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National Register of Historic Places Multiple Property Documentation Form

This form is used for documenting property groups relating to one or several historic contexts. See instructions in National Register Bulletin *How to Complete the Multiple Property Documentation Form* (formerly 16B). Complete each item by entering the requested information.

___x__ New Submission _____ Amended Submission

A. Name of Multiple Property Listing

United States Third Generation Veterans Hospitals, 1946-1958

B. Associated Historic Contexts

(Name each associated historic context, identifying theme, geographical area, and chronological period for each.)

Changes in Veterans Health Care Offered by the Federal Government to Veterans of World War II
VA Administrative History and Demand for VA Facilities
Facility Construction and Design, 1946-1958

C. Form Prepared by:

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date October 2016/revised winter 2017-2018,
by Virginia B. Price, Historian, with Darlene Richardson, Historian,
U.S. Department of Veterans Affairs

D. Certification

As the designated authority under the National Historic Preservation Act of 1966, as amended, I hereby certify that this documentation form meets the National Register documentation standards and sets forth requirements for the listing of related properties consistent with the National Register criteria. This submission meets the procedural and professional requirements set forth in 36 CFR 60 and the Secretary of the Interior's Standards and Guidelines for Archeology and Historic Preservation.

- see continuation sheet

_____ _____ _____
Signature of commenting official Title Date

_____
State or Tribal government

[signature] Federal Preservation Officer 3/30/18
Signature of certifying official Title Date

U.S. Dept of Veterans Affairs
Federal Agency

I hereby certify that this multiple property documentation form has been approved by the National Register as a basis for evaluating related properties for listing in the National Register.

[signature] 5/22/18
Signature of the Keeper Date of Action

Table of Contents for Written Narrative

Create a Table of Contents and list the page numbers for each of these sections in the space below.
Provide narrative explanations for each of these sections on continuation sheets. In the header of each section, cite the letter, page number, and name of the multiple property listing. Refer to *How to Complete the Multiple Property Documentation Form* for additional guidance.

E. Statement of Historic Contexts **1-68**
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F. Associated Property Types **69-119**
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Paperwork Reduction Act Statement: This information is being collected for applications to the National Register of Historic Places to nominate properties for listing or determine eligibility for listing, to list properties, and to amend existing listings. Response to this request is required to obtain a benefit in accordance with the National Historic Preservation Act, as amended (16 U.S.C.460 et seq.).
Estimated Burden Statement: Public reporting burden for this form is estimated to average 250 hours per response including time for reviewing instructions, gathering and maintaining data, and completing and reviewing the form. Direct comments regarding this burden estimate or any aspect of this form to the Chief, Administrative Services Division, National Park Service, PO Box 37127, Washington, DC 20013-7127; and the Office of Management and Budget, Paperwork Reductions Project (1024-0018), Washington, DC 20503.

E. Statement of Historic Context

Administrative Summary: Three Generations of Veterans Administration Hospitals

By 1950, the Veterans Administration oversaw the largest network of hospitals in the nation.[1] Its hospitals provided health care and medical treatment to veterans of the U.S. armed forces. Three wars proved seminal in the development of the federal government's hospital system: the Civil War and the two World Wars. The Civil War (1861-1865) prompted the first response, and the two twentieth-century wars refined it further to combat the diseases and disabilities each conflict brought. The site plan or campus of the Veterans Administration medical centers reflected contemporary clinical and therapeutic needs as well as architectural design at the time of construction. This was particularly true of the medical centers developed by the Veterans Administration in the mid-1940s and 1950s (Figure 1). State of the art facilities with buildings for research and patient care were the hallmarks of the post-World War II Veterans Administration medical centers referred to today as the "third generation" of veterans' hospitals. It was then that medical libraries for reference as well as scientific laboratories for testing figured more prominently in the medical campus along with the multi-story, main hospital significant for floorplan and function more so than its midcentury modern aesthetic. Examples of research specific to the postwar period include the isotopes for nuclear medical studies and a partnership with the Department of Defense in a tuberculosis/streptomycin study that essentially ended the need for tuberculosis hospitals altogether.[2] It was also in this generation of hospitals that racial segregation ended, for both patients and health care providers, even though black and white soldiers had been admitted to veterans' hospitals since the nineteenth century (Figure 2).[3]

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[1] *Administrator of Veterans Affairs Annual Report for Fiscal Year Ending June 30, 1950*, 9–10, cited in Trent Spurlock, Craig A. Potts and Karen Hudson, *United States Second Generation Veterans Hospitals National Register of Historic Places Multiple Property Documentation* (2010), Section E, 3, note 1, and Section F, 96, note 355.

[2] Other pioneering medical studies undertaken at Veterans Administration hospitals include cardiac research, namely in Buffalo, New York, where the first bypass surgery was done and where the first nuclear pacemaker was used, and in East Orange, New Jersey, where the studies of the lungs linked smoking to cancer and led to the surgeon general's warnings regarding health risks of using tobacco products being included on the product packing and advertising. Brockton, Massachusetts, also was known for its extensive use of recreational therapies. Regarding the medical research, Darlene Richardson, VHA Historian, to Virginia B. Price, NCA Historian, electronic communication, December 7, 2017. The veterans' hospital in West Haven, Connecticut, that opened in 1953 was the last built for tuberculosis care specifically. Ten percent of patients in 1945 had tuberculosis; by 1960 numbers of tuberculosis cases were reduced dramatically and lung cancer was more of a concern. See Lindsay Hannah, "West Haven Campus, VA Connecticut Health Care System," Nomination Draft 2017, National Register of Historic Places, National Park Service, copy on file, VA.

[3] Regarding the integration of VA hospitals, Darlene Richardson, VHA Historian, to Virginia B. Price, NCA Historian, electronic communication, December 7, 2017. In 1962, Howard W. Kenney, MD, the director of the hospital in Tuskegee, Alabama, and an African American, was appointed director of the VA medical center in East Orange, New Jersey. His transfer from the hospital for black veterans that was established during segregation to the New Jersey facility was significant toward the realization a fully-integrated Veterans Administration. *VAnguard*, August 29, 1962, 1; *VAnguard*, September 30, 1969, 2; "East Orange VA Hospital Will Get a Negro Director," *New York Times*, July 21, 1962; "1st Negro Heads Integrated Hospital," *Jet* (August 2, 1962): 50. Regarding integration, see also reference to Tuskegee and Montgomery, Alabama, and Jackson, Mississippi, in Section E, 19-21, below.

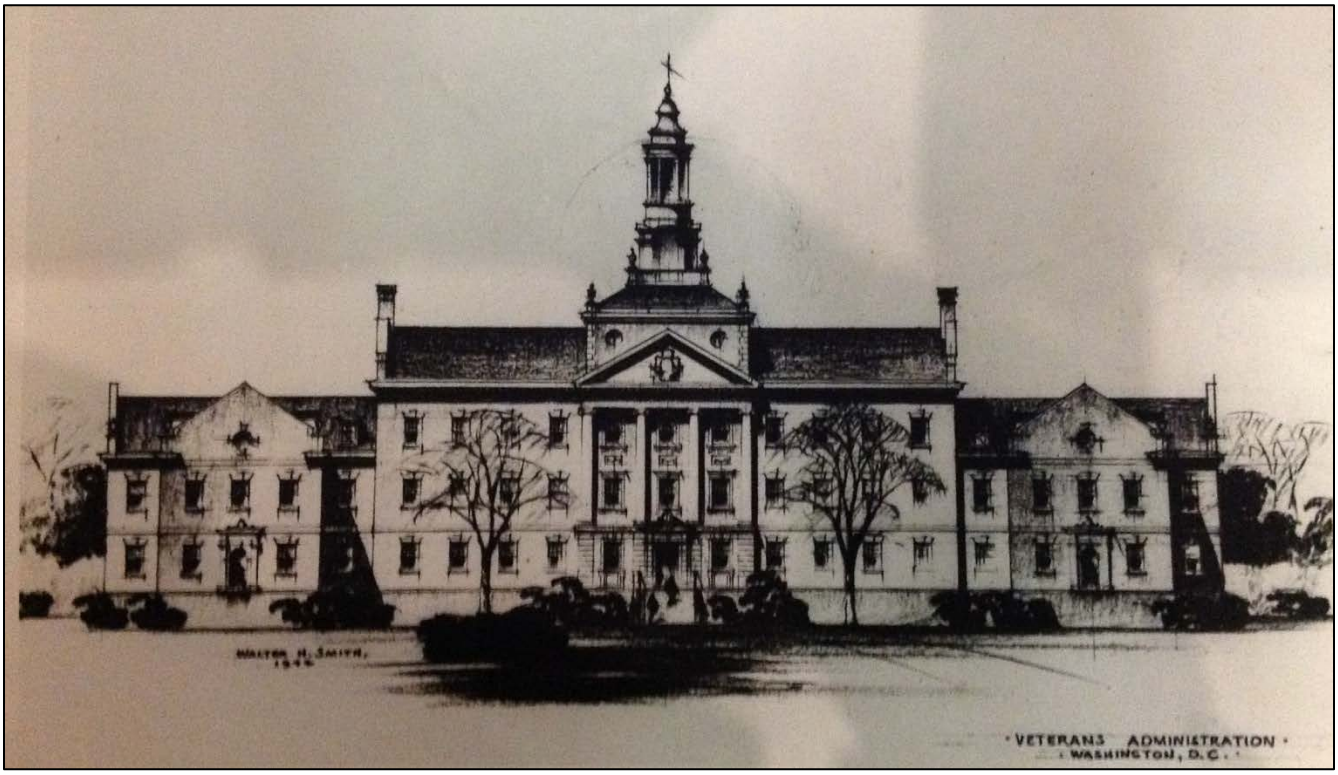

Figure 1. (top)The main building of the neuropsychiatric hospital built in Tomah, Wisconsin, that opened in 1947 - the first to open under the postwar program; (bottom) the main hospital building in Topeka, Kansas, that opened in 1958 – the last under the postwar program (VA). Regarding, Tomah, see *Annual Report* 1947, 10-11.

Figure 2. (left) Dr. Howard W. Kenney, director of the Veterans Administration Hospital in Tuskegee, Alabama, appointed to head the Veterans Administration Hospital in East Orange, New Jersey, in 1962, (center) Building No. 2, Tuskegee, and (right) the main hospital, East Orange (VA).

As the Civil War ended, a system of residential facilities for disabled and indigent veterans emerged. Between 1866, with the opening of the National Home for Disabled Volunteer Soldiers in Togus, Maine, to 1907, with the opening of the National Home in Hot Springs, South Dakota, eleven of these campuses offered Union-affiliated veterans a place of refuge and recovery. The National Homes remain in operation, albeit differently, in the twenty-first century.[4] The layout of the National Home campuses reflected that of a military post – with a parade ground, barrack-like housing, kitchen and dining facilities, hospitals and cemeteries – as well as that of asylums following the tenets of Dr. Thomas Kirkbride. Kirkbride recommended hospitals be situated in rural settings and have substantial acreage for agricultural and picturesque landscapes. The cemeteries associated with the National Homes were transferred to the jurisdiction of the present-day National Cemetery Administration in 1973; five of the eleven campuses or branches of the National Homes were designated National Historic Landmarks by the Secretary of the Interior in 2011-2012 (Figure 3).[5]

[4] The Soldiers and Sailors Home in Bath opened in the 1870s and was operated by the state; it was transferred to the federal government in 1929 and so could be considered the latest addition to the system. The date range of 1866-1907 references the construction and initial opening dates of the individual facilities, not administrative oversight.

[5] The five National Historic Landmarks (NHLs) are located in Leavenworth, Kansas; Dayton, Ohio; Hot Springs, South Dakota; Johnson City, Tennessee; and Milwaukee, Wisconsin. The National Home in Dayton was listed in 2012; the others in 2011. Regarding the transfer of national cemeteries, see National Cemeteries Act of 1973, Public Law 93-43, 87 Stat. 75-88, June 18, 1973.

Figure 3. Bird's eye view of the National Home in Milwaukee, Wisconsin, ca. 1870 (detail, HALS WI-13, sheet 1 of 14, Library of Congress).

Following World War I (1917-1918), the federal government initiated a hospital construction campaign to complement the existing system of National Homes for the medical treatment of U.S. veterans. These medical centers are recognized today as the *United States Second Generation Veterans Hospitals, 1919-1950*.[6] The rural setting, large campus, and low-scale buildings of these medical centers are a continuum of the National Homes or first generation design concept, but the hospitals themselves reflected a fundamental shift in objective from refuge and domiciliary provisions to providing rehabilitative care and a return to civilian life.[7] As a result, specific facilities for neuropsychiatric and tuberculosis patients, plus general medical and surgical patients, anchored the second generation medical center campus. Three medical centers, in Bay Pines, Florida, in Biloxi, Mississippi, and in Roseburg, Oregon, that opened during this second generation program represent the confluence of National

[6] The use of the term "generation" was introduced by the U.S. Department of Veterans Affairs to distinguish between the three large-scale hospital construction programs that each reflected its time in terms of medical care, societal mores (especially in regard to mental illness), and architectural forms between 1866 and 1958. The internal classification came into use during the survey, evaluation and nomination of the National Homes and incorporated into the name of the subsequent contextual studies for the purposes of National Register listing and related preservation initiatives from 2007 to the present (2017). Analysis of modern hospital design in this period – albeit in Montreal – is provided in Annmarie Adams, "Modernism and Medicine: The Hospitals of Stevens and Lee, 1916-1932," *Journal of the Society of Architectural Historians* 58, no. 1 (March 1999): 42-61. Adams' essay is part of a larger study in interwar hospital design that provides useful contextual information for the second generation of veterans' hospitals surveyed and nominated in 2012. *Medicine by Design: The Architect and the Modern Hospital, 1893-1943* (University of Minnesota Press, 2008).

[7] Inferred here is the shift in who sought medical treatment where – in earlier generations, the poor received treatment (or asylum) in institutions because at-home medical care was unaffordable. By World War I, hospitals were no longer charity but clinical. Jeanne Kisacky, "How Hospital Rooms Went from Airy Temples to 'Inhuman' Machines," essay (www.zocalopublicsquare.org, accessed January 25, 2018).

Home and post-World War I hospital design with provisions for domiciliary and general medicine. These three facilities included cemeteries. These three cemeteries, plus the one developed by the Veterans Administration in Houston, Texas, were transferred to the Veterans Administration as the National Cemetery System in 1973. Also transferred were all but two national cemeteries and the cemeteries located at the National Homes. A multiple property documentation form was prepared to record the context of development for the second generation of hospitals administered by the federal government; that multiple property nomination was listed in the National Register of Historic Places in 2012.[8] Thirty-two Veterans Administration medical centers were listed in 2012 under the second generation context, and, by 2017, there were more than forty so recognized.[9] Houston National Cemetery also was placed on the National Register in 2017 (Figure 4).[10]

[8] Forty-three properties were surveyed and evaluated between 2008 and 2011 in preparation for the multiple property submission to the National Register; in Section H, page 123, of the multiple property documentation form (the contextual nomination) there is a list of the second generation hospitals, with eighty developed in the first period of the program (mostly 1920s) and another forty-four in the second period. The list also includes the soldiers' homes, or first generation of veterans' hospitals known as the National Homes for Disabled Volunteer Soldiers that were transferred to the Veterans Administration in 1930. See Spurlock et al., Appendix, 124-32.
[9] Douglas Pulak, "Historic Property Surveys Benefit the U.S. Department of Veterans Affairs," [article] July 23, 2015, copy on file, VA. The numbers of nominated properties are culled from the weekly reports of the National Register of Historic Places.
[10] The nomination is available online here: https://www.cem.va.gov/pdf/nrhp/Houston_NR_Nom.pdf.

Figure 4. (top) Historic post card views of the VA homes in Roseburg, Oregon, and Los Angeles, California, and (bottom) photographic views in Houston National Cemetery taken in 2009 (VA).

Another war demanded new treatments and therapies for veterans returning home. Over 16 million served in World War II (1941-1945) and 5 million plus served during the Korean Conflict (1950-1953). The demand for health care soared as these men and women sought medical attention.[11] The mid-twentieth century also ushered in

[11] Numbers taken from: https://www.va.gov/opa/publications/factsheets/fs_americas_wars.pdf (accessed December 14, 2017).

new design ideals for hospital campuses and an integration of private and public medical research that allied government facilities with medical schools. These shifts determined the site design for the federal government's third generation of hospital construction. The Veterans Administration announced the initiative in 1946. Construction of the *United States Third Generation of Veterans Hospitals* continued to 1958 when the last medical center developed under the programmatic parameters opened.[12] Those parameters called for smaller hospital campuses located near to medical schools, largely in urban areas, each with a main hospital building taking a multi-story, flat-roofed skyscraper form and each with ample provisions for parking (Figure 5). The bucolic campus of the earlier generations evolved into a tight medical center or hospital. In this context, the term "hospital" includes the main hospital building as well as ancillary buildings for storage, clinics, laboratories, staff housing, and additional patient wards plus the parking lots required and the residual open space within the property boundaries.

Figure 5. *Below*: (top) Main hospital building in Providence, Rhode Island, in 1948, and (bottom) an example of the VA standard plan hospital campus, here under construction in Ann Arbor, Michigan, in the early 1950s: view looking to the main hospital facade and view looking to the side elevation of the main hospital building and several of the ancillary buildings (VA).

[12] The last hospital planned under the Veterans Administration's third generation of hospital construction was in Topeka, Kansas. Regarding the term "generation," see Note 6 above.

Of the medical centers established under the third generation umbrella, three property types were identified in a survey of fifty-six properties undertaken in 2012 to 2014.[13] Similar to the Veterans Administration's second generation hospitals, several existing hospitals were remade into the modern medical centers for veterans of World War II. These hospitals were created by other entities and transferred to the Veterans Administration when the war ended in 1945.[14] The other two property types are new hospital centers, with the first designed by architects in private practice and the second erected according to standardized plans drafted by Veterans Administration staff. The new hospitals designed under the Veterans Administration include two subtypes: the standard-plan skyscraper hospital campus and the neuropsychiatric hospitals known as the Haun-type after psychiatrist Paul Haun. With the exception of a medical center in Puerto Rico transferred to the Veterans Administration, i.e., an example of the first property type, third generation construction was confined to the continental United States and this nomination necessarily reflects that emphasis (See Section G and Appendix C, below).

Several marquee names in the architecture profession are associated with the design of veterans' hospitals overseen by the federal government in the 1940s and 1950s; however, as built, collectively the third generation of the Veterans Administration's facilities is significant as an example of health and medical trends in the postwar period. Significance is further underscored through the history of the U.S. military and the continuing care provided to the nation's veterans. The medical centers give tangible expression of that commitment. Various modernization campaigns reinforce the purpose behind the hospital campuses' establishment: up-to-date medical research and treatment. A design-focus on the high-rise, main hospital building in a minimalist landscape driven by parking accommodates changes to the campus and preserves integrity at same time.[15]

[13] See Section H, below, for the methodological statement for the survey and evaluation of the multiple property study known as *United States Third Generation Veterans Hospitals, 1946-1958* and presented here. Of the fifty-six properties documented in the survey, listing for twenty-two is being pursued. See Section G, below.

[14] Forty-two of these are noted in Appendix C, below. Of those listed, six were surveyed as part of this contextual study: Butler (Pennsylvania), Dublin (Georgia), Fort Meade (South Dakota), Long Beach (California), Martinsburg (West Virginia), and Temple (Texas).

[15] Additions to the medical centers made during later modernization initiatives may be eligible for listing in the National Register of Historic Places, but not under the context of the third generation of veterans' hospitals planned by the federal government and built nationwide between 1946 and 1958.

Changes in Health Care Offered by the Federal Government to Veterans of World War II

VA Administrative History and the Demand for Facilities

Through a combination of existing facilities and new construction, the Veterans Administration (VA), the forerunner to the U.S. Department of Veterans Affairs, provided modern hospitals for the nation's military veterans. Following World War II, the federal government's investment in medical centers for veterans occurred concurrently with a nationwide boom of public health care facilities, thus allowing the VA to take advantage of the proliferation of architectural and medical knowledge in the postwar period. The postwar or "third generation" of veterans' hospitals is not a collection of identical buildings or architectural styles, yet the group, as a whole, represents the federal government's response to health care needs in the years immediately following World War II, specifically from 1946 to 1958. The generational distinction referred to here is a classification system within the VA to better document and evaluate its medical campuses; the postwar hospitals reflect the third iteration of building, following the Civil War's first hospitals constructed within the soldiers' homes and those medical centers designed after World War I, from 1919 up to 1950.[16]

The influx of World War II veterans added to the overall veteran population and accommodating them strained the existing Veterans Administration hospital system. The war created a pressing need for more beds in more facilities.[17] Hospitals routinely had waiting lists. As demobilization accelerated, the needs became even greater for bed space as well as medical personnel to attend to patients.[18] The Veterans Administration's approach to hospital construction before World War II placed its hospitals in remote locations based on political pressure more so than

[16] See Note 6, above.
[17] The assessment of veterans' access to health care – and measure of demand and how the Veterans Administration construction program met it – was quantifiable by number of beds. Inferred is not just the structural infrastructure (i.e., bed space for patients), but the medical infrastructure of supplies, administrators, pharmaceuticals, clinics and laboratories, &c.; medical personnel to staff the hospitals and provide patient was a parallel concern. In the report by Clarence McKittrick Smith, *The Medical Department: Hospitalization and Evacuation, Zone of the Interior* The United States Army in World War II series, edited by Kent Roberts Greenfield, Technical Services Volume (1956; Washington, DC: Center for Military History, United States Army, 1989), Smith also correlates hospital expansion with an estimation of beds required, illustrating how the army began with the data from World War I regarding numbers of beds and average length of stay per patient to plan for medical needs in the current conflict. For the purposes of this nomination, the bed count is a barometer of scale used in the period and so is used here to track the construction over time.
[18] The number of attending physicians – as well as places for the patients (i.e., beds) was an important part of Administrator Omar Bradley's cooperative arrangement with the armed forces for bed space *and* doctors – plus that made with several states and with medical schools – while the Veterans Administration constructed the new facilities. Inadequate staffing was cited in the rational for cutting back the hospital construction effort in 1949. See, for example, "Proposed 1000-Bed VA Hospital Here Reduced by Half," *St. Louis Star and Times*, January 10, 1949, and note below.

on medical needs.[19] The relative isolation allowed for sizeable campuses of multiple low rise buildings housing large patient wards, a design favored by Kirkbride and others (Figure 6). The Veterans Administration discouraged its doctors from conducting research and medical organizations did not allow the VA's doctors to join, thus insulating them from new ideas in the medical field. Journalists and lawmakers became concerned that the approach the Veterans Administration had taken to hospital development was no longer suitable for these newly returning veterans.

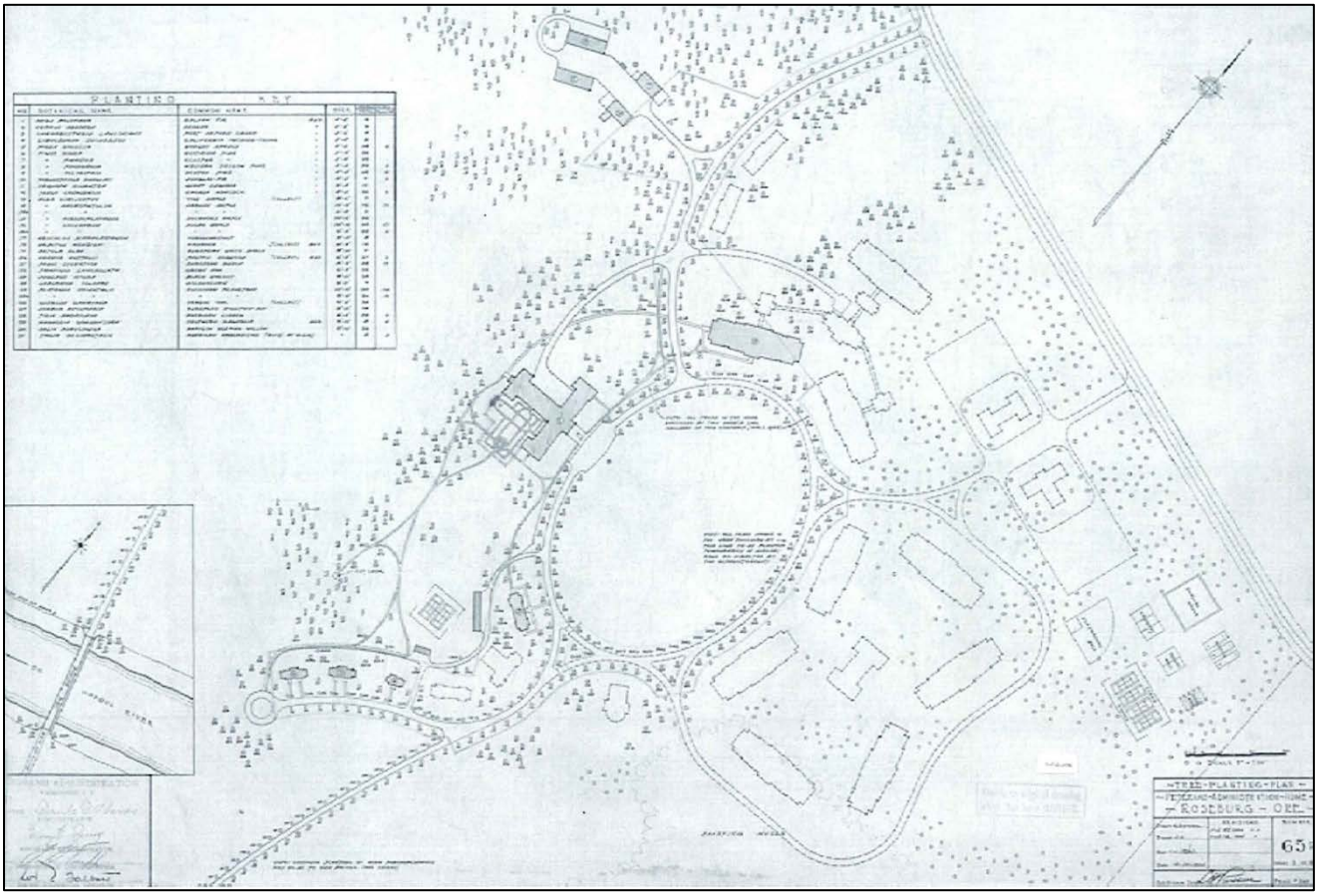

Figure 6. Site layout for the Veterans Administration Hospital in Roseburg, Oregon,1933, rev. 1934 (VA).

President Harry S. Truman tried to fix the Veterans Administration with a war hero, General Omar N. Bradley, in 1945. During his two-year tenure as Chief Administrator, Bradley initiated sweeping changes to the organization. Bradley created the Department of Medicine and Surgery that removed the VA's doctors from civil service and placed them under the VA's purview for hiring and promotion. However, one of Bradley's biggest initiatives was

[19] See, for example, "Psychiatric Care of Veterans," *Journal of Criminal Law and Criminology* 37, no. 1 (1946): 69; Paul B. Magnuson, "Medical Care for Veterans," *Annals of the American Academy of Political and Social Science* 273 (January 1951). The third generation was not immune – note the location of the medical center in Bonham, Texas.

the implementation of significant changes to the way the Veterans Administration built hospitals. Under the program that became the federal government's third generation of veterans' hospitals, newly constructed Veterans Administration hospitals were sited near urban centers, associated with medical schools, and implemented the latest in hospital design. Visually distinctive, hospital services were stacked in a single skyscraper-type building (Figure 7).

