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Wash. Files 62.010
Brief

Letter from Provinse to Eisenhower
May 16, 1942

Talked to Dr. Parran , Public Health Service, and his first suggestion that Public Health might assume complete responsibility for program (presumably health program in the centers) "from Washington right on down through the project level, providing a medical officer and a sanitary engineer (or two) for each center." WRA explained that this was unnecessary but only wanted suggestion of the most competent person for the Washington office.

.....

Letter from Dr. E. R. Coffee, Chief Med. Officer, WRA to Provinse
June 16, 1942

Need a minimum of 85 physicians or, if possible, 100 for 100,000 evacuees. Physicians should be of varied specialty. Now have 75 Japanese, and their specialites unknown until forms now being prepared are filled out. Dr. Thompson has employed 3 Caucasians, and may get another six or seven. These enough if no additional residents added.

Problem getting Reserve Commissions for Japanese physicians since many are aliens and hence not eligible for commissions in the Public Health. "However, from what I have been told it seems almost imperative that some plan be worked out whereby the Japanese physicians are paid an equitable remuneration for their services. If this is not done, it appears there will be a very low morale among the physicians which will effect the type of service they render and, in many instances, discriminatory action will have to be taken in preventing a physician leaving the Center for a position elsewhere. At least one application of this nature is already on file. As a first thought in the matter, it would seem that the Japanese physicians should be paid a minimum of $2600.00 per annum with a few who are outstanding in ability being paid $3200.00 per annum. (Note in margin:"Barrows says pay regular salaries if pay any.")"

Coffee goes on to suggest that dentists be paid $2400-$2600. per annum, and nurses at $720.00 per. Need 40 dentists but have 80 available. Need 500 nurses but have only 64 available.

.....

Memo of Information from WRA to Surgeon General, U. S. Pub. Health
Aug. 27, 1942

A Chief Medical Officer established in WRA Washington in charge of all health and medical program, directly responsible to Director. At projects, Chief Med. Officer administratively responsible to the Project Director.

Task of guarding health of 120,000 evacuees is enormous. Most projects located in sparsely settled counties where local health facilities are limited. Therefore, must be provided at centers. Of special interest opportunity to uncover every case of tuberculosis among evacuees. "Heretofore, because of the general attitude of the Japanese to tuberculosis, an effective tuberculosis control

has not been possible." Known cases of TB now about 500, but conservative estimate that 1,000 cases be turned up that needs care. Among evacuees there are approximately 75 physicians and surgeons and 60 registered nurses of varying quality. About 50 of the group of sufficient professional quality to merit Civil Service consideration, if appointments were based on Civil Service qualifications. "It has been found necessary to appoint a well-qualified Caucasian physican as Project Medical Officer at each project for the following reasons:

(a) The shortage of physicians among the evacuee group.

(b) The necessity for establishing and maintaining relationships of project operation with local and State Officials health agencies and organizations.

(c) The existence of many factions among the evacuees with the resulting difficulty in the selection of one of them as Project Medical Officer, even though professionally qualified. These factors include professional training, citizenship, loyalty and age.

(d) The shortage of nurses requires the employment of Caucasian nurses. " (end quote)

Difficulty in obtaining and retaining physicians and surgeons, nurses and other allied professional workers with adequate trainin g Prestige and facilities of U. S. Pub. Health Service would be most helpful in carrying out program. "Therefore, affiliation with the U. S. Public Health Service is desired. This affiliation, by offering reserve commissions to physicians, will improve the recruitment possibilities of Caucasian physicians, will assure selection of better qualified physicians, and will permit retention of present Project Medical Officers.".....

(The report ends with a two page account of the administrative organization of the medical division.)

.....

Memo from Thompson to Myer
Dec. 28, 1942

Submits Dr. McSparran's report of recent visit to Tule, Minidoka, and Topaz. Dr. Thompson declares: "The problem of tuberculosis and personnel continued to be outstanding."

Med.

Regional Files 541, Wash. DC
Miyamoto

Memo from G.D. Carlyle Thompson, to A.B. Carson
June 12, 1942

Your wire for caccine was received last night. The type of vaccine was not stated; however, I requisitioned Lederle Laboratories to ship you last night 72 ten point packages of Smallpox Vaccine (Lederle Code-Vine). This will give you 720 points of vaccine, and although vaccine in relatively inexpensive, it is hoped that you will be able to vaccinate more than one person with one capillary tube. Believe it or not, due to wartime circumstances, even the horses are being hard pressed for the production of necessary biologicals.

(Extract ffom longer memo)

Regional Files 541, W*sh. DC
Miyamoto

Med.

Memo from Shirrell to Fryer
Aug. 6, 1942

A very serious situation is arising in our Project relative to the practice of chiropractors. These men are licensed to practice under California state law. While I appreciate the medical complications involved I certainly feel that if people desire the services of a chiropractor they ought to have them.

Should we set them up with office space entirely separate from the Base Hospital or just how should we handle this? Please advise me at the earliest possible moment.

Regional Files 541, Wash.DC
Miyamoto

Med.

Memo from Shirrell to Fryer
July 7, 1942

Additional problems, as we certainly expected, are beginning to show. We have already made tentative arrangements which are fuuctioning satisfactorily, to take care of broken lenses with the local branch of the American Optical Comapny in Klammath Falls. This is being handles on a cost-plus basis.

A more serious condition, however, exists in respect to dental respect to dental repair work. I made a trip to Klamath Falls and, among other things, contacted the two general laboratories there. Both of them are now working far beyond normal capacity and while they stated they would do their best for us, they, nevertheless, said that a continuance of service to the project would not be possible.

I have asked our dentists to prepare a list of laboratory materials necessary for emergency repair work here in the project. I am enclosing this list to you in duplicate. We have checked in all our standard list, together with the medical catalog, and these items do not appear in any one of the three.

Since this matter is somewhat urgent, I should appreciate your immediate advice and, if possible, request that you order this material for us.

Regional Files 541, Wash. DC
Miyamoto

Med.

Memo from Shirrell to Fryer
July 10, 1942

When you were here during the early part of June, you discussed hospital supplies with Dr. Carson, and at the time were under the impression that shipment on the balance would be started from the St. Louis depot about June 21.

Since supplies have not started rolling in, we will appreciate your ruuning a tracer on this matter and letting us have your comment.

Regional Files 541, Wash. DC
Miyamoto

Med.

Teletype from Shirrell to Thompson
July 22, 1942

DENTISTS EXTREMELY ANXIOUS TO HAVE ACTION TAKEN ON CHAIRS AND EQUIPMENT CAN YOU EXPEDITE SHALL I PRUCHASE EQUIPMENT LOCALLY HUNDRED PATIENTS DAILY.

.....

Teletype from Thompson to Shirrell
July 23, 1942

HOPE TO HAVE PROCEDURE ON DENTAL AND HOSPITAL EQUIPMENT NEXT WEEK. MAjOR SAN* TILLI FORWARDING NE CESSARY CREDENTIALS FOR DOCTOR KANAI.

Regional Files 541, Wash. DC
Miyamoto

Med.

Memo from Elmer L. Shirrell, Project Director, by A.B. Carson, M.D. to Mr. E. R. Fryer, Regional Director

Aug. 26, 1942

ATTN: G. D. Carlyle Thompson, M.D. Regional Medical Officer

SUBJECT: Immunization Supplies

On July 27, 1942, we requested 2,000 cc's of pertussis vaccine and also a sufficient supply of diptheria-tetanus toxoid to immuuize 500 babies and infants.

On this Project, there are now over twenty cases of whooping cough. It is difficult to explain to our staff and to our public-health-minded citizens why some action has not been taken.

If you cannot obtain this material for us, will you please so advise and I will order immediately.

COPY

WAR RELOCATION AUTHORITY

San Francisco, California Office
Whitcomb Hotel Building

Tule Lake Project
Newell, California
August 8,1942

Memorandum to: Mr. E. R. Fryer, Regional Director
Attention: G. C. Carlyle Thompson, M.D., Regional Medical Officer
Subject: Highway Accident Patient

Eighteen year old Melvin Conley was brought in from the highway yesterday about 2:30 P.M. obviously badly burned.

He was given ¼ grain of morphine and immediately taken to surgery. Here all dead skin, blisters, etc., were thoroughly debrided. When this was done, it was found that the diagnosis was first, second and third degree burns of face, neck, chest, arms, hands, back, and thighs, penis, and scrotum. It was apparent that well over half the body surface had been badly burned, most of it severely. This correspondingly gave immediate poor prognosis.

The parents were advised that the patient was in no condition to be transferred to another hospital and could do so at their own risk.

Treatment has consisted of tannic acid sprays alternated with aqueous sprays of gentian violet, intravenous and subcutaneous fluids to a total of 600 cc. in 24 hour period, morphine to reasonably control pain and shock, and normal blood plasma, 500 cc., which was ordered immediately from Curran's drug store in Klamath Falls.

Dr. Carson recommended that the family doctor be called in and that special nurses for the 24 hour period be provided by the family was necessary for the boy's recovery.

Dr. T. C. Adams in Klamath Falls visited the patient at 12:15 A.M. and is assuming responsibility of the case. He discussed the case with Dr. Ito, the Officer of the Day, and any new orders given by him will be taken care by our Japanese staff. His comment on care given was

"Treatment is excellent and all orders and prognosis is confirmed."

Special nurses are being provided. We are tabulating the expense of all treatment and medications and Mr. Cecil Conley, Melvin's father has assured Mr. Shirrell that all expenses will be taken care of.

/Signed/ Elmer L. Shirrell
Very truly yours,
Elmer L. Shirrell
Project Director

by /s/ M. Graham R.N.
Chief Nurse

Regional Files 541, Wash. DC
Miyamoto

Med.

Letter from W. T. Nute, WRA, San Francisco, to Dr. G. D. C. Thompson
August 29, 1942

Dear Doctor Thompson:

The following telegram has been referred to this office for reply:

"LT. COL F. W. FOY
SERVICE OF SUPPLY WRA AUGUST 22 1942
WHICTOMB HOTEL BLG
SAN FRANCISCO CALIFORNIA
THE FOLLOWING TELEGRAM RECEIVED FROM CAREY PN FORT SAM HOUSTON PY QUOTE
REQUEST THAT MEDICAL SUPPLY OFFICER SAN ANTONIO QUARTERMASTER DEPOT FORT
SAM HOUSTON TEXAS BE FURNISHED PROCUREMENT AUTHORITY TO WHICH TRANSPORTA*
TION MAY BE CHARGED COVERING SHIPMENT ITEMS ON SGO REQUISITION 83136-JA
83136-G END QUOTE REQUEST YOU REPLY DIRECT

ELMER L. SHIRRELL
PROJECT DIRECTOR"

It would appear that items on SGO Requisition 83136-JA and 83136-G are being held at Quartermaster Depot Fort Sam Houston, Texas, for a requisition to cover transportation charges. It is suggested that you contact The Surgeon General and request him to advise QMC, Fort Sam Houston, Texas, that transportation charges are covered by his office.

.....etc.

Regional Files 541, Wash DC
Miyamoto

Med.

Memo from G.D. Carlyle Thompson, M.D., Regional Medical Officer to Elmer L. Shirrell, Project Director

SUBJECT: Supplies held at Fort Sam Houston, Quartermaster Depot.

Your wire of August 22, 1942, to Lt. Col. F. W. Foy, concerning supplies being held at Fort Sam Houston Quartermaster Depot has been referred to this office for action.

We have contacted the Surgeon General's Office in Washington, D.C. and he has arranged for the supplies to be shipped from the Quartermaster Depot at Fort Sam Houston, Texas.

We are advised that no further action is needed in this matter.

Regional Files 541, Wash. DC
Miyamoto

Med.

