THE MEDICAL RESERVE OFFICER IN THE WAR*

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So much has been written about the medical reserve officer and his activities in the great war that anything more said may seem to be mere repetition and superfluous. What I shall say will not deal with the scientific aspect of his connection with the army or with the methods of treatment of wounds or diseases incident to military life. I wish to speak in a broad way of the medical reserve officer himself—what he did for the army and what the army did for him. Whatever may be said of a critical nature is brought out merely in the hope that in the reorganization of the Medical Reserve Corps, cognizance may be taken of the errors made in the past with the hope that these may be avoided in the future.

While it is true that services of tremendous value to the soldier were rendered by the medical reserve officer in the cantonments, training camps and hospitals situated in this country, it is not my intention to discuss this phase of the subject, first, because of my personal ignorance of their duties, since my service was overseas, and, secondly, because I wish to discuss only the medical reserve officer's work in the war zone.

In 1908, the original Medical Reserve Corps was organized. Its personnel was selected from among the leaders in the profession throughout the United States. This was done for the purpose of giving the Reserve Corps a high standing because of the high character and professional attainments of the individuals invited to become "charter members" of the corps. After a couple of years, interest was again revived in the Medical Reserve Corps, so that by 1911 a corps of approximately three times the size of the regular army medical corps was organized.

Under limitation by a law in force at that time, all medical officers were commissioned as first lieutenants. After a space of a few years, during which time the medical officers would occasionally receive pamphlets and booklets published by the army, a correspondence course was established, and Medical Reserve Corps officers were invited to take a short course in training camps established throughout the country. A few medical officers accordingly availed themselves of the opportunity to become acquainted with the mysteries of "squads right," "morning sick report" and "service records" and their importance as cogs in the army medical machine.

INEQUALITY OF RANK

When the new bill was made law, abolishing the old corps, making the Medical Reserve Corps a part of the Officers' Reserve Corps, the rank to which a medical officer might be commissioned was raised to that of major. For some strange reason, in every other division of the Officers' Reserve Corps, the maximum rank which a reserve officer could attain was that of colonel. This was an injustice which subsequent events proved to be a severe detriment to the fullest efficiency which officers of the Medical Corps of the highest professional standing in civil life were able to render in service.

It was very soon realized by officers in the Medical Reserve Corps in overseas service that a man's professional ability, experience or attainments were judged, not by his position in the profession in civil life but entirely by the insignia of rank which he wore on his shoulder. In the dealings with medical officers of allied armies and especially with line officers and those of other staff corps of our own, this was too often the rule; and, unfortunately, the American medical officer was often outranked by his professional brothers occupying a similar position with the allied armies.

Those medical reserve officers who responded at once to the nation's call after war was declared, and who accepted whatever commission was given them without question because of their patriotic desire to serve and who went overseas in the spring and summer of 1917, have good cause to remember the penalty imposed on them by the War Department. To be a pioneer proved to be a misdemeanor or crime, because medical reserve officers who blazed the medical trail in France and who had toiled for months in helping to work out our scheme for hospitalization and for the care of the sick and wounded were presently forgotten when promotions were handed out by the powers that be.

Several months after the medical work in France was fairly well organized by the early birds, who were mostly lieutenants and captains and a few majors sprinkled here and there, a crop of newly made majors arrived on the scene. These officers, for the most part, were younger in years and experience than many of the lieutenants and captains in overseas service, and were comfortably enjoying the emoluments and comforts of civil practice while their predecessors had gone overseas and prepared the way for them.

What was our astonishment to find that many of these officers had never heard of the original Medical Reserve Corps. These officers either received their majorities direct from civil life or, after spending from sixty to ninety days in training camps, were rapidly promoted to majors and sent overseas to outrank in many cases their teachers and hospital heads at home.

It was interesting to note that at the early meetings of medical officers in Paris under the auspices of the American Red Cross, there was an absence of service stripes on the sleeves of young officers whose shoulders shone with brand new brightly polished golden oak leaves; while beneath those single and double silver bars of their more mature companions sprouted a goodly number of gold service stripes on the left sleeve and, here and there, a wound stripe on the other.

The first assistant to the chief surgeon of the American Expeditionary Forces, none other than our present Surgeon-General, soon recognized the inequality of rank among his medical reserve officers, and earnestly endeavored to rectify this inequality by recommendations for promotions made toward the end of 1917. For some as yet unexplained reason, the general staff frowned down on any promotions in the Medical Reserve Corps, while they raised the regular army medical officers at least one grade.

In the meantime, promotions up to the grade of brigadier-general were being made in other reserve corps of the army, and the officers so promoted, a few months previously, in civil life, had never heard of the corps in which they were now occupying responsible positions. At the same time, the medical profession

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was furnishing the only reserve officers who had technical training in the department in which they were to serve.

