him. Mr. Johnson, a lawyer, had served as

an officer in WWI, and just prior to WWII, was Assistant Secretary of War. While all the above was taking place, General Grow, The Air Surgeon, was masterminding the work of his own staff with that of their coordination with other agencies. Such officers as Brigadier General William Cook, Brigadier General William Kennard, Major General Harry Armstrong, Major General Dan Ogle, Brigadier General Albert Schwichtenberg, Colonel Hayden Withers, Colonel John Love, and Colonel George Green, in Washington, were extremely active and productive.

On April 12, 1949, the agreed-to "transfer order" was presented to the Secretary of Defense by the Secretary of the Army, Rogal, and Secretary of the Air Force, Symington. This transfer order and the Cooper Committee report arrived at the Office of the Secretary of Defense almost simultaneously. Mr. Johnson, after a conference with Assistant Secretary Ohley, Assistant Secretary Leva, Mr. Cooper, and Dr. Meiling, decided to approve the recommendations. On May 12, 1949, Transfer Order No.36 was issued by the Department of Defense, followed by Air Force and Army adjustment regulations Nos. 1-11-62.

The U. S. Air Force, General Order No.35 (June 8, 1949) established The United States Air Force Medical Service and the position of Surgeon General, USAF, effective July 1, 1949. At last the USAF Medical Service existed.

The military and professional careers of some officers were often in jeopardy as they worked to attain the goal of a (USAF) medical service. It was their faith which often only seemed at best a dream that finally reached fruition.

Major General Grow was a great leader. In 1915, as a young civilian physician, he had been infatuated by the daughter of the then U.S. Ambassador to the Court of St. Petersburg, and followed her to Russia. He was given a commission in the Royal Russian Guard regiments and personally established the first central Russian Medical Service of the Czar, Nicholas II, forces. He received the Order of St. Stanislaus, with crossed sabers, the highest czarist military decoration,

as well as the Medal of St. George, third and fourth grades. Following the Russian communistic takeover, he returned to the United States and soon joined the U.S. Army Medical Service and was sent to Europe. He served as senior medical officer after WWI in the American expedition to Russia. His contributions to aviation medicine are of great note. He was co-founder, with Major General Armstrong of the Aero-Med Laboratory at Wright Field, Ohio. It was an experience to spend a few hours of relaxation and listen to his expert discussion of international and domestic political affairs, as well as military studies.

Major General Harry G. Armstrong succeeded, in November 1949, General Grow as Air Force Surgeon General. The development of USAF was confronted with gigantic problems. Lack of definite care facilities, lack of board-certified specialists, lack of construction funds, lack of research funds and equipment were only a few of the daily problems of 1949-50.

President Truman and Secretary of Defense had ordered established the position of "Assistant to the Secretary of Defense for Medical and Health Affairs" (Director of Department of Defense Health Services and Chairman of the Medical and Health Advisory Board).

They selected Dr. Meiling to fill these positions and he took office on July 1, 1949 as an advisor to the Secretary of Defense until Raymond Allen, M.D., who held the post from July 1 to September 1, 1949, had returned to his position as President of the University of Washington in Seattle. Meiling held this position until June 30, 1951, when he requested relief to return to his academic career at the College of Medicine of The Ohio State University. General Marshall granted this request provided Meiling would spend one day each week as an advisor to the Secretary of Defense. Mr. Lovett continued this program after he succeeded General Marshall. Dr. Randolph Lovelace (Brig. Gen. USAF, Res.) succeeded Dr. Meiling as Assistant to the Secretary of Defense effective July 1, 1951.

In June 1949, General Eisenhower returned to active duty and sponsored a proposed Department of Defense budget for 1949-50 of a mere 14.4 billion dollars. This was indeed a period of austerity. Then he, Eisenhower, departed for Europe as military chief of the newly-organized NATO (North Atlantic Treaty Organization).

In December 1949, relations between the Air Force and the Navy, over which service was to receive the majority of the limited funds, became almost intolerable. The Navy wanted a super aircraft carrier capable of handling "strategic bombers." The Air Force wanted to be the only service with strategic bombers capable of carrying "A" bombs, namely the B-36.

The Secretary of Defense (Johnson) cancelled the construction of the super aircraft carrier (The United States). Shortly thereafter, at congressional hearings, Admiral Denfield, Chief of Naval Operations, and other Naval officers had publicly opposed President Truman, Secretary of Defense, and Secretary of Navy (Matthews) on the proposed role of the Navy in the Department of Defense. On October 27, 1949, President Truman approved the request of Secretary Matthews to remove Admiral Denfield as Chief of Naval Operations. This was an unheard of action. Admiral Denfield resigned and a minority of Congress and the press had a field day denouncing President Truman and Secretary of Defense Johnson.