Telegram from E M ROWALT to E L SHIRRELL Sept. 18, 1942

TENTATIVE POLICY ON GLASSES: "UNTIL OPTICAL EQUIPMENT AND STAFF IS ARRANGED FOR AND IN OPERATION AT CENTER, ARRANGEMENTS SHOULD BE MADE OUTSIDE CENTER FOR REFRACTIONS, PROCUREMENT OF NEW GLASSES AND REPAIRS. REFRACTIONS AND NEW GLASSES SHOULD BE KEPT AT MINIMUM AND MADE AVAILABLE ONLY UPON APPROVAL OF THE CHIEF MEDICAL OFFICER. GLASSES IF FURNISHED BY WRA MUST BE UPON DEFINITE MEDICAL INDICATION AND FRAMES MUST BE AT REASONABLE COST." WHEN OPTICAL EQUIPMENT AND STAFF ARE IN OPERATION, REFRACTIONS AND INDICATED GLASSES WILL BE AVAILABLE TO EVACUEES ON MORE LIBERAL BASIS.

Regional Files 541, Wash. DC
Miyamoto

Med.

Memo from E. M. Rowalt, Acting Regional Director to
Colonel Karl R. Bendetsen, Wartime Civil Control Administration
Aug. 22, 1942

ATTN: Lieutenant Colonel W.F. Durbin

THROUGH: Captain M. H. Astrup

SUBJECT: Laundry Equipment for Hospital Unit, Tule Lake WRA

It is requested that consideration be given to the purchase of used lauudry equipment for thehospital uuit at Tule Lake War Relocation Project to meet a ccitcal situation existing as a direct result of the failure of new equipment to arrive as ordered.

The U.S. Engineers originally ordered new lauudry equipment for this project hospital from the U.S. Hoffman Company with a contracted delivery date of August 15. This action was taken in accordance with the instructions contained in a supplemental memorandum entitled "Standards and Details - Construction of Japanese Evacuee Reception Centers", issued on June 18 as a supplement to a June 8 bulletin originating from the office of Colonel Hansston. None of the equipment has been received. In view of the fact that the vendor has repeatedly postponed the delivery date, we feel j stified in doubting his ability to deliver the equipment the third week in October, which is the date now promised for receipt of the goods.

In the meantime, action must be taken to alleviate the situation that exists in the hospital laundry. A few home-style washing machines are the only pieces of equipment being used to provide clean linens for approxiiately 150 patients. These machines are of necessity overworked, and are rapidly deteriorating, with a corresp9nding loss of efficiency in operation. Theeay is not far distant when these machines will break down and be of no further use. The work can no longer be referred to private laundries, because the large volume of work involved has resulted in refusal on their part to accept the work.

(Extract from longer memo)

Regional Files 541 Wash. DC
Miyamoto

Med.

Elmer L. Shirrell by
Memo from A.B. Carson, M.D. Chief Medical Officer to Mr. E. M. Rowalt, Acting Regional Director

ATTN: G.D. Carlyle Thompson, M.D., Regional Medical Officer
Mr. Nute

SUBJECT: Surgical Instruments

Before your latest visit here, we sent you a list of surgical instruments, as well as many other things, which we further discussed with you during your stay in the project. Upon your return to San Francisoc, as you will recall, you took with you a list of supplies received and pending, You have already taken action on some of this material and we have received same as previously indicated.

There are, however, certain surgical instruments for which we have a great need. There are two cases of carcinoma of the stomach which may require resection if operable. We have absolutely no way to perform such surgery. Considering the diagnosis, I believe you can realize the importance of obtaining the necessary instruments. We have six cases requiring cystoscopic study pending. On the average, a case of this type will cost $120.00, the six cases, therefore, representing a $720.00 investment. I have made arrangements with the Klamath Valley Hospital and Doctor Earhart, of Klamath Falls, to do this work. It could, however, be done in the project if we had a cystoscope.

There are also huudreds of infected tonsils in the project. Some of them are very badly infected and are unquestionably affecting thehealth of the patient. If you will refer to our original list, all instruments necessary for this work are mentioned.

I am, however, enclosing a requisition for Payr intestinal clamps, which are most urgently needed for gastric resection and intestinal surgery, and a uterine tenaculum, two types being mentioned and first and second choices indicated.

Will you please advise what action should be taken at this point to facilitate our obtaining some of the other surgical materials previously requested.

Regional Files 549 Wash. D.C.
Miyamoto

Med.

Memo from Robert P. Lowe, Acting Regional Sanitary Engineer to
G. D. Carlyle Thompson, M.D., Regional Medical Officer
Oct. 23, 1942

MEMORANDUM TO: G. D. Carlyle Thompson, M.D.
Regional Medical Officer

SUBJECT: Sanitation Report on Tule Lake Relocation Project

I am attaching a detailed report on the sanitation problem at the Tule Lake Relocation Project. Only unsatisfactory conditions are mentioned.

It is in the following three parts:

Part I: General Statements

Part II: Inspection Report

Part III: Recommendations

A. Immediate attention necessary

B. Needed improvements

It is hoped that this report will aid in solving the many sanitation problems at Tule Lake.

Robert P. Lowe
Acting Regional Sanitary Engineer

Enclosure

R.P. Lowe: RO 10-23-43

SANITATION REPORT ON TULE LAKE RELOCATION PROJECT

Part I: General Statements

The overall condition of the project is good, but there are a number of problems and complaints that are justified. Some things will have to receive immediate attention and others must be attended to in the near future.

Much can be done to iiprove the operation of the water system and Imhoff tank through full use of the Health Division laboratory. This can be accomplished with practically no additional expense, as all main equipment and most cheemicals are available now. Dr. A. B. Carson has given his approval of the use of the Health Division laboratory for this purpose.

It is recommended that closer coordination be developed between the Health Division's Inspection Corps, sewage treatment plant operation, and the water system operation. Because of the limited size of the project, one person could very effectively handle both the health inspection and operations aspects.

Finally, operations and inspection reports should be sent weekly to the Regional Sanitary Engineer.

Part II: Inspection Report

A. Kitchen and Mess Halls

1. Two-tub system used with "Diversey D-Luxe" for washing and "Diversol" for disinfectant. An excessive amount of "Diversol" is used with the two-tub system. Some dishes are not clean.

2. Dish towels are dirty, as few are supplied.

3. Dish scraping tables have covering loose around garbage hole in some cases.

4. Mess hall garbage cans are left uucovered in many cases. Very few are using garbage can screen protectors. Also, there is improper spparation of wet and dry garbage.

B. Latrines and Lauudries

1. There is no method for washing out pots and commodes in the latrines. This is serous, as hand basins are being used for this purpose. No water is available in the living quarters for this purpose.

2. There are no small tubs for infant bathing.

3. The women have only showers. There is some complaint about no tubs.

C. Meat Warehouse and Butcher Shop

1. No sink or water is available.

2. Dirty aprons and wiping cloths are used.

3. No garbage can is available for meat scrap.

4. No screen doors on butcher shop.

5. Insufficient meat racks--carcasses are piled on the floors.

D. Cold Storage Warehouses

1. Iced vegetables have no floor drain and therefore cause water to collect on the floor in warehouse #T347.

2. Milk cans are reported rusty quite frequently as received from the Lost River Dairy. The Klamath Falls Dairy milk is reported to have foreign particles in it. These items were mentioned in a recent Tule Lake Health Division Inspection Corps report.

E. Rubbish and Garbage Disposal

1. Garbage and rubbish is partly burned in pits and left uucovered. This has caused considerable complaint about flies from the nearest mess halls. There is danger of an odor and rodent menace. The wet garbage is only partly fed to hogs as the hog farm is not yet completed.

2. Hospital garbage and waste are not disposed of separately.

F. Water Supply

1. A standard bacteriological analysis of the tap water was made by the writer, and the supply proved to be satisfactory. However, there is no chlorine disinfection. As the engineers' building uses a sewage dump hole near Well #5, this is a definite hazard with heavy rains due soon. It is urgent that the water should have closer bacteriological control.

2. There is evidence of excessive calcium carbonate deposition in pipes and boilers. This may ruin the hot water units if not controlled.

C. Sewage Treatment Plant

1. There have been many complaints due to odor caused by the Imhoff tank. This is due to improper chemical control and lack of the proper equipment, but it can be eliminated very inexpensively by following <u>all</u> recommendations.

2. The writer discovered that the wrong type of lime was being used for tank control.

3. One more man is needed for proper operation of the Imhoff tank to catch up on work.

4. Pump pit screenings were left uncovered.

5. Sludge bed pipes are not connected. Sludge should be drained by November 1st of this year.

Part III: Recommendations

A. Immediate Attention

1. Garbage Pit: grading of both pits and coverage with 8" minimum of soil. Extension of pit to accommodate future garbage. It is recommended that one man be stationed continuously at the pit to grade and burn the refuse as much as possible and to cover each day's disposal with a thin layer of earth. Eight inches is minimum final surface cover after filling pit.

2. Butcher Shop should have a sink with hot and cold water. Heavy screen doors (two) are needed and a garbage can for meat scrap should be provided. Butchers should have clean aprons and tool cloths supplied. The butcher shop is the most serious potential danger to the project.

3. Commode washing water should be piped to some convenient place. It is suggested that a cold water tap be piped to one of the toilet bowls most convenient. This should be done to one bowl in every latrine.

4. A ten cubic foot incinerator be built or bought for disposing of hospital garbage and waste. It should be placed near the hospital. The writer will give recommendations on the proper type.

5. The engineers' building sewage pit should be disconnected immediately. A temporary septic tank should be built further away on the lower side--at least 500 feet from the building. If this is not attended to, an automatic type chlorinator will be needed.

6. One thousand pouuds of chlorinated lime should be supplied the Imhoff tank for odor control and better operation. A 50# influent doze twice per week is sufficient for winter months. Three 1" hose nozzles for the Imhoff tank are urgently needed. Connection of Imhoff tank sludge pipes with Dresser couplings to sludge beds so that the tank can be drained before cold weather.

7. If a further inspection by the Health Division Inspection Corps indicates rusty cans and foreign particles in the milk, a detailed dairy inspection is recommended.

B. Needed Improvements

1. It was discovered that Mr. Henry Omachi, Imhoff tank operator, has the qualifications of a Sanitary Engineer needed over the water, sewage, and Health Division Inspection Corps. Unification of control would improve both operation and inspection.

2. Kitchen and Mess Halls: The use of the three-tub system with dish baskets for the last tub would relieve this situation. Nearly all mess halls have already been provided with extra tubs. It is suggested that rattan or willow baskets be used (similar to those manufactured by S. Birkenwald Company, Portland, Oregon). The saving in "Diversol" would pay for these baskets. Scraping table covers should be nailed down tightly, and garbage cans should be marked for wet and dry disposal.

3. Rubbish and Garbage Disposal: Extension of the hog farm for disposal

of all edible wet garbage will greatly facilitate this problem. All hogs, however, should be immunized against hog cholora by a veterinarian.

4. Food Warehouses: There is room for eight more meat racks in the meat warehouse to eliminate piling on the floor. Warehouse #T347 should have a center floor drain with trap and four cubic foot of gravel in a drain pit below.

5. Bath Tubs: One infant bath tub is desirable for each block.

6. Water Supply: It is suggested that the plumber take down one of the oldest shower or lauudry hot water heaters for scale inspection. The chemical analysis of the water indicates that there is serious danger of stoppage of all hot water pipes ~~of~~ from this source. It may be advisable to treat the entire supply with "Calgon" to prevent deposition in the pipes (not for softening). This is very economical, as the Army has a contract for "Calgon" (Hagan Phosphate) for draftee camps. As the chlorinator on the Imhoff tank is not being used, it is suggested that it be retained for possible emergency treatment of the water supply or sewage system. It is recommended that a standard water analysis be made twice per week in the Health Division laboratory. The Sanitary Engineer should make this analysis, if possible.