Figure 7. Veterans Administration Hospital, St. Louis, Missouri, as shown in "Getting to Know Us," *VAnguard* (1965): 4 (VA).

Administering Veterans' Health Care to 1930: A Summary

The present day U.S. Department of Veterans Affairs is an agency that evolved from various colonial ordinances into a federal organization responsible for providing health care, benefits, and other services to veterans. As early as 1636, for example, leaders of the English Colony in Plymouth, Massachusetts, allocated funds for disabled soldiers. Moreover, during the Revolutionary War and federal period, the Continental Congress, and its successor, the United States Congress, offered monetary assistance to disabled veterans – honoring their service, not giving

charity, a distinction made in the period.[20] A Bureau of Pensions, established under the Secretary of War, managed the majority of the veterans programs in the early nineteenth century, including a period of "half-pay pensions" for widows and orphans of those soldiers that served in the War of 1812.[21] The War of 1812 also led to the establishment of the first facility designated for the medical care of veterans, the United States Naval Asylum in Philadelphia, Pennsylvania (Figure 8).[22]

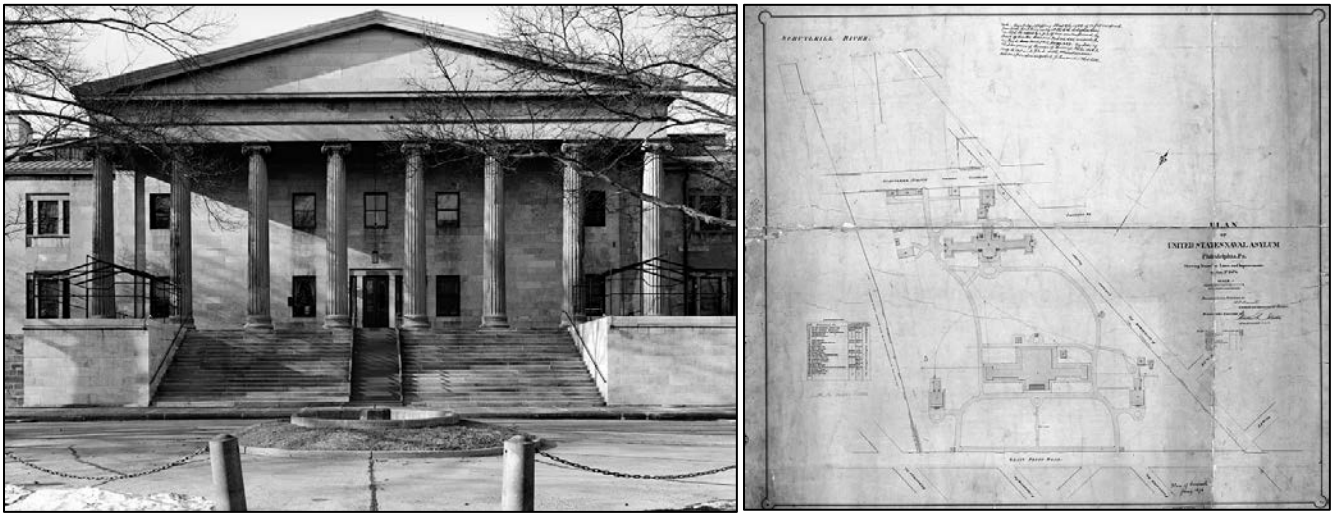

Figure 8. U.S. Naval Asylum in Philadelphia: (left) Biddle Hall designed by William Strickland and (right) plot plan for the campus in 1878 (Library of Congress).

The Civil War resulted in approximately two million Union veterans. The unprecedented numbers led to an expansion of veterans' programs in the country. In 1862, the General Pensions Act provided pensions for soldiers, as well as their survivors, based on rank, as well as some compensation if the veteran had contracted a disease during the course of service.[23] In 1865, Congress passed legislation creating the National Asylum for Disabled Volunteer Soldiers. The asylum was renamed the "National Home" in 1873 to avoid the growing negative connotations associated with the term "asylum."[24] The National Home system developed into a network of multiple branches located across the United States; three were established initially and, by 1929, there were

[20] Paul B. Magnuson, "Medical Care for Veterans," *Annals of the American Academy of Political and Social Science* 273 (January 1951): 76; Spurlock et al., Section E, 4-5. Magnuson's essay provides a summary of the veterans' medical care program in 1950 – from hospitalization to outpatient to domiciliary to home town care to clinics (including psychiatric) to dental programs, &c.; his could be interpreted as a response or update to Frank T. Hines, "Medical Care Program of the Veterans Administration," *Annals of the American Academy of Political and Social Science* 239 (May 1945): 73-79, referenced below.
[21] U.S. Department of Veterans Affairs. *VA History in Brief* (Washington, D.C.: [U.S. Department of Veterans Affairs, 2006]), http://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf (accessed November 16, 2010), 3.
[22] Spurlock et al., Section E, 5; also, http://www.loc.gov/pictures/collection/hh/item/pa0668/.
[23] *VA History in Brief*, 4.
[24] "Veterans Affairs National Home for Disabled Volunteer Service," National Park Service, http://cr.nps.gov/nr/travel/Veterans_affairs/text_only.html (accessed October 7, 2010).

eleven branches. The National Homes were modeled on military bases, with sizeable campuses and facilities to provide recreational and occupational activities including associated farms (Figure 9). Cemeteries for deceased residents were located on the properties as well.[25]

Figure 9. National Home at Togus, Maine (VA).

World War I resulted in significant changes to the care of veterans in the United States. In 1917, Public Law 90 provided medical care for injuries veterans sustained during the course of their military service. Veterans found treatment at the United States Public Health Service hospitals, but the facilities operated at or beyond their capacity, and thus provided little in the way of convalescent care. As the number of veterans increased, the Public Health Service provided additional beds by leasing facilities from federal partners, such as the army and navy, by contracting with private hospitals for space, and by converting existing structures, like the National Homes, into medical facilities.[26] While the Public Health Service covered medical care, the Bureau of War Risk Insurance handled pensions and life insurance and the Rehabilitation Division of the Federal Board for Vocational Education managed training and rehabilitation for veterans. The three organizations created a labyrinth for veterans to negotiate for access to benefits and services. Frustrations with overlapping bureaucracies and a lack of

[25] "Veterans Affairs National Home for Disabled Volunteer Service."
[26] Spurlock et al., Section E, 7-8; VA, *History in Brief*, 7.

sufficient medical care led to veterans' advocacy groups, such as The American Legion (1919) and the Disabled American Veterans (1920), calling to streamline the system.[27]

In 1921 the Veterans Bureau Act created one umbrella federal organization to combine these segregated World War I veterans services, the Veterans Bureau (renamed the U.S. Veterans Bureau shortly afterwards). The Bureau handled pensions, vocational training, and medical care. Hospitals previously under the jurisdiction of the Public Health Service were transferred to the Bureau in 1922.[28] The Veterans Bureau then embarked on a significant hospital construction program that resulted in 125 hospitals and more than 102,000 beds. These hospitals featured large rural campuses with multiple low-rise buildings.[29] The hospitals were constructed in popular architectural styles of the period, including Spanish Colonial Revival and Georgian Revival that referenced and reflected buildings of the past (Figure 10). That construction campaign is now referred to as the "second generation" of veterans' hospitals (1919-1950), with the National Homes as the first.

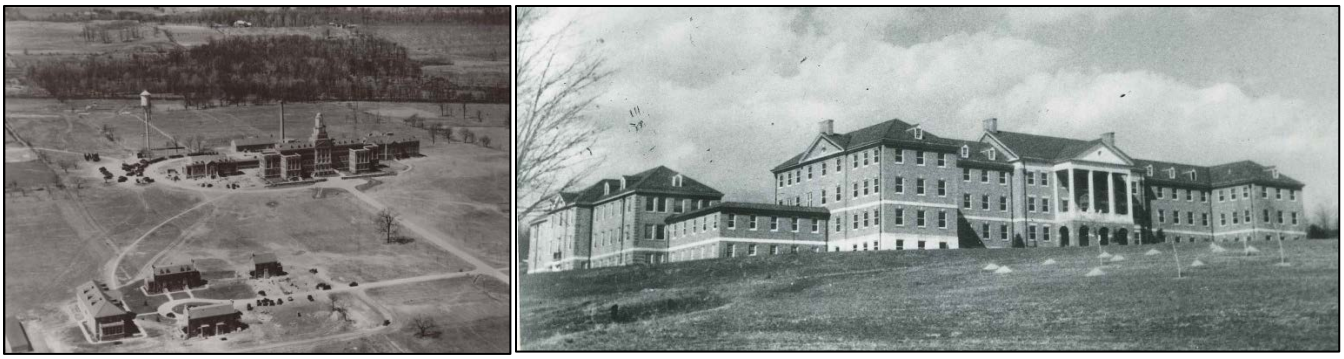

Figure 10. Revival-style campuses of the second generation of veterans' hospitals built by the Veterans Administration in Newington, Connecticut (left) and White River Junction, Vermont (right) (VA). Newington is representative of the campus plan with a prominent main building and support buildings behind it as the focal point, and a cluster of quarters for staff in an enclave of its own (show here, bottom left), while the view of the White River Junction medical campus illustrates the use of connecting corridors to link the main building to additional patient wards.

Scandal soon rocked the Veterans Bureau. Colonel Charles Forbes, appointed head of the Bureau by President Warren G. Harding, was investigated by Congress on a series of charges, including hiring incompetent architects, providing hospital plans in advance to construction companies of which he was vice president in order to give them advantages in the bidding process, and, while on government trips, engaging "in drinking and other disgraceful parties.[30] In total, Forbes is believed to have taken a significant portion of the $250 million earmarked

[27] Spurlock, et al. Section E, 7-10.
[28] Spurlock et al., Section E, 7-9.
[29] Spurlock et al., Section E, 1.
[30] "Congress: A Pretty Mess," *Time*, 5 November 1923. http://www.time.com/time/magazine/article/0,9171,716844,00.html (accessed April 1, 2011).

for hospital construction and supplies.[31] In 1924, Forbes was found guilty of "conspiracy to defraud the Government in the building of hospitals for veterans." He was sentenced to two years in the United States Penitentiary in Leavenworth and a $10,000 fine.[32]

In 1924, Congress passed the World War Veterans Act that relaxed hospital admission eligibility standards, including allowing veterans to seek medical treatment at veterans' hospitals even if the underlying condition was not directly linked to their time in service. Veterans' services were consolidated with the creation of the Veterans Administration (VA) in 1930. The Veterans Administration subsumed the Veterans Bureau, the National Homes, and the Bureau of Pensions into one entity to provide multiple benefits to veterans, including medical care. Brigadier General Frank T. Hines administered the Veterans Bureau, and then led the Veterans Administration, from 1923 to 1945 (Figure 11).

Figure 11. Historic post cards showing (left) the headquarters of the Veterans Administration and (right) the original pensions building designed by QMG Montgomery C. Meigs (VA). The pensions building is now the National Building Museum.

Medical Treatments and Advancement: Responding to World War II

The Second World War brought advances in technology in warfare and associated medical care. Many weapons were refinements and improvements to weapons developed during World War I. New metals for gun barrels combined with radio technology resulted in more reliable weapons and greater accuracy, for example, while medical innovations expanded to treat injured combatants. [33] The widespread use of sulfa drugs and penicillin combined with rapid evacuation of wounded soldiers from the front achieved a higher survival rate compared to

[31] John Mack Faragher and others, eds., *Out of Many: A History of the American People, Volume II* (Englewood Cliffs, NJ: Prentice Hall, 1994), 722.
[32] "Political Notes: Forbes Punished," *Time*, March 29, 1926. http://www.time.com/time/printout/0,8816,729065,00.html (accessed April 1, 2011).
[33] Michael Gambone, *The Greatest Generation Comes Home: The Veteran in American Society* (College Station: Texas A&M University Press, 2005), 38-39.

previous conflicts. Improved surgical techniques, both in war zones and on the homefront, increased the odds of survival for soldiers who likely would have perished from similar wounds sustained in earlier wars.[34]

This increased survival rate led to the creation of a paraplegic program within the Veterans Administration. As bluntly stated in a VA report to President Harry S. Truman, "A paraplegic problem did not exist in the Veterans' Administration prior to World War II for nearly all such patients died within the first year."[35] The survival of 2,400 paraplegics during World War II spurred a pilot program to identify appropriate standards for care and treatment as well as to define appropriate facilities for rehabilitation. The Veterans Administration established designated centers for paraplegia care in seven hospitals, with the largest numbers in the Hines, Illinois, facility.[36] While the VA generally worked towards rehabilitation and the return of the veteran to general society, it recognized that full reintegration might not be feasible for all paraplegia cases.[37]

World War II amplified many of the diseases and disabilities handled by the Veterans Administration and its partners in veterans' care. The close quarters of the military life allowed diseases like tuberculosis (TB) to flourish among soldiers and sailors. Tuberculosis is caused by a bacterium called *Mycobacterium tuberculosis,* with symptoms including hemoptysis, chills, fever, and night sweats. It is spread through coughing, sneezing, and any activities that render the TB germs airborne.[38] Treatments for tuberculosis included traveling to warm climates, surgery to repair lungs, and isolation in sanatoriums where most patients were housed in large wards.[39] World War II increased the tuberculosis patient load at the VA's existing hospitals, and while new facilities were constructed or wards converted for patient treatment under the third generation program, sanatoriums operated by state and local authorities accepted patients. Protocols remained the same for it was not until after the war that

[34] Gambone, 39.
[35] Arthur A. Abramson, Robert Dennison, and Howard A. Rusk, *Report to the President from The Committee on Veterans' Medical Service* (Washington, DC: U.S. Government Printing Office, 1950): 5.
[36] Abramson et al., 58. In Appendix XVIII "Paraplegic Patients in Veterans' Administration Hospitals March 1950" the designated hospitals were marked with an asterisk: Bronx, New York; Framingham, Massachusetts; Staten Island, New York; Richmond, Virginia; Memphis, Tennessee; Hines, Illinois; and Van Nuys, California. There were paraplegic patients in sixty general medical and surgical hospitals, fourteen neuropsychiatric hospitals, and two tuberculosis hospitals, 1470 of them in all. Hines (269), Memphis (234), and Richmond (153) had the majority of the paraplegic patients.
[37] Funds were appropriated for artificial limb research and therapies, see "$1,000,000 for Help to War Disabled," *New York Times*, October 27, 1945, and "Prosthetic Research in the Veterans' Administration," Senate Report No. 1695 (1962) and Pub. L. 80-729. Also, Howard A. Rusk, MD, in columns entitled, "Rehabilitation," reported on the VA's efforts to make obtaining prosthetics, and maintaining them, easier on its patients with the establishment of a clinic that also offered orthopedic and aural care. *New York Times*, May 12, 1946 and August 25, 1946.
[38] Centers for Disease Control and Prevention, *Get the Facts about TB Disease*, 2005. http://www.cdc.gov/tb/publications/pamphlets/TB_disease_EN_rev.pdf (accessed April 18, 2011).
[39] Spurlock, et al, Section E, 13.

controlled research studies around the antibiotic streptomycin began to show progress (Figure 12). Only then did the VA's hospital network shift in design and the use of space for tuberculosis treatment.[40]

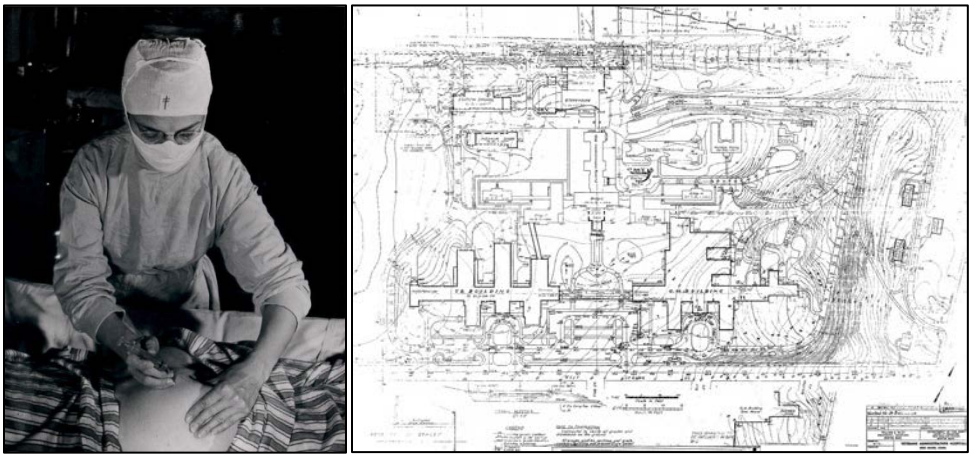

Figure 12. (left) A nurse administering streptomycin, Kerrville, Texas, and (right) site plan, West Haven, Connecticut, that includes the tuberculosis hospital (VA).

Mental illnesses were another focus of medical attention, supported by the general shift in perception prior to World War II regarding psychiatric conditions. As a result, World War II veterans often were more accepting and forthcoming when it came to mental illnesses.[41] The Veterans Administration was at the forefront of psychiatric research and utilized various treatments for mental illness including insulin-shock therapy, electrical shock therapy, and prefrontal lobotomies, all accepted treatments during the period, to care for psychiatric patients.[42] With the end of the war, the VA needed more facilities for veterans suffering from tuberculosis and neuropsychiatric conditions as well as more medical staff to care for them.[43]

[40] Frances Brian Carroll, "Progress in the Medical Care of Veterans," *New England Journal of Medicine* 244, no. 6 (February 8, 1951): 214. In this review of the Veterans Administration healthcare network in 1951 that addressed the progress of the last four years – i.e., since Bradley announced the initiative - and responded to criticism regarding expense or even the need for more hospitals at all, the author touches on the advancements of streptomycin in treating the disease and the large number of patients suffering from the disease (214). The military's study began during the war, and the Veterans Administration joined the research effort in this period addressed by Carroll. Research into the disease extended through the 1950s, and into the 1960s, as the disease was effectively eradicated. The antibiotic reduced the need for dedicated hospitals and so wards were converted to TB or from TB as patient needs shifted. See, for example, "VA Hospital at Whipple Redesignated," *Prescott Evening Courier*, July 20, 1959, as well as the *Annual Reports* for the VA throughout the period of significance.

[41] Gambone, 40.

[42] Carroll, 214. The author also references changes to the physical character of the hospital, i.e., the patient environment, so important to influential psychiatrists Paul Haun and the Menninger family. Iron bars and grilles were replaced with screens; light colored paint and brightly colored upholstery and window treatments alleviated the "gloomy" institutional atmosphere. See p. 213. Also, "The VA-Beyond the Call to Duty," *Tuscaloosa News*, February 27, 1949; "Psychiatrists Ask for a Rise in VA Funds," *New York Times*, May 22, 1947; "Panel of Psychiatrists Volunteers Aid As Veterans Pleas Swamp Other Agencies," *New York Times*, September 9, 1946; and Charles Hurd, "The Veteran: Modern Scientific Aid Will Be Given to Soldiers Who Are Mentally Ill," *New York Times*, August 19, 1945.

[43] Carroll, 213-15.

The advent of the nuclear age during World War II shifted with the war's end and created the new world of atomic medicine and research for peacetime pursuits in the medical and biological fields.[44] Atomic medicine attracted new scientific staff to the Veterans Administration hospitals in the postwar period and it required dedicated space in the hospital campuses.[45] The postwar veterans' hospitals included libraries and laboratories to accommodate the work of medical personnel as well as the patients who would benefit from the development of diagnostic tests and treatments.[46] By 1947, six veterans' hospitals had radioisotope units,[47] and in 1949, the VA established its eleventh unit in Nashville, Tennessee, attesting to the strength of the program even its infancy during the years immediately after the war.[48] From cancer treatments to thyroid studies to nuclear pacemakers, atomic medicine had far reaching effects as the programs matured.[49] The resources devoted to medical engineering also provided veterans with more immediate relief – in the hearing aids and orthopedics made to ease war-related disabilities and through the clinics at the hospital centers for the therapies and adjustments needed to use them.

The Veterans Administration and the World War II Veteran: Responding to Home

Estimates from the Veterans Administration today place the size of the postwar veteran population at 20,000,000, significantly larger than the World War I veteran population. The Veterans Administration recognized that the war necessitated revising existing plans for future expansion of its hospitals and health care for veterans; as early as 1942, the VA wrestled with issues related to personnel shortage at existing facilities, how the duration of the war would affect future hospital loads, and how future Congressional activities would affect hospitalization benefits.[50]

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[44] "Isotopes To Be Shipped," *New York Times*, July 23, 1945; "Isotopes in Use a Year," *New York Times*, September 6, 1947; "U.S. Offers Three Isotopes Free to Aid Atomic Fight on Cancer," *New York Times*, March 7, 1948; *Scientific Monthly* 68, no. 3 (March 1949): 171; "Pacemakers Going Nuclear," *New York Times*, July 23, 1972

[45] *Annual Report* 1948, 25; Joseph H. Bates, MD, "Statement of the Association of American Medical Colleges on the Department of Veterans' Affairs Research Program," Report presented to the U.S. House of Representatives, Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, October 11, 1989. Bates addresses the VA's use of clinical trials and cooperative studies program that were instrumental in the development of streptomycin to treat tuberculosis beginning in 1946 and continuing. At the time of his presentation there were fifty ongoing studies across seventy-two medical centers focusing on high blood pressure, strokes, coronary disease, and cancer.

[46] *JAMA* (October 1947): 358.

[47] They were located at the VA hospitals established in Framingham (MA), the Bronx, Cleveland, Chicago, Minneapolis, and Los Angeles. *JAMA* (October 1947): 358. The same report included "hospital news" of the Veterans Administration – namely the selection of the 19.5 acre site for the new – third generation - hospital in Indianapolis.

[48] *Scientific Monthly* 68, no. 3 (March 1949): 171.

[49] The first nuclear-powered pacemakers were implanted by surgeons at Buffalo VA hospital. "Pacemakers Going Nuclear," *New York Times*, July 23, 1972.

[50] A.D. Miller, Executive Assistant to the Administrator to [Frank Hines], the Administrator, August 19, 1943, Entry 72, A1, Record Group 15, National Archives and Records Administration, Washington, DC.

Thus, at the close of World War II, the Veterans Administration faced the task of providing medical care to millions of returning veterans. In 1945, 94 hospitals provided 75,967 beds operated under the auspices of the Veterans Administration in forty-five states and the District of Columbia. Most of these hospitals were for general medical and surgical patients rather than tuberculosis or neuropsychiatric patients. Even so, the greatest number of beds (42,241) was located in neuropsychiatric facilities.[51] The majority of the hospitals overseen by the Veterans Administration had been built after World War I and they were designed following the prevalent medical theories of the day that guided how and where hospitals were constructed. In general, the World War I –era veterans' hospitals were in rural areas and removed from large centers of population for restorative qualities needed for patient care and for real estate acquisition. The hospitals, particularly neuropsychiatric facilities, of this era sprawled over hundreds of acres with campuses comprising upwards of twenty buildings.