The Air Force had been the main force involved in the Berlin Air Lift in confronting the Soviet threat. Military, foreign policy makers, and the civilian public were deeply concerned with the U.S. strategy and foreign policy.

In this environment, the USAF Medical Service was being tested. Because of the potential Soviet reaction in Europe, the Middle East, and Asia, the Secretary of Defense, on the recommendation of the Assistant to the Secretary for Medical and Health Affairs (Meiling), directed that the USAF would be the primary service responsible for the air movement of patients, intra-theater, inter-theater, and in the United States. For the first time, the Air Force and its Medical Service was

...
serving all three military services. Thus the expensive build-up of general hospitals in overseas areas would be prevented and patients requiring prolonged definitive care would be brought to the United States where staff and scarce specialty professionals would be available for both the military and civilian sectors. The problem of matching the Soviet threat in several areas and maintaining United States civilian, as well as military needs of the military programs, was being given full attention. Hospital ships and hospital trains were put in storage. University hospitals were assigning a portion of their beds as temporary military hospitals in case of a national emergency.

In June 1950, the Korean situation exploded and the United States, with its United Nations allies met the challenge. The Air Force expanded in strength some two and one-half times, as did the Air Force Medical Service. Navy and Army reserve physicians were ordered to duty and assigned to USAF medical services by the Secretary of Defense. This was a legal test of the authority of the President and the Secretary of Defense. The military budget was no longer an insuperable problem for the Department of Defense.

Congress, in 1952, authorized the establishment of the Air Force Aeromedical Center at Brook Air Force Base, Texas.

In 1953, largely through the continued efforts of Major General Otis Benson (and his staff) and the USAF Surgeon General (and his staff), Aviation Medicine was recognized as a civilian medical specialty with board certification following examination.

Major General Armstrong (Surgeon General) was justly proud to state that the USAF Medical Service attained in its first five years a degree of effectiveness which, up until that time, had never been equalled by any other military medical service.

The achievements of Major General Dan Ogle, Major General O.K. Niess, Lt. General Richard L. Bohannon, Lt. General Kenneth E. Pletcher, Lt. General Alonzo Towne,

Lt. General Robert Patterson, Lt. General George Schaeffer, Lt. General Paul Myers and Lt. General Max Bralliar have, as duly appointed surgeons general of the United States Air Force, brought the necessary leadership, medical professional status, military knowledge, and personal contact with the chiefs of staff and their staffs, which have meant so much these past thirty-four years. Colonel Donald Westra, MAC, played a decisive role as executive officer of the various surgeons general of the USAF; he was a staff officer of the highest qualities.

The USAF Medical Service is the enlisted personnel, the officer personnel, and the Air Force family which understands loyalty down, and promotes loyalty up. He or she of the Medical Service who would wear the "air force blue" should accept the reason for a military service and career. They should seek continuing higher education in the military schools with the same degree of intensity they seek continuing medical and health care professional education.

Participation in "Red Flag exercise" and "Alert" programs are the essence of a military career, i.e., to be prepared to serve one's service, one's nation, and one's family.

The role of the USAF Medical Service in the years of turmoil in Korea, VietNam, the Lebanon situation, the Suez Canal Affair, etc., provided combat training and support or logistic exercises of great value during 1960-75. However, this part of the story of the USAF Medical Service shall be the responsibility of another history buff.

The art of military arms intertwined with the art of military medicine form a tradition in which the red thread of patriotism will always be recognized in the United States Air Force.

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About the Author--

RICHARD L. MEILING, MAJOR GENERAL, USAF (retired)

Born in Springfield, Ohio, 1908; received his A.B. degree from Wittenberg University, Springfield, Ohio, and his medical degree from the University of Munich, Germany; Board-certified in Obstetrics and Gynecology, as well as in Aviation Medicine (Preventive Medicine).

Entered the U.S. Army Air Corps as a Flying Cadet in 1932; commissioned First Lieutenant, M.C., U.S. Army 1938; Graduate of School of Aviation Medicine and of the Command and General Staff School.