I know of one instance in which the president of a large bank whose only interest in railroad engineering was the possession of large blocks of railroad securities was commissioned as lieutenant-colonel in the engineering corps and rapidly promoted to colonel, later becoming brigadier-general. In the meantime, surgeons whose names were household words in America were serving as captains, in a few cases as majors.

ATTEMPTS AT CORRECTION

It was not until the spring of 1918, nearly a year after some of the reserve officers had begun their service in France that, through the loophole of the National Army, some majors became lieutenant-colonels. The lieutenants and captains, however, without regard to their professional attainments, were still outranked by their interns, assistants and students fresh from home. In spite of all this, let it be said for the medical reserve officers that they kept on doing their duty and attending the sick and wounded, always cherishing the hope that some day conditions would be remedied. The result was that in many hospitals and even in line organizations, lieutenants and captains whose professional and military worth was early recognized were holding responsible administrative positions which, according to the tables of organizations, should have been occupied by officers of field rank. In some of our base hospitals, a captain, and in at least one case a lieutenant, was director in charge of the surgical division; and in one of our famous National Guard divisions, the ranking regimental medical officer for several months, and at the front, was a first lieutenant!

In the spring of 1918, in all other departments of the army, promotions began to appear. The Medical Department, realizing that the position of the pioneer medical reserve officer was unjust and humiliating, endeavored to find some way to remedy the existing conditions. After much thought and many conferences, a wonderful scheme which secured the approval of the general staff was decided on. This was the scheme to promote medical officers, not by the value of their services or of their professional qualifications or of their length of active service, but first and foremost by their age. It was decreed that no matter how valuable a first lieutenant's services might be, if he was unfortunate enough to have been born at so recent a date that he was not 35 years of age, he could not be promoted to a captaincy. Until he had reached the dignity of 40 years of age, no matter how valuable and efficient an officer in the Medical Corps he was, a majority was denied him.

The chief surgeon's office, in an endeavor to get the approval of the general staff on these so-called "corrective" promotions, secured the following concession: For every three months of active service the officer was to receive a year's credit in computing his age for the purposes of promotion. In other words, a lieutenant 33 years of age, who had served six months, would be considered 35 years old for the purpose of promotion to a captaincy. When the first large batch of recommendations for promotions was sent to Washington in July, 1918, however, the actual age was the basis, and not the actual age plus the credit for active service. The names of the officers who did not attain the actual age required were put on a roster for future promotion which was to include the added credit for actual service. Officers showing exceptional ability or meritorious service were supposed to be exceptions to the general rule. If such exceptional promotions did occur, the majority of medical reserve officers in France and England never heard of them.

UNFORTUNATE RESULTS

Why the reserve medical officer, professionally equipped for his work, was held down arbitrarily by an age limit, while in every other branch of the service the age limit was unheard of, is one of the mysteries of the war on which the medical reserve officer would be pleased to be enlightened.

Many faithful and efficient men were so disappointed by this ruling that their morale was severely affected, and, in spite of themselves, they were not giving their best efforts to their work. The conditions were so intolerable that apologetic and explanatory official circulars were published; in the meantime, however, promotions, except for a few which came through strictly on the age propositions, were slow to come to the medical reserve officer.

It was of the utmost importance that medical officers of high standing in the profession should insure the enforcement of their recommendations. Think of the humiliating position of a leading surgeon of one of our great cities, ranking as a captain, endeavoring to have certain important regulations enforced in a regiment whose colonel in civil life was a merchant who "hadn't much use for doctors."

When rank was needed the most by reserve medical officers, it was denied them by the general staff. Months after the armistice was signed and their relations with medical officers of allied armies and with other officers of our own were on an entirely different plane, then apparently as an act of eleventh-hour repentance, promotions were passed out freely. After the activity of war was over and medical officers were getting impatient awaiting their turns to go home, these belated promotions were not accepted in the spirit which they would have been had they come when higher rank was most needed. On account of the fact that the average practitioner of medicine is not a good business man, many left their families in meager circumstances. When one considers that a practitioner leaving his practice makes a greater sacrifice than the business man who leaves a "going concern" for his assistants to run, the financial part assumes great importance. The difference in salary and commutation between lieutenants' or captains' and field officers' rank meant often the difference between comparative want and comfort for the dear ones at home.

It would be interesting to see the proportion of medical reserve officers who saw overseas service who are now members of the Medical Reserve Corps, as compared with those who refused commissions in the corps. I have listened to conversations between discharged medical officers time and time again, and have found that the feeling of the great majority was that they had been unjustly treated, and that unless the situation was greatly improved, they would hesitate a long time before rushing into service again.

I believe that the "powers that be" at Washington are now commencing to realize that the medical reserve officer was not treated fairly, and I feel that with the

full knowledge of the valuable services rendered by the corps, the reorganization of the Medical Reserve Corps will give the medical officer at least an equal standing with the reserve officer of any other corps of the army.

