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Lh.

Washington, D. C.
June 10, 1942

To: H. S. Eisenhower ✓

From: John H. Provine

The problem of maintaining on our projects sufficient well trained doctors to fulfill our obligations of public health and medical care may prove a serious one. If we establish the doctors at the \$19 monthly wage rate and then arrange for furloughs for those who can find acceptable work outside, it is Dr. Coffey's opinion that we will not be able to retain any of our Japanese medical personnel, since the opportunities for them to move to laboratories or hospitals will be numerous.

It is possible, of course, to establish an arbitrary ruling that doctors will not be allowed to go on furlough in the same way in which other of the evacuees will be, but this seems extremely unfair unless they are paid some additional bonus for remaining.

In talking this over with Commander Kingle, ⁺ he suggested that some plan might be established whereby Japanese doctors would be drafted in the same way in which it is contemplated that other medically trained people may be drafted for the war effort. Following through this line of thinking, it seems possible that we might approach the Public Health Service and arrange for them to give reserve commissions to the Japanese doctors (and to the nurses and possibly dentists) and pay them wages commensurate with their rank, expecting them then, of course, to take care of such dependents as they might have on the projects.

Such a procedure does, of course, open up the probability that other professional people will also want differential treatment on the projects, but I do not think that the other professions will be able to move off the projects with the same facility as will the medical staff.


Mr. Barrows [✓] informs me that should our plans change to pay the Japanese medical staff, it will increase our budget by approximately \$175,000, which of course is no small item. On the other hand, if our Japanese doctors do leave on furlough, we will be

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forced to employ Caucasian doctors, which will in turn automatically increase our expenditures for medical care. Also, if the Japanese doctors leave, it may be quite difficult to obtain substitute Caucasian doctors, and the projects will be inadequately staffed for us to carry out our commitment of adequate public health and medical care.

I am sending a copy of this memorandum to Dr. ^{C.R.} Coffey ^x with a request that he give it consideration, and as soon as I hear from him I will get in touch with Dr. Duncan or someone else in the Public Health Service to get their opinion as to the possibility of obtaining commissions. If such an arrangement can be worked out, it is possible that we can make use of the doctors of the conscientious objectors' group in some similar way. It will be more expensive, but I am sure that we cannot neglect this obligation to care for the health and welfare of the evacuee population.

cc: Dr. E. R. Coffey
Mr. Barrows
Mr. Glick
Com. Ringle


JHP hp

WAR RELOCATION AUTHORITY

In reply, please refer to:
Health Division

SAN FRANCISCO, CALIFORNIA, OFFICE
WHITCOMB HOTEL BUILDING

December 28, 1942

Referred to *McSparran*

By *JS*

MEMORANDUM TO: Mr. Dillon S. Myer, Director
War Relocation Authority

SUBJECT: Report by Dr. Joseph L. McSparran concerning
recent visits at Tule Lake, Minidoka, and
Central Utah Relocation Projects

As you will recall, Dr. Joseph McSparran, recently appointed as Principal Medical Officer temporarily attached to the San Francisco Office, formerly practiced medicine in Tokyo for 25 years, returning to this country on the Gripsholm after a six months' period in solitary confinement in Japan.

After a few days in the Regional Office, he visited Tule Lake, Minidoka, and Utah Projects in that order. A copy of his report to me is attached. I thought it would be of special interest to you. I was particularly impressed with the readiness with which he grasped the situation, adapted himself to the program, and sensed out general problems which affected the Project health service operation.

While I was aware of many of the problems which he noted and some of the Projects had already instigated plans for dealing with these problems, we have made note of his impressions which will be helpful. The problem of tuberculosis and personnel continued to be outstanding.

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

Enc. 11566



62.010

Health Division

December 12, 1942

MEMORANDUM TO: Dr. G. D. Carlyle Thompson,
Medical Officer, WRA

SUBJECT: Report of Observation of Medical Work
at Tule Lake, Minidoka and Topaz,
November 21 to December 6, 1942

I am enclosing a detailed report on medical
work in Tule Lake, Minidoka, and Topaz Projects in
the following three parts:

1. General Considerations
2. Special Problems
3. Summary with recommendations

(SIGNED)

Joseph L. McSparran, ~~M.D.~~
Principal Medical Officer

JLMcSparran:evs 12/12/42

December 11, 1942

I. ORGANIZATION AND POLICY

A. Organization

As at present constituted the organization of the medical work in the Projects, consisting of a skeleton staff of Caucasian doctors and nurses, supplemented by Japanese personnel, who form the greater part of the staffs, seems to be the best possible plan under the circumstances. In the opinion of the writer such a set-up is superior to staffs made up of Japanese or Caucasians only. The main weakness of the existing arrangement, in my opinion, is the disproportionate representation of the two classes of personnel: the Caucasians are too few and the staff efficiency could be greatly enhanced by the additional strategically placed and specially qualified individuals such as: (1) Assistant Medical Officers, who could, in some cases, serve as executive officers or hospital superintendents, thus freeing the Chief Medical Officer for duties more strictly professional as distinguished from detail requirements; (2) Dietitians, whose duties would include not only responsibility for general and special hospital diets, but also general consultative responsibility for the dietetic policy of the entire Project in close cooperation with the Project Chief Steward; (3) Public Health nurses able to assume charge of home care of borderline chronic cases and light types of acute infectious diseases, and qualified to teach family attendants the essentials of home nursing; (4) trained record workers, preferably with a background of nursing or laboratory training. This service should be based upon standard records for all hospitals and should emphasize completeness and cross filing with reference to numerical sequence, name and diagnosis. Too much care cannot be exercised in this respect, particularly with a view to follow-up work and possible postwar claims for mal-practice. At the same time it is a valuable check on efficiency of the medical staff.