Within this framework of veterans' health care, African-American veterans and women veterans did not receive care equitable to their white, male counterparts. Neither the military nor the Veterans Administration was racially integrated at the end of World War II, and one result of segregation was the designation of the veterans' hospital in Tuskegee, Alabama, for the care of African-American veterans exclusively. By 1930, approximately 50 percent of African-American veterans that sought hospitalization benefits received their health care at Tuskegee, even though segregated wards existed in other veterans' hospitals for their treatment.[52] In 1947, the Veterans Administration identified 103 out of 127 of its hospitals as providing care for all veterans, regardless of race. The statistic does not address segregated wards or waiting room sections in those hospitals, however. The high cost of moving African-American veterans to Tuskegee when beds in nearby veterans' hospitals were available combined with varying local attitudes towards race and mounting attention from civil rights organizations dampened any attempt by the Veterans Administration to enforce a fully segregated hospital system after World War II. Yet in 1953, 47 out of 166 veterans' hospitals still functioned as segregated facilities.[53]

President Dwight D. Eisenhower forced the integration of the Veterans Administration in 1954, but not all hospitals desegregated smoothly. In 1956 the VA hospital in Jackson, Mississippi, found itself the focus of a local furor after it placed a white, female patient in a room near African-American male patients. The hospital lacked a designated ward for female patients, whether that was because so few sought admission to veterans'

[51] Frank T. Hines, "Medical Care Program of the Veterans Administration," *Annals of the American Academy of Political and Social Science* 239 (May 1945): 74. There were fifty of the general medical and surgical hospitals.
[52] Vanessa Northington Gamble, *Making A Place for Ourselves: The Black Hospital Movement, 1920-1945* (New York: Oxford University Press, 1995): 102.
[53] Alexander Bielakowski, ed., *Ethnic and Racial Minorities in the U.S. Military* (Santa Barbara, CA: ABC-CLIO, 2013), 161.

hospitals that the space was not provided or a lack of space for them prevented many from seeking care is not clear. Bed space was critical for all veterans regardless, and so racial distinctions added stress to the system as hospital administrator A. W. Woolford noted. Woolford, the Jackson VA hospital administrator, observed "to keep the races [segregated] together would necessitate either juggling patients or denying admission to sick men. We would spend more time in the purpose of segregation than in the purpose of taking care of the sick."[54] Local press and veterans' advocacy organizations waded in on the perceived scandal, as did the governor, the state attorney general, and the Mississippi State Sovereignty Commission, a state organization intended to ensure segregation. While many of these groups decried integration as a blow to the "southern way of life," they simultaneously petitioned for replacement of the aged Jackson VA hospital with a new facility. As the Veterans Administration made it clear any new hospital would be integrated, proponents wriggled out of the conflict by admitting the hospital was desperately needed, and the new design featured individual rooms, thus allowing patients to determine with whom he interacted. In 1962 the fully integrated hospital opened in Jackson.[55]

Women veterans of World War II also faced roadblocks in obtaining health care from Veterans Administration hospitals in the postwar period. At the end of the 1945 fiscal year, the Veterans Administration had 71,229 total veterans in hospital beds spread across its health care system. Women veterans numbered only 755 of those patients, roughly 1 percent of the total patient population.[56] However, at the end of the war, approximately 280,000 women remained in the armed forces, including 100,000 women in the Women's Army Corps (WAC) and 86,000 women in the Women Accepted for Voluntary Service (WAVES).[57] These women were part of the army and navy, respectively. The WAC and WAVES were organized as part of military, rather than as auxiliaries, and women held ranks that corresponded to their male counterparts. Health care benefits were available to eligible veterans, and discerning whether or not one qualified likely restricted women's access to or influenced decisions about where to seek medical attention. Gender bias in the allocation of space in hospital design could also have played a role in the low numbers of female patients admitted relative to numbers of veterans of the war.[58]

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[54] A. W. Woolford, quoted in David Barton Smith, "The Politics of Racial Disparities: Desegregating the Hospitals in Jackson, Mississippi," *Milbank Quarterly* 83 (June 2005): 247-69.
[55] Woolford, quoted in Smith, 247-69.
[56] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1945* (Washington DC: Government Printing Office, 1945): 58.
[57] National Center for Veterans Analysis and Statistics. *America's Women Veterans: Military Service History and VA Benefit Utilization Statistics* (Washington, D.C.: National Center for Veterans Analysis and Statistics, Department of Veterans Affairs, 2011): 3.
[58] Mary Lou Kendrigan. *Gender Differences: Their Impact on Public Policy* (New York: Greenwood Press, 1991): 176. Note: Records indicate in the years after World War I, women were admitted to the National Homes and were treated at hospitals. Moreover, regulations regarding domiciliary and hospital care, and burial benefits, were amended to include the forerunner to WAC (i.e., the auxiliary corps) and naval reserves in 1943; see, PL 78-10 (57 Stat. 21) dated March 17, 1943. Benefits also included access to education, insurance and home loans under the GI Bills. The first WAC and first WAVE veterans received loans to buy houses in February 1945. "First WAC Veteran Gets GI Loan," *New York Times*, February 17, 1945; "Ex-WAVE Gets Loan," *Journal Courier*, February 24, 1945. They were Elizabeth

Dedicated wards for women veterans were rare in the general medical and surgical hospitals, including those of the third generation. A ward for female patients was included in the initial plans for the eighth floor at the hospital in Wilmington, Delaware, for example, but it was never activated. Yet in designated neuropsychiatric hospitals, such as those facilities in Montrose, New York, and Topeka, Kansas, did include dedicated buildings for women veterans in this era (Figure 13). Only in the last quarter of the twentieth century did awareness of women's veteran status expand. Access to benefits through the Veterans Administration increased at this time as well when veteran eligibility was better defined.[59]

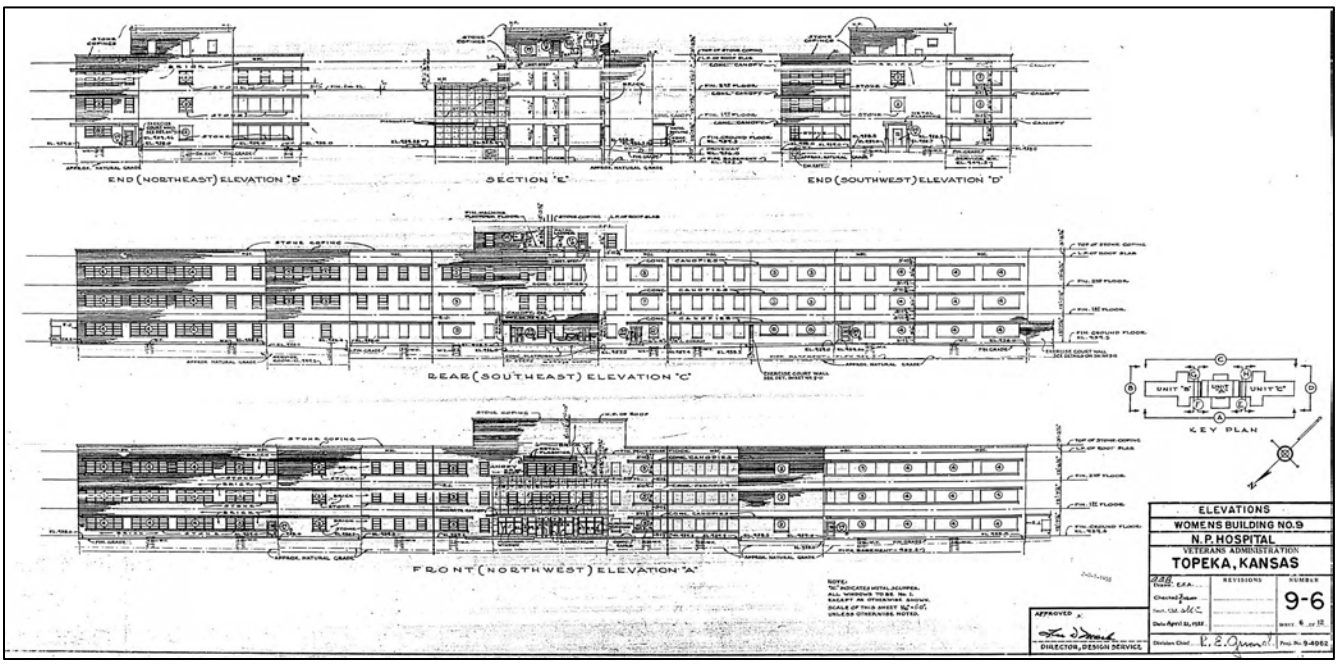

Figure 13. Elevation drawings for the women's building at the Veterans Administration Hospital in Topeka, Kansas, 1955 (VA).

Investigation into Veterans Administration Practices, 1945

The condition of these Veterans Administration facilities led to a public demand that returning veterans deserved only the best, modern facilities, and not the old fashioned hospitals of the past. In early 1945, Albert Deutsch, a journalist with a particular interest in the care of the mentally ill, published a series of articles in the New York City newspaper *PM* that criticized the medical care provided by the Veterans Administration. Deutsch conducted

Lutz and Anna Theresa Hayes. The bias – or expectation of low numbers of female patients – arguably was reflected in the program provided by the VA for its hospital design, in effect discouraging women veterans from seeking admission. See *Requirements for 300 – Bed General Hospital (Revised)*, June 12, 1946, referenced below.

[59] *America's Women Veterans*, 6. The Army Reorganization Act of 1901 changed the status of the army's nurses, who were eligible for pensions and for burial in national cemeteries in the 1890s, to a military position; the navy followed suit in 1908. After World War I, nurses from that conflict were eligible for health care and were admitted to the National Homes. In 1948, the Women's Armed Services Integration Act authorized women to serve in the military in peacetime as well as under wartime emergencies.

a survey of multiple VA facilities and interviewed VA staff including General Hines, lower level employees, doctors, and members of veterans' groups. Deutsch identified multiple problems within the Veterans Administration, including a "medieval attitude towards medicine" that discouraged young doctors from joining the VA, limited medical research, a massive bureaucratic system that restricted the time doctors spent with patients, and "undue kow-towing" to political pressures. [60] While Deutsch acknowledged that the Veterans Administration likely did not suffer from the same corruption that had triggered the scandal that led to the Hines appointment in 1923, he condemned the administrator's ability to provide the necessary medical care for the veteran population. At one point, Deutsch suggested Hines must adhere to the tenets of Christian Science, a faith reliant on prayer over medicine for healing, as it could be the "only logical explanation for his otherwise incomprehensible antagonism to medicine." Hines responded he was Episcopalian.[61]

Deutsch identified multiple ways to fix these problems. Suggestions included creating a VA medical corps independent within the Veterans Administration, constructing new hospitals in urban areas near medical schools, forging connections with medical schools to ensure the Veterans Administration's doctors were aware of the latest research and medical innovations, allowing young doctors to intern at Veterans Administration hospitals, convincing the American Medical Association to permit the VA's doctors to join, hiring African-American doctors and nurses, and "break[ing] down the isolationist tradition in the VA system."[62]

These charges and calls for an investigation were echoed in other publications, including the *Journal of the American Medical Association*, *Cosmopolitan* magazine, and the *New York Times*, which claimed "more attention has been devoted to the construction of monumental hospital buildings than to the standards of care within them."[63] The *New York Times* summarized the complaints alleged "brutal treatment, unwarranted overcrowding, neglect, improper care, poor food, bad sanitation, and inferior medical care."[64] The Veterans Administration responded with denials, but acknowledged there may be isolated incidents that were the result of issues with under staffing rather than a systemic problem.[65]

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[60] Alfred Deutsch, "Vets' Setup Needs Revamping Now to Avert Scandal," *PM*, January 7, 1945, 6.
[61] Alfred Deutsch, "Program for Vets: Remove Hines," *PM*, March 14, 1945, 8.
[62] Deutsch, "Vets Setup," 6; Alfred Deutsch, "Hospitals Should be Freed from Medical Isolationism," *PM*, March 15, 1945, 5; Alfred Deutsch, "'Paper Work Doctors' in Vet Hospitals Should be Freed to Relieve Shortage," *PM*, March 16, 1945, 9.
[63] Leo Egan, "Veteran Hospitals Widely Criticized," *New York Times*, May 16, 1945.
[64] Leo Egan, "Veterans Critical of their Hospitals," *New York Times*, May 17, 1945.
[65] Egan, "Veterans Critical of their Hospitals."

Several investigations were launched, including those by the National Tuberculosis Association, the National Mental Hygiene Committee, and the U.S. Congress. Senator Claude Pepper's (D-Fla) subcommittee of the Committee on Education and Labor conducted a review and identified four categories of general criticism: salary levels and the classification system for personnel did not attract the best candidates, hospitals were too isolated, better use could be made of medical consultants, and the lack of connections with medical groups were detrimental to both personnel and patients. Representative Phillip J. Philbin (D-Mass) introduced legislation in the House calling for "an independent and factual investigation" of the Veterans Administration.[66] Representative John E. Rankin (D-Miss), chairman of the House Veterans' Committee, member of the House Un-American Activities Committee and, according to *Time* magazine, "in favor of the poll-tax, white supremacy and Southern womanhood," held a closed door meeting with Hines and subsequently announced that if any investigation was going to be done, his committee would be the one to do it.[67] The House defeated Philbin's legislation and handed Rankin the investigation. As Charles Hurd, reporter from the *New York Times*, described it, "This means that the committee which fathered the Veterans' Administration, approved its actions, passed on its programs and undoubtedly enjoyed considerable patronage from it, now will presumably judge its works."[68]

As part of the investigation, the Committee called Alfred Deutsch to testify. During the course of his testimony, Deutsch refused to provide the names of those nurses and doctors that had given him information, asserting freedom of the press and the right to protect confidential sources. Rankin responded by citing Deutsch for contempt. His Committee was reluctant to endorse the action, requiring multiple sessions to obtain a majority. The eventual support of the Committee, in accordance with legislative procedure, led to the motion moving to the floor of the House for a vote. If it passed, Deutsch could have received a $1,000 fine and a month in jail.[69] Journalists understandably decried the move, but Rankin found little support among his Congressional colleagues. Members of the House, including the Republican House Leader and the Democratic Whip, supported the reporter.[70]

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[66] Charles Hurd, "House Veterans Committee Deflects Inquiry on Medical Care of Soldiers," *New York Times*, April 1, 1945.
[67] "Will Soldiers Vote?" *Time*, February 14, 1944, www.time.com/time/magazine/article/0.9171,885334,00.html (accessed April 4, 2011).
[68] Hurd, "Committee Deflects Inquiry."
[69] Nathan Robertson, "Rankin Tries to Railroad Deutsch to Jail," *PM*, May 20, 1945, 3.
[70] Milton Murray, "Colleagues Condemn Rankin Action Against Newsman," *PM*, May 20, 1945, 8. Note: At the time the House Leader was Joe Martin (Massachusetts), who held the position in the 76th through 79th Congress (1939-1947); typically the House Leader (from the majority party) schedules the legislative calendar and manages the House committees. The Minority Whip – here the Democratic Whip – assists the Minority Leader with the party's legislative agenda. At this time, Robert Ramspeck (Georgia) was the Democratic Whip. Ramspeck held the position in the 78th Congress through the first session of the 79th Congress (1943-1945).

The situation escalated the investigation of the Veterans Administration to greater heights of national scrutiny. Outspoken radio commentator Walter Winchell condemned Rankin during his radio broadcast, and former First Lady Eleanor Roosevelt supported Deutsch in her syndicated column.[71] Meanwhile, Rankin's Committee accomplished little in terms of the investigation of the Veterans Administration. Albert Maisel, the reporter who published similar claims in *Cosmopolitan*, was called to testify for three days, before the investigation was temporarily suspended as Rankin met with President Harry S. Truman regarding legislation connected with veterans.[72]

Rankin sought to resolve the situation by introducing legislation that addressed some of the claims, mainly via establishing a medical corps within the Veterans Administration that would provide able medical staff. But the Deutsch contempt citation remained unresolved and *PM* newspaper continued to howl about Rankin, the "dew-lapped little bigot."[73] Shortly thereafter, the Veterans Committee defied Rankin, when Representative James Domengeaux (D-La.) introduced a motion to rescind the contempt citation. Rankin voted against the measure, but the motion passed, 13 to 2.[74] In early June 1945, President Truman asked for the resignation of Frank T. Hines and announced the appointment of General Omar N. Bradley as the new leader of the Veterans Administration.

General Omar N. Bradley (1893-1981)

General Omar Nelson Bradley served as the first post-World War II chief of the Veterans Administration. Bradley attended West Point and graduated with the class of 1915, from which 59 of 164 graduates reached the rank of brigadier general.[75] Following graduation from West Point, Bradley served the U.S. Army in numerous capacities, including infantry duties in several American locations. He also was a mathematics instructor at West Point, an instructor in tactics and other operations at various military schools, and the officer in charge of the National Guard and of Reserve/ROTC affairs for the U.S. Territory of Hawaii. Over the decades between the world wars, Bradley continued to move upward in his infantry career. By the time Britain and France declared war on Nazi Germany on September 3, 1939, he was serving on the U.S. War Department General Staff in Washington, D.C., as an assistant secretary to the Chief of Staff, General George C. Marshall. In February 1941, Bradley was

[71] *PM*, May 21, 1945, 7; *PM*, May 23, 1945, 5.
[72] Elizabeth Donahue, "Vet Committee Still Kowtows to Boss Rankin," *PM*, May 25, 1945, 10.
[73] Albert Deutsch, "Rankin's Stop-Gap Bill Sidesteps Main VA Issues," *PM*, May 28, 1945, 11; Charles Mitchie, "Rankin Still Opposes Hearing Truth on VA," *PM*, May 31, 1945, 7.
[74] Elizabeth Donahue, "Rankin Group Rebels, Clears Deutsch," *PM*, May 30, 1945, 3.
[75] Omar N. Bradley and Clay Blair, *A General's Life: An Autobiography* (New York: Simon and Schuster, 1983), 17-18, 31, 37.

ordered to assume the command of both Fort Benning (Georgia) and its Infantry School. As commandant, he was promoted to the temporary rank of brigadier general, the first of his West Point class to achieve that rank.[76]

Several months after Bradley took command at Fort Benning, the Empire of Japan attacked Pearl Harbor on December 7, 1941, prompting a drastic turn in his military career track.[77] During World War II, Bradley was promoted to permanent ranks, successively, of brigadier general and major general. He commanded forces in North Africa and Sicily in 1943, and he "commanded the [U.S.] First Army and the 12th Army Group in the [Normandy] invasion and final campaigns of western Europe, 1944-1945."[78]

While still in command of the 12th Army Group in Europe, Bradley was appointed by President Harry S. Truman in June 1945 to take over as head of the Veterans Administration.[79] The previous administrator, Brigadier General Frank Hines, had held that office for twenty-two years, but, as noted above, he faced growing criticism as hundreds of thousands of World War II veterans entered an antiquated system that was ill-equipped to handle the ever-increasing needs of returning military personnel. As hostilities were drawing to a close, the Commander-in-Chief "felt that World War II veterans should have a World War II veteran to run the show."[80] By appointing Bradley (dubbed "The Doughboy's General" by *Time* magazine[81]), Truman "took out of the war one of his best field commanders" and "the top tactician in the European Theater."[82]

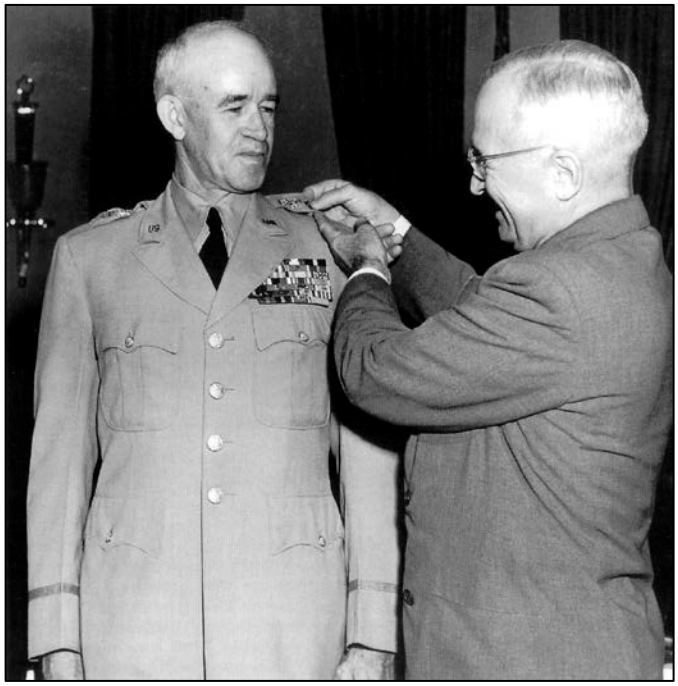

Figure 14. President Harry S. Truman pinning the five-star general insignia to Omar Bradley's uniform, September 22, 1950 (Joint Chiefs of Staff).

[76] Bradley and Blair, 59, 79-86, 94; Kirkpatrick, *Centennial*; "Omar Nelson Bradley," U.S. Army Center of Military History, last modified October 3, 2003, http://www.history.army.mil/faq/brad_bio.htm (accessed December 3, 2010).
[77] Bradley and Blair, 102-11; Kirkpatrick, "Omar Nelson Bradley."
[78] Kirkpatrick, "Omar Nelson Bradley."
[79] Charles Hurd, "Bradley Is Sworn As Veterans' Head," Special to *The New York Times*, August 16, 1945, http://www.nytimes.com/ref/membercenter/nytarchive.html (December 30, 2010).
[80] "Inspired Choice," *Time*, June 18, 1945, http://www.time.com/time/magazine/article/0,9171,775886,00.html (accessed December 8, 2010).
[81] Bradley and Blair, 241.
[82] "Inspired Choice."

Bradley led the Veterans Administration until 1947 and, in 1950, was promoted to the rank of five-star general – he was the last of only four Army officers to attain that rank - since World War II (Figure 14).[83]

Bradley as VA Administrator, 1945-1947

The end of World War II was declared on August 14, 1945, and, on the following day, General Bradley took office as the Administrator of the VA – "one of the biggest, hardest, touchiest jobs in the U.S."[84] At the time, it was anticipated that Veterans Administration operations would "directly concern one out of every three U.S. families,"[85] and, therefore, Truman expected Bradley "to modernize the organization so that it could cope with the problems of the millions of veterans."[86] During World War II, there were only an estimated five million veterans registered with the Veterans Administration; by 1946, within a few months of the end of hostilities, the organization counted nearly 17 million veterans in its records.[87] Bradley had misgivings regarding the mission and scope of his new position, but, immediately upon taking office, he informed reporters that "I don't think there's any job in the country I'd sooner not have nor any job in the world I'd like to do better. For even though it is burdened with problems, it [the Veterans Administration] gives me the chance to do something for the men who did so much for us."[88]

When Bradley took control of the Veterans Administration, it was "the largest independent agency within the [federal] government" with over 65,000 employees and nearly one hundred hospital facilities scattered throughout the country.[89] Under General Hines' tenure, all Veterans Administration policy decisions had been routed through the national headquarters staff in Washington, D.C., a centralized system that simply couldn't handle the massive wave of new claims entered at the war's end.[90] "As Bradley later recounted, 'When we came in we found it impossible to pile the huge load of World War II on a chassis built for World War I.'"[91] Recognizing the grave enormity of the situation, Bradley and his staff – culled from the administrative staff of the 12th Army Group – immediately went to work to revamp and decentralize the VA's operations, an "intensely controversial" move.[92]

[83] Bradley and Blair, 467-70, 504-06, 552-53, 648, 662; Kirkpatrick, "Omar Nelson Bradley."
[84] Hurd, "Bradley Is Sworn As Veterans' Head;" "Inspired Choice."
[85] "Inspired Choice."
[86] Hurd, "Bradley Is Sworn As Veterans' Head."
[87] Kirkpatrick, *Centennial*.
[88] Bradley and Blair, 440-46.
[89] Bradley and Blair, 447.
[90] Bradley and Blair, 450.
[91] Gambone, 34.
[92] Bradley and Blair, 450-51. The decentralization and administrative shifts were noted elsewhere as well. See Gladys M. Kammerer, "The Veterans Administration in Transition," *Public Administration Review* 8 no. 2 (Spring 1948): 103-09.

As remarked by the army, "Bradley completely rebuilt the organization on a regional basis and insisted on basing his decisions on the needs of the veteran, rather than on the political considerations that had so often governed in the past in such matters as the location of Veterans Administration hospitals."[93]

The national press recognized the modern advances effected in the Veterans Administration medical system. According to one article published in a popular magazine of the times, "In two years General Omar N. Bradley has transformed the medical service of the Veterans Administration from a national scandal to a model establishment."[94]

Department of Medicine and Surgery

Upon being sworn in, Bradley moved swiftly to answer the charges brought by Deutsch and others that had received national attention. He also sought to resolve the strains the growing veteran population placed on the Veteran Administration programs. For the medical care of veterans, Bradley focused on improving the quality of the medical staff and the construction of modern hospitals.

Between the announcement and his investiture, Bradley sought assistance from fellow military men and those outside the Veterans Administration establishment. He first wanted the counsel of General Paul R. Hawley as the VA's Chief Medical Director regarding the medical corps. Hawley had been Chief Surgeon in the European Theater of Operations during World War II, where medical units were paired with United States medical schools for instruction and supervision.[95] While still on active duty, in September 1945, Hawley was appointed Acting Surgeon General, a position that became permanent in May 1946. Dr. Paul Magnuson, a Chicago surgeon with connections in the country's medical schools, was retained as Assistant Chief Medical Director for Research and Education. Magnuson had approached the previous Administrator, Frank T. Hines, with the proposal of embedding medical school staff and students in Veterans Administration hospitals, but the concept gained little traction in the Hines years.[96] Bradley, Hawley, and Magnuson recognized that linking Veterans Administration

[93] Kirkpatrick, *Centennial*.
[94] "Veterans' Medicine: Second to None!" *Reader's Digest* 51 (September 1947), n. 305, quoted in Bradley and Blair, 462.
[95] *Medical Care of Veterans (MCV)*, Washington, DC: U. S. Government Printing Office, 1967: 207.
[96] Marguerite T. Hays, *A Historical Look at the Establishment of the Department of Veterans Affairs Research and Development Program*, Washington, DC: U.S. Government Printing Office, 2010: 89, 91.

hospitals and medical schools through consultations and residency training programs was of utmost importance to the successful overhaul of the Veterans Administration's medical program.[97]

Furthermore, Bradley, Hawley, and Magnuson sought to wrench the control of the Veterans Administration's medical staff out from the Civil Service Commission's jurisdiction and to establish the Department of Medicine and Surgery. With the VA medical staff part of the Civil Service, salaries could not measure up to those offered in the private sector and promotions were based on seniority rather than ability. As Hawley described the process of selecting doctors from lists provided by Civil Service:

> Now, for many months, coming over as No. 1 on the list is a physician 87 years old. No. 2 is a lady physician, age 76. There are people on the list who have been committed to mental institutions for insanity and for alcoholism. Of the 80-odd people on the list sent over to us, 60 percent are over the age of 60.[98]

A bill was introduced before Congress to address these concerns, and it passed quickly in both the House and Senate despite opposition from the Civil Service Commission which protested giving Bradley the power to hire and fire doctors and nurses. The American Legion, Disabled American Veterans, and the Veterans of Foreign Wars also protested the bill. They claimed it did not do enough to encourage hiring veterans. The organizations dropped their objections when Bradley provided assurances that veterans would receive full consideration during the hiring process.[99]

Meanwhile, the Bureau of the Budget had the ear of President Truman, insisting the bill be vetoed. Bradley, Hawley, and Magnuson approached the presidential assistant in charge of personnel manners, stating their case for the bill. When all seemed for naught, the trio agreed to try working with the Civil Service requirements, despite grave misgivings. If they were unable to effect the necessary changes with the Civil Service in tow, Bradley would quit. Truman decided against the veto.[100] The Department of Medicine and Surgery, authorized by Congress on January 3, 1946, was now free to hire the necessary doctors and nurses to provide modern medical care for veterans.[101]

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[97] Hays, 208-09. Their plans were endorsed by the American Psychiatric Association, specifically locating the hospitals near medical centers and on basis of veterans' needs rather than patronage that was responsible for a number of small veterans' hospitals in "inaccessible" places, removed from medical centers and possibility of consultation and without staff. See "Psychiatric Care of Veterans," *Journal of Criminal Law and Criminology* 37, no. 1 (1946): 69.
[98] Major General Paul R. Hawley, quoted in *MCV*, 210.
[99] San Francisco *Chronicle*, 4 January 1946, reprinted in *California and Western Medicine* 64, no. 1 (January 1946): 36.
[100] *MCV*, 212.
[101] PL 79-293, 59 Stat. 675, U.S. Statutes at Large, January 3, 1946.

With the establishment of the Department of Medicine and Surgery, the Veterans Administration formalized relationships with medical schools across the country.[102] These ties not only addressed staffing concerns but also emphasized research to be conducted jointly by the VA and the medical schools. Research funded by the Veterans Administration ranged across disciplines and focused on issues germane to veterans' health care. As catalogued by the Veterans Administration's 1949 *Annual Report*, a sampling of research topics included war wounds of the hand, tropical diseases, prosthetics, paraplegia, epilepsy, tuberculosis, spinal cord lesions, shock therapy, aphasia, nerve and vascular injuries, and syphilis.[103] Dedicated research space was incorporated into plans for new Veterans Administration hospitals and inserted into existing VA hospitals via the conversion of closets, bathrooms, and garages for the purpose.[104] Additional research funds were spent on short term, intra-VA projects across multiple Veterans Administration hospitals. As the research program expanded, the Veterans Administration also financed studies at nonprofit institutions that offered superior staff and facilities necessary for the research.[105]

In 1948, Public Law 729 authorized an annual $1,000,000 for the Veterans Administration solely "for prosthetic research, including all forms of prosthetic and orthopedic appliances and sensory devices," contingent on the VA rendering the results available to the public.[106] Prosthetic research exemplified the Veterans Administration's financing of studies at nonprofit organizations, such as the National Research Council and the National Academy of Sciences, and universities, such as the University of California, Berkeley and Northwestern University.[107] At the University of California, Los Angeles, a partnership with famed aircraft manufacturer Northrop Corporation (now Northrop Grumman) led to advances in prosthetics education, motion studies, and upper-extremity prosthetic models, all funded by the Veterans Administration.[108] Research conducted with International Business

[102] "Veterans Hospitals Institute Reforms," *New York Times*, May 19, 1945; "Bradley Asks Best for Disabled Men," *New York Times*, October 21, 1945; "Veterans Research Aid Named," *New York Times*, November 24, 1945; "Medical Units Join to Help Veterans," *New York Times*, January 6, 1946; "Dartmouth Medical School to Help Vets," *Lewiston Daily News*, January 10. 1946; "KU Will Help Veterans Hospitals," *Lawrence Journal-World*, January 10, 1946; Paul Magnuson, Chief Medical Officer, to Assistant Administrator for Legislation, Memo February 1948; "Research Hospital Planned for Vets," *Northwestern University Sunday Star*, August 13, 1950 [shared with Northwestern University in Chicago, with features for betatron for research and treating cancer patients]; "Research Veterans Hospital," *The Bulletin*, September 5, 1950 [the Northwestern/VA hospital with x-ray equipment taking the entire second floor – more than any other VA facility]; "VA Trains Thousands," *New York Times*, December 12, 1961.
[103] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1949* (Washington DC: Government Printing Office, 1950): 23-30.
[104] Hays, *A Historical Look*, 92, 97.
[105] *Annual Report* 1949, 30.
[106] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1948* (Washington DC: Government Printing Office, 1949): 88.
[107] Hays, 419.
[108] Hays, 425.