7. Sewage Treatment Plant: Proper operation tests with but very little additional equipment will eliminate most odors. The raw sewage ponds and seepage beds show a contamination with B. Coli. It is advisable to eliminate this section from the accessible project area. The seepage beds need grading and raking before cold weather to facilitate drainage. Screenings from the pump pit screens should have wooden covers on the containers and chlorinated lime should be sprinkled over it. The Imhoff tank operator needs the following small equipment: (1) Imhoff Gone, (2) four fifteen-foot poles, (3) two ten-foot poles, (4) two stiff one-foot brushes, (5) two dozen standard bile tubes.

8. It is recommended that miieographed forms be provided for reports by the Sanitary Engineer. These reports should be sent to the Regional Sanitary Engineer each week and should be divided into the following divisions:

I. Carbage and Rubbish Disposal Inspection (hog farms, dumps, and incinerators)

II. Food Handling Facilities (butcher shop, cold storage warehouses, and stoves)

III. Farm Sanitation (if separate)

IV. Industrial Sanitation and Safety

V. General Housing Sanitation

VI. Communicable Disease Control

VII. Communicable Disease Control

VIII. Mess Hall Inspection (twice weekly)

IX. Latrine and Lauudry Inspection (twice weekly)

X. Water Supply Report

XI. Sewage Plant Report

Water and sewage plant flow records will have to be made up to suit each project. A proper set of report forms will be furnished by the writer upon request.

Regional Files 541, Wash DC
Miyamoto

Med.

Nov. 4, 1942

Memo from G. D. Carlyle Thompson, M. D., Regional Medical Officer to
Mr. Elmer L. Shirrell, Project Director
Oct. 17, 1942
Attn: Dr. A. B. Carson, Project Medical Officer

Miss Stuart has informed us that you have not received a cystoscope, although you have requested it on numerous occasions. It was our understanding that the Walters Surgical Supply Company had submitted prices to you on the two cystoscopes appearing in your Supplemental Surgical Instrument List. In the event you have failed to receive these prices, we quote them to you:

1 Cystoscope, Braosch, 24 Fr.	$31.50
1 Cystoscope, 16 Fr.	31.50
1 Transformer and Cords to fit above	10.80

We would order these items for you if we could locate a requisition number to which they could be charged. However, as we informed you in a recent letter, we cannot place orders for the projects unless the items appear on a requisition bearing the signature of the Project Procurement Officer ane a number assigned by him. In this particular case, it is our suggestion that you request the Project Procurement Officer to issue a purchase order to Walters Surgical Company, 522 Sutter Street.

Regional Files 541, Wash. DC
Miyamoto

Med.

Letter from G. K. Hashiba M. D. Tule Lake, to Dr. C. Thopson,
Regional Medical Director, San Francisco, Calif.

Nov. 30, 1942

Enclosed is the list of work done by E. N. T. department and Surgical Division during past one month at Tule Lake. I sent it to you for your file.

We had very uuconfortable time for the first three weeks to have to live in the empty apartments due to lumber supplies. However, a few days ago we received very small supply which made us feel little happier.

Emergency supplies for the hospital is little easier to obtain now, although we are very short of equipments. I brought with me several trunks full of special instruments with which someof the works were carried out and will continue to do so but I hope the government supplies soon be available.

Regional Files 541
Miyamoto

Med.

Memo from G. D. Carlyle Thompson, M. D., Regional Medical Officer to
Mr. Elmer L. Shirrell, Project Director, Tule Lake WRA

ATTN: Dr. A. B. Carson, Project Medical Officer

We have been advised that we cannot issue purchase orders in this office uuless the requisition from the project contains a project requisition number. Since your requisition does not contain this number, we are returning it in order that you may request the Project Procurement Officer to issue a purchase order direct to Walters Surgical Supply Company. It is possible to do that now, since you have the exact price and terms for delivery of these instruments.

(Extract from longer memo)

Regional Files 541
Miyamoto

Med.

Telegram from Elmer L. Shirrell to Mr. E. M. Rowalt

3 TULE LAKE PROJECT TO WRA REGIONAL OFFICE 10-22-42 145 P

ATTN Dr G D CARLYLE THOMPSON

DESPITE SEEING ADMINISTRATIVE INSTRUCTION 45, DOCTORS DESIRE ABSOLUTE ASSURANCE PULLMAN RESERVATIONS FOR SELVES AND FAMILIES.

OTHERWISE REFUSE TO GO.

Regional Files 541 Wash DC
Miyamoto

Med.

Night Letter from G D CARLYLE THOMPSON, M.D. to DR E R COFFEY , Wash DC
San Francisco, Calif., Aug. 14, 1942

RE TT AUGUST 14. PREPARATION DEFICIENCY LISTS EACH PROJECT ENORMOUS TASK AND CHANGES WITH RECEIPT OF NEW ITEMS AT PROJECT. STANDARD WRA LIST CONTAINS ALL SUCH ITEMS BUT MEDICAL DEPOTS APPARENTLY SHIPPING ONLY STANDARD ARMY STATION HOSPITAL LIST. SURGEON WDC AND FA REQUISITIONED FOR WRA HOSPITALS ON BASIS WRA STANDARD LIST. QUESTION IS IS ARMY ABLE AND WILLING TO FURNISH ITEMS ON BASIS WRA LIST OR ONLY ARMY STANDARD LIST. IF NOT WE MIGHT AS WELL PLAN TO BUY ITEMS PECULIAR TO WRA LIST ON MARKET. HOWEVER ARMY SHOULD PROVIDE THEM AS ITEMS ARE ESSENTIAL TO CIVILIAN HOSPITAL OPERATION. MANY ITEMS IN ARMY STANDARD LIST ALSO DEFICIENT. IF YOU STILL WISH DEFICIENCY LIST PLEASE ADVISE WHETHER IT SHOULD BE BASED ON ARMY OR WRA STANDARD. IF ARMY LIST TO BE FOLLOWED ADVISE WHAT BED LIST SHOULD BE USED AND OBTAIN AT LEAST 25 COPIES OF SUCH LISTS. HAVE REQUESTED LIST HERE BUT NOT AVAILABLE. IF WRA STANDARD LIST NOT BEING FOLLOWED SUGGEST FOLLOWING: ALL TEN THOUSAND PROJECTS SHOULD BE EQUIPPED ON BASIS OF ARMY HUNDRED BED STATION HOSPITAL LIST PLUS 50 BED PLUS 25 BED EXPANSION LIST. TULE LAKE; GILA RIVER, AND PARKER SHOULD HAVE ADDITIONAL 50 BED PLUS 25 BED EXPANSION LIST. IF REQUEST OF SURGEON WDC FOR WRA HOSPITALS BEING FOLLOWED AS SUBMITTED? NEEDS WILL BE MET. IF ARMY STANDARD LIST FOLLOWED AS NOTED ABOVE ALL NON-STANDARD ITEMS NOW SHOWN AND ADDITIONAL STANDARD ITEMS AND QUANTITIES WILL HAVE TO BE ADDED FOR ARMY PURCHASE OR BE OBTAINED BY US. MANY IMPORTANT ITEMS NOW MISSING ENTIRELY OR QUANTITY INSUFFICIENT. TULE LAKE DEFICIENCY LIST 27 PAGES LONG AND INCLUDES SUCH ITEMS AS BEDS, CRIBS; MATTRESSES FOR CRIBS; BEDDING ALL KINDS FOR ADULTS AND CHILDREN; NURSING BOTTLES, TYPEWRITERS; CYLINDERS OXYGEN AND CARBONOGEN; OPERATING TABLE, OBSTERRICAL TABLE, EXAMINATION TABLES; CABINETS; SUTURE NEEDLES, HYPODERMIC NEEDLES, CATHETERS, INSULIN, PITUITRIN, INTRAVENOUS DEXTROSE AND SALINE, MOST NON-STAN ITEMS IN CLASS 5, MANY ITEMS IN CLASSES 1, 2, 3, 4, 7 AND 9, AND MOST NON-STANDARD ITEMS IN ALL

CLASSES. GILA RIVER DEFICIENCY SIMILAR: NO BEDS, BASSINETS, CRIBS, OPERATING TABLE, OBSTETRICAL TABLE, BEDDING ALL KINDS. PICTURE OTHER CENTERS SIMILAR. SURGEON WDC REPORTS GILA RIVER DEFICIENCY ITEMS BEING ASSIGNED OTHER MEDICAL DEPOTS FROM ST LOUIS BUT DO NOT KNOW ON WHAT BASIS DEFICIENCY ITEMS DETERMINED AND HAVE NO REPORT ON OTHER PROJECTS. PERHAPS YOU CAN EXPEDITE THROUGH SG-SOS AND ADVISE.

Med. Section

Regional Files 540
Washington D.C.
Miyamoto

Letter from Joy Barragrey Stuart , Nursing Consultant to
Miss Claribel A. Wheeler, Executive Secretary
National League of Nursing Education
Sept. 19, 1942

We are endeavoringat the Projects to have a complete community health service, which includes a hospital (165-200 bed, according to the size of the project), an out-patient department, and a public health service. In charge of the health service at each project is a Caucasian Medical Officer and Chief Nurse, and uuder them will work Japanese professional personnel and such Caucasian as are necessary to carry out the program.

The number of Japanese professional people is small. For over 100,000 people, we have 65 R. N.'s, only 58 of whom are physically able to work. We have, however, about 103 student nurses who have had anywhere from 4 months to 2½ years training. (The above figures change constantly, as some of the nurses do not report as soon as they enter the Project; however, I doubt that we ~~still~~ will ever have more than 75 R. N.'s and 125 student nurses among the evacuees.)

Extracts from longer letter.

Regional Files, 110 (General) Wash., D. C.
Miyamoto

Letter from Dr. Thompson, Regional Medical Officer to Dr. Coffey.
July 16, 1942

The other day I asked Mr. Fryer to inquire of Mr. Myer during his long distance telephone conversation with regard to the possibilities of Public Health Service reserve commissions for medical officers. Mr. Fryer reported afterwards that there was still some uncertainty as to reestablishment of such apolicy.

I know that from the standpoint of the Regional Office and from Mr. Fryer's personal point of view that we all feel very definitely that such commissioning would be most desirable. Doctor Sleath just arrived from Tule Lake and was thoroughly in accord with commissioning. His only doubt expressed was in regard to the attitude of the Japanese toward a man in uniform in the Center. We have all discussed this point before and have felt that the Public Health Service affiliation would be most helpful in solving rather than creating problems with the Japanese physicians and people.

I am convinced more than ever that it is desirable that such commissioning be arranged for. I know that recruitment of physicians both of military and non-military age would be expedited if such commissions were available. In talking with physicians during the past few weeks, I have found more difficulty in obtaining their interest in the work than I had discovered before. Most of them seemed to prefer to stay at their present positions or practice rather than to accept a change that did not carry a commission.

The prefer nce for a commission in the Public Health Service is based purely on the individual's training, experience, and interest, especially those who have had any Public Health work. The purely clinical man is generally not interested anyway unless he has had some Public Health philosophy imbued in him in the past.

I know that while you were here you were not 100 percent sold on the idea of commissioning the Medical Officers, and I honestly weighed certain disadvantages to such a move also. However, as you know, when you left I concluded that it was the desirable thing to do from everybody's point of view. I feel more convinced of that today than ever. In fact, from the standpoint of the total medical service, I think the problem of obtaining even the minimum number of physicians for WRA Centers without commissions is so great that I am almost certain that we will eighter be forced to obtain marginal or submarginal persons or go without.