B. Policy

Assuming an organization along lines outlined above the general policy of depending primarily upon

Japanese personnel for routine work, under supervision were necessary, is to be commended. The tendency to leave details too much to the discretion of the subordinate staff is to be decried, but individual initiative should be encouraged, so long as it does not tend to over step the safe limits of a rational settled policy. Practically it is difficult to lay down hard and fast rules as to how much or how little supervision should be exercised. This to a considerable extent must be governed by individual characteristics and supervisory discretion. In Projects visited by the writer supervision and control varies all the way from practically none to the verge of a too meticulous insistence upon limitation of initiative. However, it must not be overlooked that control and responsibility must go hand in hand, not forgetting that irresponsible and unwise practices on the part of subordinates will inevitably reflect upon those in authority. This is not to be interpreted to mean that heads of services should insist upon making every decision. A certain amount of elasticity in application is a necessary stimulant to initiative and progress and at the same time is helpful in maintenance of esprit de corps. After all, in most cases the human element must be considered.

C. Cooperation

The success of any organization and policy depends fundamentally upon cooperation. This observer was much pleased to find general cooperation in the Project Medical Units at a high level. There were just enough exceptions, however, to call for some comment intended to bring to the fore certain weaknesses that could and should be eliminated. Of course, varying degrees of both group and individual cooperation were evident. In one instance definite lack of sympathy with the Chief Medical Officer was observed, but somewhat surprisingly this was not accompanied by any manifest unwillingness to perform routine duties. The tendency to assume a superiority in training experience and performance sometimes extended to to a definite expression of opinion on the part of the subordinate staff to the effect that Caucasian control was undesirable and unnecessary. Likewise, in one group the assertion of a sense of their own importance and indispensability was openly made. This is attributed to too lax control and it must inevitably lead to confusion and a breakdown of efficiency. It is folly to suppose that medical work can be successfully done in these Projects without the control of a responsible Caucasian

head. If for no other reason the tendency toward non-cooperation of Japanese personnel with each other would circumvent smooth and efficient functioning. Deviousness, suspicion, and covert criticism of colleagues are typical of this race, and it is disappointing that a generation of exposure to American ideals and practices has made no conspicuous headway against these characteristic weaknesses. I do not claim that these defects are sui generis as regards Japanese, but they are, in my experience, more conspicuously developed among them than among other groups, and, therefore, it behooves us to take due cognizance of that fact and to be governed accordingly.

D. Efficiency

The efficiency of any group effort may be said to depend in great measure upon the excellence of organization and the cooperation of personnel but that is not enough. Individual skill and experience constitute the final touchstone and by that results must be measured. In the medical groups we have an extremely varied range of education, experience, and skill. There are a few outstanding men and women, but they are too patently in the minority to excite a reasonable hope of a high degree of efficiency. Performance has a tendency to follow the general average of training and skill, and we are not justified in expecting that results in the Project hospitals shall measure up to accepted standards in outside institutions. We have to keep in mind that we must do the best we can with facilities and skill available and not lose sight of the fact that we are working under extraordinary conditions, and have no reason to expect that we can follow accustomed practices prevailing in pre-war environments. So the general conclusion to be drawn from what I have said is that we cannot expect and have no reasonable grounds for insisting upon a high standard of efficiency in the Project hospitals, but nevertheless we must strive for ever increasing excellence. In many respects the service can be improved. This will be discussed under the heading of Special Problems.

E. Expansion

Naturally, in view of the short time the Projects have been in operation, our medical program has not reached its full expansion, and there are many conspicuous gaps in the development of the work for most of which there are plans already made or in the making. In some places the

minimum services are already in operation, with other services in process of equipment. Some Projects are even now engaged in related or extension services and are planning others. Not at all surprising is that these developments are hindered by certain handicaps which are always a feature of any work hastily conceived and pressed into operation before being completely equipped.

F. Handicaps

The main handicaps as I see them today are first WRA policy and second lack of materials and finished goods necessary to full equipment of the plants and auxiliary services.