Machines Corporation, more commonly known as IBM, yielded developments for prosthetic arms powered by electricity. Through the Army Prosthetic Research Laboratory, the Veterans Administration funded exploration of prosthetics operated voluntarily through captured body movement and synthetic "skin-like" coverings.[109] In the 1970s, prosthetic research became its own department, newly christened the Rehabilitation Engineering Research and Development Service within the Veterans Administration. The VA continues prosthetic research to the present day.[110]

Tuberculosis became one of the Veterans Administration's primary research efforts during the immediate postwar period. A bacterial infection easily transmitted in the close quarters of wartime military life, tuberculosis accounted for almost 10 percent of the VA's patient load in 1945.[111] The Veterans Administration also struggled with tubercular patients leaving its hospitals before the completion of treatment, resulting in fears the contagion would spread to the civilian population.[112] In 1946, the Veterans Administration together with the armed forces began research on the effectiveness of streptomycin as a treatment of tuberculosis. Seven Veterans Administration hospitals and two armed forces hospitals were chosen for the initial trials. Following promising early results, including significant reduction in the presence of the tuberculosis bacilli in patients, side effects and drug resistance led to additional studies by other governmental agencies, including the Public Health Service. The combined research efforts led to the development of a treatment for tuberculosis that utilized streptomycin in conjunction with other drugs.[113] By 1950, chemotherapy for tuberculosis was the largest research program for the Veterans Administration.[114] Five years later, forty-six VA hospitals were involved in testing of various treatment measures for tuberculosis, including testing of new drugs.[115] By 1960, sufficient advances in treatments were made to allow eight dedicated tuberculosis hospitals to be converted to general medical and surgical hospitals due

[109] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1951* (Washington DC: Government Printing Office, 1952): 62.
[110] Hays, *A Historical Look*, 431.
[111] *Annual Report* 1945, 3.
[112] William B. Tollen, "Irregular Discharge: The Problem of Hospitalization of the Tuberculous," *Public Health Reports* 63, no. 45 (November 5, 1948): 1441.
[113] Hays, 147, 150, 161.
[114] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1950* (Washington DC: Government Printing Office, 1951): 39.
[115] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1955* (Washington DC: Government Printing Office, 1956): 34.

to shorter tuberculosis hospitalization periods and dramatically smaller patient load.[116] The Veterans Administration continued tuberculosis research well into the 1960s.[117]

As with tuberculosis, the Veterans Administration directed research funds towards neuropsychiatric issues due to the prevalence of veterans seeking treatment for postwar neuropsychiatric issues. In 1946, approximately 57 percent of the patients at Veterans Administration hospitals nationwide sought care primarily for neuropsychiatric issues and an average stay for a neuropsychiatric patient at a VA hospital lasted 179.6 days.[118] The postwar period was a transitional era for neuropsychiatric care at the Veterans Administration. The Veterans Administration adopted frontal lobotomies as a method for treating schizophrenia, and by 1950, forty-seven VA hospitals had been approved to carry out the treatment.[119] Subsequently, the Veterans Administration initiated a three year study of 373 patients treated at six VA hospitals to determine the efficacy of lobotomies.[120] The Veterans Administration determined lobotomies were "not a cure," but did result in "recovery to a degree."[121] The practice of using lobotomies to treat psychiatric illnesses eventually yielded to treatment with psychotropic drugs. Initial studies focused on the efficacy of the drugs, including chlorpromazine and phenobarbital.[122] In 1956, the Veterans Administration launched a neuropsychiatric research center at its new hospital in Pittsburgh, Pennsylvania, specifically to "correlate neuropharmacologic and neurophysiologic studies with clinical material."[123] Additional studies from that year included schizophrenia, efficacy of reserpine-based treatment, initiation of a five-year evaluation of hospital design on recovery of neuropsychiatric patients, and a study on hereditary neurological diseases.[124] By 1957, the Veterans Administration had 933 different ongoing studies regarding neuropsychiatric issues.[125]

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[116] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1960* (Washington DC: Government Printing Office, 1961): 4, 36. The conversion shifted about 3,000 beds to general medical and surgical treatments; the eight hospitals where the reassignment, or change in designation, took place were not named in the report text. In addition, "tuberculosis services" were discontinued at the VA hospitals in Wilmington, Delaware, and in Montgomery, Alabama, because of the reduced patient need.
[117] Hays, 149.
[118] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1946* (Washington DC: Government Printing Office, 1946): 4-5. Regarding the treatment of mental illness, see "The VA – Beyond the Call of Duty," *Tuscaloosa News*, February 27, 1949.
[119] Annual Report 1950: 26.
[120] Hays, *A Historical Look*, 211.
[121] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1954* (Washington DC: Government Printing Office, 19455): 43.
[122] Hays, *A Historical Look*, 214.
[123] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1956* (Washington DC: Government Printing Office, 1957): 55.
[124] *Annual Report* 1956, 55-56.
[125] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1957* (Washington DC: Government Printing Office, 1958): 29-30.

Facility Construction and Design, 1946-1958

Temporary Hospitals

In order for the newly-minted Veterans Administration doctors to provide modern health care for veterans, modern hospitals were required. However, even Bradley's considerable drive to overhaul the Veterans Administration health care network could not expedite the bureaucratic process necessary to construct a new hospital center. Therefore, under Bradley, the Veterans Administration developed two means of providing temporary health care outside of VA hospitals: veterans could receive health care in their local facilities with treatment paid for by the Veterans Administration and the VA could assume control of existing facilities, primarily surplus army and navy hospitals.[126]

By November 1945, General Hawley announced plans for providing medical care for veterans at local facilities.[127] The Veterans Administration bargained with the American Hospital Association for hospital beds, leading to the designation of 20,000 beds in over 3,400 hospitals across the country. By April 1946, the states of California and Michigan codified the process for veterans to seek medical care at local facilities within their boundaries and signed contracts with the Veterans Administration to provide such services. The American Legion, a watchdog of VA affairs, did not endorse the program because it did not resolve the need for hospitals specifically dedicated to veterans' care, but it did not outright condemn the program.[128] In California, the Veterans Administration and physicians reached an agreement that outlined a very specific set of treatments available to veterans, along with a fee schedule. For example, a routine first office visit to a physician was not to exceed $5, removal of an ingrown toenail was $12.50, and the amputation of a foot was $75, but that cost did include two weeks after-care.[129] Both male and female veterans were "entitled to care by the physician of his own choice," as long as the injury could be linked to their service in the armed forces, the illness was aggravating a service connected injury, the veteran was attending school under the G.I. Bill of Rights or part of the Vocational Rehabilitation Training program. However, veterans could not seek health care under these provisions if a local Veterans Administration hospital was available to them.[130]

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[126] The first option, wherein veterans received health care services at local hospitals that were paid for through the Veterans Administration, served veterans outside the continental United States. Insular offices handled the hospital bills/benefits in Hawaii, Puerto Rico, and the Philippines for example as well as in postwar Germany. See Section G, below.
[127] "'Reforms' in Veteran Medical Setup," *California and Western Medicine* 63, no. 6 (December 1945): 289.
[128] "Home-Town Medical Care for Veterans on Trial in Two States: Michigan and California," *California and Western Medicine* 64, no. 4, April 1946, 265.
[129] "V.A. – C.P.S. Fee Schedule," *California and Western Medicine* 64, no. 3 (March 1946): 144-47.
[130] "California Physicians' Service – Veterans' Administration Program," *California and Western Medicine*, Vol. 64, No. 4 (April 1946): 270.

Another option utilized by the Veterans Administration involved taking over army and navy hospitals constructed and used during World War II, but considered surplus when the war ended.[131] During World War II, the army and navy insisted on expedited hospital construction to meet the growing need; therefore, they built simple buildings that minimized the use of precious building materials. Using standardized plans to create "theater-of-operations" cantonment type hospitals, the army and navy erected hundreds of no-frills structures designed for temporary use.[132] By spring 1943, the Federal Board of Hospitalization, charged with preventing duplication of federal hospital services, suggested the army use standardized plans developed by the Veterans Administration during the second generation hospital program with the intent of turning over those hospitals to the VA upon the close of the war. Using those plans as a basis, the army created a hybrid of the cantonment type, temporary hospitals with several wards constructed along the Veterans Administration designs. Two army hospitals were constructed in this manner, McGuire in Richmond, Virginia, and Vaughan in Hines, Illinois.[133]

Not all of the army and navy hospitals in operation during the course of World War II were constructed by the armed forces. In Staten Island, New York, the army converted Halloran Hospital from a state school for mentally disabled children to a hospital with 3,000 beds, the largest army hospital in the United States at the time. Halloran had been constructed in the 1930s, but World War II prevented the State of New York from activating the school.[134] In 1941, the army took over the empty buildings and effected a major renovation to the structures. The architect, William Gehron, worked with the U.S. Army Corps of Engineers to design and develop a new surgical wing and walkways. Halloran shifted from a standard army hospital with 1,500 beds to a receiving hospital, a facility for soldiers to receive treatment before returning to duty or home, thus greatly expanding the number of prospective patients. As a result, further renovations were necessary, including new clinic buildings, barracks, a chapel, recreation facilities, and the other support buildings essential for caring for 3,000 men. The army even reached an agreement with New York City's Metropolitan Museum of Art to loan sculptures, paintings, drawings, and even suits of armor to the facility to facilitate "more cheerfulness in the rooms."[135] Halloran later became part of the surplus facilities transferred to the Veterans Administration (Figure 15).

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[131] For the list of facilities transferred from the military to the Veterans Administration, see Appendix C.
[132] Clarence McKittrick Smith, *United States Army in World War II, The Medical Department: Hospitalization and Evacuation, Zone of Interior* (Washington, DC: Center of Military History, United States Army, 1989), 68-69.
[133] Smith,76.
[134] "Willowbrook's Halloran General: Largest Army hospital in the world," *Staten Island Advance*, March 26, 2011, http://www.silive.com/specialreports/index.ssf/2011/03/willbrooks_halloran_general.html (accessed April 7, 2011).
[135] "Quickly Converted for Casualties," *Architectural Record* 95, no. 1 (January 1944): 77-78.

Figure 15. U.S. Army, Halloran General Hospital, Staten Island, New York (NIH).

The demobilization effort led the army and navy to quickly declare many hospitals surplus property. Major General Norman T. Kirk, the Surgeon General, announced on January 1, 1946, that twenty-three out of the sixty-five wartime hospitals would be available to be transferred to the Veterans Administration. Leased properties were to be returned to their pre-war owners.[136] While these hospitals supplied beds during a time when facilities were desperately needed, they were not ideally suited for the modern health care envisioned by Bradley and other Veterans Administration leaders. Many hospitals were located in remote locations, making them difficult to staff and to access.[137] While many of these sites were to become permanent Veterans Administration property, the temporary nature of these buildings did not lend themselves to providing health care in the long term.

While the beds in civilian and various armed services hospitals provided much needed relief to the thousands of veterans seeking health care, the measures were mere stop gaps. One enterprising senator even suggested using surplus warships as hospitals, but there is no indication the Veterans Administration took him up on the idea.[138] The Veterans Administration needed new hospitals and a program to construct eighty new hospitals was underway shortly after Bradley took office as Administrator. This program allowed the Veterans Administration to demonstrate it was moving away from the perceived old-fashioned medicine provided in its existing hospitals and towards current health care offered in modern facilities. As a result, a VA hospital of this period is one of

[136] "Army to Release 23 Hospitals by January 1," *California and Western Medicine* 63, no. 6 (December 1945): 290.
[137] *MCV*, 201.
[138] "Ships Might Solve Hospital Shortage," Spartanburg *Herald-Journal*, February 11, 1946.

three types: existing hospitals pressed into service, new hospitals designed by private architects, and new hospitals designed by the Veterans Administration architecture staff based on standardized plans (See Section F, below). The Veterans Administration was pressured further by a nationwide boom in hospital construction in the postwar period that not only amplified the differences between the VA's existing hospitals and modern health care but also gave architects an opportunity to develop standards for contemporary hospital architecture that would, in turn, influence the VA's construction program through the 1950s.

Hospital Construction Nationwide

Following World War II, the United States renewed its commitment to improved health care facilities across the country. Hospital construction between the two world wars was characterized by a period of great expansion, leading to a total of 6,852 public and private hospitals in the United States in 1928, followed by a period of constriction due to the Great Depression when as many as seven hundred hospitals were shuttered. The facilities that remained open were distributed poorly leaving large segments of the population, particularly in rural parts of the country, without adequate access to health care.[139]

Activities that supported the war effort necessitated the construction of numerous ancillary facilities, such as training camps and factories. Many of these facilities were located in rural areas without hospitals. To remedy this dearth of hospitals, the federal government implemented an emergency measure that built 874 hospitals and associated health facilities between 1940 and 1945 at the cost of $100 million.[140] These facilities were developed in areas experiencing population booms due to wartime production efforts. They were not intended to fill the gaps in health care services left by the haphazard growth and subsequent failure of hospitals in the preceding period. In January 1945, Senator Lister Hill (D-Ala) and Senator Harold Burton (R-Ohio) introduced legislation to provide federal funds for the construction of hospitals in the United States, particularly targeting those areas that were lacking facilities. This act, technically called the Hospital Survey and Construction Act but more commonly referred to as the Hill-Burton Act, passed into law in August 1946.[141]

[139] V. M. Hoge, "Hospitals and Public Health Centers," *Annals of the American Academy of Political and Social Science* 273 (January 1951): 34-35.
[140] Hoge, 35.
[141] Hoge, 36.

The Hill-Burton Act provided $75 million annually in federal funds for five fiscal years to be used by individual states towards the construction of hospitals. In 1949, this figure was raised to $150 million.[142] Distribution of funds to states was based on population and per capita income, thus supplying more funds to the poorer states. Hill-Burton Act funds provided one-third of the costs for constructing these health facilities, with the state or private non-profits covering the balance. Before each state could obtain its share of the Hill-Burton cash, a state plan had to be developed that included a survey of existing hospitals, with the overall number of hospital beds, how many of those beds were considered acceptable, the location and disposition of hospitals, and if these facilities met certain standards outlined by the government.[143] In addition, each state plan had to identify how the state was going to maintain the hospital and ensure its successful operation. Each state was required to provide 4.5 beds per 1,000 residents for general hospitals, except in areas of low population where 5 to 5.5 beds per 1,000 residents was considered acceptable. Five beds per 1,000 residents were required for mental hospitals, and two beds per 1,000 residents for chronic hospitals. For tuberculosis hospitals, the state had to provide the number of beds equivalent to 2.5 times the average annual number of deaths from the disease.[144] Based on these surveys, the United States had 397,000 total acceptable hospital beds, but needed 256,000 additional beds to meet the revised standards. Mental hospitals housed 382,000 acceptable beds, but were lacking a further 311,000 beds. Tuberculosis hospitals only had 72,000 acceptable beds, with an additional 84,000 required. An additional 1,853 health centers were needed to supplement the existing 468 centers.[145]

The Hill-Burton Act mandated anti-discrimination policies, requiring that each state plan "shall provide for adequate hospital facilities for the people of the state without discrimination on account of race, creed or color."[146] While states in the South adopted these provisions in order to qualify for the federal funds, the resulting hospitals often still exhibited Jim Crow-era segregation. For example, the Crittenden County General Hospital in West Memphis, Arkansas, was designed to serve the underserviced population across the Mississippi River from Memphis, Tennessee. Planned with Hill-Burton funds, the hospital featured bedrooms arranged linearly along a corridor so that "the color line can be shifted one way or another as demanded by various patient loads."[147]

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[142] Paul A. Brinker and Burley Walker, "The Hill-Burton Act: 1948-1954," *The Review of Economics and Statistics* 44, no. 2 (May 1962): 209.
[143] Beds were generally considered unacceptable if certain issues were present, such as fire hazards, inappropriate design, or obsolescence.
[144] Vane M. Hoge, "The National Hospital Construction Program," *Journal of the National Medical Association* 40, no. 3 (May 1948): 103.
[145] V. M. Hoge, "Progress Report on Hospital Survey and Construction Act," *American Journal of Public Health* 39 (July 1949): 890.
[146] Hoge, "The National Hospital Construction Program," 104.
[147] "Large Hospital for a Rural Area," *Architectural Record* 103, no. 6 (June 1948): 96. See also, Karen Kruse Thomas, "The Hill-Burton Act and Civil Rights: Expanding Hospital Care for Black Southerners, 1939-1960," *Journal of Southern History* 72, no. 4 (November 2006): 823-70.

By the end of October 1948, 540 construction projects had been approved, initially, with 135 of those at the final stages of the process. The total value of approved projects was estimated at $302 million, with $93 million in Federal funds and $209 million from local sources. These projects included 387 general hospitals, sixteen tuberculosis hospitals, twenty-six mental hospitals, and nine chronic hospitals, adding a total of 24,418 beds. For the most part, the general hospitals were located in smaller communities and featured less than fifty beds.[148] The Hill-Burton hospital construction projects continued apace; by July 1956, the United States had 1,122,864 acceptable beds across all types of hospitals, with an additional 453,842 beds planned for upcoming construction cycles, for a total of 1,576,706 hospital beds.[149]

Modern Hospital Design

The glut of cash available for hospital design and construction, both those funded by Hill-Burton and the Veterans Administration, attracted the interest of medical professionals and architects alike. Revisiting these topics was appropriate, especially since many of the standard available texts predated the Great Depression. Professional journals and publications addressed how to build a modern hospital and roles for hospital administrators and staff in the development and design of these new facilities. For example, the *American Journal of Nursing* featured articles on how "nurses may participate effectively in the planning and construction of hospitals" as well as how to read blueprints.[150] The architecture field was particularly responsive to the rising need for modern hospital designs. Architects put forward articles in publications geared towards hospital administrators, such as *Modern Hospital* and *Hospital Progress*, describing and debating the correct orientation, siting, department layout and even the appropriate colors for final finishes on the interior for hospitals. While theory and reality often collided, almost every publication agreed that constructing hospitals in the same manner as older existing hospitals was not acceptable. Publications focused on new construction with little to no print devoted to altering existing structures. Modern hospitals were needed, even if what constituted a modern hospital was left open to some interpretation.

For the hospital administrator or governing board, every aspect of a hospital was subject to revision and change, from the type of site selected and orientation of the new building to whether blinds or curtains were more appropriate for patient rooms. Multiple articles stressed the need for retaining a hospital consultant and an

[148] Hoge, "Progress Report," 890-91.
[149] Leslie Morgan Abbe and Anna Mae Baney. *The Nation's Health Facilities: Ten Years of the Hill-Burton Hospital and Medical Facilities Program, 1946-1956* ([Washington, DC]: U.S. Department of Health, Education and Welfare, Public Health Service, Division of Hospital and Medical Facilities, Program Evaluation and Reports Branch, [1958]): 26.
[150] Louise O. Waagen, "The Hospital Survey and Construction Act," *American Journal of Nursing* 48, no. 6 (June 1948): 361; Ben John Small, "How to Read a Blueprint," *American Journal of Nursing* 54, no. 5 (May 1954).

architect during early phases of the planning process. The hospital consultant served as a representative of the governing body of the hospital, particularly during development of the overall program that would guide the design of the hospital led by the hospital architect. These consultants were often accredited by organizations such as the American Hospital Association or the American College of Surgeons.[151] Every minute detail was examined and re-examined. The Public Health Service circulated numerous articles regarding components of hospital design. For example, in a discussion regarding a new site for a hospital, the Public Health Service identified the following areas of concern: accessibility, public utilities, nuisances, orientation, exposure, cost, dimensions, topography, and landscaping. As the health service officials explained, selecting the correct hospital site was of "vital importance" for if it was done poorly, "the community has no method of correcting the error than to abandon the whole investment."[152]

The architecture field identified hospitals as "the most important of all planning assignments now before architects and engineers."[153] Architects recognized that hospitals were incredibly complex structures and struggled with designing modern hospitals when new innovations in medicine and medical theory created constantly shifting targets. Furthermore, medical journals stressed the need for new facilities but recommended simultaneously hiring architects with extensive experience with hospital construction, presumably those same architects that had developed the now-outmoded hospitals in the first place. As a result, a plethora of data on hospital design circulated through the architecture field via dedicated journals and special hospital planning conferences, allowing architects with limited hospital experience to become more familiar with the process. No less an architect than Frank Lloyd Wright, known worldwide for his skill but not necessarily for his humility, acknowledged that if he were to design a hospital, he would first have to complete extensive research into hospital functions and procedures.[154]

The Hospital Facilities Section of the Public Health Service circulated numerous plans and spatial requirements through architectural journals. The Public Health Service stressed the representative plans were "suggestive only," as local conditions and individual hospital project requirements would dictate the details. For example, in one issue of *Architectural Record* from 1946, the Public Health Service provided representative plans for a nursing unit with an offset corridor and southern exposure, a contagious disease nursing unit, open wards, four-bed rooms,

[151] Waagen, 361; Small, "How to Read a Blueprint."
[152] Division of Hospital Facilities, United States Public Health Service, "The Functional Basis of Hospital Planning: The Hospital Site," *The Modern Hospital* 68, no. 3 (March 1947): 50.
[153] Emerson Goble, "Hospitals," *Architectural Record* 107, no. 2 (Feb. 1950): 99.
[154] "Frank Lloyd Wright on Hospital Design," *Modern Hospital* 71, no. 3 (September 1948): 52.

pediatric nursing units, a kitchen for a one hundred-bed hospital, and a combined doctor's office, examination and treatment room that also featured a waiting room.[155] The plans were accompanied with details on furnishing the rooms, down to the size of the bread box in the kitchen for a fifty-bed hospital.[156] Generally, architects welcomed these articles, as the health service provided a "valuable fund of planning information" that would assist in the successful completion of their hospital commissions.[157]

Architects reached some consensus regarding certain aspects of hospital construction for this period, particularly the vertical stacking of the components of a hospital, architectural style, and orientation. Vertical stacking of components in a hospital into one central block, as opposed to the multiple-building, mid-rise campuses of previous generations' hospitals, had several appealing qualities. Historically, operating rooms were placed on the uppermost floors to allow for natural light to flood the room via skylights.[158] With the advent of artificial lighting, operating rooms could be placed anywhere within the structure, thus allowing architects and hospital administrators greater freedom in planning the rest of the facility. Elevators allowed for expedited vertical travel as well as some degree of isolation between floors, further supporting the construction of a block-type hospital. Kitchens, laundries, and other support facilities were contained within one building, thus rendering the vertical hospital more self-sufficient. Finally, hospital towers often required a smaller footprint, a key quality in urban areas where land was often expensive and difficult to come by.[159]

Figure 16. Lever House, New York, 1952 (Gottscho-Schleisner Collection, Library of Congress).

The concept of draping an older architectural style on top of their modern hospitals was almost universally rejected by architects involved with the hospital construction boom in this period. Architects discarded past trends in hospital design; no longer was the "worth of a hospital" dependent on "how faithfully certain forms of traditional architecture were incorporated."[160]

[155] "Elements of the General Hospital," *Architectural Record* 106, no. 1 (July 1946): 76-90.
[156] "Elements of the General Hospital," 83.
[157] Goble, "Hospitals," 99.
[158] Alfred Mufflen, "Operating Rooms on the Ground Floor," *Hospital Management* 65, no. 1 (January 1948): 29.
[159] Charles Butler, *Hospital Planning* (New York: F. W. Dodge, 1946): 9.
[160] Alfred L. Aydelott, "The Hospital as Living Architecture," *Hospital Progress,* 30, no. 1 (January 1949): 4.