Another solution might be the payment of much larger salaries, which I think would offer many points for criticism.

I am hoping that you have not cooled to the idea of commissioning medical officers of of developing a plan with WRA so that the Public Health Service is cooperating in the health program. If you have, I am wondering if you might not wish to give reconsideration; if you have not, if you will lend your moral support to the Washington staff in adopting a policy which would make possible such a commission.

You will receive the latest Standards Lists of order requests for the new Projects and a set of hospital forms in a few days.

Regional Files 549, Wash DC
Miyamoto

Med

Memo from G.D. Carlyle Thompson, M.D., Regional Medical Officer to
E.R. Fryer, Regional Director
Aug. 22, 1942

SUBJECT: Gila River Medical Officer's Report of Existing Conditions.

I know you are terribly busy and probably extremely tired but the attached memorandum reporting existing health conditions at Gila River is so significant that I believe it requires our immediate attention.

I have talked with Major Sharp on the telephone this afternoon and read to him significant paragraphs in this report and explained in the memorandum prepared for your signature to Colonel Bendetsen. He has agreed to teletype this afternoon to the Engineer at Gila River requesting connection of the autoclave within 24 hours, completion of a ward in unit 2 within 48 hours and the outpatient building to follow immediately in the next 24 hours.

While the above meet the needs temporarily, they are certainly inadequate for the population expected at Gila River in the next few days. Unless some change is made in construction schedule or for movement of evacuees, it appears evident that the story of Manzanar will be repeated. The mild epedemic of diarrhea which has been moving through the project may not be significant but it surely is improper that we should trust to luck.

Wash. Files 82.010
Health (General)

December 31, 1942

Memorandum to: The files

Subject: Medical Care for Yoshiye Togasaki, M.D.

The correspondence files will show that Doctor Togasaki became ill while on duty at Manzanar. They will also show a statement prepared by Dr. James Goto, who was in attendance at the time. Because of the serious illness of Dr. Togasaki, her sister, who was a Public Health Nurse in Tanforan, was permitted to travel to Manzanar through arrangements made directly at Tanforan by WCCA.

I had requested that Dr. Kazue Togasaki, another sister, gotto Manzanar in the interest of her sister's recovery. She was unable to do so because of duties at Tanforan. In place thereof, another sister, Dr. Teru Togasaki, who is in residence at the Colorado River Relocation Project, although at that time she was not active on the hospital staff at Colorado River, came to Manzanar.

Shortly after, I visited Manzanar and held consultation with Dr. Goto, Dr. Teru and her sister, the Public Health Nurse, as well as discussed Yoshiye's illness with her. Just prior to this, the question had been raised of providing medical consulation in San Francisco. I did not concur in this plan at the time, and there was some doubt about the advisability of moving Dr. Yoshiye, which resulted in making arrangements for Dr. Teru to go to Manzanar. At the time of my visit, the consultation was further discussed, in view of the proposed transfer of Dr. Yoshiye to Tule Lake, and I proposed that a stop-off be arranged in San Francisco for medical consultation if such consultation was still deemed necessary. Dr. Teru, speaking for the family, reported that she did not consider it necessary at that time. This was also the feeling of Dr. Yoshiye.

After arrival at Manzanar, letters were received from Dr. Kazue and Dr. Carson concerning the need for medical consultation. In view of these letters, and also after several telephone conversations with Dr. Carson, it was determined that medical consultation was required to determine the risk involved directly relating to Dr. Yoshiye's heart condition. Upon medical examination at Tule Lake by Dr. Hashiba, a hysterectomy was recommended (I did not receive a full medical diagnosis.), the hysterectomy to be done by Dr. Hashiba and Dr. Kazue to give the anesthetic. However, before either wished to assume the surgical risk involved, they desired consultation regarding Dr. Yoshiye's heart condition.

Therefore, the project was advised by wire that if it was determined that suitable consultation was available at Tule Lake, that WRA would pay any expense involved, and if not available at Tule Lake, WRA would pay expenses involved in arranging for such consultation in San Francisco. If consultation was available in Klmath Falls and the family did not accept the consultation there, San Francisco consultation would be at the expense of the family.

Mr. Shirrell reported directly to me by telephone on the day that Dr. Togasaki left Tule Lake for San Francisco that Dr. Carson had determined that suitable consultation was available at Klamath Falls. I informed Mr. Shirrell that under the circumstances, I would not be able to recommend that he overrule Dr. Carson's decision, even though the Togasaki family would not accept such consultation services, believing them to be inadequate.

I suggested that they obtain the opinion of the medical consultant in Klamath Falls; in the event that it did not prove satisfactory, that a report be made and if, in the opinion of Dr. Carson the consultation was inadequate, we could then be in a position to arrange consultation at a more distant point. The family refused to follow this suggestion. The family proceeded to San Francisco at their own expense.

Dr. Carson later advised me that he interviewed physicians in Klamath Falls and determined that two electrocardiograph machines were available, that he was advised by Klamath Falls physicians that they would refer patients with similar difficulty to the physicians owning these instruments for consultation.

I visited Dr. Yoshiye at Children's Hospital in San Francisco. She was unhappy and disturbed over the delay in getting her to San Francisco and because WRA did not assume her expenses. She was also distrubed about conditions at Tule Lake and frankly disliked Dr. Carson's general attitude to the Japanese. She was critical of WRA staff because certain items, in her mind most urgently needed in a hospital, were not at Tule Lake. Most important item mentioned was Kline Antigen for serological work. Not receiving this item through WRA channels, she obtained some through personal channels in San Francisco. The item is not that important at Tule Lake, since complete serological service is available in Klamath Falls at any time it is needed, and for less urgent cases it is available through the California Health Department in San Francisco.

She resented not being able to have a physician of her choice or not being able to go to a University Medical Center for consultation at WRA expense. I explained the diffiuclty and actual lack of justification for arranging such consultation for all evacuees. This she accepted for others, and seemed to be more satisfied with the situation for herself.

I talked with her physician, Dr. Purdy, who though not through with a complete medical study, stated definitely that no coronary disease existed. She was uncertain about the need for abdominal surgery, but it was still under consideration the need for abdominal surgery, but it was still under consideration the basis of an exploratory. In any event, the situation has not been an emergency. If surgery is to be done, Dr. Purty reports that Dr. Yoshiye is considering returning to Tule Lake so that it can be done by Dr. Hashiba. She probably prefers surgery in San Francisco, but in respect to Dr. Hashiba and in consideration of the prestige of the medical service at Tule Lake, she feels it her duty to return there for surgery, if any is to be done. Dr. Hashiba is qualified, however, to do it.

G. D. Carlyle Thompson, M. D.
Medical Officer WRA

Wash. Files 62.010

Memorandum

Date: June 16, 1943

To: Dillon S. Myer

From: G. D. Carlyle Thompson
Subject: Assignment Army Medcial Department Staff to WRA.

As per your request during recent conference between you and Mr. Provinse and myself, the following information is given relating to the immediate situation regarding physicians and nurses at War Relocation Authority Centers as a basis for exploring with the War Department the possibility of their assigning commissioned officers to WRA for services at Centers.

On the basis of present average daily hospital census and the Center population, and in addition to those now working the minimum immediate request to the War Department is for 71 registered nurses and 16 physicians. It is most important that three of the physicians be able general surgeons and on e or two be specially trained in tuberculosis. The surgeons are needed at Centers which are now without surgeons while the tuberculosis physicians are needed to cover all Centers.

We have been unable to employ surgeons. One physician employed in tuberculosis work was recently commissioned in the Army and we have been unable to locate a replacement.

Summary Physicians and Nurses-Ten Projects
(Includes both Evacuee and Appointees)

Registered Nurses required now	166
Registered Nurses on duty now	95
Registered Nurses short and needed now	71
Physicians required now	84
Physicians on duty now	68
Physicians short and needed now	16

Basis for Determining Physicians and Nurses Needed

In general the basic factor used in determining physician needs at each Center is the ratio of one physician to 1500 population. Only three Centers approach this ratio at this time. This basic ratio is modified at some Centers by the following factors:

(1) The degree of isolation of the Center and the lack of available nearby medical and hospital facilities.

(2) The living arrangements within each Center such as number of spparate camps.

(3) The age, skill and health of evacuee physicians.

(4) The prevalence of certain diseases and their concentration at certain Centers such as tuberculosis.

Furthermore, the population basis as the major factor in determining physician needs,will become less important as relocation progresses while the hospital census will become a factor of greater importance. The total hospital census at all Centers has not reduced with the advent of relocation, in fact during the last part of May, the census was higher than during the previous three months.

Registered nurse needs are determined on the basis of one registered nurse per 21 hospital patients, plus one chief nurse and one public health nurse. The nurse hospital patient ratio also covers the nursing service required in the operation of all clinics. Clinics are no small factor for duing the past few months daily patient clinics have varied between 125 and 350, depending upon the size of the Center. Operating with such very low Registered nurse standards supplementation through the use of evacuee nurse aides, orderlies and hospital attendants is required. A program to utilize this type of worker has always been in operation and continues so. The training of such workers requires considerable time on the part of the physicians and registered nurses.

Factors Hindering Recruitment of Nurses and Physicians:

(1) General shortage of physicians and nurses throughout the country.

(2) Prevalent unwillingness of nurses and particularly physicians to voluntarily leave their present community, hospitals, or health department to render service in Japanese Centers without military commissions or orders. This results partly from the recognition of the existing needs of their community and the fear of criticism by their own patients, or health departments, affecting their post war status.

(3) Salaries: Recent increases in nurses' salaries in public and private hospitals and the growing demand for nurses at high salaries in Industrial plants offer greater attraction than Civil Service salaries for physicians are very much lower than even the less competent physicians are able to earn in private practice or Industrial war plants.

(4) Isolated nature of Centers and inconvenient living accomodations.

(5) A rather frequent initial dislike for the Japanese race especially under war time conditions. Such dislike is generally only successfully over-come through personal interviews. Interviews at the time of initial contacts with interested applicants while important, is generally not possible.

(6) Objection by some nurses and phsycians to the policy of replacing evacuee nurses and phsycians with appointed nurses and physicians when no objection is voiced to supplementation of staff.

No request or statement has been included covering dietitians, laboratory and X-Ray technicians, also essential for operation of hospitals at Centers. While there is immediate need for workers in these fields at most Centers at this time, we do not believe we have yet fully pursued civilian resources. This is being done as rapidly as possible.

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Physicians Available and Working - Ten Projects

Physicians	Original	April 1	May 15	June 15	Maximum Expected
Evacuee	# 86	69	60	54	## 35
*Appointed	-	13	12	14	?
Total	-	82	72	68	-

\# Not all able to work at all times.

Have not yet indicated they are relocating. It is reasonable to expect a further reduction in the number of physicians who may remain at the Centers.

* Continual recruitment has been in force for Chief Medical Officers. Since the loss of Japanese phsyicians, effort has been made to recruit physicians for general clinical service. There have also been several resignations of appointive staff.

Nurses Available and Working - Ten Projects

Nurses	Original	April 1	May 15	June 15	Max. Ex
Evacuee Registered Nurses	# 72	42	31	22	## 15
Evacuee Student Nurses	# 79	45	32	28	0
Total Evacuee Nurses	# 151	87	63	50	15
*Appointed Registered Nurses	-	72	71	73	?
Total Registered Nurses	*	114	104	95	-

\# Not all able to work at all times.

Have not yet indicated they are relocating. It is reasonable to expect a further reduction in the number of nurses who may remain at the Centers.

* Continued recruitment has been in force, but it has been with great difficulty that replacements have been found for resignations.