As for present WRA policy embracing the speedy relocation of evacuees, I can say that it is operating to discourage the development of the Projects and is rather effectually killing individual initiative with the probable result that many existing plans will either be abandoned or modified. This policy bids fair to be fatal to hospital staff organization, and we are facing an early acute shortage of trained personnel. In one hospital four out of seven and in another four out of five of the Japanese doctors expressed a desire to leave for outside relocation. This ratio would probably apply to nursing, dental, pharmaceutical and auxiliary personnel also. Unfortunately, we have no reserve personnel from which to draw replacements, with the possible exception of dentists and pharmacists. The necessity for the medical work to operate at full capacity will, no doubt, continue to exist for some time to come, and our most insistent problem is how we are to manage this with greatly reduced staffs. One solution recommends itself as eminently practical and easily possible i.e. to change conditions under which professional personnel are operating so that it will be more attractive to them to remain than to leave. This can be done by improving their living conditions and giving them salaries commensurate with their training, experience, and skill. We have doctors working for \$19.00 per month plus a small clothing allowance and living in bare barracks, who in private practice could earn an income of a good many thousand dollars a year. No one can justly blame such men for being dissatisfied with present conditions and for wishing to get back into positions where they can earn the necessities for a decent existence. It would be a wise move

on the part of the authorities to change the present regulations so that these men will not be lost to our work. We need them, and they are better fitted to do the work among their own kind than any group of Caucasians. Also, I have reason to think that the majority of them would be willing to remain if given satisfactory working and living conditions.

The only alternative to the above, that readily occurs to me, is to replace Japanese personnel with Caucasians. In the present emergency this would be very difficult, and in view of the special nature of our work, dealing as it does with Japanese, very unsatisfactory to both personnel and patients. To cite one instance, among many, it would be next to impossible at the present time to get Caucasian personnel willing to work with Japanese and be sympathetic toward them, not that I deem a sympathetic attitude a prerequisite condition however desirable, but certainly a broad humanitarian viewpoint is the very minimum with which we could reasonably hope for any considerable degree of success. At this time with a war on and the basest passions running riot, manifested, among other ways, in the almost universal attitude of bitterness and revenge against everything Japanese, it won't be easy to find people to work with them without giving range to these elementary but atavistic impulses. We have a trained personnel of their own kind now and let's keep them at all adds. Any other course would be rife with possibilities of all sorts of disagreeable eventualities.

II. SPECIAL PROBLEMS

What I shall say under this heading is meant to bring under consideration or rather encourage further consideration, looking toward speedy action of problems that are in urgent need of satisfactory solution, the first and foremost of which is the problem of satisfactory provision for Tuberculosis cases.

A. Tuberculosis

There is no special provision in any Project for such cases and it is definitely unsuitable and positively menacing to introduce them into general hospital facilities, yet that is what we are doing for want of any other recourse. We have put in only the limited number of the

more urgent cases that can be accommodated in our general wards, many of them advanced cases and a source of great danger of infection to others. Doubtless, there are many open cases at liberty in the confines of the Projects, and it is appalling to contemplate what the final harvest in increased incidence will be. It has been estimated that each open case will probably give rise to ten or fifteen new cases, and at that rate both humanity and self preservation call loudly for remedial action. What is the answer?

Here again we can think of several alternatives, such as (1) special hospitals in selected Projects for these cases, (2) State and/or Government aid in placing them in institutions outside, and (3) segregating them in special barracks apart from the main residential sections of the Projects. Of these, the first is the most desirable solution, and it is hoped that it will be brought to pass without undue delay. With the Winter season we may expect the usual seasonal incidence of respiratory diseases, which are too frequently the starting point of definite Tuberculosis, especially where there are, doubtless, many unrecognized incipient and arrested cases.

B. Chronic Cases and Convalescents

The second special problem is that of dealing with chronic ambulatory cases and convalescents. In one Project hospital a large proportion of the in-patients were of these classes. This, of course, is very uneconomical and very inconvenient and it creates at times acute shortage of space for acute cases. This problem could be handled in several ways, including segregation in special health extension barracks under the general supervision of the medical staff and the special supervision of dietitians and public health workers. Related to this is the group of subnormal children and these probably could be dealt with in a similar manner.

C. Borderline Mental Cases and Epileptics

Again borderline mental cases have to be considered. Definitely demented cases may be referred to State institutions, but as for borderline cases and epileptics we, as far as I know, can draw upon no outside aid. I see no special difficulty in grouping these two classes with those previously mentioned, but in any case with already inadequate facilities they should not be a burden upon our general hospitals.

D. Acute Infections

A consideration of acute infectious diseases is in order here. Facilities for handling such cases are necessarily limited and this class of diseases is an extraordinary burden on the regular hospital staffs, requiring as they do special quarantine and prophylactic routine. A partial solution, although by no means ideal, or even desirable, is to keep the least severe types at home and care for them through public health extension with the help of practical home nursing under supervision. I refer particularly to Measles, Mumps, and Chicken Pox. Some such scheme is already being tried in at least one of the Projects and it has at least the merit of being an expedient entailing a reasonable minimum of risk.

E. Optional Major Surgery

Two phases of the work that possibly do not loom large as problems, but which nevertheless should receive careful consideration are optional major surgery and outside medical and dental consultations and treatments. The first is largely an abuse of privilege on the part of the Japanese medical personnel encouraged by a desire in some cases to gain additional surgical experience and abetted by the desire of the victims to get free surgery. This practice should be generally discouraged and strictly regulated.

F. Outside Medical Aid.

Medical and dental aid from outside is in some cases a necessity, as we cannot cover all the specialties with our staffs, and formerly, before we got our hospitals in operation, was of very great aid to us. Now the need for it exists only in special cases, but it continues to be largely on an optional basis. This, like optional surgery, should be the responsibility of the Chief Medical Officers for strict regulation. In this connection, an unfortunate feature is the lack of confidence of the Japanese in their professional personnel. Sometime they frankly express such a lack of confidence and demand the services of Caucasian practitioners. This, of course, is hard to deal with but in every case pressure should be brought to induce the patients to use our own facilities to the utmost extent.