Architecture in the United States embraced the International Style in the 1930s, particularly its rejection of unnecessary architectural ornamentation and emphasis on glorifying the structural components of the building. The International Style in the United States emphasized the linear qualities of buildings, even in the horizontal lines of stacked floors of skyscrapers.[161] During the post-World War II era, renowned architect Mies van der Rohe and his "celebration" of the steel skeleton of the skyscraper heavily influenced modern architecture of the period, as represented by structures such as Skidmore, Owings, and Merrill's Lever House (Figure 16).[162] The literature regarding hospital design limited recommendations regarding hospital appearance. As noted in an editorial in *Progressive Architecture*, "At a time when the United States needs thousands of schoolrooms, hundreds of thousands of hospital beds, and millions of homes, too many people are spending their time self-consciously discussing "styles" instead of producing buildings which are well designed."[163]

These overarching theories and plans developed by architects were heavily controlled by the orientation of the final structure, particularly as it related to the influx of sunlight into patients rooms, as the "great therapeutic value of sunlight is universally admitted."[164] In 1912, William Atkinson, a Boston architect, published his findings regarding orientation of buildings and sunlight, a treatise that was still referenced in the hospital planning literature roughly forty years later. Atkinson concluded that hospital wards should be arranged along a main axis arranged as close to northeast or southwest as feasible, providing for the greatest amount of sunlight with the fewest amount of hours in deep shadow.[165] Ideally, wards should project from one side of a central spine, placed far enough apart to provide sunlight to reach central courts and not leave one side constantly in shadow.[166] Orientation was also influenced heavily by the hospital's location. Emphasizing southern exposure and its

[161] John C. Poppeliers, S. Allen Chambers, Jr. and Nancy B. Schwartz, *What Style Is It?* (New York: Preservation Press, John Wiley & Sons, Inc., 1983): 92.
[162] Spiro Kostoff, *A History of Architecture* (New York: Oxford University Press, 1985; reprint, 1995): 727.
[163] "Architecture – not Style," *Progressive Architecture* 29, no. 12 (December 1948): 49.
[164] "Architecture –not Style," 5. In "How Hospital Rooms Went from Airy Temples to 'Inhuman' Machines," Jeanne Kisacky traces the arc of hospital planning from a window in every space – for light initially and for germicidal properties of ultraviolet rays in the early twentieth century – to a "tool to facilitate medicine." The windows introduced air and light to the interiors, but created inefficient floor plans both long and narrow. Efficiency began to characterize the medical treatment and physical plant, but not the patient rooms during this period of hospital design around the Second World War. Wilber McLin addressed this in *Modern Hospital* (1942), and this design solution was upended by Charles Neergaard's double pavilion plan wherein he kept windows in patient rooms and eliminated them from service rooms nearby – making the modern hospital less a therapy than a tool of medicine. This influence would be felt in the late twentieth century – after the third generation of veterans' hospitals program ended – with windowless spaces. The architecture prompted new studies about the faster recovery of patients in rooms with windows than those without. See Kisacky's essay (www.zocalopublicsquare.org, accessed January 25, 2018) and her book, *Rise of the Modern Hospital: An Architectural History of Health and Healing, 1870-1940* (Pittsburgh: University of Pittsburgh Press, 2017). The third generation of veterans' hospitals struck a balance, and Kisacky's larger work addresses the dialogue that informed their design – including the resignation of Carl Erickson and Edward Stevens from a committee rather than be identified with Neergaard's windowless proposal. Erickson would be an important voice at the inauguration of Bradley's program. See also Alan Beattie and Jude Curtis, "Hospital Corridors as a Case Study in Architectural Psychology," *Journal of Architectural Research* 3, no. 2 (May 1974): 44-50.
[165] William Atkinson, *The Orientation of Buildings of Planning for Sunlight* (New York: John Wiley & Sons, 1912): 84.
[166] Atkinson, 96.

correlating abundance of sunshine may not be as desirable as shade in southern climates, possibly necessitating the addition of overhangs to the exterior of the structure.[167] As translated to modern hospitals of the post-World War II era, Atkinson's recommendations became a plan resembling a T, with support services along the cross and patients rooms in the stem. A number of T-shaped building wings could be constructed in a chain to provide additional spaces for patients. Nathaniel Owings, a founding partner of noted architecture firm Skidmore, Owings, & Merrill, called for taking this plan a step further. He arranged the patient wards of the veterans' hospital at Fort Hamilton, New York, in a linear block with rooms along one side of the corridor with supporting services on the other, resulting in a "simple rectangular structure without expensive breaks, dark corners, [and] complicated structural systems."[168]

In addition to sunlight, orientation assisted ventilation through access to prevailing winds in an era before air conditioning was standard in new construction. As important as the consideration of southern exposure was in the South, the consideration of prevailing winds in northern climates where hospital design sought to protect the building from winter storms was of equal importance. Finally, orientation of the hospital structure affected the views available to the patients housed within, of particular concern to hospitals that provided long term care, such as tuberculosis or psychiatric hospitals. [169]

Specialized Hospitals

While much of the literature was devoted to general medical hospitals, specialized hospitals for tuberculosis and psychiatric patients were also the subject of extended discussion. Both tuberculosis and psychiatric hospitals had different requirements from those of their general medical counterparts, as they devoted greater space to different treatment methods and required extended stays for the majority of their patients. For example, in 1951, the average length of stay at a non-federal hospital was eight days, but the average stay at a tuberculosis hospital was eighteen months.[170] Furthermore, the treatments for tuberculosis and psychiatric disorders underwent significant changes during the post-World War II era; these changes are reflected in the hospital architecture of the period.

[167] Butler, 5.
[168] Nathaniel Owings, "Basic Considerations in Hospital Design," *Modern Hospital* 70, no. 3 (March 1948): 59.
[169] Butler, 6-7.
[170] Peter N. Jensen, "Notes on Tuberculosis Hospital Planning," *Architectural Record* 109, no. 4 (April 1951): 137.

Despite early treatments for tuberculosis (TB) that ranged from improving sanitary conditions to special diets and a "well regulated hospital life," the disease remained a persistent health threat well into the twentieth century.[171] In 1904, The National Association of the Study and Prevention of Tuberculosis formed. The Association had twin goals of prevention of the spread of tuberculosis through public education along with the "education of public sentiment to a point where it would demand and secure proper legislation and adequate provision for tuberculosis cases through hospitals, sanitoria, and dispensaries."[172] By 1911, 22,000 beds for tuberculosis patients were available, "a drop in the bucket compared with the necessities of the situation."[173] Standardized treatments for tuberculosis patients focused on housing patients in large sanatoriums, either in the sizeable wards of institutional buildings or in smaller cottages. These sanatoriums were removed from urban centers, not only to prevent infecting the local population, but also to provide the patient with the quiet, contemplative environment viewed as essential for recovery.[174] By the mid-twentieth century, the National Tuberculosis Association had established a general guideline for the requisite number of hospital beds for the proper care of tuberculosis: 2.5 beds per annual death. This standard was recognized as fairly "arbitrary," and fluctuated over succeeding years.[175] Tuberculosis hospitals in the 1940s began to be constructed as wings to general medical hospitals.[176] This trend provided tuberculosis patients with modern medical care, prevented them from being isolated from their families, and, as the cases of TB began to wane due to advancements in drug therapy, allowed hospitals to convert the wings into general medical beds or other functions. Tuberculosis hospitals were not immune to governing forces beyond the medical community; in the early 1950s, Mississippi constructed separate tuberculosis facilities at its existing state sanatorium for its African-American population.[177]

While the core tuberculosis hospital rooms resembled their counterparts in general medical hospitals, the use of the remaining space pointed to a very different type of hospital. Planners and architects advocated for adding additional spaces for medical staff and visitors to change gowns and wash their hands to limit further spread of the disease. Of particular importance was disposal of sputum, the mucus coughed up by tuberculosis patients. Different hospitals had different disposal methods, but a designated space was of utmost importance to prevent further contagion. Treatment rooms, particularly for determining the progression of tuberculosis-caused lesions,

[171] "A History of Tuberculosis Treatment," New Jersey Medical School, Global Tuberculosis Institute, Available online at umdng.edu/utbc/tbhistory.htm (accessed July 27, 2011).
[172] Dr. Livingston Farrand, "The National Association for the Study and Prevention of Tuberculosis," *Journal of the American Public Health Association* 1, no. 5 (May 1911): 334.
[173] Farrand, 336.
[174] Spurlock et al., Section E, 13.
[175] Robert J. Anderson, "Tuberculosis Hospitals," *Architectural Record* 109, no. 4 (April 1951): 135.
[176] Anderson, 136.
[177] "Tuberculosis Infirmary for Negroes," *Architectural Record* 109, no. 4 (April 1951): 142.

needed to be housed near patient rooms for ease of caring for patients. Non-medical services that often were included in a tuberculosis hospital included an auditorium that could double as a chapel, barber/beauty shop, library, occupational and vocational therapy spaces, and activities areas for patients.[178]

The Veterans Administration responded to the special needs of tuberculosis patients with the construction of designated tuberculosis hospitals, a trend that lasted well into the construction campaign that produced the third generation of veterans' hospitals. By 1944, the VA operated twelve tuberculosis hospitals.[179] The Veterans Administration placed its tuberculosis hospitals in predominately rural locations, with the hospital sited on higher ground to provide fresh air to the patients. Like other hospitals built during the second generation of veterans' hospitals, these tuberculosis hospitals followed the established design pattern with multiple buildings, a large campus, and patients segregated by their condition.[180]

Hospitals designated for the care of psychiatric patients often had to wrestle with the same issues as tuberculosis hospitals, particularly extended patient stays. Therefore, psychiatric hospitals often featured extensive recreation facilities, agricultural components, auditoriums, chapels, libraries, and other amenities for patients.[181] Frequently these hospitals were significantly larger than neighboring non-federal medical hospitals, with beds numbering in the thousands. As with tuberculosis, psychiatric care had shifted from housing patients in large wards in rural settings to treating patients with the goal of returning them to society, but the requirements for specific treatments shifted constantly. Hospitals constructed in the late 1940s often contained spaces for hydrotherapy, a treatment method that was drastically reduced by the mid-1950s.[182] Architects struggled with finding accurate information on the approved treatment methods that would impact their designs and plans for the mental hospital; as characterized by one architect, the architect "must lead, for there is virtually nothing he may follow."[183]

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[178] Jensen, 137-38.
[179] The peak year for tuberculosis hospitals in the Veterans Administration's healthcare network was 1954 when twenty-one TB hospitals were in operation. The last tuberculosis hospital closed in 1968, and reopened as a general hospital in 1969. This was the hospital in Indianapolis, on Cold Spring Road. Darlene Richardson, VHA Historian, to Virginia B. Price, NCA Historian, electronic communication, March 22, 2018.
[180] Spurlock et al., Section E, 60, who cite Edwin B. Morris, editor, *The Federal Architect* 13, no. 1 (October 1944): 17, 28. The journal provided the number of tuberculosis hospitals (twelve) and in the section entitled, "Tuberculosis Veterans Hospitals (Sub-type 2)," Spurlock et al., write those hospitals were located in California, Arizona, New Mexico, Texas, Missouri, Kentucky, New York, and Massachusetts.
[181] One of the programs offered in these spaces was music. See, for example, Ray Green, "The Music Program in Veterans Administration Hospitals," *Bulletin of the Music Teachers National Association*, 13 no. 1 (Spring 1947): 11-16. Just 44 hospitals had trained musicians on staff – community volunteers and patients themselves filled the gap – yet in December 1946 about 80,000 patients participated in performing groups; of those, 7538 participated because their doctors recommended it. Similar statistics exist for instruction in piano, guitar, trumpet, saxophone, and violin. Almost 1500 received tutelage, and 601 did so by prescription. Vocal lessons were given to almost 1500 patients, and concerts were attended by more the 275,000. See pg. 15.
[182] John W. Cronin and Wilber R. Taylor, "Environment for Mental Therapy," *Architectural Record* 120, no. 5 (November 1956): 201.
[183] Owen A. Luckenbach, "Planning the Mental Hospital," *Architectural Record* 101, no. 6 (June 1947): 107.

Extended treatises on hospital design for this period, such as architects Isadore Rosenfield's *Hospitals: Integrated Design* and Charles Butler's *Hospital Planning*, devoted chapters to special hospitals, including mental hospitals. For the most part, room layouts were disregarded in favor of general recommendations. Butler's recommendations included spaces designated for court hearings as well as social work, using durable, impervious flooring, and heavy-gauge wire screen instead of bars.[184] Rosenfeld advocated for all doors to open outwards to prevent a patient from barricading himself within, with the exception of toilets and baths which should have no doors at all.[185] Perhaps architects struggled with designing mental hospitals because "psychiatric architecture…consists of a multitude of details which are as frequently negative as positive…they are a matter of what not to do as well as what to do."[186]

As with its tuberculosis hospitals, the Veterans Administration constructed specialized hospitals for the care of neuropsychiatric patients. On the eve of the third generation program, the Veterans Administration maintained thirty hospitals dedicated for neuropsychiatric patients. With these hospitals, the Veterans Administration emphasized rural locations that allowed for large campus-like hospitals comprised of multiple low-rise structures. The neuropsychiatric hospitals, much like the tuberculosis hospitals, segregated patients based on affliction.[187] The Veterans Administration elected to retain some of these trends in the construction of neuropsychiatric hospitals during its third generation campaign (1946-1958).[188]

Creating the U.S. Third Generation Veterans Hospitals, 1946-1958

Within the framework of new hospital construction plans underway throughout the United States, induced by the Hill-Burton Act, and accelerated demobilization of troops adding further pressure to civilian and federal hospitals, the Veterans Administration sought to meet an ever increasing demand through the construction of new hospitals and additions to existing facilities. At the close of its 1944 fiscal year, the Veterans Administration had thirty-six construction projects in progress at existing hospitals and funding in place for another twenty-six construction projects that included new hospitals planned for sites in Pennsylvania, New York, Wisconsin, and South

[184] Butler, 168-70.
[185] Isadore Rosenfield, *Hospitals: Integrated Design* (New York: Reinhold Publishing Corporation, 1947): 210.
[186] Rosenfield, 212.
[187] Spurlock et al., Section E, 54.
[188] See Section F, below.

Dakota.[189] Many of these projects appeared to be located at existing VA facilities at the time, primarily the second generation of veterans' hospitals (1919-1950). By the next year, construction work-in-progress continued on the new buildings and retrofitting of existing hospital and domiciliary space for patient needs or other additions to the medical campuses. Thirty-one locations across the country were impacted.[190] Funding approval for upcoming projects included another thirty-five locations, and all but nine, possibly ten, were for new hospital projects. Three tuberculosis hospitals, and potentially a fourth, were planned; three others were marked for neuropsychiatric patients.[191] While a majority of the hospitals were associated with a specific town or city, several were identified merely by their intended state.[192] In addition to this work, Bradley submitted a new building program with hospitals distributed across various states and by type to the Federal Board of Hospitalization for review, and this initiative was approved by President Truman in August. Truman authorized the number – 29,100 beds – without reference to location to give Bradley's administration a chance to reevaluate need. Shortly thereafter, in October, Bradley announced preliminary locations for nineteen of the new hospitals. The expansion represented an increase by 30 percent of the total beds available within the Veterans Administration hospitals and provided a preview of the goals for the upcoming nationwide hospital construction program, as it emphasized association with medical schools and locations for hospitals that benefitted veterans.[193] Congress authorized funds, but construction proceeded slowly.[194]

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[189] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1944* (Washington DC: Government Printing Office, 1944): 10-11. Thirty-six projects were underway at twenty-six locations: Augusta, Georgia (2); Bedford, Massachusetts; Canandaigus, New York (2); Chillicothe, Ohio (2); Coatesville, Pennsylvania; Downey, Illinois; Fort Custer, Michigan (3); Fort Lyon, Colorado; Knoxville, Iowa; Lexington, Kentucky; Livermore, California; Los Angeles, California (2); Lyons, New Jersey (2); Marion, Indiana (3); Mountain Home, Tennessee; Northampton, Massachusetts; Northport, New York; Perry Point, Maryland; Roanoke, Virginia; Rutland Heights, Massachusetts; St. Cloud, Minnesota; Tuscaloosa, Alabama; Tuskegee, Alabama (2); Waco, Texas; W[illegible], Wisconsin; and Wichita, Kansas. Of the approved sites, one in Kansas was a conversion to a neuropsychiatric hospital, five were new hospitals (as stated in the text above, with two in South Dakota), and the others were additions to existing facilities in American Lake, Washington; Bedford, Massachusetts; Coatesville, Pennsylvania; Dearborn, Michigan; Dwight, Illinois; Fargo, North Dakota; Fort Harrison, Montana; Fort Lyon, Colorado; Gulfport, Mississippi; Hines, Illinois; Lexington, Kentucky; Livermore, California; Los Angeles, California; Marion, Indiana; Murfreesboro, Tennessee; Little Rock, Arkansas; Perry Point, Maryland; Sheridan, Wyoming; Tuscaloosa, Alabama; and Waco, Texas.

[190] Those locations were similar to those of the year before, suggesting the continuation of that work rather than something initiated in the fiscal year, and the Administrator's *Annual Report* for 1945 (p. 7, full citation below) lists them by location, with number of beds and estimated completion dates for each. For the purposes of the nomination, just the locations are given here: American Lake, Washington; Bath, New York; Bedford, Massachusetts; Canandaigus, New York; Chillicothe, Ohio; Coatesville, Pennsylvania; Dearborn, Michigan; Dwight, Illinois; Fargo, North Dakota; Fort Custer, Michigan; Fort Howard, Maryland; Fort Lyon, Colorado; Fort Washington, Maryland; Gulfport, Mississippi; Lebanon, Pennsylvania; Lexington, Kentucky; Los Angeles, California; Lyons, New Jersey; Mountain Home, Tennessee; Murfreesboro, Tennessee; Northampton, Massachusetts; N. Little Rock, Arkansas; Perry Point, Maryland; Roanoke, Virginia; Salina, Kansas; Sheridan, Wyoming; Tomah, Wisconsin; Tuscaloosa, Alabama; Tuskegee, Alabama; Waco, Texas; and Whipple, Arizona.

[191] The project in Missouri was approved for either an addition or a new tuberculosis hospital.

[192] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1945*(Washington DC: Government Printing Office, 1945): 8.

[193] "Establishment of Hospitals for Veterans," *California and Western Medicine* 63, no. 6 (December 1945): 292-93. The locations are not provided here; however, the announcement was picked up in newspapers across the country that then referenced the site or sites within their jurisdiction. See, for example, "Locations Are Approved for 19 New Veterans Hospitals," *Oakland Tribune*, October 21, 1945; "Locations for Veterans Hospitals Are Approved," *Gallup Independent* (New Mexico), October 18, 1945; "19 New Veterans Hospitals Approved," *Eau Claire Leader*, October 19, 1945; "Truman Approves 19 New Hospitals for War Veterans," *Palladium-Item* (Indiana),

These measures were insufficient to meet the pressing need for adequate medical care for veterans. The proposed renovations to existing hospitals were small additions that added a few hundred beds in locations scattered across the United States. The construction projects, including new hospitals, were approved and funded, but construction had only begun on a few sites with many wallowing in the planning stages. Furthermore, the Veterans Administration did not overhaul its existing bureaucratic system; the VA's architects-engineers modeled their new hospitals after existing second generation hospitals, the very hospitals criticized as outmoded and medieval. The gradual completion rate of construction projects was outstripped by demobilized troops returning home and seeking medical treatment. The Veterans Administration had to find a solution that expedited design and construction.

Given the patient need, the Veterans Administration focused on constructing hospitals that offered primarily general medical and surgical services. The VA classified hospitals based on the preponderance of beds allocated for particular medical care, i.e., a tuberculosis hospital had the majority of its beds designated for the care and treatment of tuberculosis patients. However, medical treatments were not limited solely to those described by the hospital type. General medical and surgical hospitals designated floors for the care of neuropsychiatric patients, despite the construction of eleven hospitals for the express purpose of caring for psychiatric patients. As tuberculosis remained a continuing concern for the VA's medical staff, five hospitals had a preponderance of beds designated for the care of the tuberculosis patients. Only one hospital, the facility designated for Bonham, Texas, was identified as predominately domiciliary in purpose.[195] Available beds and, therefore, hospital classification, changed based on the veterans' needs.

October 18, 1945; "Roseburg to Get Hospital Addition," *Daily Capital Journal*, October 18, 1945; "19 Hospitals for Soldiers Approved," *The Times* (Shreveport, Louisiana), October 19, 1945; &c. The *Tampa Bay Times* provided most of the site locations, seventeen of the nineteen new hospitals, twelve of the fifteen additions to existing hospitals, and all four of the additions to the National Homes (Bath, Mountain Home, Bay Pines, and Dayton). In December, the *Washington Missourian* accounted for the all nineteen; a report in the *Daily Mail* (Hagerstown, Maryland) suggested Baltimore was added soon after the announcement; it was included in the December accounting. The nineteen chosen were: New Haven, Albany, Buffalo, Newark, Washington, DC, Clarksburg, Louisville, Decatur, Illinois; Duluth, Minnesota; Iowa City, Iowa; Omaha, Nebraska; New Orleans, Louisiana; Phoenix, Arizona; Cincinnati, Ohio; with three neuropsychiatric hospitals in Gainesville, Florida; El Paso, Texas; and Oklahoma City, Oklahoma; and the two publicized in December with the previous locations: Baltimore, Maryland and Southern Minnesota. "New Veterans Hospitals," *Washington Missourian*, December 6, 1945; "Gainesville to Get 1000-Bed Hospital," *Tampa Times*, October 19, 1945; and "Bay Pines to Get Small Addition," *Tampa Bay Times*, October 19, 1945. The *Annual Report* for fiscal year 1946 referenced the President's approval of forty-two locations, and that as the fiscal year ended, the VA was preparing reports regarding locations for another thirty-six. *Annual Repor*t 1946, 48.

[194] *MCV,* 192.

[195] The numbers mentioned here are drawn from Table 78 – *Proposed Additional Hospital Count* prepared for the 1946 fiscal year report by the Veterans Administration and excerpted for Appendix A, below. *Annual Report* 1946, 176. Bonham was the only new domiciliary project; others were additions planned for existing campuses in Bath, Bay Pines, Mountain Home, and Dayton. The new tuberculosis hospitals listed were in Ann Arbor, Michigan; Eastern Connecticut; Baltimore, Maryland; Southwest Georgia; Madison, Wisconsin; and Kansas City, Missouri. The Kansas City project was one of two there, and tuberculosis hospital smaller by bed count – 250 to the almost

On February 16, 1946, the Veterans Administration announced its solution, "the most gigantic hospital building program in the history of the world," consisting of eighty new hospitals, including three already under construction and several already in planning stages.[196] The *New York Times* announced that six hospitals were to be constructed in New York State, from a 1,000 bed hospital in Fort Hamilton, Brooklyn, at the cost of $10,848,763 to the 1,000 bed hospital in Syracuse at a cost of $7,426,300. The article conceded that neighboring New Jersey and Connecticut would also receive hospitals (Figure 17).[197] The complete list of towns and cities selected to receive new hospitals, with the intended type of hospital and number of beds, reported by the Veterans Administration in 1946, follows as Appendix A. [198] Only seven states were not chosen for the site of a new hospital.[199]

500 for general medical and surgical patients. Discounting Kansas City's, the remaining five would be the preponderance referenced in the text above. Similarly, sixteen hospitals were earmarked for neuropsychiatric patients, five with just one-fourth the number of beds as allotted for general medical and surgical patients. All five were in New York. The remaining eleven were El Paso, Texas; Gainesville, Florida; Houston, Texas; Montrose, New York; Oklahoma City, Oklahoma; Salisbury, North Carolina; Salt Lake City, Utah; Southern Mississippi; St. Louis, Missouri; Toledo, Ohio; and Western Pennsylvania.

[196] "Veterans Will Get 183 New Hospitals," *New York Times,* February 17, 1946. The three hospitals were not named, nor were the forty-seven sites identified for hospitals listed in the news accounts. When all the hospitals were complete, the Veterans Administration would oversee 183. Bradley appointed three architects as advisors: Carl Erickson (Chicago), Addison Erdman (New York City), and Slocum Kingsbury (Washington, DC). Also at the time, the Veterans Administration received five hospitals from the army, with steps taken for thirteen others including a naval hospital. Navy officials also promised to provide almost 10,000 beds in its hospitals for veterans, including staff to care for them. The army matched the navy's offer – but couldn't commit to the staffing. Sixty-three medical schools agreed to assist the VA with visiting residents and staff, and four states partnered with the VA for more local care for veterans with service-related disabilities, making longer term hospital stays more pleasant and freeing space in the VA facilities for those without service-related ailments. State hospital associations also allied with the VA under Bradley to provide beds in private hospitals – all to meet the more immediate needs of veterans while the construction of ground-up medical centers took place. Moreover, the Department of Medicine and Surgery was staffed in January with 538 doctors, 66 dentists, and 787 nurses. The announcement – "outline" - came on the eve of a meeting between Bradley and the leader of The American Legion, John Stelle in Indianapolis, and was picked up by newspapers across the country. See, for example, "Army Speeds Work on New Vet Hospitals," *Tampa Tribune* (Florida), February 17, 1946, 12A; "80 Hospitals Due for Vets," *Des Moines Register* (Iowa), February 17, 1946, 5; "VA Enlists Army's Aid to Rush New Hospitals," *Detroit Free Press* (Michigan), February 17, 1946, 2; "Veterans Group Enlists Army Engineers to Speed Hospitals," *Arizona Daily Star*, February 17, 1946, 12; plus *The Monitor* (McAllen, Texas), 6; *Montana Standard*, 1-2; *Jackson Sun* (Tennessee), 1-2; *Tallahassee Democrat* (Florida), 1; *The News Leader* (Staunton, Virginia), 2; *Salt Lake Tribune* (Utah), 2; *Post-Standard* (Syracuse, New York), 45; *Los Angeles Times*, 16; *Asbury Park Press* (New Jersey), 15; *St. Louis Post-Dispatch*, 3; *Courier-Journal* (Louisville, Kentucky), 5; &c. Finally, *The Times and Democrat* (Orangeburg, South Carolina), March 5, 1946, 3, merely noted "war veterans to get 183 hospitals in thirty-nine states."

[197] "Engineers, VA Open Talks on Hospitals," *New York Times*, February 18, 1946. The other New York hospital locations were in New York City (undetermined site), Albany (general medical), Buffalo (general medical), and Peekskill [Montrose] (neuropsychiatric). The New Jersey hospital was earmarked for Newark (general medical) and the Connecticut hospital was actually two – both in New Haven (general medical and tuberculosis).

[198] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1946* (Washington DC: Government Printing Office, 1946): 176. In Table 78 (p. 176) seventy-seven locations were listed. Those, plus the three in-progress, make up the eighty proposed and reported in the newspapers.

[199] Those states were Maine, Vermont, Kansas, New Mexico, Wyoming, Idaho, and Nevada. Alaska and Hawaii were not yet states in 1946. The reasons for omission were not enumerated, but can be inferred to be political – even benignly so, such as the existence of a hospital already adapted for service in the demographic area (as in Kansas). Some of these states would later be slated for a third generation veterans' hospital, including the last one built under the programmatic guidelines that opened in Topeka, Kansas, in 1958.

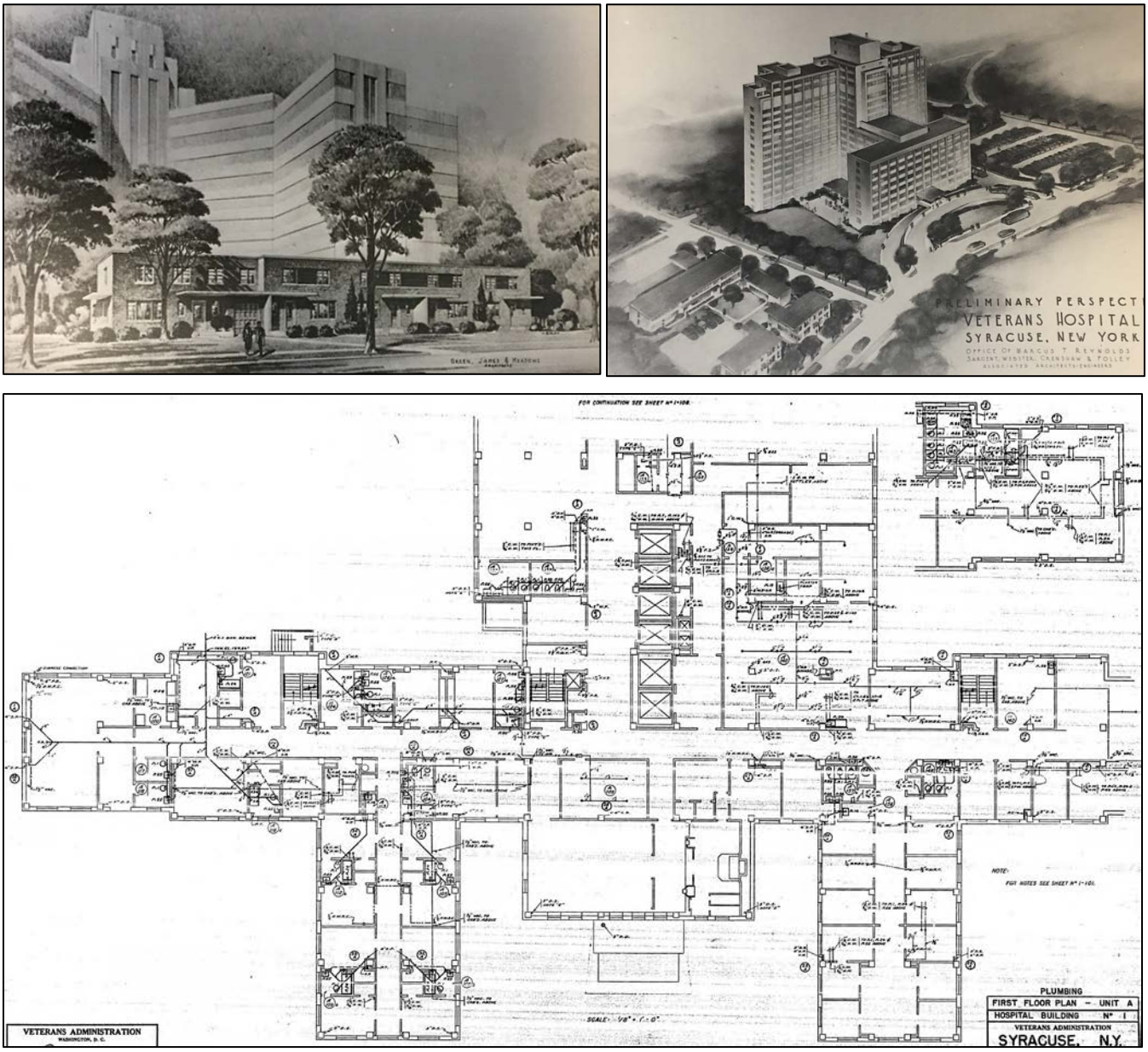

Figure 17. Architectural renderings for the veterans' hospitals proposed for Buffalo and Syracuse, New York. The staff quarters for the Buffalo hospital center are in the foreground (top left), while the rendering for Syracuse (top right) was tabled and the standard plan developed by the VA staff architects used instead. The footprint of the main building in the new hospitals built to the VA standard plan is shown in this first-floor plan, albeit drawn for utilities (VA).