Served as company commander, 7th Med. Bn, Bn Commander 52nd Med. Bn, Medical Supply Officer, and Assistant Surgeon I Army Corps, Assistant Surgeon First Air Force, Assistant Surgeon Twentieth Air Force, Special Assistant to the Air Surgeon, USAAF, Air Evacuation Officer and Medical Regulating Officer, member of the Post-War Long-Range Air Force Planning Board, C.O. Morale Division U.S. Strategic Bombing Survey, Assistant to the Secretary of Defense for Medical and Health Affairs, 1949-51, Assistant to the USAF Surgeon General 1949-68, Chief Flight Surgeon, Consultant to the Surgeon General in Obstetrics and Gynecology.

Currently Emeritus Vice President and Emeritus Professor, The Ohio State University.

Major General Meiling, a reserve officer, retired on December 21, 1968, from the U. S. Air Force and its medical service.

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APPENDIX I

All who contributed to the development of the United States Air Force Medical Service are not personally known to the author. Some who the author knew and with whom he was associated are listed as follows. To each, listed or not, we pay homage and express profound gratitude for what they did to further a worthy cause.

U.S. AIR CORPS AND U.S. ARMY AIR FORCE

The USAAF, The Air Surgeon

Major General David N W Grant
Major General Malcolm C. Grow

Staff

Brig. General Eugene Reinartz
Brig. General Howard Rusk
Colonel Fabian Pratt
Colonel Cadmus Baker
Colonel Ehrling Berquist
Colonel Walter Jensen
Colonel Clay Chenault
Colonel Robert Rutherford
Colonel Mott Gann
Colonel Dale Rice
Colonel William Glasser
Colonel John McGraw
Colonel Paul Holbrook
Colonel Gus Ledfords
Colonel Donald Hastings
Colonel Michael Conners
Colonel Paul Shands
Colonel Russell Lee
Colonel John Hargreaves
Colonel Herbert Wright
Lt. Colonel Melbourne W. Boynton
Major Cortez I. Enloe
Liaison Officer, USAAF to Office of The Surgeon General, USASF

Brig. General Albert Schwichtenberg

USAAF Air Evacuation Officer and Medical Regulatory Officer

Major General Richard L. Meiling

Appendix I (continued)

Special Assistants to The Air Surgeon, USAAF

Major General Richard L. Meiling
Colonel Robert Rutherford

U.S. AIR FORCE

The Surgeons General of the USAF

Major General Malcolm C. Grow *
Major General Harry Armstrong *
Major General Daniel Ogle
Major General Oliver K. Niess
Lieutenant General Richard Bohannon
Lieutenant General Kenneth Pletcher
Lieutenant General Alonzo A. Towner
Lieutenant General Robert Patterson
Lieutenant General George E. Schaffer
Lieutenant General Paul W. Myers
Lieutenant General Max Bralliar

* Deceased

Command, Plans, and Staff

Major General Harold Twitchel
Major General M. Samuel White
Major General John Cullen
Major General William Powell
Major General Wilford Hall
Major General Otis Benson
Major General Archie Hoffman
Major General Don Wenger
Major General Olin F. McIlroy
Major General Raymond Jenkins
Major General Charles Roadman
Brig. General Otis B. Schreuder
Brig. General Earl Maxwell
Brig. General Ben. H. Strickland
Brig. General William Cook
Brig. General Edward Kennard
Brig. General Harold Funsch
Brig. General Fratus Duff
Colonel George Green
Colonel Louis Arnoldi
Colonel Hayden Withers

Appendix I (continued)

Aero-Space Medicine

Major General Otis Benson
Major General Theodore Bedwell
Major General Donald Flickinger
Major General James Humphrey
Brig. General Randolph Lovelace
Brig. General Lloyd Griffiths
Brig. General Jack Bolerud
Brig. General Victor Byrnes
Colonel Robert Benford
Colonel Paul Campbell
Colonel Harold Ellingson
Colonel Vance Marchbanks
Colonel John Stapp

Dental Officers (AAF)

Major General George Kennebeck
Major General Marvin Kennebeck
Brig. General James Hollers

Nurse Officers (AAF)

Lieutenant Colonel Nellie Close
Colonel Juanita Redmond

USAF (Medical) Assistant Air Attaches

Major General Charles Roadman (Argentina)
Lieutenant General Kenneth Pletcher (England)
Colonel Paul Campbell (England)
Colonel George Green (France)

MAC Officers

Colonel Donald Westra (Dr. Jur)
Colonel George Hahn
Colonel Alfred P. Urquia
Colonel Daniel Herrin
Colonel James W. Polkenhorn