III. SUMMARY

In general the internal organization and policy of Project hospitals is along the right lines and should be continued.

Cooperation of staffs is on the whole good, but is marred by jealousies and individual differences among members of the Japanese staffs. Efficiency is not of the highest but is possibly as good as could be expected with a group of hastily assembled personnel of widely varied training, experience, and skill. As the various groups work together this should improve, but if our staffs are to be greatly depleted by relocation it will get much worse. Expansion of the work is in progress, but certain outstanding needs should be provided for, namely, Tuberculosis and chronic cases. Some definite plan should be speedily adopted to replace professional staffs that will be depleted by relocation. This is most urgent.

Joseph L. McSparran
Principal Medical Officer

JLMcSparran:evs 12/11/42

Check with Dr. Thompson on personnel possibilities and on whether we can now present the case for increasing doctors' salaries at the projects.

Frase says only two have gone out so far.

12-15-42 Rgm
12-17

Venereal Disease and Sewerage Problems

This item of my report I am omitting from copies in my files and am not intrusting it to my stenographer to type. I am preparing it separately at home and will mail it to you from Twin Falls. I omit copies to other projects. It seems to me that there is danger in the matter I am about to discuss if it should become known to evacuees in other centers, since information quickly goes from one center to another. Dr. Neher at the Monday staff meeting reported cases of gonorrhea were found in the obstetrical ward, and other women admitted to the hospital were also found infected. Husbands were examined and found not infected. His conclusion, against what he said was his medical knowledge, was that the spread was through the outside latrines. All that is necessary for their elimination are a couple of disposal pumps since the sewerage system is otherwise finished. Any pressure that you can bring to have this center provided with such pumps will in my opinion prevent legal, medical, social, cooperative, and economic problems that will otherwise arise. Mr. Stafford has called me to assert legal pressure in this connection and perhaps this constitutes legal pressure. There is the question of legal liability which I suspect does not exist. I should like your opinion on that point and also in the matter of the falling window incident mentioned above, where again I suspect no liability exists. Tony is going to do what he can to relieve this problem in San Francisco and I have also asked Mr. Rossman to do anything he can.

It has come to my attention that although the staff does not know it generally the evacuees have knowledge of the gonorrhea situation. Children have asked the teachers about it in the schools.

Moore

Peddicord visited Minidoka, according to one report by him, and concluded that gonorrhea infections caused by men returning from short-term leaves. This obviously false according to all other reports.

Mujamoto

SA
Lewis Sigler, Acting Solicitor

2/3/43

G. D. Carlyle Thompson, M. D.

Your note to Mr. Provinse dated Jan. 29, transmitting an excerpt from James Terry's report of Jan. 9 regarding "valley fever" interested me also.

While I realize that Mr. Terry's report is somewhat of a personal note, its inclusion in official documents may have an adverse effect because of several possible implications. There has been considerable misunderstanding over the disease "valley fever". However, it is not a "new and almost unknown disease". It is endemic in the agricultural valleys of California and in parts of Arizona and has been known to exist for many years. We do not understand all features of the disease. Most of the cases of valley fever at Gila River came there from the assembly centers and their homes in the California valleys. New cases, most of them fortunately of a minor type, obviously occurred at the project, as the infectious agent is carried in the dust.

There is no controversy as to the cause of the death of the chief nurse at the hospital or of other persons. There may be rumor and lay talk, but the medical facts are available through the Chief Medical Officer and on death certificates.

I fully sympathize with Mr. Terry's concern about avoiding this disease and I do not mean to make too much over his report. I am only concerned because when the employed staff have such vague feelings or ideas and participate in conversation about this problem on the project in this manner, it is difficult for the evacuee residents not to have this attitude. The evacuees have tended to be greatly concerned, naturally, and have laid the blame upon WRA for their predicament, even though they have lived in an endemic area all their lives.

GDCarlyle Thompson HP

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Mr. C. H. Powers ✓

March 1, 1943

G. D. Carlyle Thompson, M.D.

The following statements justifying the cooling unit at the Gila River hospital may be useful for inclusion in the statement you are preparing for the War Production Board on the basis of our recent conference with Messrs. Marshall and Terry:

GENERAL STATEMENTS

In determining the need for a cooling system at the Gila River hospital, it is important to consider factors which are peculiar to it rather than the application of a formula used for hospitals. The following points are significant:

1. The War Relocation Authority is responsible for the operation of hospitals recently built at ten Centers. An extensive hospital cooling unit is considered essential in only two of these Centers although eight Centers are located in areas where evaporating type coolers would function and would be highly desirable. Both hospitals requiring cooling are located in the extremely hot section of southwestern Arizona desert.

One of these at Parker, Arizona obtained individual window cooling units last August with Army assistance. The other hospital is Gila River, covered by this request. Gila River hospital construction was not completed until late November, 1942. Temporary hospital facilities were set up in the late summer of 1942 providing for emergency work only for the first movement of people to this area. Two infant deaths were reported, however, at that time as due to heat.