As of June 1946, the Veterans Administration operated 91,675 hospital beds, 4,867 of those located in transferred Army hospitals.[200] The new hospitals announced in February would add a total of 38,923 beds, with 24,718 beds (64 percent) for general medical care, 2,200 (6 percent) beds for tuberculosis, and 11,705 beds (30 percent) for neuropsychiatric cases. When combined with all the beds in non-federal and domiciliary facilities, along with the planned additions to existing hospitals, the Veterans Administration anticipated managing 163,476 beds upon completion of the construction program announced in 1946.[201]

Bradley publicized several key components of the plan that marked significant departures from the VA's second generation of veterans' hospitals. These departures included constructing skyscraper hospitals that required smaller parcels of land, partnering the new hospitals with local medical schools, and bringing in outside medical professionals to upgrade medical care for veterans.[202] The program sought to retain private architectural firms, and not the VA's architectural staff, to ensure the Veterans Administration was constructing fully modern facilities. As described by Bradley in an address to the American Institute of Architects, utilizing the existing VA system would result in 1920-vintage hospitals being constructed in 1946.[203] Preliminary plans were to be drawn up by architects Addison Erdman, Slocum Kingsbury, and Carl A. Erickson.[204] Each of these architects had extensive hospital experience or worked in a firm with acknowledged experts in the field. For example, Addison Erdman was a partner in Butler, Kohn & Erdman with Charles Butler, the author of *Hospital Planning,* a reference text for the general architectural field on hospital construction.

Estimated costs of the new hospital construction program were $448 million, with funding for the first forty-seven hospitals in place and the additional thirty in progress.[205] Construction costs for the individual hospitals were to

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[200] *Annual Report* 1946, 8. The VA operated 109 hospitals in forty-five states, plus the District of Columbia, twelve more than a year before. Most of these facilities came on-line from the military – ten of them, actually. The VA's construction work was ongoing at nineteen locations: seventeen additions to existing hospital centers and two new (Lebanon, Pennsylvania; Tomah, Wisconsin). Plans for seventy-six new hospitals and twenty-four additions/conversions were proposed. VA staff provided plans for two, while another three were in the design phase. These five must correspond to the newspaper accounts regarding the new hospital-building campaign announced by Bradley in February.
[201] *Annual Report* 1946, 8, 46.
[202] "Veterans Will Get 183 New Hospitals," *New York Times,* February 17, 1946.
[203] Remarks of Cyrus E. Silling, AIA Convention, Salt Lake City, Utah, June 23, 1948, printed in *Bulletin of the American Institute of Architects*, July 1948: 40.
[204] "Veterans Will Get 183 New Hospitals," *New York Times,* February 17, 1946; if these plans are extant, they were not located during the course of research.
[205] "Veterans Will Get 183 New Hospitals," *New York Times,* February 17, 1946. Funds were appropriated in 1946 for the hospitals and additions in the program approved by President Truman in August 1945. Funds for the rest of the program were requested in the next fiscal year budget. "Establishment of Hospitals for Veterans," 293. In 1952, a summary of the hospital program was provided. From 1919 (Public Law 326) to 1952 (Public Law 455), funds totaling $1,147,791,876 were made available for construction in that 32 –year time period. This figure included monies from the National Recovery Act (1933) and Public Works Administration appropriation (1938). *History of*

range from $2.5 million to $10 million.[206] While the Veterans Administration sought to locate its new hospitals in areas with significant populations of veterans, local officials and politicians wanted to ensure these multi-million dollar construction projects took place in their districts. The Veterans Administration hospitals were often located "in a remote district of a favorite legislative son."[207] During the end of Hines' tenure, when preliminary plans were made for new hospital construction, cities and states clamored to be chosen as a site for the new hospitals. In California, the state senate passed a resolution requesting an additional eight thousand beds for veterans in the state. The resolution was sent to Bradley, the Federal Board of Hospitalization, and all of California's congressional delegation.[208] In Nebraska, the Omaha Chamber of Commerce teamed up with The American Legion and the World War II Memorial Association to pass a resolution that the best way to honor veterans was to forgo plans for a memorial park and instead ensure Omaha was chosen for a hospital site.[209] Phoenix, Arizona, was particularly creative with its request, asking for a three thousand bed hospital by presenting President Harry Truman with a ten-gallon hat.[210]

Despite mounting excitement over the new Veterans Administration hospitals, the National Association for the Advancement of Colored People (NAACP) protested the decision to build segregated hospitals in Mound Bayou, Mississippi, and Rocky Mount, Virginia, solely for African-American veterans. Calling it "a step backward," the NAACP questioned why a segregated hospital was necessary when wartime government hospitals were integrated.[211] Shortly thereafter, planning for both hospitals was stopped, but reasons were not given by the Veterans Administration.[212]

Location of New Hospitals

When Omar Bradley became Administrator and the new hospital construction program was announced, political pressure came to bear when the Chief Medical Director, General Paul Hawley, disregarded earlier plans by Hines

Veterans' Administration Hospital Construction Programs, Report January 27, 1953, printed for the Committee on Veterans' Affairs (Washington, DC: Government Printing Office, 1953), 1-7.
[206] "Army Will Help Build 80 Veterans Hospitals," *California and Western Medicine* 64, no. 3 (March 1946): 154.
[207] Gambone, 49.
[208] "Veterans' Hospital Facilities in California," *California and Western Medicine* 63, no. 6 (December 1945): 296.
[209] "Vets' Hospital Plan Backed," *Omaha World-Herald*, February 15, 1945; "Vet Hospital 'U.S. Affair'," *Omaha World-Herald*, March 11, 1945.
[210] "10-Gallon Hat to Truman," *New York Times*, August 29, 1945.
[211] "Negroes Protest Hospital Plan," *New York Times*, March 22, 1947; "Providing for the Establishment of a Veterans' Hospital for Negro Veterans at the Birthplace of Booker T. Washington, in Franklin County, VA, U.S. House of Representatives, Report No. 925, 80th Congress, 1st session, July 15, 1947; "Providing for the Establishment of a Veterans' Hospital for Negro Veterans at the Birthplace of Booker T. Washington, U.S. House of Representatives, Report No. 1317, August 24, 1949; "Negro V.A. Hospital is Rejected in House," *New York Times*, June 7, 1951.
[212] "VA Ponders Setting Up Separate Dixie Staffs," *Baltimore Afro-American*, May 4, 1946.

for facilities to be built in specific locations across the United States.[213] After Bradley's political maneuvering to secure changes to the hiring of medical staff, he did not seek to overhaul entirely the tradition of hospitals as congressional plums.[214] As a result, while some hospitals were still constructed in remote areas, many hospitals were moved to sites that fulfilled the goal of locating the hospital in an urban area without denying any politicians, local veterans groups, or city governments their promised hospital. For example, the preliminary announcement by Hines that a hospital was to be located in eastern Nebraska or western Iowa was clarified by Bradley that Omaha (Nebraska) was to be the site of construction after the local chapter of The American Legion expressed concerns.[215] Ruffled senatorial feathers occasionally required soothing. In October 1945, Bradley explained to Senator Homer Ferguson (R-Mich) that the geographical distribution of veterans in the Michigan area favored the selection of Iron Mountain, Michigan, as the best site for the new veterans hospital, no matter how much data was supplied by the mayor of nearby Marquette.[216]

Once a geographical area or city was chosen for a hospital, the specific site had to be selected and approved by the Federal Board of Hospitalization through a resolution approved by the President. The Board originated in 1921 to serve as an advisory body to the President regarding all hospitals operated by federal agencies, from the armed forces to the Veterans Bureau (after 1930, Veterans Administration). During World War II, the Board sought to co-ordinate efforts by the military and the Veterans Administration to minimize redundancy between efforts. The Federal Board of Hospitalization consisted of representatives from the army and navy, plus the Public Health Service, Bureau of Indian Affairs, Bureau of Prisons, and the Veterans Administration.[217]

The Federal Board of Hospitalization resolution identified the specific parcel of land on which a hospital was to be built as well as why available government land in the area was unsuitable. In Harrisburg, Pennsylvania, the government had 19.5 acres available, but the property was bordered by a railroad on one side and an operating quarry on another. Given the noise from the railroad traffic and the quarry's blasting activities, the site was deemed "unsuitable."[218] The specific type of hospital often governed why one site was more acceptable than

[213] "Veterans' Hospital Head Unmoved by 'Pressure'" San Francisco *Chronicle*, reprinted in *California and Western Medicine* 64, no. 2 (February 1946): 96.
[214] Gambone, 49.
[215] "Vet Hospital Plans Same," *Omaha World-Herald*, April 2, 1945.
[216] General Omar N. Bradley to Honorable Homer Ferguson, October 19, 1945, Geographic Files 1919-1959, Department of Medicine and Surgery, Veterans Administration, Record Group 15, A1, Entry 64, National Archives and Records Administration, Washington, DC.
[217] National Archives and Records Administration, *Federal Records of World War II, Volume I* (Washington DC: Government Printing Office, 1950): 95.
[218] Resolution Adopted by the Federal Board of Hospitalization, September 24, 1946, Geographic Files 1919-1959, Department of Medicine and Surgery, Veterans Administration, Record Group 15, A1, Entry 64, National Archives and Records Administration, Washington, DC.

others. For example, for the neuropsychiatric hospital designated for El Paso, Texas, the Veterans Administration recommended purchasing the "Sorenson Estate" because the property had irrigated land that would be appropriate for the farming component of the occupational therapy for the psychiatric patients.[219] Often the best site was located closest to the local medical school, as was the case in Durham, North Carolina, where the VA chose a 17.5 acre site adjacent to Duke University at a cost of $31,000.[220] Generally the Veterans Administration sought to purchase the chosen property and worked with local governments in the plans for development of the site. In St. Louis, the Veterans Administration reviewed fourteen sites on which to build its hospital. The preferred one, also the site ultimately chosen, was located about a mile from the local medical school and consisted of twenty-six individual owners with "fourteen old mansion type houses and a number of commercial establishments."[221] While the site was acceptable, the surrounding area was not as the neighborhood had deteriorated; however, the city plan suggested "that this situation will eventually be improved."[222]

The locations of the new veterans' hospitals were not necessarily fully incorporated with other hospital activities taking place as part of the Hill-Burton program, either on a nationwide or local level. This exclusion was particularly problematic as veterans were counted among the population numbers that states used to determine the disposition of their new hospitals; however, veterans were more likely to seek medical care from VA hospitals. The American Hospital Association was particularly vehement about the situation, claiming veterans "should not be segregated into a separate class."[223]

The Role of United States Army Corps of Engineers, 1946-1954

Veterans needed open hospitals and not just empty parcels of land. To expedite construction, the Veterans Administration announced that building of the hospitals would be handled by the United States Army Corps of Engineers. [224] The U.S. Army Corps of Engineers were attractive partners for the Veterans Administration as the War Powers Act of 1941 granted the Corps of Engineers the ability "to manipulate the contracting process

[219] Resolution Adopted by the Federal Board of Hospitalization, July 10, 1946, Geographic Files 1919-1959, Department of Medicine and Surgery, Veterans Administration, Record Group 15, A1, Entry 64, National Archives and Records Administration, Washington, DC.
[220] Resolution Adopted by the Federal Board of Hospitalization, June 12, 1946, Geographic Files 1919-1959, Department of Medicine and Surgery, Veterans Administration, Record Group 15, A1, Entry 64, National Archives and Records Administration, Washington, DC.
[221] Resolution Adopted by the Federal Board of Hospitalization, January 8, 1947, Geographic Files 1919-1959, Department of Medicine and Surgery, Veterans Administration, Record Group 15, A1, Entry 64, National Archives and Records Administration, Washington, DC.
[222] Resolution Adopted by the Federal Board of Hospitalization, January 8, 1947, Geographic Files 1919-1959, Department of Medicine and Surgery, Veterans Administration, Record Group 15, A1, Entry 64, National Archives and Records Administration, Washington, DC.
[223] Committee on Public Health Relations of the New York Academy of Medicine, "Hospitalization of Veterans," *Bulletin of the New York Academy of Medicine*, 25, No. 9 (September 1949): 594.
[224] "Veterans Will Get 183 New Hospitals," *New York Times,* February 17, 1946.

favorably" to accelerate the purchase of supplies for wartime construction efforts.[225] At the time the VA's third generation hospital construction campaign began, the War Powers Act was still in effect, and its subsequent Congressional extensions allowed the Corps of Engineers to purchase supplies and services that would ultimately aid the Veterans Administration in its hospital construction.[226] Furthermore, the Corps of Engineers already had contacts within private architecture and construction firms that further accelerated the process. With the Corps of Engineers on board, the Veterans Administration anticipated the hospitals would be completed in eighteen to twenty-four months.[227]

The announcement that not only was the Veterans Administration commencing a major construction program, but that the majority of the work would pass to private architecture firms quickly caught the attention of the architectural field. The American Institute of Architects (AIA) formed a committee on veterans' hospitals. *Architectural Record* happily published hospital standards and plans, courtesy of Public Health Service, in June 1946, shortly after the hospital program was made public.[228] By April 1947, the Corps of Engineers had secured contracts with fifty-two independent private architectural firms, with several firms receiving more than one hospital contract. Five hospitals were to be designed by staff architects from the VA.[229] Bradley was optimistic about retaining the private architects, as the size and scope of the program "would greatly outstrip the capacities of the VA's own architect-engineer staff."[230]

The architects under contract with the Corps of Engineers for the VA program were well suited to the task of developing modern hospitals for veterans. They had been educated at schools such as Ecole des Beaux Arts, Massachusetts Institute of Technology, Yale University, and the University of Pennsylvania. Many were veterans themselves, likely making them uniquely suited to understand the pressing need for new facilities. The majority of the architects had been involved with projects for the federal government before, including for the Corps of Engineers as well as for the Post Office and the Army. Several firms had designed hospitals for public and private

[225] James Ciment, ed., *The Home Front Encyclopedia* (Santa Barbara, CA: ABC-CLIO, Inc., 2007), 826.
[226] K.O. Shrewsbury to Assistant Administrator for Construction, Supply and Real Estate, Veterans Administration, May 19, 1948, Box, 1, Entry 72, Record Group 15, National Archives and Records Administration, Washington, DC.
[227] "Army Will Help Build 80 Veterans Hospitals," *California and Western Medicine* 64, no. 3 (March 1946): 154.
[228] Kenneth K. Stowell, "What Are Essential Buildings?" *Architectural Record* 99, no. 6 (June 1946): 71.
[229] List of Architect – Engineers and Construction Contractors, Hospital Branch, Construction Operations Division, Office of the Chief Engineers, Veterans Hospital Construction Program, April 21, 1947, Record Group 15, National Archives and Records Administration, Washington, DC. Of the eighty-five proposed new hospitals, and two additions or conversions, named in April 1947, the five designed by VA architects were located in Providence, Rhode Island; Peekskill, New York; Sioux Falls, South Dakota; Minot, North Dakota; and Grand Junction, Colorado. The two additions were to the hospitals in Jefferson Barracks, Missouri, and Minneapolis, Minnesota.
[230] "Private Firms Predominate in V.A. Hospital Program," *Architectural Record* 102, no. 4 (October 1947): 100.

clients, but few had completed projects that rivaled the dollar amounts proffered by the Veterans Administration.[231]

The initial phases of design and construction went fairly smoothly for the Veterans Administration, the Corps of Engineers, and supporting architects. Architects understood that they would receive standards and programs from the Veterans Administration, would be expected to work at top speed, and would be paid via lump sum contracts with the Corps of Engineers. Architects praised their own efforts as a "magnificent demonstration of the ability of architects in private practice" and that they "had brought the design of veterans' hospitals to a point which may be cited as the last word in hospital planning."[232] However, there were to be no standardized plans.[233] Within a few months, the Veterans Administration and the Corps of Engineers awarded contracts valued at $770 million, with many projects ready to move from conceptual drawings to working drawings, a marked change from previous VA hospital construction projects.[234] The Corps of Engineers developed some ideas as to how to expedite construction itself, including altering the way it requested drawings from architecture firms and releasing contracts for difficult foundation work separately.[235]

New Hospitals – Second Generation as Model

When Bradley announced the new hospital construction campaign, the Veterans Administration had three hospitals under construction. A comparison of a VA-designed, early third generation veterans' hospital with a second generation hospital built for the same purpose, the care of neuropsychiatric patients, revealed several common characteristics and a few marked differences. These differences suggest that the Veterans Administration's existing plans for its second generation of hospitals were adopted, and expanded, for the early third generation construction projects. A comparison of two hospital centers illustrates this premise. The first, in New York, was completed in the early years of the third generation program, although plans for the campus were started before Bradley came on board while the other, in Virginia, was established and operating under the auspices of the second generation of the Veterans Administration's hospital building campaign.

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[231] Various, Questionnaire for Architects' Roster and/or Register of Architect Qualified for Federal Public Works, American Institute of Architects, 1947, http://communities.aia.org/sites/hdoaa/wiki/Wiki%20Pages/Find%20Names.aspx (October 2010)
[232] Board of the American Institute of Architects, "Veterans Hospitals," reprinted in *Bulletin of the American Institute of Architects*, July 1948, 29. This praise was a prelude to the concern of the 1948 program for fourteen hospital projects to be designed by VA staff rather than by architects in private practice.
[233] Stowell, "Essential Buildings," 71.
[234] "Progress Report: The Veterans Hospital Program," *Progressive Architecture* 28, no. 8 (August 1947): 20.
[235] Lieutenant General R. A. Wheeler to General Omar Bradley, June 7, 1946, Record Group #15, National Archives and Records Administration, Washington, DC.; Brigadier General J. S. Bragdon to F. H. Dryden, June 11, 1946, Record Group 15, National Archives and Records Administration, Washington, DC.

The Franklin Delano Roosevelt Hospital, commonly referred to as "Montrose" after the nearby town in New York State, was constructed using drawings completed by the Veterans Administration in September 1946. The hospital opened to receive neuropsychiatric patients in May 1950. For the Salem Veterans Hospital, also a neuropsychiatric hospital and located in rural southwest Virginia, the Veterans Administration completed drawings in November 1933; the Salem facility opened for patients in April 1935.[236] The exteriors of the respective hospitals are similar (Figure 18). They are both constructed of red brick and exhibit limited architectural elements that refer to previous architectural styles.[237] Moreover, shallow colonnades accentuate the central entrances to the primary administration buildings of both campuses, and inside, large patient wards dominated the floor plan. The wards housed over twenty beds each. In plan, these wards were placed perpendicular to the main corridor and, within each ward, a central row of beds was oriented perpendicular to the windows. There are no indications of partitions or other means of establishing privacy. Across the main corridor from the wards, plans provided generous day rooms that led to screened porches. Every floor had a porch, unlike later veterans' hospitals that limited porches to the top floor. The main corridors also contained smaller patient rooms. At the juncture of the ward wings and the main corridor were the dressing rooms and patient gang toilets. Doctors' offices, nurses' areas, treatment rooms, and visitor rooms filled the remaining spaces on the corridor. Elevators were centrally located, while the stairhalls were closer to the wards. Differences in the two hospital plans suggest a shift in patient care took place after World War II. Notably in the Montrose plan, the patient floors added private rooms, with a single bed in each, to the wards as well as smaller wards than that created in Salem. The smaller wards offered patients limited privacy through cubicle partitions and the arrangement of beds parallel to the windows. The emphasis on privacy followed the then current hospital theories. Montrose also had another elevator which suggests an increased reliance on this mode of transporting patients between floors.

[236] Drawings for Building No. 8, Franklin Delano Roosevelt Hospital, obtained from Engineering Office, Montrose Campus, VA Hudson Valley Health Care System, January 2011; Drawings for Building No. 6, Salem Veterans Hospital, obtained from Historic American Buildings Survey, Library of Congress (www.loc.gov/pictures, accessed April 22, 2011).

[237] The brick facing used in the veterans' hospital buildings is the primary building material considered in this nomination – for reference to colonial period architecture for second generation construction, and cost efficiency and uniformity in the third generation. The use of stone and metal for detailing (i/.e., ground level accents, fenestration banding and surrounds) varied with each property, although a minimalism characterized all the building exteriors. The foundations were typically concrete, in keeping with building practice at the time.

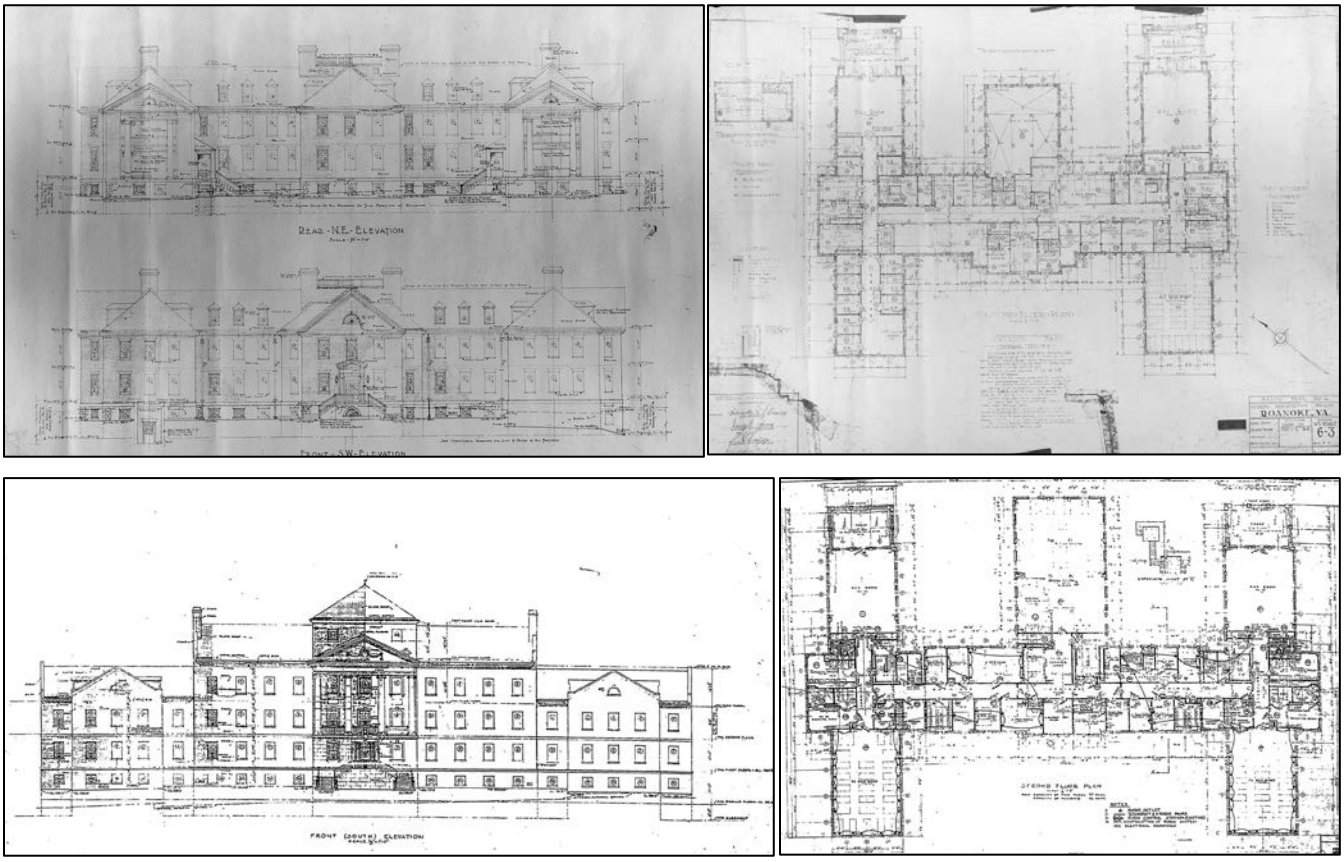

Figure 18. (top) Elevation and plans for the veterans' hospital in Salem, Virginia (Library of Congress), and (bottom) elevation and plans for the veterans' hospital in Montrose, New York (VA).

New Hospitals – Designed under the U.S. Army Corps of Engineers

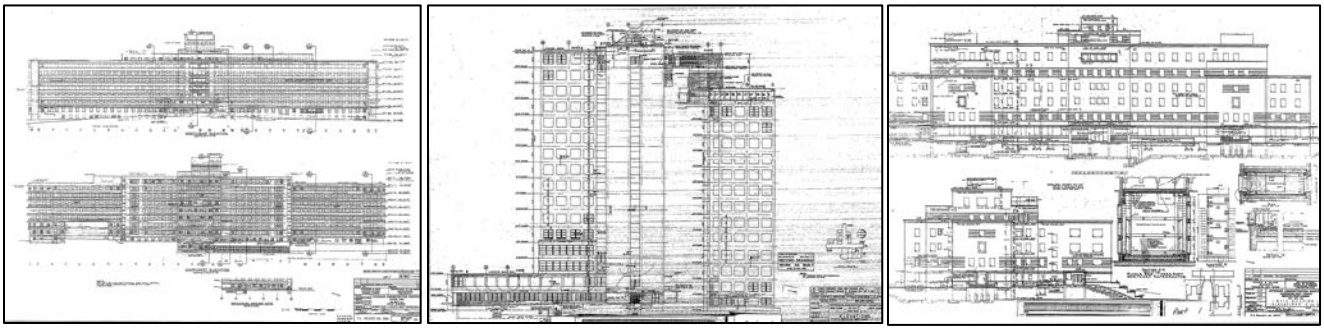

Figure 19. Elevation drawings for three of the Veterans Administration Hospitals designed by architects in private practice (L to R): Madison, WI (Holabird & Root), Manhattan, NY (Alfred Hopkins), Clarksburg, WV (Tucker & Silling) (VA).