Public Relations and History - Congressional Inquiry

Dr. Mae Link
Mrs. Pat Bragg
Chief Master Sgt. Raymond T. Smith, USAF

GLOSSARY

A

AAC-----Alaskan Air Command
Acheson, Dean G., Secretary of State
Ainsworth, Maj Gen Fred C.
Alison, Maj Gen John R.
Allen, Dr. Raymond
AMA-----American Medical Association
Armstrong, Maj Gen Harry G.
Arnold, Gen Henry H.
ASTP-----Army Specialized Training Program
AT&T-----American Telephone and Telegraph Company
ATC-----Air Transport Command
AU-----Air University

B

Baker, Col Cadmus J.
Baldwin, Hanson W.
Baruch, Bernard M.
Batch, Lt Col Joseph W.
BBC-----British Broadcasting Corporation
Benson, Maj Gen Otis O., Jr.
Bevis, Dr. Howard
Billings, John S.
Bliss, Maj Gen Raymond W.
Bohannon, Lt Gen Richard L.
Boone, Vice Adm Joel
Boynton, Lt Col Melbourne W.
Bradley, Maj Gen Follett

Bragg, Pat
Bralliar, Lt Gen Max B.
Brandt, Dr. Karl
Bruckner, Lt Wilhelm

C

Campbell, Col Paul A.
Cannon, Gen John K.
Churchill, Dr. Edward
Churchill, Sir Winston
CIA-----Central Intelligence Agency
Ciano, Count Galeazzo
Clay, Gen Lucius D.
Cochran, Lt Col Jacqueline
Cochran, Col Philip G.
ComZ-----Communications Zone
Connelly, Matthew
Cook, Brig Gen William F.
Coolidge, President Calvin
Cooper, Charles, Deputy Secretary of Defense, Medical and
Health Affairs
Cooper, Proctor
Craig, Rear Adm Winchell Mc.

D

Davis, Adm Donald C.
De Bakey, Dr. Michael E.
demob-----demobilization
Diehl, Dr. Harold
DOD-----Department of Defense

D'Olier, Franklin
Dollfuss, Engelbert
Dönitz, Adm Karl
Doolittle, Gen James H.
Dulles, Allen

E

Eberstadt, Ferdinand
Eisenhower, Gen of the Army Dwight D.

F

FBI-----Federal Bureau of Investigation
Fitts, Col Francis M.
Forrestal, James V., Secretary of Defense
Franco, Francisco

G

Gill, Covington
Glenn, Brig Gen Charles R.
Goebbels, Joseph
Göring, Reichmarschall Hermann
Graham, Maj Gen Wallace H.
Grant, Maj Gen David N. W.
Grow, Maj Gen Malcolm C.
Gruenther, Gen Alfred M.

H

Handloser, Siegfried Gen
Handy, Gen Thomas T.
Harding, President Warren G.
Hasdorff, Dr. James C.
Hatch, Senator Carl A., Dem-NM
Hawley, Maj Gen Paul R.
Heim, Dr. J. W.
HEW-----Health, Education, and Welfare
Himmler, Heinrich
Hindenberg, Field Marshal Paul von
Hitler, Adolf
Hobby, Oveta C., Secretary of Health, Education, and Welfare
Hoffman, Gen Max
Hood, Lt Gen Sir Alexander
Hoover, President Herbert C.
Hopkins, Harry

I

Ireland, Maj Gen Merritte W.

J

JAG-----Judge Advocate General
Johnson, Louis A., Secretary of Defense

K

Keller, Col William
Kelly, Lt John
Kennard, Brig Gen William J.
Kennedy, President John F.
Kenner, Maj Gen Albert W.
Kenney, Gen George C.
King, Fleet Adm Ernest J.
Kirk, Maj Gen Norman T.
Knox, Frank, Secretary of the Navy
Kohn, Dr. Richard H.

L

L&L-----Legislative Liaison
Leahy, Dr. Frank
Lee, Gen Robert M.
LeMay, Gen Curtis E.
Leva, Marx, Special Assistant to the Secretary of Defense
Lickert, Dr. Rensus
Lindburgh, Brig Gen Charles A.
Liston, Col David E.
Long, Col Peron
Love, Brig Gen Albert G.
Lovelace, Brig Gen William R. III
Lovett, Robert A., Assistant Secretary of War for Air
Ludendorff, Gen Erich F. W.
Lutes, Lt Gen LeRoy
Lyster, Brig Gen Theodore C.