2. The heat of this area is dry, ~~is~~ reaching extreme temperatures for at least five months of the year, ^{and} remaining hot during the night. In addition, the countryside is extremely dusty and subject to daily strong winds necessitating closing of hospital windows and doors or the hazard of quantities of dust throughout the buildings. Many of the more critical areas in the hospital, for example, the surgery building, the obstetrical delivery rooms and the new-born nursery have requested ^{and} sealing of all windows, doors, ceiling vents, ^{and} wall, ceiling and floor cracks, in order to avoid the dust hazard in these critical places. Cooling, therefore, is essential. Ventilation is not practical nor safe as a cooling device.

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3. No other hospital, new or old, in this area of the State, including the city of Phoenix, is without a cooling system. Nearly every home is cooled by modern means or some home improvised method.

4. Cooling units are requested only for those portions of the hospital which directly affect the care of the patients, except the doctors' and nurses' quarters which because of the serious shortage of these workers indirectly affects the care of patients. Of the 19 hospital buildings in the group no cooling is requested for ~~buildings 13 through 19~~ *seven buildings*

SPECIFIC BUILDINGS SERVICES

1. Surgery Building. Contains 2 regular and 1 emergency operating room.

2. Out-patient Building. This building 30 x 160 feet includes many services essential both to out-patient clinic operation and also to the hospital operation. Each of the services listed below are the only services of their type in the community which serves nearly 15,000 people. The building is crowded under the best conditions, working at all times to its maximum capacity.

30% of the building used for out-patient medical and surgical clinics, carrying the patient load through 8 examination and treatment cubicles equivalent to 15-18 private physicians' offices in an ordinary peace time American community.

15% of the building used for dental operative clinics with an adjacent dental laboratory which is an inside room.

15% of the building used for X-ray and fluroscopic room with developing dark room for X-ray films which is an interior room.

10% of the building used for eye, ear, nose and throat clinic with examination and treatment dark room as interior room.

15% of the building used for clinical laboratory.

pharmacy
10% of the building used for pharmacy compounding and dispensing to entire community.

PHYSICIANS AND NURSES QUARTERS

3-4-5. Cooling of the physicians' and nurses' quarters is not proposed as a comfort to these persons, but is based purely in terms of care to hospital patients. With a shortage of physicians and an even more serious shortage of nurses it is necessary that

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extra long hours be worked and an extra heavy patient load be carried. Unless provision is made for adequate day and night sleeping, the staff will be unable to continue to carry the load. Furthermore, since the staff, particularly the nurses, are Civil Service employees and not subject to military orders, they will resign to accept similar employment in Phoenix or other nearby small towns where all hospitals are cooled.

6. Obstetric Building. Contains the delivery rooms, labor rooms, new-born nursery, and mothers' wards and rooms for post delivery care and convalescence. Cooling is essential for all except the convalescent patient, but this building is so constructed that cooling one part only would be most difficult, and would offer health hazards to infants, mothers and personnel who work there. During the fall of 1942 when persons were first cared for in this community and no cooling was available 2 new-born infants are reported as died from the heat.

7. Children's Ward Building. Sick children under 14 are cared for here, medical and surgical patients, including post-operative. Infants under one year and particularly sick new-borns cared for here require cooling if medical care is to be effective and certain deaths avoided. The building is partitioned into 8 small 3 and 4 bed wards and several single rooms to permit necessary segregation by ages, sex and disease.

8-9. Standard Ward Building. These are adult post-operative wards for men and women. It would be impossible to cool one part of one of the wards only without some building alteration. Furthermore, the entire building functions as a unit. The two buildings will be served by common personnel to a large measure. It is essential to avoid the prolonged extremely high temperatures of this locality for post-operative patients.

10-11. Standard Ward Building. These are adult general medical wards. Diagnostic cases, convalescent cases and patients under general medical care are kept here. A large number of patients with tuberculosis are also cared for, partly in these two buildings and also in building 12. The incidence of tuberculosis is extremely high among these people. Some 300 tuberculosis patients now on the Pacific coast must be moved to the interior to release hospital beds for acute illness. If proper cooling is available a shortage of Pacific coast hospital beds can be eased by moving some 75 tuberculosis patients to Gila. The dust problem of this locality is also a most important factor in care of tuberculosis. Cooling will control this hazard.

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12. Isolating Building. Contagious disease, both acute and some chronic forms, are kept here. The nature of these diseases in the windy, dusty country requires closing of all windows. Therefore, in this hot country cooling becomes essential. If it should prove impossible to allow cooling for all 3 buildings, 10, 11 and 12, and only one building is allowed, No. 12 should have the preference. Due to its type of construction No. 12 is subject to more flexible hospital use. The most acutely critically ill medical cases as well as contagion could be cared for there.

13. Morgue and Disinfecting Building. Contains autopsy and embalming room; large pressure sterilizing room.

14. Warehouse Building. General storage.

15. Warehouse Building. Contains large central sterile supply room.

16. Mess Hall Building. Hospital kitchen for preparing and serving patient meals. Personnel dining room.

17. Laundry. Hospital laundry and ironing. Linen supply.

18. Boiler House Building. Hospital heating plant, source steam pressure for sterilizing equipment.

19. Administration Building. Hospital administration offices. Public Health Department offices.

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Mr. Leland Barrows, Executive Officer

May 21, 1943

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

Subject: Removal of Japanese from West Coast Hospitals

The attached newspaper item of May 18th regarding removal of Japanese from Los Angeles hospitals may be the forerunner to some real pressure.