For its new, modern hospitals to be built by the U.S. Army Corps of Engineers, the Veterans Administration developed guidelines that provided general program requirements. In these requirements, the VA identified six

ways its hospitals would be markedly different from civilian hospitals: longer patient stays, greater need for recreational facilities, requirement for religious facilities, spaces for vocational and occupational therapies, additional administrative facilities as related to pensions and other agency related activities, and significantly fewer female patients. However, the Veterans Administration did not intend "to standardize any particular type of architectural design or prototype building, but to standardize the components of particular facilities contained within the envelope of the building or buildings."[238] Thus the Veterans Administration's health care program left the exterior appearance to the architect, and the requirements guided the interior arrangement of space without dictating specifically in plan where the components should go (Figure 19). A notable exception is the required placement of the psychiatric unit on the top floor of the facility in order to allow patients access to an enclosed roof garden (Figure 20).[239] These guidelines provided some general spatial recommendations, such as waiting rooms should be near the entrance leading from the main lobby, but for the most part allowed a free hand in how the hospital should be organized, thus allowing the architect in private practice to apply modern hospital theory with the VA's requirements. The requirements were vague when compared to recommendations put forth in the general hospital literature. Necessities were stated for the standard patient bedrooms, such as 160 square feet for rooms with a single bed but 80 square feet per bed in rooms with multiple beds, but other requirements were limited to units or total number.[240] For example, the three hundred-bed hospital was to include in its design two major operating rooms, location "to be determined," with one endoscopic room, one plaster room, one sterilization room adjacent to the nurses work room, one instrument cabinet, one office for the Operating Room

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[238] U.S. Veterans Administration, *Requirements for 300 – Bed General Hospital (Revised)*, June 12, 1946: 1, Construction Subject Files, Record Group 15, A1, Entry 72, National Archives and Records Administration, Washington, DC.

[239] *Requirements for 300 – Bed General Hospital (Revised)*, June 12, 1946: 9. Paul Haun, M.D., argues for integrating psychiatric units into general medical and surgical hospitals, i.e., the upper floors, for the better treatment of patients during curative and domiciliary programs. He was also a proponent of recreational therapies and helped further the understanding of the interconnectedness of mental and physical health, along with the Doctors Menninger. In 1950 Dr. Haun – with the input of architects Frank W. Bail, Charles F. Neergaard, Addison Erdman, and Carl A. Erikson and with permission of the Chief Medical Officer of the VA – published *Psychiatric Sections in General Hospitals: An Architectural Record Book* (New York: F.W. Dodge Corporation, printed by Country Life Press, 1950). Dr. Karl Menninger provided the introduction. In this architectural record book, floor plans were evaluated for how well they were suited to then current psychiatric care; in addition to Haun's analysis of psychiatric units, he asked Charles Butler and Addison Erdman to provide plans for a hypothetical hospital that would be about 200 beds in size and include psychiatric units for both male and female patients. That unit was on the 6th floor – the uppermost – and included roof gardens opening off of solariums. The solarium/roof gardens were communal areas for patients and so were located behind the nurses' station on the main axis of the building. Patient rooms were located on cross axis, occupying the (truncated) arms of an elongated H building footprint. (see Plan No. IX, p. 62). While published in 1950, the guidelines and analysis of requirements for psychiatric hospital design were done in the mid to late 1940s, in concert with the postwar veterans' hospital construction campaign of the Veterans Administration. They also reference the 1947 report by the Commission on Hospital Care. At the time of publication, Haun was an Associate Professor at Georgetown University.

The effectiveness of the roof garden – or provision of garden space – in environmental psychology and its return to hospital design in the late twentieth century was addressed in Sam Bass Warner, Jr., and J.H. Baron, "Restorative Gardens: Green Thoughts and a Green Shade," *BMJ: British Medical Journal* 306, no. 6885 (April 24, 1993): 1080-81. Also, Renate Cervinka et al., "Evaluation of Hospital Gardens and Implications for Design: Benefits from Environmental Psychology for Architecture and Landscape Planning," *Journal of Architectural Planning and Research* 31, no. 1 (Spring 2014): 43-56.

[240] *Requirements for 300 – Bed General Hospital (Revised)*, June 12, 1946: 3.

Supervisor, and multiple other spaces with specific purposes.[241] But any direction the requirements gave to the project architect was imprecise, only utilizing descriptors such as "located near" and "adjoining."

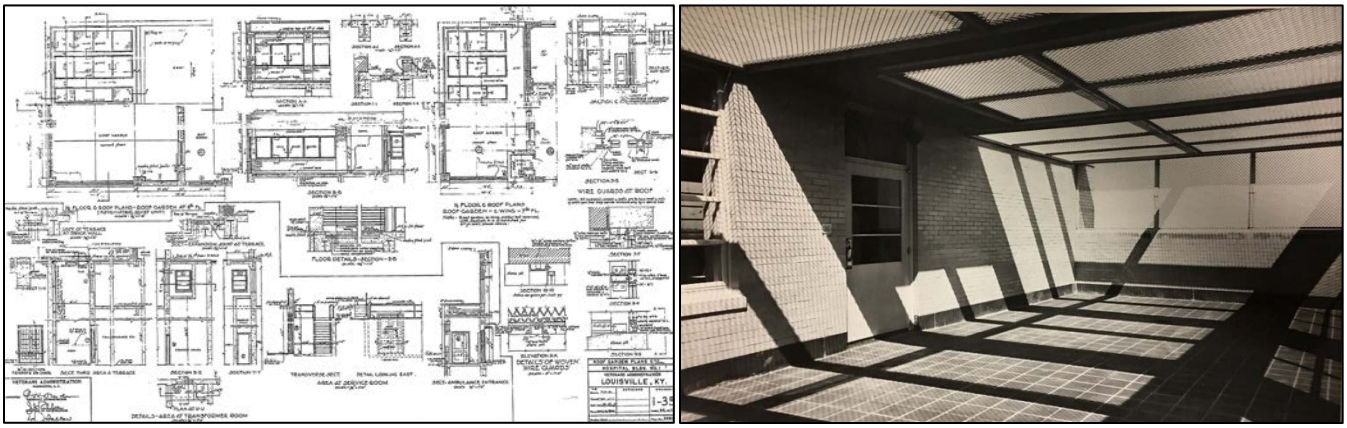

Figure 20. Representative plan for roof gardens in the veterans' hospitals (left), and view of enclosed sun deck, Grand Island, Nebraska (VA).

Subsequently, the resulting plans developed by a variety of architects and architecture firms were not identical. Commonalities reflected current theories governing the design of hospitals of the postwar period and the Veterans Administration's requirements. The hospitals tended to be organized with storage, trash, and mechanical services in the basement, spaces where the public would interact with the veterans on the lower floors, predominately medical services and labs on the upper floors, with neuropsychiatric patients on the uppermost floors. Tying the new hospitals to medical schools and encouraging research required a whole new host of rooms previously not necessarily found in veterans' hospitals. These spaces included training rooms for nurses, extensive laboratories, dedicated medical libraries, and observation rooms for medical students placed overlooking operating rooms. Given the large number of patients that were fed, kitchens were often large and located near elevators to expedite food service to non-ambulatory patients. At the Fort Hamilton facility in Brooklyn, dumbwaiters were added to transport meals to upper floors. As these hospitals ranged upwards of twelve to fifteen stories, rather than spread horizontally over hundreds of acres, they featured banks of multiple elevators just off the main lobby, with a parallel bank that served as service elevators (Figure 21).

[241] *Requirements for 300 – Bed General Hospital (Revised)*, June 12, 1946: 19-20.

The transition between public and private generally occurred in the first and second floors of the hospital. Admissions were located generally just off the main lobby, as were services that would likely not require an overnight stay, such as dental care. Travel offices were located near patient waiting rooms. A majority of the Veterans Administration hospitals had chapels, usually located on the first floor, along with dedicated offices for Catholic and Protestant chaplains.

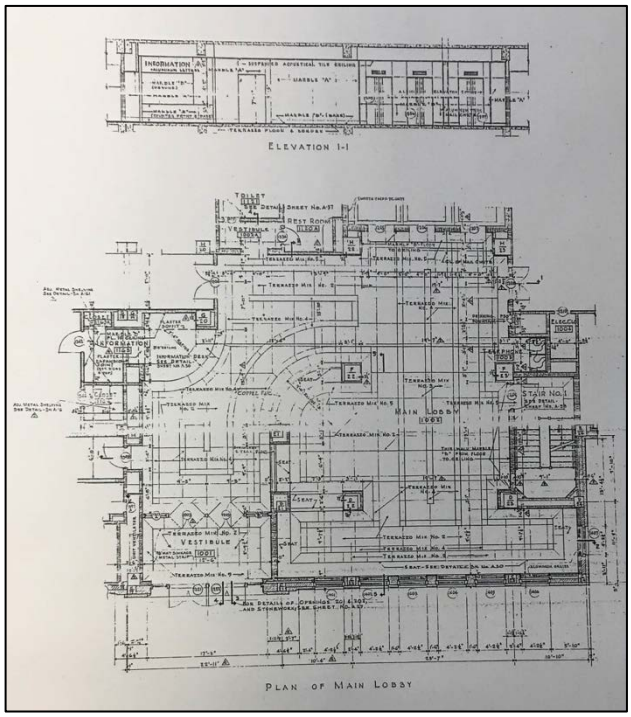

Figure 21. Detail of drawings for the lobby, Veterans Administration Hospital, in Wilmington, Delaware (VA).

The hospital chapels, attended by ministers of different denominations, were a consistent feature in all iterations of the veterans' hospitals from the National Homes to the midcentury modern facilities of the third generation. The National Homes also had separate chapels, reportedly "beautiful and commodious" and entirely "unsectarian in form and character," for the residents. The army's chaplaincy service was extended in the World War I era, with approval for an additional twenty chaplains if needed.[242] In September 1945, the first chief of the veterans' chaplaincy service Crawford W. Brown conducted a survey of VA facilities to determine the numbers of chaplains needed so soldiers returning from World War II could be accommodated while they were "under the care of the Veterans Administration for varying periods." Brown advocated for full-time chaplains at hospitals with five hundred or more beds, and part-time chaplains for smaller facilities. He hoped to hire one hundred for the chaplaincy service and had the support of General Bradley to do so.[243] By the next year, a VA chaplaincy service had been formally established and consisted of 143 Protestant, 58 Catholic, and 2 Jewish chaplains employed full-time and another 126 on a part-time basis. These numbers were a sizable increase from the 11 full-time, and 175 part-time, that Brown had in the service initially.[244] The chaplains conducted services in chapels

[242] "Religious Privileges and Advantages," Excerpt from *National Home for Disabled Voltnteer* [sic] *Soldiers Annual Report* 1877, 28-29, copy on file, VA; *An Act Authorizing Appointment of Chaplains at large for the United States Army*, Public Law 65-79 (39 Stat.176). October 6, 1917.
[243] "U.S. to Provide Adequate Spiritual Care for Hospitalized Veterans," *Pittsburgh Press*, September 1, 1945, 5.
[244] *Annual Report* 1946, 11, 99. The *Annual Report* discussed the special services program launched in November 1945 to augment patients' well-being with recreational activities coordinated with medical care received. Libraries, music and movies (performances), and recreation/athletics were offered as well as the spiritual ministry. Regarding the needs of Jewish personnel in the military, see Louis Kraft, "Serviceman and Veterans," *The American Jewish Year Book* 48 (1946-1947): 164-72; Louis Kraft, "Jews in the Armed Forces," *The American Jewish Year Book* 46 (1944-1945): 129-33.

and administered to patients in the wards. They were veterans of the army and navy. The sacrifice of four who died after giving their life jackets to their comrades on a torpedoed ship was honored in the dedication of the "Four Chaplains" therapeutic pool at the Bronx veterans' hospital in 1947.[245]

The importance of the chaplaincy service within the Veterans Administration is reflected in the space allocated for its work in the veterans' hospitals. In the third generation veterans' hospitals, the "unsectarian" chapel of the National Homes was interpreted as multi-purpose. In Northport, for example, the chapel had three altars placed on revolving platform so Catholic, Protestant, and Jewish ceremonies could each be conducted. The revolving altar became a distinguishing feature of the chapels, although even this ingenuous solution was improved upon in one hospital that placed altars behind sliding doors instead of on a platform.[246] The chapels were fitted out primarily through the Veterans Administration "Voluntary Services" – at least in the New York area – for furnishings, altars, organs, and even stained glass.[247] By 1955, ten years on, 268 full-time chaplains and 305 part-time chaplains served patients in the VA's hospitals and the Veterans Administration looked to reduce the numbers employed.[248] The chapel, however, remained a significant feature in the modern hospital and an important public-private or visitor-patient shared space that reflected the longer periods of treatment needed by returning veterans, especially the tuberculosis and neuropsychiatric patients. The revolving altar defined the multi-denominational practice offered to patients and their families by the chaplaincy service in the third generation of hospital design from 1946 to 1958.

For patient rooms, the large wards had for the most part been abolished and the majority of bed spaces were single or double rooms. The largest typical ward housed sixteen semi-private rooms with curtained partitions. The beds were arranged parallel to the exterior walls and windows. These larger wards filled the ends of the building wings while smaller capacity rooms were situated closer to the center of the building. Nurses' stations were centrally located to allow ease of access and supervision of all rooms. This floor plan followed the pattern for patient spaces that emerged in Montrose as the third generation program matured.

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[245] "Pool Is Dedicated to Four Chaplains," *New York Times*, July 28, 1947. The chaplains were Rev. John P. Washington, Rev. George L. Fox, Rev. Clark V. Poling, and Rabbi Alexander Goode. They were onboard the transport *Dorchester* when it was torpedoed and they drowned February 3, 1943, last seen standing with locked arms praying as the *Dorchester* sank. On the duties of the chaplains, see *Annual Report* 1950, 51.

[246] The altars cost $10,000 and were donated by the Order of the Eastern Star; chaplains dedicated the altars separately. "Chapel Altar Dedicated," *New York Times*, November 28, 1949; "Chaplains of VA Will Be Honored," *New York Times*, July 31, 1955.

[247] "Chaplains of VA Will Be Honored." Similarly, volunteers provided services at the veterans' hospital in Saginaw, Michigan, offering navigational assistance and childcare. The local bowling association donated an electric organ for the chapel.

[248] Chaplains to be Honored," *Times-News Henderson*, July 25, 1955, C7; *Annual Report* 1950, 51; *Annual Report* 1955, 55-56.

For the administrative functions of the modern hospitals, the Veterans Administration continued the practice of locating hospital management offices on the first floor. Generally found at the end of a corridor that led from the main lobby, the office of the hospital director was surrounded by administrative support staff. The director's office was also immediately adjacent to the finance division, and this arrangement is seen in the early hospitals of this period, such as Montrose, as well as in the later hospitals, such as Louisville, in Kentucky.

Hospital Program Matures

By early June 1946, the Veterans Administration had directed the Corps of Engineers to prepare plans and specifications for seventeen hospitals, surveys for fifteen additional sites, and studies for additions to ten existing hospitals. The VA had a total of ninety-one hospital projects, comprised of new hospitals, additions to existing hospitals, and possible replacement of temporary hospitals obtained from the army, that would be executed by the Corps of Engineers, leaving forty-nine still in planning stages. Four contracts had already been signed with architecture firms, exhausting the $1.5 million the Corps of Engineers had received from the Veterans Administration. The Corps of Engineers was ready to sign contracts with an additional nine architectural firms, but lacked the funds to do so.[249] The Veterans Administration was held in check by congressional appropriations that limited funds for design, supervision, inspection and overhead to 3 percent of total construction funds.[250] By August 1946, the Corps of Engineers required $43,650,000 to cover its technical services support to the VA.[251]

While architects had been given the general program needs developed by the Veterans Administration, they had not been limited to specific budgets.[252] The completed drawings and specification documents were distributed to obtain construction bids. Preliminary budgets had been based on hospital construction averages from 1945, with an average of $0.85 a square foot.[253] Following the war, construction costs increased, partially due to shortages of steel, copper, and aluminum. As a result, the bids were coming back at almost $1.80 a square foot, adding another $150 million in construction costs across the program.[254] In April 1946, the Veterans Administration announced that these increased costs would balloon the budget to $900 million.[255] While budget numbers were

[249] Wheeler to Bradley, June 7, 1946
[250] Bragdon to Dryden, June 11, 1946.
[251] F. H. Dryden to Assistant Administrator for Construction and Supplies, August 8, 1946, Record Group 15, National Archives and Records Administration, Washington, DC.
[252] "Progress Report," August 1947, 20.
[253] "VA Revises Plans for 61 Hospitals," *New York Times*, August 2, 1947.
[254] Wesley Gilbertson and Harold A. Kahn, "Construction of Hospitals, Health Centers, and Other Health Facilities, 1951-1952," *Public Health Reports (1896-1970),* 67, no. 12 (December 1952):1168; "Progress Report," August 1947, 20.
[255] "Cost of VA Hospitals May Rise Near Billion," *New York Times*, April 17, 1946.

made available to the public, those numbers included purchasing the site, designing the hospital and associated facilities, and constructing the final product.

New Hospitals – VA Standard Plan

The Veterans Administration sought ways to cut costs for its hospitals. It recommended eliminating any non-essential parts of the hospital complexes, including auditoriums and recreation facilities. The Veterans Administration inserted itself more into the design and procurement process, rather than leaving it solely to the discretion of the Corps of Engineers. The Veterans Administration also began to evaluate using standardized plans developed in-house by staff architects, and so save money by designing a building once and then constructing it multiple times in different sites across the country (Figure 22).[256]

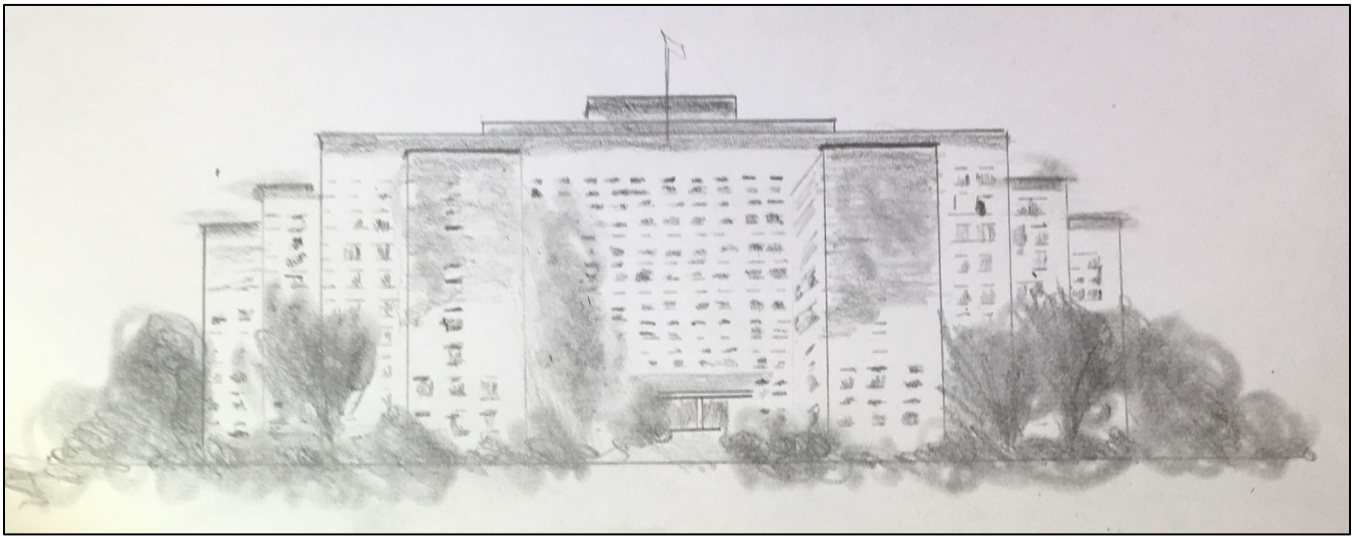

Figure 22. Sketch based on the elevation illustration included in the announcement of the hospital in Syracuse, New York, and the VA's adaptation of the design for the Cleveland, Ohio, hospital for several – including Syracuse – hospital locations across the country. This is the "VA standard plan" third generation veterans' hospital. The announcement also included a sketch of original design by Sargent, Webster, Crenshaw and Folley. *Post Standard*, March 13, 1949, 6.

In February 1947, architects characterized the Corps of Engineers as having essentially withdrawn from the process, leaving a VA-led board of review to evaluate their drawings. The program ground to a halt, as the Veterans Administration decided whether or not to pursue additional funds and the Corps of Engineers "found the increasing interference…unbearably hampering, and about a month ago practically stopped the entire design

[256] Extant standardized plans were not located during the course of research. The model was announced in March 1949, see "Penthouse, Model for VA Hospital: Design Will Be Same used in 10 Other Cities," [Syracuse] *Post-Journal*, March 13, 1949.

program."[257] Finally the rift had grown too great, and, in early 1948, the Veterans Administration announced future hospital projects would be handled by its own architecture-engineering staff.[258]

The private architects resented the implication that their work had been unsatisfactory, thus requiring the Veterans Administration to take it over once again. Representatives from American Institute of Architects (AIA) met with Bradley and his successor, Major General Carl R. Gray, to determine if future hospital design work would be executed by private architects or by the VA's architects. While the Veterans Administration claimed to require time to decide the issue, the AIA maintained plans were circulated for a hospital in Texas based on drawings completed by VA staff. Furthermore, the Veterans Administration had increased its staff in the architect's office from 217 to 990 people. In response, the American Institute of Architects presented its claims in congressional hearings before an appropriation subcommittee of the House of Representatives. The main charges levied by the AIA centered on the issue of federal tax dollars being used to pay government architects for federal projects that would have been made available to architects in private practice otherwise, thus taking prospective projects and their resulting commissions away from private firms, despite the fact that the majority of the planned hospitals had been let to private architects to design.[259]

The Veterans Administration was probably not helped by the fact that its architects were not members of the American Institute of Architects, reminiscent of charges rendered against the VA regarding the isolation of its medical staff from the wider medical field during the Hines era. Of the twenty-seven architects listed in *Federal Architect* in July 1945, not a single architect was a member of the AIA while they were in service to the Veterans Administration. Two later joined, but only after they had moved to private practice.[260]

Gray testified at the same congressional hearing, proffering that the Veterans Administration's program had not changed. The original set of hospitals were circulated to private architectural firms and it was only the newly added fourteen hospitals that were going to be handled in the manner most advantageous to the government, whether by private firms or by the VA's architects. As the Veterans Administration was going to implement the same plan for the fourteen hospitals, it did not appear to be cost effective to retain outside architectural

[257] "Progress Report," August 1947, 20.
[258] This proved to be the case. See "Penthouse, Model for VA Hospital: Design Will Be Same used in 10 Other Cities," [Syracuse] *Post-Journal*, March 13, 1949. The ten cities were Syracuse, Cleveland, Denver, Indianapolis, Ann Arbor, Philadelphia, Atlanta, Cincinnati, Louisville, Chicago, Oklahoma City, and St. Louis.
[259] John Fugard speaking for the American Institute of Architects to the Subcommittee of the Committee on Appropriations of the House of Representatives, May 25, 1948, reprinted in *Bulletin of the American Institute of Architects*, July 1948: 32-33.
[260] Review of AIA Historical Directory of American Architects, http://communities.aia.org/sites/hdoaa/wiki/Wiki%20Pages/Find%20Names.aspx (April 8, 2011).

consultants. Furthermore, the upswing in Veterans Administration staff was not to steal hospital planning from private architecture firms, but to handle additions and alterations to existing facilities along with revisions to existing plans.[261]

While the members of the subcommittee supported the American Institute of Architects, and stated as such on the record, they did not find it necessary to include explicit language to the effect in the appropriation bill under consideration. The American Institute of Architects continued to belabor the issue and met with the Veterans Administration, but by the close of the fiscal year of 1948, the VA had contracts in place to construct twenty-eight additional hospitals, with sixty-one hospitals still on the drawing board. The Corps of Engineers was charged with constructing sixty-nine of the new hospitals, along with one addition, while the Veterans Administration would handle eighteen of the new hospitals. At this point, the Veterans Administration had 125 hospitals in operation with 102,200 beds, with an increase in patient load still expected.[262]

Scaling Back the Program

Furthermore, the Veterans Administration came under scrutiny from the Hoover Commission, a body designated with reviewing activities of the federal executive branch with the goal of making recommendations to create a more cost efficient and streamlined federal government. The resulting report recommended that the VA's hospital program be merged with army and naval hospitals, as well as Public Health Service hospitals, to create one federal hospital system. The distribution of hospitals in rural locations that could not be staffed was a disservice to both veterans and the tax payer, especially with the cost per bed for a VA hospital ranging from $20,000 to $50,000.[263]

The Veterans Administration harbored its own concerns about staffing such a large number of hospitals, especially with additional hospitals in the early stages of planning and several located in remote locations. As a result, 16,000 beds, in the form of twenty-four hospitals, were removed from the budget plans for 1950; the complete list follows in Appendix B. In many cases, the Veterans Administration had already obtained land for these hospitals. Now determined surplus, the properties were transferred to the government landlord, the General

[261] General Carl R. Gray speaking for the Veterans Administration to the Subcommittee of the Committee on Appropriations of the House of Representatives, May 25, 1948, reprinted in *Bulletin of the American Institute of Architects*, July 1948: 35-37.
[262] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1948* (Washington DC: Government Printing Office, 1949): 5, 8, 80.
[263] Committee on Public Health Relations, New York Academy of Medicine, "Hospitalization of Veterans," *Bulletin of the New York Academy of Medicine*, September 1949, 592.

Services Administration. If no other federal agency was interested, the General Services Administration disposed of the property according to federal law.[264]

However, the Veterans Administration fought the other recommendations from the Hoover Commission. President Truman appointed a special committee, featuring prominent physician Howard Rusk, to review the VA's hospitalization efforts. They submitted their findings in 1950 addressing the main charges of the high cost of operating the VA's hospital network and the need to subsume it into a larger federal hospital system. The committee identified a dozen reasons that affected the cost of the Veterans Administration hospitals, many programmatic in nature, such as the dedicated stockroom required for storage of ninety days of supplies and the spaces designated for veterans' organizations, which were specific to the VA.[265] The report detailed that the Veterans Administration provided unique hospitalization services, thus necessitating independent hospitals. One of the key arguments related to demographics: the Veterans Administration's patients were overwhelmingly adults and 98 percent male, thus eliminating the need for spaces designated for obstetrics and pediatrics, while army and navy hospitals also cared for dependents.[266] The Veterans Administration succeeded in keeping its system independent, and plans for several of the eliminated third generation of veterans' hospitals eventually were revived, notably in New York and Houston, Texas, as the Korean Conflict (1950-1953) required another increase in hospital beds for veterans.