M

MAC-----Medical Administrative Corps
 MAC-----Military Airlift Command
 MacArthur, Gen of the Army Douglas
 Macready, Maj John A.
 Magee, Maj Gen James C.
 Marshall, Gen George C.
 Marx, Karl
 MASH-----mobile Army surgical hospital
 Matthews, Francis P., Secretary of the Navy
 McIntire, Vice Adm Ross
 McNair, Gen Lesley J.
 McNarney, Gen Joseph T.
 McNeil, W. J., Special Assistant to the Secretary of Defense
 MEDICAID-----Medical Aid
 Meiling, Ann Elizabeth Lucas
 Meiling, Capt George R. L.
 Meiling, Capt Margaret Ludy
 Mikhailovitch, Draza
 Milch, Field Marshal Erhard
 Morgan, Gen Daniel
 Morgenthau, Henry, Jr.
 MP-----military police
 Murphy, Ambassador Robert
 Mussolini, Benito
 Myer, Gen Albert J.
 Myers, Lt Gen Paul W.

N

NATO-----North Atlantic Treaty Organization
 Newton, Col George D.

Niemoller, Martin
Niess, Maj Gen Oliver K.
Nitze, Paul A.
Nixon, President Richard M.
noncom-----noncommissioned officers
Norstad, Gen Lauris
NSDAP-----National Socialist German Workers Party

O

Oestreicher, Hans L.
Ogle, Maj Gen Dan C.
Ohly, John H., Special Assistant to the Secretary of Defense
OSS-----Office of Strategic Services

P

PACAF-----Pacific Air Forces
Patterson, Lt Gen Robert A.
Patton, Gen George S.
Paullin, Dr. James
Pershing, Gen John J.
Pletcher, Lt Gen Kenneth E.

R

Radford, Adm Arthur W.
Ramey, Lt Gen Roger M.
Reinartz, Brig Gen Eugen G.
Renfrow, Brig Gen Louis H.
Reynolds, Maj Gen Charles R.

Richtofen, Wolfram von
Ribbentrop, Joachim von
Ridgway, Gen Matthew B.
Riefenstahl, Leni
Rockefeller, Nelson A.
Röhm, Capt Ernst
Roosevelt, Mrs. Eleanor
Roosevelt, President Franklin D.
Roosevelt, Brig Gen Theodore, Jr.
ROTC-----Reserve Officers' Training Corps
Rupprecht, King
Rusk, Benjamin
Rusk, Brig Gen Howard A.

S

SA-----Sturmabteilung (Stormtroopers)
SAC-----Strategic Air Command
Sargent, Dr. James
Schacht, Hjalmar
Schroeder, Gen Oskar
Schwichtenberg, Brig Gen Albert H.
SGO-----Surgeon General's Office
SHAPE-----Supreme Headquarters Allied Powers Europe
Simpson, Wallis Warfield
Smith, Howard K.
Smith, Lt Col Truman
Snyder, Maj Gen Howard McC.
Somervell, Gen Brehon B.
SOS-----Services of Supply
Spaatz, Gen Carl
spec-----specialty

Speer, Albert
Sperrle, Lt Gen Hugo
SS-----Schutzstaffel (Guard Detachment)
Staempfli, Capt George
Stämpfli, Col William
Stepp, Dr. William
Stimson, Henry L., Secretary of War
Strecker, Dr. Edward A.
Streicher, Julius
Strughold, Dr. Hubertus
Sutherland, Lt Gen Richard K.
Swanson, Rear Adm Clifford A.
Swofford, Lt Gen Ralph P., Jr.
Symington, W. Stuart, Secretary of the Air Force

T

T&O-----table of organization
TAC-----Tactical Air Command
Taft, Senator Robert, Jr., Rep-OH
Timberlake, Lt Gen Patrick W.
Tito, Josip Broz
Truman, President Harry S.
Twitchell, Maj Gen Harold H.

U

Ulio, Maj Gen James A.
UN-----United Nations
USAFE-----United States Air Forces in Europe
USSBS-----United States Strategic Bombing Survey

V

Vandenberg, Gen Hoyt S.
Vaughan, Maj Gen Harry B.
vet-----veterinary
Voorhees, Tracy, Chairman of Committee on Health Affairs

W

Wadhams, Col Sanford H.
Wagner, Col Robert F.
WASP-----Women's Airforce Service Pilots
Wasserman, August P. von
Wedemeyer, Gen Albert C.
Wilson, Brig Gen William L.
Withers, Col Hayden W.
Wood, Gen Leonard

Z

Zhukov, Marshal Georgi K.
Zollinger, Dr. Robert M.