The item was clipped from a Washington newspaper. I suspect it made a bigger story on the West Coast where there are more than 800 Japanese patients hospitalized or institutionalized and where there are approximately 300 in Los Angeles County. Of this 300 in Los Angeles County, a large number are from Oregon and Washington as well as from Central and Northern California counties.

One of the reasons why I flew to the West Coast early in April was to attempt to keep this matter under control and out of the newspapers. I believe my trip was highly successful or the newspaper story would have been more alarming. The significance of the McDonough statements is in the interpretation of the phrase, "Whose health might be impaired by a transfer." Actually, the process of moving more than half of the patients on the Pacific Coast would not impair their health. However, their health would be impaired as well as other Center residents' if the extra burden were added to the Center's present load. When Mr. McDonough finds this out, WRA and the Army may expect real pressure starting in Los Angeles and extending through the West Coast for the transfer of these patients. However, we do have the understanding and support of most of the hospital and medical personnel concerned with the care of these patients *and* I do not believe Mr. McDonough and other County Supervisors will learn the true situation.

Whether or not the case which Mr. McDonough would present to the press is justified, and which the Los Angeles press would eagerly headline, is not important. The publicity, however, given to the cases hospitalized on the coast is important as it no doubt will raise the old "bugaboo" of Japanese into the public eye and I doubt if such publicity would contribute to the success of the WRA program. Furthermore, in view of such publicity, the understanding and support which we now have from hospital and medical personnel may be lost or very much weakened, since such persons are actually employed by the County Supervisors who are raising the issue.

Attachment - 1

GDCThompson:lor

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Mr. Dillon S. Myer, Director

May 27, 1943

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

Reference is made to Mr. Province's memorandum of February 27th to you involving comments and recommendations concerning the health program.

I wish to make a few comments for the record interpreting my point of view. The delay in these comments results in the fact that since the referred to memorandum came to my attention this has been my first period in Washington.

With reference to his comment on frustration, I would like to make it clear that neither myself or any member of the Health staff has had a feeling of frustration because of the organization pattern which included the Health Section as a part of the Community Services Division. However, if any frustration appeared to exist it resulted purely from the tremendous volume of work which has been required and from certain problems affecting the health program for which solutions were not readily obtained or did not exist within the operating WPA policy. The Health staff has never been adequate; it does not even yet contain the number of workers which were recommended in April, 1942 by the United States Public Health Service as the beginning minimum staff. The medical social work position was a recommendation of the U. S. Children's Bureau. Regarding the staff, it is noted that following the Medical Officer's appointment in April, 1942 two months lapsed before the Nursing Consultant was appointed, four months before the Administrative Assistant, six months before the Sanitary Engineer and eight months before the Medical Social Worker. The Administrative Assistant resigned four months ago, at the time of the move to Washington, with no replacement secured. Furthermore, the inadequacy for many months of a responsible clerical and stenographic staff and office arrangements handicapped in a very great degree the carrying out of essential duties. This latter situation repeated itself upon transfer to Washington. Yet, the full requirements relating to the health program existed from the very beginning and much of it was on a truly medical emergency basis, so much in fact, that under the circumstances described here maximum effort was required even to meet the emergency.

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With this picture in mind, getting the emergency job done was at best very difficult. Eyes were set on the job to be done, not on a routine of an organizational chart. Consequently administrative lines were frequently ~~crossed~~^{crossed}; frustration avoided. I believe, however, whether considering education, welfare, personnel, procurement, public works or other phases of WRA activities that cooperative working relationships and channels of operation were very early developed and that their effectiveness was as complete as could be expected from the limited staff. When new situations between any of the above programs arose which created an obstacle to the proper accomplishment of the job, solutions were found in conferences with the San Francisco personnel involved so that future delay in handling similar problems did not occur.

Before I joined the WRA staff, I was fully aware of its organizational pattern. While I did not concur with it at the time, I accepted it without comment for a period of months in view of the fact that there was such an overwhelming job to be immediately undertaken and accomplished. I was impressed with the quality of the San Francisco staff and proceeded on the basis that as the program developed the organizational pattern would be modified to meet needs or I would be convinced of the wisdom of the original. I still feel that the pattern of the organization is not the most desirable. Nevertheless, I have attempted to respect it in an increasing capacity as the emergency passed. That the Centers do not follow the chart in many instances cannot be attributed to any effort on my part. However, I have not criticized the Centers for not following the chart. Often I have been asked about this matter but always stated that the responsibility rested with the Project Director for determining whether or not the chart should be followed at his Center.

So far as Mr. Province personally and professionally is concerned, I have the greatest respect notwithstanding our disagreement on the participation of the United States Public Health Service in the WRA program and on the WRA organizational plan. On frequent occasions he has devoted considerable effort in attempting to solve problems which were seriously affecting the health program. I believe that he has a more realistic understanding of its true concept and of its problems than most members of WRA. So far as I am concerned, there is no personality issue involved with Mr. Province.