WAR RELOCATION AUTHORITY

Memorandum

To: Mr. J. H. Provinse, Community Management Date: June 19, 1943

From: G. D. Carlyle Thompson, M.D., Chief Medical Officer

Subject: Tule Lake Social Analyst's Report, attached

The Social Analyst's report which Mr. Coverley submitted with his letter of June 16 has many excellent features and represents considerable investigation and thought by Mr. Opler. Except where he has made statements or propounded opinions in fields which are highly controversial and which he apparently does not realize, and except in a few instances through absence of complete facts, the report is good and generally very helpful. I have made marginal notes in numerous places, not for the purpose of argument, but simply for the purpose of noting incomplete statement or that there is another point of view which must be considered in passing judgment upon either the regime or the individuals responsible for the regime.

I do not know whether Mr. Opler is a member of one of the Tule Lake factions, of which I understand there are several, which has difference of opinion with Dr. Pedicord because of his failure to provide medical services to appointed personnel. I state this because Mr. Opler reports no improvement in the administration or operation following Dr. Pedicord's arrival. It cannot be denied that such improvement occurred and in fact it was of a very noticeable degree.

Some of the situations described I am familiar with and probably could write a long dissertation setting forth many phases which Mr. Opler has failed to mention and probably failed to note or learn about, since it is very unlikely that the information would come from the evacuees. For example, some of the doctors involved in transfers from Tule Lake were problems before they got there and some were problems after they left. Others who were transferred to Tule Lake worked out very satisfactorily while others transferred away worked out satisfactorily at the new Centers. Such transfers occurred both during the administration of Dr. Carson and Dr. Pedicord.

The excessive overstaffing of the hospital in many of the nonprofessional and nontechnical departments resulted in a large measure to the original policy of WRA to give every evacuee employment. Dr. Pedicord found over 600 employees on the hospital staff when he assumed responsibility. To my amazement, I believe Dr. Carson was devoting nearly fifty per cent of his time to giving care to appointed staff thus not being able to fulfill his proper duties in hospital operation.

Mr. Opler is quite off base in a number of points relating to medical care and hospital procedures in that he could not possibly obtain all of the information required to let the situation in any way influence his reasoning. An example of this is the statements regarding the Doctors Togosaki. The fact that one woman died under the circumstances that caused the death at Tule Lake is an indictment against any physician in which event it is most difficult for the physician to satisfactorily justify, explain, or in any other manner deny responsibility and in most instances to deny very incompetent service. In this

instance Dr. Pedicord was concerned and placed definite restrictions on future use of the procedure by the individual involved. The individual continued to ignore the restriction and thus the suspension from the staff. I was there at the time of the suspension which was not publicized and was never announced except by the doctor involved. The physician involved actually had been ill and Dr. Pedicord extended the courtesy to the individual of accepting short leave. Actual suspension in writing followed violation of the leave.

Summary: In conclusion, it is granted that Dr. Pedicord was not tactful in his approach to many of the problems. At my last visit I attempted to council him in this matter and have also discussed the problem with Mr. Coverley requesting him to council Dr. Pedicord.

The relationship between the Acting Chief Nurse and Dr. Pedicord also was difficult at one time but after Miss Stuart's and my visit, the situation had been reported to be very good. Miss Stuart so noted at her last visit to Tule Lake. The difficulty between the nurse and Dr. Pedicord arose from two factors, I believe. First, the nurse was not well and, second, the evacuee staff sensing a sympathetic person in the nurse, and a few having a very definite dislike for Dr. Pedicord, followed a technique which played the nurse against the Chief Medical Officer and vice versa.

I should go to Tule Lake soon. In the meantime Dr. Pedicord, I believe, should remain. However, it may be advisable to effect a transfer to another center, and in fact if I am convinced that his attitude was characterized only by the tone of this report, I question whether he would work out at any Center. A number of our persons, however, have had difficulty at their post of original assignment and have been most successful in a new situation.

Attachment

WAR RELOCATION AUTHORITY

Memorandum

To: Dillon S. Myer Date: 6/23/43

From: John H. Provinse

This is the report from Tule Lake which Harvey used to support his request for Dr. Collier's remaining at Tule in place of Pedicord. Dr. Thompson has read and his comments are attached. He has also indicated that the report is useful to him, and he will visit Tule Lake in July to see whether some change should be made. In the meantime, Collier has returned to Gila to replace Sleath who is coming into Washington temporarily.

In justice to Opler, it should be pointed out that with one exception (p. 3 where he discusses medical vs. administrative functions) he has held himself to his reporting job and is not expressing judgments on the hospital situation. He has done what Harvey has asked him to do, and I think rather well when his length of time at the Project is considered. It is perhaps unfortunate that his first assignment at the project -- after only a week's residence -- should have been this rather controversial problem, any report on which is likely to be interpreted as taking sides.

Attachments

WAR RELOCATION AUTHORITY
Tule Lake Project
Newell, California

WAR RELOCATION AUTHORITY
COMMUNITY ANALYSIS SECTION

CONFIDENTIAL

SUBJECT: Memorandum for Mr. H. M. Coverley,
Project Administrator
FROM: M. K. Opler, Social Analyst, in response to a request of 6/11/43

COMMUNITY ATTITUDES TOWARD HOSPITAL ADMINISTRATION AT TULE LAKE PROJECT

Among topics currently discussed by residents of Tule Lake, two appear to be of major importance in the minds of the colonists: resettlement and hospital administration. Of these, only the latter involves mention of particular personalities, and the personalities, in turn, evoke a picture of administrative procedures in marked contrast one to another. Since the colonists willingly described this striking contrast, and expressed a definite preference for certain types of administrative procedure, apparently represented in the one personality and not in the other, the author, despite the delicacy of the topic under discussion, took particular pains to assemble the entire story. It should be added that attitudes on hospital administration are far from difficult to obtain. As a matter of fact, earnest individuals in the community see in hospital administration an index of community attitude on two contrasting types of administration in general.

The following report therefore has possible significance beyond the field of medical service. As such, it is based on a cross-section, and I think a consensus of community opinion. To achieve this, we incorporate, unless otherwise stated, only such attitudes as emanated from (1) a number of separate neighborhoods and informal group associations, or (2) received emphasis in accounts of individuals widely recognized as community leaders. All such statements were generally agreed to by people who worked in the hospital or are at present employed in the organization. To avoid hasty or random judgments, [statements were cross-checked, and care was taken to avoid reliance on particular factions in the community while assessing the total picture.

This picture, as I receive it, may be divided for purposes of clarification into three administrations, two of which succeeded each other: first, Dr. C's and then Dr. P's. For reasons of delicacy, I shall call the earlier administration, that of Dr. C., by the term: "the old regime." The current administration, that of Dr. P, I shall call by the term: "the new regime." To avoid monotonous repetition of phrases smacking of oversimplified French history, I shall refer directly to the temporary administration of Dr. Collier in plain English. The reference to the two preceding "regimes" is thought necessary, since each administration at Tule Lake is discussed by colonists in terms of its immediate antecedent, and as we shall see, in contrast to it.

The "old regime" of Dr. C was one in which a minimum of friction existed in relationships between administration, on the one hand, and resident staff and colonists, on the other. It is surprising, therefore, that the "old regime" is described critically. Apparently, a maximum of laxity, of laissez-faire, was present in this administration, amounting at times to virtual absence of administrative control. Resident doctors state, for example, that the practice of

consulting them, of relying on their judgment, and of incorporating their decisions severally on each and every matter, proceeded to the point where resident staff doctors were deferred to in questions where their answers and judgments were well enough known in advance to preclude the necessity of consultation, and where much time was wasted by a tendency to overlook the need of defining functions and working out flexible rules which might then be used as guides to future action. Administration was apparently a day to day affair, this or that doctor constantly being interrupted at his work to furnish an idea, approve a plan, or consult on a procedure. In all of this, the chief medical officer was liked for personal qualities, and democratic impulses, and further, respected as a fellow physician. At the same time it is generally recognized that controls and policies were too diffuse, too random and too slow in achievement to guarantee efficiency in operation so necessary in a functioning hospital service which does its job. I stress this point of criticism of the laxity in the "old regime" as I have heard it to indicate quite clearly from the very outset that the resident doctors and colonists alike have no particular love of laissez-faire and are duly conscious of its possible shortcomings. Of the three regimes, however, Dr. C's stands midway in the scale of criticism. He was liked as a friend, and is so criticized. Indeed, the residents find it quite possible to explain his shortcomings as administrator in terms of his young years and apparent inexperience at the time in this phase of his work. The implication is that Dr. C is an expert physician, and may some day become an equally efficient administrator. But turning back to the past, it is likewise charged that the oversupply of certain medical products and the overstaffing in resident personnel which greeted his successor, Dr. P, upon arrival, were not the result of wilful extravagance on the part of resident doctors so much as an inevitable consequence of this lack of organization, of reliance upon separate and individual staff judgments, of leaning heavily on personal contact and friendly relations to the exclusion of collective responsibility and entire staff consultation to the end of defining and adhering to a body of procedural rules.

Perhaps partly as a result of this heritage and partly because of a marked difference in personality and administrative attitude, the next incumbent ushered in a "new regime" which literally leaped to the opposite extreme. I suspect the contrast was jarring, to begin with, and certainly was not helped by a tendency, quickly reported and broadcast in the colony, to refer to Japanese-American physicians and patients as "Japs" vis-a-vis, to assume authority not only in an administrative sense but in a medical sense as well, and to do all this in a manner calculated to convince the resident staff that skin-color would henceforth be a criterion in scientific judgment and that colonists must submit to medical methods of the "I won't coddle you" variety. At any rate, word went throughout the colony that childbirth would henceforth be an ordeal, and pain, in general, might be expected. In retaliation, I am told, colonists made their own judgments of scientific ability as between Caucasian and resident medical staff.

In the "new regime," authority was now centralized to a degree where, again, staff consultation involving the entire medical corps was excluded, though in a manner far different from the "old regime" and for diametically opposed reasons. Medical service, formerly a part of Community Services, soon began to function as a separate Division in the Project with dominant authority in matters both scientific and administrative forcefully exercised by its chief officer. I am told that this distance between the two regimes organizationally was more than exceeded by the change in administrative attitude as exemplified by the new incumbent. As a matter of fact, the resident medical staff was advised of the difference immediately in no uncertain terms, and on numerous subsequent occasions reminded that the authority, administrative and medical, was now vested in one man.

I should stop at this point in the account to add that the recent experience of Japanese-Americans, in the period of federal investigations, during evacuation, in the assembly centers, and to a certain extent in the Relocation Centers, had made them doubly conscious of their existence as a group. For the time being, a distinct feeling of a group subordination was manifest and informal leadership was felt to exist, under these conditions, in the person of professional and educated individuals. Thus, the subordination of doctors, many of whom had enjoyed enviable reputations and high professional status up and down the West Coast, was taken as a symbol of the entire process of group subordination.

Group sentiment was quick to extend sympathy to the resident doctors and to court leadership in what was thought to be a matter of caste distinction. This process is still going on, though it is important to note that the opposition is aimed at the "new regime" exclusively and that Dr. Collier's administration pro tem is hailed by both resident doctors and colonists as the solution to the problem. It is said that Dr. Collier is a "gentleman and a scholar" (a phrase I have heard more than a few times and for which there seems to be ample concrete evidence.) The following pages contrast this "new regime" and Dr. Collier's administration pro tem, as I have heard it described.