Our regular army medical corps was, of course, pitifully small at the beginning of the war. Let me say this to the credit of those few men: They had to be spread out very thin in order to form any sort of a backbone to the organization. This meant, of course, that they were all required for headquarters and administrative work and to instruct reserve corps officers. It therefore necessarily followed that all of the professional work, with a very few exceptions early in the war, was done by the reserve corps officers.

The medical reserve officer showed such a marked aptitude for his work that very soon many important administrative positions were likewise filled by reserve officers. The glowing reports of Surgeon-General Ireland testify to the wonderful work done by the medical reserve officers.

From personal observation of the service rendered in front line positions by the reserve officers, I wish to say that patients came back to the field hospitals, in the main, in most excellent condition. The exceptions to this rule were so few that they need practically not be mentioned. In evacuation and base hospital work, medical and surgical teams were composed of men who were leaders at home, and sick and wounded soldiers received a type of professional care that has been seldom surpassed in our leading city hospitals. The casualties among medical reserve officers were high, as were also the citations and awards for individual bravery

Let it be said to the credit of our profession that, though smarting under the lack of recognition of their work and deserved promotion, they "delivered the goods" in a way that will always remain a tradition to be looked up to by the coming generation. The fact, however, that of 35,000 medical officers in service, a little over 10 per cent. have accepted commissions in the present reserve corps indicates that much missionary work must be done by the officers in charge.

SUGGESTIONS FOR THE BUILDING UP OF AN EFFECTIVE MEDICAL RESERVE CORPS

It is hoped that this subject will be discussed by the members of this association, and that in the discussion will be brought out suggestions which will prove of value to the Surgeon-General's Office in the building up of a reserve corps of excellent personnel and of goodly numbers. Might I make the following suggestions:

1. In order to secure an efficient corps, we have now a wealth of material from which to select its personnel. Approximately 35,000 physicians have seen active service, and a goodly proportion overseas service in the theater of operations. It is proposed, therefore, that all commissions in the Medical Reserve Corps for the next five years be limited to men who have been in active service.

2. Since the Surgeon-General's Office is in possession of data as to the fitness, capability, medicomilitary experience and military adaptability of every medical officer, this information will be of the greatest value in securing the highest type of material for medical officers.

3. Since it is now well recognized that inequality and injustice were frequent in the grading of Medical Reserve Corps officers, particularly in overseas service, it is suggested that all officers be recommissioned in the reorganized corps. Many officers deserve, by the character of their work and the postitions they filled, much higher grading than that with which they were discharged. Others were graded notoriously too high for the service they rendered.

4. It is recommended that all applicants for positions who have not seen military service be commissioned as first lieutenants. Since there are so many thousands of officers whose military experience and adaptability are on record, it is obviously unfair to these that a man from civil life should receive higher military commission than one who has shown his worth in active service. Every man in the profession, no matter how prominent he may be professionally or medicopolitically, had his opportunity to do his bit during the war. If he did not, he should take his place at the end of the line if he wants to join the corps at this late date. If all officers start as first lieutenants, they can be promoted as soon as they show that they are qualified to perform the duties of higher grade.

5. In securing professional information and data regarding the qualifications of civilians for commissions in the Medical Reserve Corps, it is hoped that such information will be secured from official rather than personal or political sources. It naturally follows that prospective medical reserve officers should be affiliated with their county medical society, the American Medical Association, hospitals, colleges or universities. From sources such as these, authentic information as to their professional qualifications, personal character and general suitability for the service can be gathered. It is assumed that a hospital in which a man practices his profession will be in a better position to report on his professional ability than will the congressman from his district.

6. As the soldiers of today were the civilians of yesterday, they are subject to the same illnesses and injuries as those of a purely military character. It therefore follows that all the specialties of medicine in civil life should be represented in like proportion in the army. If this had been done in the mobilization camps and recruiting stations, a more thorough system of preliminary examinations would have kept out those soldiers who later on required hospitalization overseas to the exclusion of battle casualties.

7. As different grades in the Medical Reserve Corps are in the same proportion as those in the regular army corps, it is recommended that all of those officers who held commissions who were not called to active duty be honorably discharged. It is well known that while many of these officers were prominent professionally, they were incapacitated for service either by age or unsuitability, and are holding commissions when they cannot possibly serve on active duty. These commissions, if vacated by honorable discharge, would assist in providing higher grades in the Reserve Corps for officers who have refused commissions because they felt they had not been fairly treated.

Let us hope that the Surgeon-General's Office, under its present able leadership, will take cognizance of the unfortunate error of our previous unpreparedness and will build up a Reserve Corps for future emergency which will have as its watchword "efficiency first."

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