Regarding Mr. Province's reference to my desire for "complete autonomy for the health service" I can only answer that it is not true. My record in public health work for the past seven years will speak for itself on this point. It was unfortunate, though never the-

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less true, that the Washington office was without a Medical Officer for so long or only on a scattered basis, that opportunity did not exist for normal educational developments and their resultant understandings between the health program and other phases of WRA.

Finally, I would like to emphasize that whatever I personally and professionally believe to be a sound organizational pattern for WRA will never in any way affect my efforts to render the best possible service in the health program. It naturally follows that work relationships with all Divisions or Sections within or without the Division of Community Service and with which any health program is normally related will always be established regardless of any organizational pattern which WRA may establish from time to time. Nevertheless, my working under any organizational pattern which WRA adopts does not necessarily imply that the plan has my professional approval as the one which will further the best interest of WRA and permit the most effective health service possible.

CHThompson:llr

CC: Mr. Province
Mr. Barrows

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Dillon S Myer

June 24, 1943

Dr. G. D. Carlyle Thompson

SUBJECT: Assignment Army Medical Department Staff to War Relocation Authority
Current Statement

Since my memorandum of June 16th outlining needs as of that date, the picture has changed through loss of evacuee personnel and resignations of appointed staff. In addition to the evacuee registered nurses, there has been 9 appointed registered nurses leave or will leave by July 1st.

To meet minimum requirements which will provide minimum services at all ten Centers as determined by information available today, the following staff will be required by July 1st.

Registered nurses short and required 79

Physicians short and required 22

This represents an increase over the June 16th date of 8 registered nurses and 6 physicians. The current losses make even more important the assignment of three general surgeons.

Recruitment has continued. A few appointments have been made. Some interested candidates are not available because of their inability to obtain their employers release in accordance with War Manpower Commission regulations.

The maximum number of evacuee registered nurses who may be expected to remain is reduced from 15 to 14 and evacuee physicians from 35 to 33.

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

GDC: Thompson at
CC: Mr. Provins

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JUL 16 1943

Elmer M. Rowalt

D. S. Myer

Some time ago I received a detailed analysis from Dr. Thompson and Mr. Provinse regarding our needs for doctors, nurses, and other medical services. I presented the situation verbally to Mr. McCloy and asked if he would take the matter up with the Surgeon General to see whether the Army might assign either doctors or nurses or both to the WRA. I particularly raised a question regarding people who might not be physically fit for combat duty. I followed up on this matter yesterday and found that he had not yet received a report from the Surgeon General and I am not sure that the matter has even been taken up, although Mr. McCloy was under the impression that he had presented the case. I thought it would be more effective if he would arrange for you, Mr. Provinse, and probably Dr. Sleath, to present the problem in some detail to someone high up in the office of the Surgeon General. If this could be done with Mr. McCloy's endorsement I think we might have a better chance to secure some assistance than we would if it were simply presented formally by Mr. McCloy to the Surgeon General without his having any background. I told him that you would follow up on this to try to arrange for such a meeting. Mr. Provinse has copies of the statement of needs supplied by Dr. Thompson and I think is fully conversant with the problem. If you will follow up on this during my absence I will appreciate it very much.

Other matters discussed with Mr. McCloy and which should be follow up, are:

1. The request for assignment of Colonel Bicknell as consultant and Captain Blake full-time for a while in connection with our leave and segregation program.
2. The letter from Mr. McCloy approving the Tule Lake Project as a segregation center.
3. The withdrawal and realignment of the Army's report concerning House Resolution 37 and House Resolution 32.
4. Submission of the problem of warehouses on the West Coast as soon as Mr. Arnold receives ~~it~~ ^{information} from the West Coast offices.
5. Securing a copy of the WACE directive which should be available in a day or two and, of course, an announcement should be made to the centers as soon as it is available.

D. S. Myer

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Mr. Leland Barrows, Acting Director

July 27, 1943

Jack C. Sleath, M.D., Acting Chief Medical Officer

Subject: Shortage of Health Personnel at Relocation Centers

Reference is made to Dr. Thompson's letters to the Director of June 16 and June 24, 1943 concerning the assignment of Army Medical Department staff to the WRA. The letters indicate a rather serious shortage of technically trained health personnel and particularly physicians at the Centers, and were written to give the Director current information on this subject preparatory to approaching the War Department.

Following these letters, the Director contacted the Surgeon General's Office relative to the assignment of doctors and nurses from the Army to WRA. On July 20, 1943 an answer was received from the War Department through the office of the Assistant Secretary, signed by John J. McCloy. This letter stated that the matter had been taken up with the Surgeon General and that the War Department felt it impossible to offer us any assistance. They recommended that the U. S. Public Health Service be contacted in this regard, since they felt this service would be in the best position to assist us.

As you probably know, on May 5, 1943 a letter had been sent to Honorable Paul V. McNutt by the Director in which he outlined the rather serious medical situation existing in the WRA and asked consideration whereby the U. S. Public Health Service might assume certain responsibilities for the health service at our Centers. A reply to this letter was written by Mr. McNutt to Mr. Myer on May 25, 1943 and this letter outlined certain conditions under which the U. S. Public Health Service would be willing to assist the WRA. Although not familiar with the discussion which followed this proposal, I believe it was decided at that time to table the matter and investigate Army possibilities.