Before passing on the contrast in community attitude toward these two administrations, it would be well to record an opinion found in the colony, which although not widespread, nevertheless is heard more and more frequently. It is simply that in the administration of hospital and clinical agencies, medical and administrative functions should be kept separate. The idea is an arresting one, particularly since it agrees with current theoretical opinion as recorded by experts in the field of executive administration. Findings on hospital administration indicate that such administration is most efficient and entails fewer complications when in the hands of non-medical experts in administration, who of course rely on medical staff in scientific matters, but who in their own operations are able to avoid involvements in professional jealousies, in favoritism, and in professional jockeying for position. The existence of such hospitals, as well as those headed by medical personnel, allow for neat contrasts which range all the way from budgetary considerations, to matters of tenure, fairness in personnel procedures and the like. It is a well-known fact, in comparing these two types of administration in American hospitals throughout the nation, that in those administered by doctors exclusively, questions of who is to operate, who is to be placed in charge of a given department and who is to be advanced frequently result in a confusion of medical and administrative questions. As a consequence, medical matters are often not decided by scientific lights alone, while administrative matters tend to be complicated by considerations which are basically professional. In the colony, the criticism of this fault in administration is quite unconscious of theoretic virtues, but rather proceeds as a hostile attitude toward a particular administration, -- the "new regime," -- and its chief exponent, the Caucasian medical officer:

1. "Why do we need a Caucasian doctor in charge? This doesn't square with the interest in economizing. After all, Dr. P can't decide everything about the cases. The people go to the Japanese doctors anyway, because they like the ones they have. It was different with Dr. Iki, who used to be here. The people from Marysville hated him because he charged high prices for immunization, like typhoid shots, which they had to have, and then ran things in the assembly center so that he made a lot of money. Iki finally had to go to a different assenbly center. (They hated that lawyer, Walter Tsukamoto, for the

same reason and he became a Commissioned army man -- he had a Reserved Officer). But they like their own doctors who work for them. Iki went to a different Relocation Center, while three of the doctors here signed pledges to stay as long as there are people around. The doctors know their case(s) and after all they're working their hardest for the people. If Dr. P tries to step in, he might not know the case as well. He can't understand the old people if they only know Japanese language. And the other doctors (the resident physicians) can't stop and ask him for his orders when the patient is an emergency on the operating table. They shouldn't have to consult him for everything and worry about who is boss. Sometimes they feel they must go ahead and do something not in his book. That's when I guess he bangs the table and calls in the Japanese doctor to tell him who is boss here. I guess the doctors here sometimes don't agree with his methods but instead of talking things out, he says "I'm boss and you do things my way."

2. "A doctor should do a doctor's work, and not have to worry about red tape. It seems Dr. P wanted to cut out certain things and cut down on the people working. He just went ahead and did it. Then he told the other doctor's staffs later. He cut down on nurses too much; made a figure and cut it down to that. Then Dr. H (resident physician) made a careful estimate and showed they have to have a few more. Each time, they (J-a physicians) have to prove it to him. Then they can't get along if they disagree after Dr. P has made the order. A doctor is busy. Sometimes they get only a couple hours sleep a night. They shouldn't have to worry about forms, about supplies. All that should be out of doctor's hands. Residents' staff should do that work."

3. "... The mess-hall was just one example. P ___ cut it out for nurses and doctors. Those people work very hard, and they're on their feet most of the time. Still they worry about running the hospital. I think it should be off their minds. Someone else should take care of it, if Dr. P doesn't know how."

Other accounts suggest more than a bifurcation of function. It is realized that since caste inevitably enters into the situation in a W.R.A. hospital, the confusion of medicine and administration is many times compounded. Some feel, for example, that a Japanese-American doctor should be placed in charge of the medical function, while the administrative function should be placed in the hands of a separate resident staff.

It will be seen from the foregoing that the matter of subordination of resident medical personnel looms large in the thinking of the colonists. The "new regime" apparently was thought dictatorial from the very outset, and very early stories were circulated which tend to illustrate this view. The opposite seems true of Dr. Collier's administration pro tem even though it has functioned for a limited period of time. Stories of the "new regime," which have wide currency, are now told with reference to the difference between Dr. P's methods and Dr. Collier's. I should like to enumerate a few of these accounts since they give a concrete basis for comparison, if not of administrations (Dr. P's and Dr. Collier's), then at least of residents' attitudes towards them. Instances of medical judgment are found in some of these, but since they are discussed and repeated widely, they are common property in the realm of information and rumor.

1. Loss of Resident Doctors and Disagreements on Matters of Technique.

Formerly as the story is told, a staff of about a dozen well-qualified Japanese-American physicians functioned under the direction of a chief medical officer of Caucasian extraction. This was at the beginning of the "new regime."

Under W.R.A., according to his interpretation, both administrative and medical decisions came under his jurisdiction, and he indicated quite early that he disapproved of certain practices of his staff and would not countenance them in the future. Whereas Tule Lake once had a large number of resident physicians, it now has six, some of the ablest having transferred to other Relocation Centers. The story is usually told with emphasis suggesting that all, or practically all, transferred to escape the dictation of Dr. P. Further questioning indicates that many of them did, while some resettled in eastern areas of the country.

The cases most frequently mentioned involve two noted women physicians, sisters, the Drs. Togasaki. Both have enviable West Coast reputations, one as pediatrician and one as gynecologist. (The author had heard of the Drs. Togasaki a number of years ago in Portland, Oregon.) They were particular favorites on the staff among Issei women and, I believe, one of the boasts of educated young Nisei of outstanding Americans of Japanese ancestry in the Tule Lake Project. Both are said to have left because of the authoritarian regime, though there is no indication that either complained to colonists of their feelings on the matter of their treatment here. Only a very few individuals actually had heard that one of the Drs. Togasaki, suspended by the chief medical officer for using a certain method in a difficult operation, intended to write up the case in scholarly fashion for a leading medical journal. The fact that she was summarily suspended from operating for a brief period of time because she used this method in an emergency maternity is widely known, however, and it is always added that Dr. T. decidedly experienced in this type of work, had saved both mother and child by the method distasteful to Dr. P. The feud over operating methods had proceeded for some time, and personnel, experienced in surgery, were annoyed by Dr. P's interference. The resident physicians, for their part, have been in unanimous agreement for some time that the chief medical officer is not a surgeon apparently, and the story has it that they keep the ball rolling in such a way that he is prevented from performing operations.

In regard to Dr. Collier, it is said that he uses methods of medical consultation to good effect and in a manner which wins the confidence of resident staff. In checking this opinion both with Dr. Collier and with the staff physicians, I find not only mutual respect and confidence between both administrator and staff, but also abundant evidence that medical matters are decided in an atmosphere conducive to good teamwork. Dr. Collier respects the abilities represented in his staff, and the staff doctors, in turn, appreciate his tact, his professional integrity, and his purposes. There is no indication here of a repetition of the old regime. Decisions in the interests of efficiency -- like the removal of unsterile clothing and coats from rooms where hospital equipment is stored, or the removal of semi-pornographic "art" (dustcatchers) from hospital wards, or the decision to make cabinets for patients' belongings -- all are viewed as steps in the direction of making the hospital a better institution.

2. The Criticisms of "Economy at Any Price."

A stock criticism of the new regime is that it exemplifies an "economy at any price" attitude, which, in reference to the cases of particular patients, works considerable hardship. Often this criticism suggests that the chief medical officer cares little about the patients because they are of Japanese ancestry; sometimes, it is said, he neglects cases requiring surgical attention because of the above-mentioned feud anent surgery and a feeling that surgery should be avoided. One person said, "Dr. H (resident physician) is a well-known surgeon. Dr. P (chief medical officer) is not. They don't get along generally, and they don't get along on this question either. Because of the fight, and

because of Dr. P's authority, the cases which should be operated get neglected. Dr. H is made to buy his own operation tools (surgical instruments) out of his own pocket. If he breaks one of his tools he has to buy another. You'd think Dr. P would get some of these things here, but he is stubborn, too. He refuses to do anything about those cases, so the patients get it in the neck."

The following cases, widely discussed in the colony, are included not as medical evidence, but as indications of a point on which the "new regime" is criticized and Dr. Collier's administration respected. They are therefore pertinent evidence of a difference between administrations, as viewed by colonists.

Case A: The first case concerns a young lady who arrived at the Center with an uncorrected congenital dislocation of the hip. In her former household, where meals were served in the home and walking at a minimum or, at any rate, on pavement or even flooring, this disorder occasioned no great pain or inconvenience. In the Project, however, with meals served in a mess hall, roads on the gravel and bumpy side, and social centers scattered throughout, the problem of walking for this lady at first necessitated the use of crutches and even this method, in the course of time, became quite painful. Referring her case to the hospital, and coming under the surveillance of a resident doctor, it was decided that the only proper course in her situation involved an operation for which special instruments were necessary. I was told by more than one doctor that the thigh-bone in this case was actually pressing against the outer surface, quite painfully, and that the condition had deteriorated in the period of residence at the Tule Lake Project. The instruments needed for a corrective operation (I believe a particular type of bone saw) were in storage in one of the resident physician's effects in his home town (California). He offered to go, under escort, and to bring the equipment back, as well as to perform the operation on return. Doctors on the staff, following consultation decided to approach Dr. P and offer a series of alternative solutions: (1) for the physician in question to return to his home town, under escort, and get the needed equipment; (2) to order similar instruments for the hospital; or (3) through administrative channels -- the chief medical officer -- see the lady off to the nearest clinic where materials for such operation could be had. The story goes that the administrative channel was the one selected, but that no action was taken. A resident doctor, writing to the nearby clinic to ascertain the reason for the delay, learned to his utter surprise and dismay that the clinic was entirely unaware of the existence of any previous correspondence on the case. It is said that some months had passed, and that the resident staff, by this time, had assumed that their recommendation for an operation, already agreed to (though grudgingly), and their selection of a clinic, was now implemented by correspondence with that clinic on this particular case. The word reached the colony and the residents, angry at the protracted delay, proceeded to raise funds by means of benefits for the special equipment. The fund is now raised, and future benefits for additional equipment are being planned. Although no direct action has yet been taken, it is said throughout the colony that the acting medical officer, Dr. Collier, is sympathetic to such cases when brought to his attention, and entirely willing to cooperate in seeing them through to conclusion. One typical statement was the following: "Dr. Collier, instead of standing in the way and doing nothing, wants to go ahead and help us solve these problems. He takes part with the doctors. He doesn't argue against operations just because they're operations, and once he says he'll do a thing, it's his word of honor he'll do it." I have heard it said, though perhaps it is a rumor, that action is now guaranteed, thanks to Dr. Collier, on Case A.

Case B: The second case involves a young man with TB of the spine. Again by mutual agreement of resident staff doctors, the case requires immediate operation. Equipment, similar to that of Case B, is needed, and roughly the same period of time has elapsed pending action with results which, though possibly less painful to the patient, are decidedly more serious. The attempts to arrange for outside operation follow the pattern of Case A, some saying that the two cases were grouped together. It is likewise said that the regular chief medical officer procrastinated in regard to this case, some adding that the temporary medical officer, Dr. Collier, has already acted expeditiously on this case.

Case C: The third case requires no great attention to detail. It involves a cancer of the throat. Fortunately for the patient, the cancer has remained hard and localized, though the need for radium treatment has not been fulfilled. (Colonists refer to this treatment as "X-ray treatment," which apparently is J-A terminology for radium treatment and is not completely understood by older Issei. The eldest doctor also slips into the "X-ray" terminology.) The same charge is levelled against Dr. P, of making no sustained attempt to arrange for treatment of this case. One prominent resident physician complained that "the harder and more serious the case, the less attention it gets. In emergency situations, sometimes almost as serious as this case, we are put at the mercy and under the orders of a second in command who doesn't even have medical training. When Dr. P is gone, he's supposed to be boss." (And there followed charges of a more serious personal sort against both Dr. P and the Caucasian "second in command.") In Case C, one doctor on the staff stated that "Collier would take the necessary steps, and I think he's doing something about this case too."