While investigations were under way with the U. S. Public Health Service and the War Department, the Health Section has continued with its efforts to secure physicians through Civil Service recruitment. This source has turned out to be almost a complete failure as far as adding physicians to the Center staffs is concerned. Since May 12, 1943, not a single physician has been added to our medical staff who is now available for Center duty. Although during this period two

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appointments were actually made, one resigned the day of his appointment due to draft board induction and the second resigned two days after arrival at his assigned Center. During this period approximately 50 doctors' applications referred from Civil Service have been processed with about 10 others from outside sources.

The question of utilizing paroled evacuees was also considered but it was deemed administratively inadvisable both by the Director and by this office to request the release of such paroled physicians even though they might be available.

Since the onset of relocation the number of evacuee M.D. personnel available at the Centers has been steadily decreasing. Recent advices from the Centers indicate that there will be a further loss of physicians from the Centers between now and August 15th. That the serious situation pertaining to physicians available at the Centers for health service is of considerable concern to evacuee populations and Project Directors is well evidenced by teletypes and letters on file in this office. Since proposed policies of increasing wage scales for evacuee physicians or instituting some form of freexing order for evacuee M.D.'s at the Center have been deemed administratively inadvisable, as well as the recent Public Health Service offer, the present turn down by the Army makes our medical situation almost untenable.

The potential effect on Center populations that may result from further reduction in medical personnel seems obvious and in my opinion impends serious repercussions.

Since Dr. Thompson is still away and I feel that action in this matter should not be delayed pending his return, I would appreciate your advice as to what steps will be taken now to remedy this crucial situation.

JCS, eath:lbr

CC: Dr. Thompson

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July 27, 1943

AIR MAIL

Mr. Paul A. Taylor
Project Director
Jerome Relocation Center
Denson, Arkansas

Attention: Joseph L. McSparran, M.D., Chief Medical Officer

Dear Mr. Taylor:

In reference to Administrative Instruction No. 100 concerning impending segregation movements, it is expected that detailed instructions will be furnished from Dr. Thompson's office to the Chief Medical Officers regarding the handling of matters which will pertain particularly to the medical aspects of the program.

In order that the Project Director's wire which is required under Section V-A, Paragraph 3 of Administrative Instruction No. 100 may contain the desired health information needed at that time the following determinations have been made:

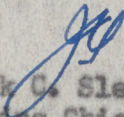
1. Tourist Pullman Accommodations will be Provided for:
 - a) Aged and infirm. Roughly individuals 65 years or older.
 - b) Pregnancy between 3-6 months.
 - c) Mothers with babies 1-18 months old.
 - d) Special medical cases authorized by Project Medical Officer.
2. Following Cases will be Temporarily Held Back:
 - a) Mothers beyond 6 months pregnancy.
 - b) Mothers with babies under 1 month.
 - c) Special medical cases authorized by Project Medical Officer.

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It is hoped that detailed medical instructions pertaining to the segregation movements will be ready in the near future.

Sincerely yours,


Jack C. Sleath, M.D.
Acting Chief Medical Officer

JCSleath:lib

CC: E. S. Whitaker

WAR RELOCATION AUTHORITY
TULE LAKE PROJECT

O F F I C E M E M O R A N D U M

Date: August 19, 1943

TO: Mr. C. R. Kallam (Chief of Agriculture)
FROM: Sanitary Corp (Base Hospital)
SUBJECT: Farm Well and Privies

Water test made of the new well for the farm mess hall showed absence of Bacterium Coli organisms.

Inspection of the immediate area surrounding the well reveals that there are three privies within 300 feet from the well. Two privies located N.N.E. of the well are approximately 160 feet and 180 feet from the well. The privy N.E. of the well is about 235 feet from the well.

Ordinarily privies located 200 feet or more from the well would be considered safe; but, due to the fact that the soil in the immediate area surrounding the well is loose and sandy together with surface irrigation in the close neighborhood of the well, it is advisable that privies be located 300 feet or more from the well. Under these circumstances, it is possible that the farm well may become unsafe because of sewage contamination.

Therefore, we deem it advisable that all other project should be secondary and the removal of the privies to a distance of 300 feet or greater and the chlorination of the present pits should be effected immediately.

/s/ G. K. Yamamura
Acting Chairman

Approved by:

/s/ Dr. R. Pedicord
Chief Medical Officer

GKY:f

WAR RELOCATION AUTHORITY

Tule Lake Project
Newell, California

February 3, 1944

MEMORANDUM TO: All Administrative Personnel of the Tule Lake
Center

All Evacuee Residents of the Tule Lake Center

SUBJECT: Inoculation of All Pets

Inoculation of all dogs and cats for rabies will be
held at Mess Warehouse #325 at a cost of \$1.00 on the
Following days:

FEBRUARY 4, 1944

10:00 A.M. to 12:00 Noon

1:00 P.M. to 5:00 P.M.

FEBRUARY 5, 1944

8:30 A.M. to 11:00 A.M.

As stated before if such animals have been inoculated
a certificate of inoculation must be presented. After the
above dates, all animals found within the confines of the
Tule Lake Center without evidence of having been inoculated
will be confiscated unless they are removed from the Center.

R. R. Best

R. R. Best
Project Director

Harry K. Marks M.D.

Harry K. Marks, M.D.
Acting Prin. Medical Officer