In the colony, such cases are frequently described as attempts to economize at the expense of patients. One leader of opinion in the community said, "You can tell even from the short time he's been here that (Dr.) Collier looks on the hospital as a plant with a job to do, just like on the outside. P. looks on it just like an organization for charity which he's got to run cheap(ly). Since he (Dr. P) has been here, it's been a continual cutting down. Cut things out! That's one of the reasons all those doctors transfer to other centers; they hate to see it that way. If you thought of the patients first, you wouldn't do it that way, -- you'd do it (Dr.) Collier's way. He starts with the needs, not the organization. The doctors would still be here if he had been (Dr. Collier had been) in charge after C left. Now they're short and the doctor's (Dr. P's) way of doing things make it just so much harder for the Japanese doctors left here."

Concerning the alleged shortage of medical staff, there is some potency in this argument. Liberal estimates of the proper ratio of Doctors to population run about one physician per 1,000; while conservative estimates run about 1,500 population per physician. Taking the latter estimate, Tule Lake is short 3-4 doctors in all probability insofar as the physicians concerned take part in the active management of a hospital, which in other situations is separate and distinct from private residential-office types of practice. Besides this, the semi-permanent housing in barracks, the often crowded living conditions, [illegible] the change in many cases to colder climate, and the previous difficult conditions imposed in assembly centers, probably are not in sum conducive to the best health imaginable. At any rate, residents frequently group point one (Loss of Resident Doctors) and point two (Economy at Any Price) as joint threats to their health security. They likewise say "their doctors" would have remained to take care of their needs much more willingly had service to the colonists been the dominating motivation of the "new regime." As they see it, resident physicians

experienced feelings of discouragement and some succumbed, leaving the project. The stalwarts, so to speak, reacted differently, half of the remaining number signing a pledge to "stick it out" (as one individual put it). Thus the new regime is viewed as a threat to their security. How much abstraction, based psychologically on their previous loss of security is present in this view I am not prepared to say. Undoubtedly, the exact weighting of past and present experiences and resultant attitudes cannot be measured; but it is certain, none the less, when the administration of Dr. Collier is regarded as a solvent for these fears, that much of the feeling of insecurity, in regard to health, emanates directly from administrative pressures and practices inextricably linked to the "new regime." This observation will be discussed further in regard to the following point.

3. Curtailment in Functions -- Hospital Connected

Another report having widespread circulation concerns the question of administrative orders suddenly curtailing or ending former hospital-connected functions in the Project. The first of these, in the minds of the residents, was an order ending the serving of meals in the hospital for all personnel, like ambulance drivers, nurses' aides, nurses, etc. I find that this "incident" is not discussed in the colony in a prejudiced and one-sided manner, but rather that it is generally admitted that there were abuses of this function (food hoarding, or over-ordering of more delectable food items). As a matter of fact, a petition circulated to have the chief medical officer's order prohibiting a general hospital mess rescinded was quickly recalled in the initial stage because of this realization of the vulnerability of the case against the "no hospital-mess order." Similarly, it is felt that Dr. Collier's earnest attention in regard to the somewhat lavish ordering of food is amply justified, and that the lax situation does require real and immediate correction. Rather, the criticism aimed at Dr. P. on this matter, centers in the sudden and drastic steps taken to correct a situation which had existed a considerable length of time. "He tightened up suddenly," said one informant, "as if it wasn't partly his fault that there wasn't all-around discipline and respect for his Project orders. He had let it go some time, and then cracked down. That's the way of cat and mice."

It is therefore argued that the method of correction was punitive rather than simply corrective. According to both physicians and colonists, nurses and nurses' aides were suddenly ordered to return to their respective mess-halls in the blocks, in many cases at a considerable distance from the hospital. These individuals, who work long hours (on their feet) and who lack facilities, in the hospital, for occasional rest and relaxation, pointed out that "outside hospitals" make such provisions for staff where companionship and quiet surroundings break the edge of an exacting routine. The ruling annoyed the medical staff especially since it came withoutprevious consultation. Because the order limited lunch to only one individual from each department in the hospital, it was contended that from the point of view of hospital administration alone, it was arbitrary and ill-considered. Illness knows no noon hours and consequently, it was said, more than one ambulance driver might be needed on the premises for emergencies, or more than one nurse in a ward for treatment purposes. The rule, therefore, is construed as more than an economy measure, and in actuality, a curtailment of necessary functions. Then, too, outside hospitals, it is said, provide lunch-rooms for staff, who otherwise might experience additional hardship in being kept on their feet and on the run longer.

The most crucial argument is that in the penalization of staff for past misdemeanors, Dr. P arbitrarily impaired the functioning of the hospital by imposing burdens on the staff and by limiting the noon-hour effectiveness of several departments. While the author cannot comment on the second contention, the first was checked to the extent of determining that while most of the doctors live fairly close by the hospital, most of the staff (nurses, etc.) do not.

It can be seen from the foregoing that while some individuals informed me of Dr. Collier's likewise adamant opposition to food wastage, these accounts contain no measure of criticism, or animosity toward the administration characteristic of versions of the "no hospital-mess order." The general impression one gets, on the other hand, is that Dr. Collier is regarded as the kind of person who conceivably might enlist the aid of staff in achieving a careful and considered plan for correcting the situation. One account ended significantly: "Dr. Collier would try to think of the job from the hospital angle. The nurses and doctors have no real place to sit down. Instead of cutting out things that give them 'school spirit' type of feeling, Dr. Collier tries to think of ways to get a hospital running like one -- just like a hospital should be run anywhere -- here or outside." The typical physicians' comment on Dr. Collier in connections such as this run the "gentleman and scholar" pattern. One doctor, who liked to stress this phrase, said: "He's a gentleman and a scholar, because he thinks like one. That's why we like him fine."

To clarify this point further, a second recent order might be discussed from an entirely administrative point of view. There was in operation until quite recently at Tule Lake a practice of serving people in need of special diets (diabetics, ulcer cases, and the like) in separate blocks, the food for such meals coming from the hospital kitchen. The story goes that in the interests of economy, a sudden order was issued to discontinue this supervision of diet, and ineeed, the entire service. (The author, no physician, wonders at the wisdom of this proposal, but that is not the question.) What is significant about this incident, as most colonists view it, is that staff doctors were met by patients from the special diet areas at noon and asked why the special diets had suddenly been curtailed. Apparently, insufficient provision had been made for the transfer of this function. As I have heard it expressed, the provisioning of special diets had been turned over to the housekeeper's aide service of the Social Welfare Department, which, incidentally, was unequipped and totally unprepared to carry on with the additional task, and, as a matter of fact, learned of entire transfer almost as suddenly as the residents themselves. In other words, as the story would have it, a semblance of economy was achieved by unloading functions. Here again, the staff physicians were not consulted, nor was the situation effectively canvassed with the Social Welfare Department. The added function, I am told, was an impossible undertaking for housekeeper's aides, especially since they are not, by training, safe guarantees of proper diet for diabetics. What colonists comment on here is lack of consultation with those best able to comment on the dietary needs of patients. From a purely administrative point of view, one might wonder at the results if the process of unloading functions overnight and without consultation were practiced widely in W.R.A.

4. The Extension of Functions, Hospital-Connected

The greatest distinction of a concrete sort between the "new regime" and the administrative procedure of Dr. Collier is discussed in terms of another set of stories. Doctors on the staff as well as colonists have been especially frank

in drawing this distinction which seems to be, basically, in what Dr. Collier is "for" and Dr. P, apparently, "against." The following is a list of these policies which colonists feel would improve the hospital, and which they say, in partisan fashion, Dr. Collier is "for." I have checked each item in conversations with Dr. Collier and find that he actually is in favor of these policies:

(a) Nurse's aides and nursing personnel should receive credit for their work here in the form of proper credentials or certificates of service and in-training. Such personnel, colonists know, receive transferable credit for such work in outside institutions, and the current shortage of nurse's aides (corroborated by article recently in Tulean Dispatch), they claim, would be offset if such credit were given. The reasoning is simple. Credit would provide an incentive for engaging in this arduous type of work here, and a further incentive to resettlement since there is a shortage of qualified nurses and nurse's aides throughout the nation. Dr. Collier's feeling (as reported and as checked) is firstly, that the credit is a reasonable demand, and a type of compensation which helps justify the low wage scales paid on all projects for skilled work such as this; secondly, that an inquiry should be made, with all good circumspection, as to the exact qualifications and methods of certification necessary; thirdly, that the inquiry and the formulation of a plan should be carried forward with no delay.

(b) Along the same line, it is stated that only a few nurses have uniforms and the proper type of white footgear. Besides wearing out their personal clothing in this type of work (especially shoes), such costumes are not sterile no matter how fastidious and neat the wearer. Some time ago, the hospital pharmicists staff, after requests for white work coats had brought no results, turned up at work for weeks in their dirtiest cords and worn coats as a gentle reminder. Repeated requests for uniforms and footgear, the latter for nursing staff, were apparently of no avail.

(c) Though not discussed in the colony, a third point might be adduced to indicate the sort of thing that Dr. Collier is for. At present, classes for nursing personnel are held in the morgue, frequently in the presence of dead bodies. Dr. Collier has taken note of this, and out of a fine sense of consideration for the individuals (and families) involved, has decided to have the place of instruction changed. There are other evidences of his sensibilities, which I have discovered, and still others, I believe, not mentioned in this report, but discovered by others. A good sign is that his staff is unanimous in remarking his administrative abilities, and this fact should count heavily. To understand this, one should realize that the Japanese-American doctors are individuals of good professional reputation, particularly their informal leaders. One doctor here, though receiving the usual $19 per month, carried as a regular expense subscriptions to medical journals amounting to over $150. Doctors use their own equipment, and the gentleman in question has bought expensive additions and replacements, partly because of the limited materials available. The doctors feel, to a surprizing extent, the need to carry on as usual and to exceed their efforts for the benefit of their people. In this, they incur financial loss, as they have already incurred loss in status, loss in practice, and in a certain way, loss in confidence. Their average day is, to undertake the case, a busy work day. Undoubtedly, annoyances have entered into the picture of relationships with the chief medical officer, and I dare say, professional jealousies and group (caste) feeling as well. But it is a token of their good faith and caste pride and professional pride have not blinded them to the value of an administration which appears to be, in their own telling, sensitive and fair-minded and intelligent. That colonists have not been blinded by the past, the foregoing pages I think attest.

Respectfully submitted,

M. K. Opler, Social Analyst

WAR RELOCATION AUTHORITY

Memorandum

To: Mr. J. H. Provinse, Community Management Date: June 19, 1943

From: G. D. Carlyle Thompson, M.D., Chief Medical Officer

Subject: Tule Lake Social Analyst's Report, attached

The Social Analyst's report which Mr. Coverley submitted with his letter of June 16 has many excellent features and represents considerable investigation and thought by Mr. Opler. Except where he has made statements or propounded opinions in fieldswhich are highly controversial and which he apparently does not realize, and except in a few instances through absence of complete facts, the report is good and generally very helpful. I have made marginal notes in numerous places, not for the purpose of argument, but simply for the purpose of noting incomplete statement or that there is another point of view which must be considered in passing judgment upon either the regime or the individuals responsible for the regime.

I do not know whether Mr. Opler is a member of one of the Tule Lake factions, of which I understand there are several, which has difference of opinion with Dr. Pedicord because of his failure to provide medical services to appointed personnel. I state this because Mr. Opler reports no improvement in the administration or operation following Dr. Pedicord's arrival. It cannot be denied that such improvement occurred and in fact it was of a very noticeable degree.

Some of the situations described I am familiar with and probably could write a long dissertation setting forth many phases which Mr. Opler has failed to mention and probably failed to note or learn about, since it is very unlikely that the information would come from the evacuees. For example, some of the doctors involved in transfers from Tule Lake were problems before they got there and some were problems after they left. Others who were transferred to Tule Lake worked out very satisfactorily while others transferred away worked out satisfactorily at the new Centers. Such transfers occurred both during the administration of Dr. Carson and Dr. Pedicord.

The excessive overstaffing of the hospital in many of the nonprofessional and nontechnical departments resulted in a large measure to the original policy of WRA to give every evacuee employment. Dr. Pedicord found over 600 employees on the hospital staff when he assumed responsibility. To my amazement, I believe Dr. Carson was devoting nearly fifty per cent of his time to giving care to appointed staff thus not being able to fulfill his proper duties in hospital operation.

Mr. Opler is quite off base in a number of points relating to medical care and hospital procedures in that he could not possibly obtain all of the information required to let the situation in any way influence his reasoning. An example of this is the statements regarding the Doctors Togosaki. The fact that one woman died under the circumstances that caused the death at Tule Lake is an indictment against any physician in which event it is most difficult for the physician to satisfactorily justify, explain, or in any other manner deny responsibility and in most instances to deny very incompetent service. In this

instance Dr. Pedicord was concerned and placed definite restrictions on future use of the procedure by the individual involved. The individual continued to ignore the restriction and thus the suspension from the staff. I was there at the time of the suspension which was not publicized and was never announced except by the doctor involved. The physician involved actually had been ill and Dr. Pedicord extended the courtesy to the individual of accepting short leave. Actual suspension in writing followed violation of the leave.

Summary: In conclusion, it is granted that Dr. Pedicord was not tactful in his approach to many of the problems. At my last visit I attempted to council him in this matter and have also discussed the problem with Mr. Coverley requesting him to council Dr. Pedicord.

The relationship between the Acting Chief Nurse and Dr. Pedicord also was difficult at one time but after Miss Stuart's and my visit, the situation had been reported to be very good. Miss Stuart so noted at her last visit to Tule Lake. The difficulty between the nurse and Dr. Pedicord arose from two factors, I believe. First, the nurse was not well and, second, the evacuee staff sensing a sympathetic person in the nurse, and a few having a very definite dislike for Dr. Pedicord, followed a technique which played the nurse against the Chief Medical Officer and vice versa.

I should go to Tule Lake soon. In the meantime Dr. Pedicord, I believe, should remain. However, it may be advisable to effect a transfer to another center, and in fact if I am convinced that his attitude was characterized only by the tone of this report, I question whether he would work out at any Center. A number of our persons, however, have had difficulty at their post of original assignment and have been most successful in a new situation.

Attachment

WAR RELOCATION AUTHORITY

Memorandum

To: Dillon S. Myer Date: 6/23/43

From: John H. Provinse

This is the report from Tule Lake which Harvey used to support his request for Dr. Collier's remaining at Tule in place of Pedicord. Dr. Thompson has read and his comments are attached. He has also indicated that the report is useful to him, and he will visit Tule Lake in July to see whether some change should be made. In the meantime, Collier has returned to Gila to replace Sleath who is coming into Washington temporarily.

In justice to Opler, it should be pointed out that with one exception (p. 3 where he discusses medical vs. administrative functions) he has held himself to his reporting job and is not expressing judgments on the hospital situation. He has done what Harvey has asked him to do, and I think rather well when his length of time at the Project is considered. It is perhaps unfortunate that his first assignment at the project -- after only a week's residence -- should have been this rather controversial problem, any report on which is likely to be interpreted as taking sides.

Attachments

Letter accompanying the petition to Provinse: 6/28/43

Mr. John S. Provinse
Head, Community Services Division
WRA
Washington, DC

Dear Dr. Provinse:

The colonists of Tule Lake WRA Center are very hopeful ~~KK~~ an imminent shortage of medical personnel at the center may be averted by prompt action in regard to two items.

You will find enclosed with this letter a statement of a delegation ffom the colony to the project administrator which was very kindly received.

A petition signed by 7,500names of colonists of age over 18 from the T.L. colony follows.

In addressing these documents to your office and to that of Dr. C. G. Thompson as well as to the project administrator we hope to avert the above unfortunate circumstances.

Respectfully yours,

COLONISTS OF THE TULE
LAKE WAR RELOCATION AUTHORITY
CENTER

Carter File

Petitions

(Confidential-Non official) Suggestions arising from Evacuees.

BASE HOSPITAL

A year's experience on the project indicates that the Base Hospital and health program is closely tied up with the morale of the people in the center. Proper medical care for any group of people is only humane and natural, and the government has committed itself to the provision of such for the evacuees. Continuation of the present inadequate medical program will give further impetus to present bitterness among the evacuees and is likely to result in international repercussions involving reprisals against Americans interned by the Japanese Government.

Dr. Pedicord during 5 months of hospital administration has proven himself incapable of operating an adquate health program.

During this period, he has enegendered hatred from his staff and patients as well as becoming notorious within the colony as a whole. This hatred and resentment has been developed by the following characteristic traits of the chief medical officer. His attitude toward evacuees, both staff and patients, is unsympathetic and dictatorial. This lack of sympathy coupled with discourtesy is illustrated by his habit of addressing evacuees as "Japs"; and by his consistent rude and heavy handed treatment.

In Dr. Pedicord's dictatorial attitude toward his staff, he is guilty of continual flaunting of authority and enforces discipline by means of orders rather than through organization and the respect of his staff.

The base hospital has on its professional staff, highly skilled physicians who prior to evacuation had achieved recognition and high standing in the medical field. Dr. Pedicord interferes with their professional duties, and in spite of lack of experience in recent years in modern medicine, insists that the other physicians follow hi close direction. He allows personal differences with his fellow physicians to effect his decisions in respect to treatment of patients.

Dr. Pedicord does not make a sincere effort to obtain necessary medical equipment for the hospital. This is illustrated by the fact that the hospital committee found it necessary to collect funds from the evacuees for purchase of necessary equipment despite the government's commitment to provide medical necessities. Shortages of equipment due to war conditions has been given as an excuse for lack of action. However, necessary equipment belonging to resident physicians is available in storage.Dr. Pedicord has made no attempt to utilize it. If it is impossible to obtain such equipment, then it is the responsibility of the administration to take the patient to the nearest hospital where it is available. This he has refuesed to consider.

The chief medical officer's whole approach to hospital administration is characterized by acting in terms of economy rather than service. This he has accomplished by economizing not through organization or streamlining, but by curtailment of services. This is illustrated by the complete abolishment of special diet kitchens for diabetics, ulcer cases, etc. Overnight he terminated the entire home nursing program for the colony.

Evacuee physicians and dentists have a deep feeling of loyalty and responsibility for the care of their fellow evacuees. As a result of the above type of administration, many feel that they can no longer function under Dr. Pedicord's administration and either be of service to the evacuees or retain their own integrity. Therefore, we are faced with rapid relocation by dentists and physicians.

This is not a true nor healthy relocation, since many are leaving for non-professional work such as agricultural labor. This in turn, coupled with distrust of the hospital administration, is resulting in a greatly accelerated sentiment of bitterness, resentment, and distrust by the colonists toward the whole govt. program as well as justified fear for their own health and welfare.

During Dr. Pedicord's recent absence of several weeks, the Base Hospital after months of chaotic administration, enjoyed a short period of honest, sympathetic, and intelligent supervision from Dr. Collier who, we understand, has now been transferred to the Gila River project.

This committee feels that the government is sincere in its attempt to provide adequate medical care and proper health administration for the project and therefore requests that Dr. Pedicord be removed from the project and Dr. Collier be appointed as Chief Medical Officer.

Coverley's Files

The Base Hospital:

Letter from Coverley to Mayeda, June 28, 1943

Dear Harry:

On Friday, June 25, 1943 I received a visit from a committee consisting of Mr. Ikeda, Mr. Yoshida, and Mr. Y. Tsukamoto who presented me with an undated and unsigned statement making a number of serious charges against Dr. Pedicord and his administration of the base hospital. This committee advised me that you were also a member and that you had joined with them in presenting the statement. I informed the committee that I could not give serious consideration to any petitions representations of this character unless the persons who had originated it would assume responsibility for their actions. The committee then agreed to acknowledge such responsibility on behalf of the Planning Board, the hospital committee, and the residents in general. Yesterday there was delivered to my office a copy of a letter of the same date addressed to Dr. John S. Provinse of our Washington staff signed "Colonists of the T.L. Relocation Center." Attached to this letter was a copy of the letter mentioned above. Accompanying this correspondence were 63 identiaal petitions bearing the names and addresses of persons presumed to be residents of the center and signers of the petition. This petition reiterates many of the statements made in the document handed to me on June 25 and requests that Dr. Pedicord be removed from his present position and that Dr. Douglas R. Collier be appointed his successor.

I am asking an inquiry into the accusations directed against Dr. Pedicord in order to satisfy myself completely as to their truth or falsity. I am prepared to state from my own experience that some of the charges are unfounded. For example, it is said that he has made no effort to obtain needed medical equipment and supplies. I can assure you that this is not the case. Furthermore, you may not be aware that Dr. Pedicord has made numerous and persistent attempts to obtain military passes for his staff to return to the restricted area in order to secure some of their personally owned instruments. He extracted from a promise to call personally at the Presidio in order to secure such a permit even though I was convinced that it would be useless. I did talk however, with the military authorities in an effort to obtain such a permit which was refused as I had expected.

It was also charged that Dr. Pedicord had neglected or declined to take patients to outside hospitals for necessary treatments. I happen to know that he has written numerous letters to doctors outside the project whom he knew to be qualified to give certain types of treatment in an effort to induce them to render services to our patients. The fact that the doctors refused to take the patients is of course, no fault of Dr. Pedicord. It is also stated that he terminated the entire Home Nursing Program for the patients. This is not a fact. The Home Nursing Program was discontinued upon instructions from Miss Joy B. Stuart, Nursing Consultant from the Washington office

Furthermore, it is my understanding and belief that some members of the professional staff of the hospital have found it quite possible to work harmoniously with and effectively with Dr. Pedicord. I am

skeptical therefore as to whether or not he merits the accusation that he has earned the hatred and contempt of his entire staff.

I am glad that you are aware from our past associations that I am always glad to receive in a spirit of cooperation, reason, abd equity any complaints the residents might have regarding the services rendered by the WRA. I make it plain however, that the actions to be taken in rectifying any adverse condition (alleged) or improving any service are my administrative responsibilities. Whether the action requires termination or replacement of personnel is a decision which I must mke. I think it fair to advise you that I refuse to become subject to the type of pressure represented by the petition insofar as it calls for personal changes. The appointed employees of the WRA have a right to expect that determinations regarding their status with the organization shall be made by the government and not by the evacuees. I will appreciate it if you will communicate my views on this point to the other members of your committee and to any one else who may be interested.

Sincerely yours,

/s/ Coverley

cc: Harkness
Dillon Myer
Pedicord
Hayes
Busselle

Coverley's files:

Letters re the removal of Dr. Pedicord:

Dr. Yamato Ichihashi claims that on the 63 petitions circulated there are 7478 names. These were added on a calculator and proved to be the case. Coverley answers:

Dear Dr. Ichihashi:

Upon my return from Washington a few days ago Mr. Hayes referred your letter to me in which inquired regarding the number of residents who signed the petition requesting the removal of certain hospital personnel. It took some time to count all the signatures and for that reason I was unable to give the exact information immediately. The count is now complete and shows 7478 names signed to the petition.

/s/ Coverley

Letters from several of Pedicord's staff are included as showing that they were able to get along with Pedicord and that they like and respect him/