End of the Third Generation Program

Over the succeeding years, the hospitals were completed, staffed, and opened to receive veterans. As these new hospitals came on line, hospitals that were only intended to provide stop gap measures or those that now provided duplicate services were transferred out of the Veterans Administration's control. For example, during the fiscal year for 1952, eight new hospitals were opened in Miles City, Montana; Phoenix, Arizona; Madison, Wisconsin; Bonham, Texas; Indianapolis, Indiana; Iowa City, Iowa; Denver, Colorado; and Louisville, Kentucky. As a result, the Veterans Administration closed its old army hospitals in Phoenix, Fort Logan (near Denver in Colorado), and Louisville. The old hospital in Indianapolis was closed as its services were duplicated in the new hospital. Instead of being transferred out of the Veterans Administration network, the hospital was renovated and reopened to serve

[264] "Giving Up Sites for Hospitals," Erie *Times-News*, November 21, 1952.
[265] Abramson, et al. *Report to the President*, 49.
[266] Abramson et al., 51.

tuberculosis patients.[267] This trend continued throughout the 1950s, with the Veterans Administration completing construction of new hospitals and closing those that became superfluous.

By 1954, the Veterans Administration recognized the "post-World-War-II bed-expansion program now nearing completion has been pushed forward under stress of emergency at the expense of certain basic long-range needs."[268] These needs were based on the veterans' population reaching a record number of 20,850,000, with a significant percentage of that increase triggered by the conflict in Korea.[269] Furthermore, the Veterans Administration had to renovate existing facilities to make them compliant with new statutory requirements for fire-proof construction and to remove obsolescent equipment and utilities. The increased workload resulted in the Veterans Administration hiring private architecture firms once again in order to ensure that projects were completed in a timely fashion.[270] The last hospitals identified as part of the post-World War II program were opened in the late 1950s, with delays triggered by site-specific problems.

The hospitals constructed as part of the *United States Third Generation Veterans Hospital* building campaign represent a significant change in the way the Veterans Administration provided health care to the swelling veteran population. By employing temporary measures of beds in non-federal hospitals and cobbling together a mix of former army and navy facilities, the Veterans Administration was able to provide stopgap health care during the period of demobilization immediately following the cessation of hostilities. However, to provide truly modern health care to veterans, the VA developed a plan for new hospitals that embraced current theories governing hospital operations and hospital design. These hospitals served as symbols that the Veterans Administration was no longer going to operate in isolation. The new facilities were not located in rural backwater areas, but in cities that provided connections with medical schools and community hospitals. The Veterans Administration signaled the shift away from the old-fashioned, sprawling hospital campus by building sleek modern towers designed by architects in private practice. The VA built hospitals based on projected veterans' need, including hospitals specifically designated for tuberculosis and neuropsychiatric patients, from designs based on medical innovations. The Veterans Administration partnered with the U.S. Army Corps of Engineers to expedite construction of the new hospitals, thus ensuring modern health care was provided quickly to the veterans of World War II (Figure 23).

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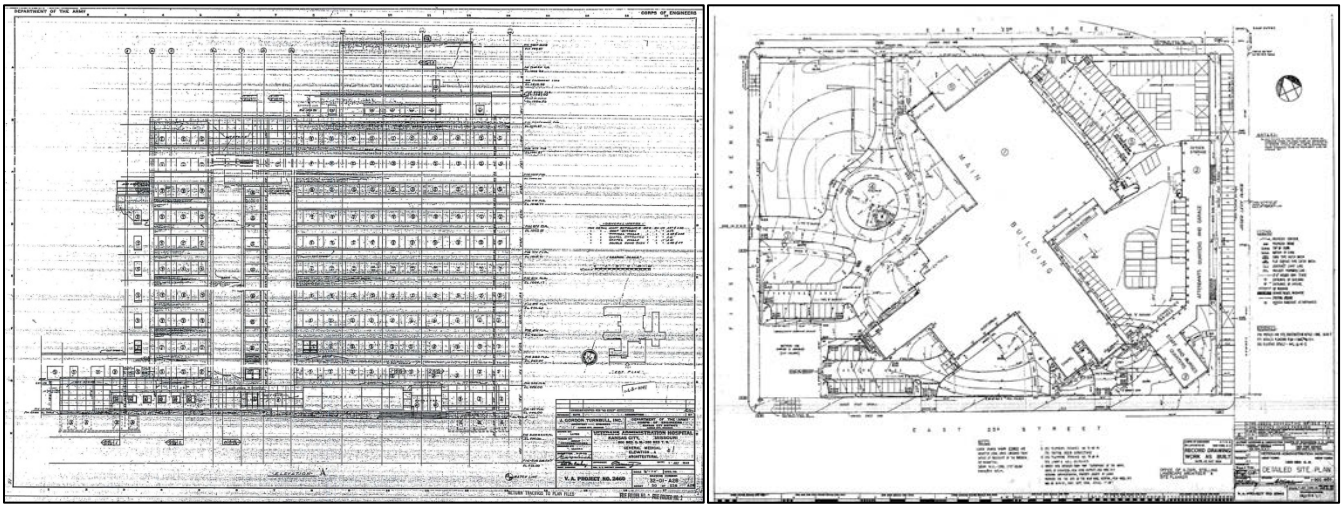
[267] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1952* (Washington DC: Government Printing Office, 1953): 11.
[268] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1954* (Washington DC: Government Printing Office, 1955): 152.
[269] *Annual Report* 1954, 1.
[270] *Annual Report* 1954, 152-53.

Figure 23. (top) View looking to the main hospital building, Big Spring, Texas, and (bottom left) view looking to the main hospital building in Iron Mountain, Michigan, both Veterans Administration Hospitals built with the Corps of Engineers and both opened in 1950, and (bottom right) view looking to the main hospital buildings in West Haven, Connecticut, that was built to the VA standard plan, with the tuberculosis hospital in the foreground (VA). *Below*: (left) Elevation, main hospital, Kansas City, Missouri, and (right) site plan, Veterans Administration Hospital, Manhattan, New York (VA).



F. Associated Property Types

Following World War II, the Veterans Administration faced surging medical care requirements due to an unprecedented number of veterans entitled to healthcare. To meet the new demand, the Veterans Administration cobbled together a network of impermanent armed forces facilities and existing civilian facilities to provide treatment. These transitional hospitals filled an acute need while the Veterans Administration constructed new, modern hospitals designed especially for the veterans' care. Together, the transitional facilities and the new construction constituted what is described today by the Veterans Administration as the *United States Third Generation Veterans Hospitals, 1946-1958*. While these categories – the transitional and the new – of federal hospitals follow one another conceptually and, for the most part, chronologically, the scale of the Veterans Administration's third generation push meant there was some overlap in the fill-the-need-right-now hospitals coming online and the construction of the new ones intended to succeed them. Moreover, hospital construction was routinely delayed due to issues related to budget, site selection, availability of construction materials, or shifts in the programmatic requirements of the Veterans Administration. These interruptions led to years elapsing between completed designs and open hospital doors. For example, the veterans' hospital for Cincinnati, Ohio, was announced in 1946 but did not open until 1954. Hospitals in Durham, North Carolina; Louisville, Kentucky; and Topeka, Kansas had similar delays (Figure 24).

Figure 24. (top) The main hospital and support buildings in Cincinnati, Ohio, and (bottom) views of the main hospital and support buildings in Durham, North Carolina, in the early 1950s (VA).

Transitional Hospitals

The Veterans Administration's postwar healthcare initiative was multifaceted and required some ingenuity as design and construction began so returning veterans could receive timely medical treatment. The first hospitals, described here as transitional hospitals, provided provisional measures for veterans' care prior to the completion

of the massive hospital construction campaign between 1946 and 1958. To expedite availability of hospital beds, and retain attending staff, the Veterans Administration utilized facilities that were already operating as hospitals. Thus, the transition of the property into a Veterans Administration facility required little more than new signage at the entrance, and the VA opted not to construct new, elaborate entrances or install new landscaping. These ready-made facilities were appealing to the Veterans Administration because little to no intervention was required to open them for veterans. While the Veterans Administration replaced some of these properties during the course of its third generation hospital construction plan, several remain part of the VA's network to the present day. The transitional hospitals do not have a singular plan or appearance as they originated from a variety of sources. Yet all share the significance of serving an important means of providing health care to a growing veteran population, while affording General Omar Bradley and the Veterans Administration enough breathing room to develop new, modern hospitals. These interim hospitals consisted of facilities constructed by the U.S. Army and U.S. Navy during World War II and transferred to the Veterans Administration after the cessation of hostilities.[271] Also within this transitional hospital property type are those veterans' hospitals already in the planning or construction stage when Bradley announced the new (now, third) construction campaign in 1946. These facilities were initially planned by architects with the Veterans Administration according to the VA's post World War I design tenets and, under Bradley, were expanded to meet surging patient loads. The third category or subtype of transitional hospitals includes existing hospitals built by various states and agencies that the Veterans Administration then incorporated into its healthcare system.

Subtype: Army / Navy Hospitals

Description

One of the first kinds of hospitals utilized by the Veterans Administration following World War II was the cantonment-type hospital constructed during the war by the U.S. Army. During the war, the army doubled the number of hospitals from those it operated during World War I and saw an increase in the convalescent and specialty hospitals required for military personnel needing amputee care or treatment for tropical diseases and trench foot, for example. To meet the needs of war, the army pressed other facilities into service – from federal and civilian hospitals to school and hotel buildings – preferring that to new construction. However, as the war continued and facilities that could be adapted were, in practice, far fewer than anticipated, the army erected new hospitals following a low-scale, cost-efficient, expedient mode of building described as a cantonment-type hospital.[272]

[271] See Appendix C, below.
[272] Smith, 68-72. For example, the army's hospital in Augusta, Georgia, was initially a hotel. See Table 15, 310.

The cantonment-type hospital buildings were one-story in height and made of wood-frame, until shortages of materials made brick and tile more accessible than lumber.[273] Changes to the cantonment-type hospital center were initiated in 1942-1943 at the request of the Surgeon General, whose office wanted more efficient ward placement, improved neurological wards and dining facilities, and more administrative space, and at the urging of the administrator of the Veterans Administration who cautioned against investing in hospitals that could not be converted to peacetime use. Cost and medical staffing were also factors. Modifications to the cantonment-type, therefore, produced standard plans for buildings used in varying combinations to create hospitals of any size, from a mere twenty-five up to two thousand beds;[274] two hospitals, McGuire in Richmond, Virginia, and Hines in Illinois, were planned specifically to be transferred to the VA at the war's end and thus, in construction, built the VA's preferred two-story wards rather than the army's one-story standard.[275] To accommodate more patients in the modified cantonment-type hospitals, corridors were lengthened and wards were placed on either side; however, the site plan adhered to the cantonment's pavilion principle wherein the buildings were spaced at least 50' apart and connected by walkways.[276] The diffuse site plan took a large amount of ground space and this pavilion model would be rejected in the Veterans Administration's postwar hospital initiative.

In sum, both the U.S. Army and U.S. Navy required hospitals that could be constructed quickly and adapted easily based on the number of needed beds, and by World War II, a revised cantonment-type standard emerged that was referred to as the "Type A" hospital to distinguish it from earlier designs. This hospital template featured multiple one-story buildings designed to be erected quickly to meet urgent medical care needs. The main administration building served as the central organizing fixture for the medical campus. The core tenets of this hospital design became: compact rows of closely-aligned buildings linked via windowless corridors; buildings organized by use, but always placing nurses' and doctors' quarters near a public road; wards for psychiatric patients isolated near the rear of the campus; and medical services lodged near the middle of the facility. General patient wards filled the remaining spaces. The army constructed these types of hospitals throughout the United States as part of the greater war effort, and over twenty of the cantonment-type facilities transferred to the Veterans Administration

[273] The army hospital (McCloskey) in Temple, Texas, is an example of this semi-permanent cantonment facility, as are the army hospitals built in Clinton, Iowa, and Memphis, Tennessee. Smith, Table 15, 308-09, 311.
[274] Regarding the flexibility in bed count (or hospital size), Smith, 14.
[275] On the modifications for anticipated use by the VA, see Smith, 76 and Section E, above.
[276] Summary of the cantonment-type extracted from Smith, 68-78. The Surgeon General contracted with a private firm, York and Sawyer, to modify the cantonment plans (a standard plan developed in the 1930s) for contemporary needs. Forty-nine drawings provided plans for a number of buildings that made up the army hospital, such as wards, clinics, administrative offices, storage, dining facilities, and housing for military personnel, and in various combinations, these plans were the basis of hospitals of all sizes.

when the army began shedding surplus property after the war.[277] World War II naval hospitals followed similar design trends, but fewer hospitals shifted to the custody of the Veterans Administration after the war because the navy tended to construct their hospital centers as part of larger installations, not separate properties. Two naval hospitals were included in the survey and evaluation work completed for the *United States Third Generation Veterans Hospitals* study, one in Long Beach, California, and one in Dublin, Georgia.

Figure 25. Aerial view of the Veterans Administration Hospital, Dublin, Georgia (VA).

[277] Of the twelve constructed to the "Type A" plan, four were transferred (Baker, Birmingham, Crile, Cushing) as well as McGuire and Hines. Smith, 76, note 34; Appendix C, below.

Note: The "over twenty" hospitals referenced in the text here refer to the U.S. Army facilities in the United States during World War II as listed in Smith, Table 15, 304-13. Twenty-five were transferred, including three wherein the VA received a shared portion of the hospital – with the navy or public housing, for example; most were cantonment-type constructed in wood although examples of the type in brick, cinder block, and tile existed. Foster General Hospital in Jackson, Mississippi, was also built to the "Type A" plan, but in brick, and was transferred to the VA. It is unclear why it was not included in the list with the other twelve in the report (Smith, 76, note 34). Perhaps the difference in building material accounts for it.

For the list of military facilities transferred to the Veterans Administration after World War II, please see Appendix C. Of the initial army hospital centers that remained open in the VA network at the time of the nomination preparation, three were surveyed: Fort Meade, South Dakota; Martinsburg, West Virginia; and Temple, Texas.[278]

A representative example of this Army/Navy subtype of *United States Third Generation Veterans Hospital* is the Carl Vinson VA Medical Center in Dublin, Georgia. The Dublin hospital center consists of a network of low rise, red brick buildings constructed by the navy between 1943 and 1945. While the majority of the interiors have been altered, the original campus plan survives. The main administration building with its Colonial Revival detailing serves as the central organizing feature for the campus (Figure 26). Patient treatment buildings are arranged in a chevron pattern behind the main building and linked via a series of connecting corridors (Figure 25). Support facilities, such as the boiler house and laundry, are removed from the main healthcare facilities. The facility remains highly intact from the navy period, retaining the original campus layout and many architectural details and presenting few modern intrusions.

Figure 26. Main hospital building, Dublin, Georgia (VA).

Significance

The transitional hospitals are significant under the National Register of Historic Places Criterion A for their association with health care and medicine, particularly the advancement of research and development of therapies

[278] The VA medical center in Butler, Pennsylvania, is included on the list in Appendix C but is categorized here as another subtype because of its development by the Commonwealth of Pennsylvania. Nor is it a cantonment-type hospital.

and treatment protocols by the Veterans Administration in the aftermath of World War II.[279] The built expression of the Veterans Administration's postwar medical care was the urban, multistory main hospital building that technological advancements such as the elevator made possible. However dramatic the shift in location and form would be in the newly constructed hospital centers, the transitional facilities are lynchpins in the revolution led by the administrator of the VA, General Omar Bradley, in 1946. Just as the army did as the war began, the Veterans Administration did as the war ended – the VA adapted and reused existing facilities while defining a standard plan for new construction that would symbolize modernity and satisfy contemporary needs. The first hospitals in this postwar generation were those developed by the military and then transferred to the Veterans Administration, and their significance is further underscored by the dialogue between the Surgeon General and the VA about the cantonment hospital design and long-term use of the facilities as active-duty soldiers became veterans and their medical conditions persisted.

Registration Requirements

Because the Army/Navy Hospitals were built during World War II by the military, before becoming a crucial part of the Veterans Administration's postwar health care network, the buildings are also part of a continuum of military hospital construction. This continuum was elucidated in a Department of Defense Legacy Resource Management study of military hospital construction completed in 2008.[280] Results of the study revealed that none of the temporary hospitals developed during World War I are extant, but several of the interwar period facilities exist and these informed the Office of the Surgeon General's revision of the cantonment model then in use into the "Type A" template of the early 1940s. The characteristics of the military hospitals built between 1921 and 1940 include a headquarters building, a pavilion plan, covered or enclosed corridors, and support buildings placed to the rear of the property. The pavilion plan was used in military hospital design from the Civil War to World War II for general hospital installations; the plan called for separate wards connected by walkways or corridors. Each ward or pavilion was one or two stories tall. A modification of the pavilion plan into one large building with the administrative functions in the central block and patient wards in flanking wings proved the most popular.[281] This three-part classical architectural form characterized the VA's second generation of veterans' hospitals that were constructed at the same time as the military's interwar period buildings. The sprawling campus generated by the pavilion layout is also characteristic of both installations.

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[279] Here, for example, the hospital in Dublin, Georgia, was home to research in rheumatic fever during World War II and medical advancements in treatment followed; architecturally the Colonial Revival campus is also significant and so is considered under National Register Criterion C as well.
[280] Adam Smith and Sunny Stone, *Department of Defense, Legacy Resource Management Program: Military Hospitals Historic Context*, U.S. Army Corps of Engineers, Engineer Research and Development Center, June 2008.
[281] Smith and Stone, 4-5, 279-80.

Few of the World War II military hospitals survive in terms of scale and integrity to the period; those under the purview of the Department of Defense were determined eligible for the National Register under an agreement crafted in 1986 to mitigate the temporary facilities before the congressionally-mandated demolition. The loss of the Department of Defense cantonment hospitals accentuates the importance of those conscripted by the Veterans Administration for its postwar medical program; however, the architectural landscape of those hospitals - the transitional hospital subtype – is provided in the 2008 study. With comparable examples of the cantonment hospital catalogued in the study, the hospitals administered by the VA can be evaluated for listing in the National Register under the third generation of veterans' hospitals context. [282] As cantonment hospitals, the pavilion plan positioned the administration building at the front of the campus, often in the center, facing the internal drive and the ancillary or support buildings at the back of the property. The support buildings were those used for storage or laundry and the power plant. Near the administration building at the front of the campus were additional administrative buildings, barracks, and officers' quarters. Patient wards, kitchens, and dining (mess) facilities filled the spaces in-between.[283] Scale and site layout are essential to understand for evaluating the properties, especially in terms of integrity of design, setting, materials, and feeling, thus a number of the buildings on the property must survive and, specifically, these must be:

-Administration Building;
-Surgery Building;
-A number of patient wards; and
-Enclosed corridors.

Without these features, the property is ineligible for listing in the National Register. The condition or survival of the other buildings on the cantonment hospital campus, such as the mess halls or dining facilities, kitchens, recreation and day rooms or halls, barracks, and laundries, is less important for purposes of evaluation for listing in the National Register, according to the Department of Defense study of military hospitals that provides the architectural context for those that launched the VA's third generation of veterans' hospital centers.[284]

For the third generation of veterans' hospitals, these transitional hospitals of the Army/Navy subtype must have a majority of the original buildings in place on the property, including the administration and surgery buildings,

[282] Smith and Stone, 280.
[283] Smith and Stone, 222.
[284] Adam Smith and Sunny Stone, *Department of Defense, Legacy Resource Management Program: Military Hospitals Historic Context*, U.S. Army Corps of Engineers, Engineer Research and Development Center, June 2008.

enclosed corridors, and patient wards, and in their original locations in order to convey intention of design and integrity in location and setting. Integrity is measured by scale – degree of change to the extant buildings and circulation patterns and if the initial site layout is intact. Because these hospitals are the products of a standard plan, and important as the bridge between hospitals built in times of war by the military and the inauguration of new phase of veterans' health care after World War II by the Veterans Administration, they are unlikely to eligible for listing for their architectural design or construction under the National Register of Historic Places Criterion C. Their associative significance with the federal government's third generation of veterans' hospitals is paramount, and the physical features collectively speak to that rather than as hallmarks of architectural design. The architecture of the cantonment-type hospital reflects its military origin rather than a particular time period and its construction method is similarly hard to classify temporally. Thus the eligibility of the Army/Navy Hospital subtype for listing in the National Register is considered under Criterion A for the *United States Third Generation Veterans Hospitals, 1946-1958*.

Subtype: Expanded Second Generation Hospitals

Description

When General Omar Bradley announced the Veterans Administration's new hospital program in 1946, several hospitals were already in various stages of planning and construction. These became the foil for the Veterans Administration hospital of the postwar era. In what was, by then, familiar visual language in architectural design, historicism gave way to midcentury modernism in building style, while technological advances such as electricity freed interior floor plans from available natural light and elevators solved concerns around accessibility and floor-to-floor transport. Aesthetic and technological shifts suited the modern hospital architectural concept in its symbolic break with past Veterans Administration facilities, i.e., the National Homes and post-World War I campuses. New buildings that *looked* new housed research centers and those centers connected the Veterans Administration's doctors to those in private practice as studies improved prosthetics and stamped out tuberculosis, for example. Advancements were also made in cardiac care and identifying causes of lung cancer. Yet the hospitals built in revival styles of architecture remained open, readily identifiable as the World War I-era campuses; of those "second generation" of veterans' hospitals initiated as Bradley arrived at the Veterans Administration, two were pulled into his modernizing program and so are considered in that later context.[285]

[285] The second generation of veterans' hospitals was built from 1919 to 1950, and the multiple property nomination, *United States Second Generation Veterans Hospitals, 1919-1950*, listed in the National Register in 2012. See Spurlock et al., and summary above.

This subtype of transitional hospital is rare. Just two medical centers fall within the Expanded Second Generation category for listing in the National Register of Historic Places under the postwar or third generation context of veterans' hospitals: West Roxbury, Massachusetts, and Montrose, New York.[286] Others authorized under the Veterans Administration's second generation of hospitals were completed in the 1940s as well, but were further along in the construction phase when Bradley came onboard. As the last hospital campuses built under the prescription of the second generation were completed, new medical centers were proposed and approved. This caused an overlap that created confusion regarding numbers and locations of facilities built, added onto, or closed and possibly reopened. Eighty new hospitals were heralded in 1946 for the postwar building campaign, and the figure was almost immediately conflated with all of the VA's hospitals and reported as 183, just as an example.[287]

Like the military hospitals transferred to the Veterans Administration, the second generation of veterans' hospitals were authorized before Bradley's time and so the planning and design for them followed that established after World War I and constructed from 1919 through 1950. The VA's second generation hospitals subscribed to similar philosophies regarding healthcare and medical treatment as the military's interwar hospitals (1921-1940) and so the pavilion principle of design is found in both. For the Veterans Administration, the second generation of veterans' hospital design required large parcels of land in rural locations for its campuses.[288] The campus layout included landscaped portions close to the buildings and sections reserved for agricultural and therapeutic gardening endeavors. The developed part of the campus consisted of low-scale buildings organized around a central greenspace, with the most prominent housing the administrative offices and the support service buildings generally placed at the periphery. Buildings for patient care clustered around the administrative building, and inside, the wards were large with twenty-six or more beds. Yet the total number of hospital beds generally was limited to five hundred per facility, any more was considered too unwieldy to manage at the time.[289] The rural

[286] Both are referenced in the multiple property submission, *United States Second Generation Veterans Hospitals, 1919-1950*, and were determined eligible for listing in the National Register in the early 1980s, before either multiple property study was conducted and before any in-house periodization of the resources occurred. See Spurlock, et al., Section F, 98, and Appendix, 125, 129. While their physical features are in step with the second generation formula, and in the case of West Roxbury, determined eligible for listing under Criterion C, the interior spatial arrangement and medical program reflect those of the third generation and so the two are seminal in the transition that occurred in healthcare after World War II and in the VA's hospital design and construction. Tomah, in Wisconsin, fits within the second generation of veterans' hospitals and is referenced in the multiple property submission as one of the first of the second generation hospitals completed by the Veterans Administration under Bradley; Montrose was the last. Spurlock et al., Section F, 98. (Also, *Annual Report* 1947, 10-11). However, because of its transfer to the VA from the Bureau of Indian Affairs initially, and the presence of the earlier campus, Tomah is considered under the third transitional hospital subtype for the purposes of this nomination.

[287] "Veterans Will Get 183 New Hospitals," *New York Times*, February 17, 1946; and note above.

[288] During the second generation program, selecting the locations of the hospitals became politicized and significance of the choice has two sides – one contextual as part of the tainted reputation that the third generation was initiated to counter and other more retrospective as a contemporary consideration of significance (politics/government) under Criterion A along with health care and medicine. Not all third generation veterans' hospitals were immune, as the architectural form at East Orange, New Jersey, suggests and the location of the hospital in Bonham, Texas, attests.

[289] Spurlock, et al., Section E, 41.

location of the large medical campus also fit well for psychiatric patients for whom seclusion and quiet were thought to be essential elements of treatment.

The Veterans Administration introduced three kinds of hospitals during its second generation of hospital design: neuropsychiatric, tuberculosis, and general medical and surgical facilities.[290] The layout for neuropsychiatric hospitals was guided by the courtyard and the various buildings making up the hospital faced onto one. Buildings of the hospital included a main administrative building, plus multiple two-story buildings dedicated to specific types of patient care; kitchen, dining, and recreation facilities; residential quarters; connecting corridors; and support facilities, such as the boiler house, water tower, and carpentry shops. The tuberculosis hospitals included a main building housing both administrative and healthcare functions, as well as the complement of other buildings resembling the facilities found at neuropsychiatric hospitals of the period. The general medical and surgical hospitals adopted an H-shaped central building, which accommodated the majority of the hospital functions, including administrative offices and clinical spaces. The three hospital designations - neurological, tuberculosis, and general medical and surgical – remained in effect as the World War I generation of buildings gave way to World War II and Korea era of veterans' hospitals.

In the Expanded Second Generation Hospital, the medical centers operated according to the programmatic requirements developed by the Veterans Administration after World War II. Aesthetic elements, such as the use of revival styles of architecture on the main building of the hospital campus looked back to the 1920s but the interior organization of the main hospital was influenced by electricity and elevators and so operating rooms no longer needed to be on the top floor for light and patient wards could be stacked in multiple stories on double loaded corridors rather in cantonment hospital's one-story pavilions spaced some 50' apart. The association with nearby medical schools, such as Harvard University in Boston, and development of specialty centers around research, such as spinal cord injuries in the nearby West Roxbury hospital, are firmly within the VA's third generation program.

The Veterans Administration hospital in Montrose, New York, serves as an exemplar of this transitional type of third generation hospital. Initial planning commenced in 1945. A product of the VA's second generation of

[290] These three classifications of hospital became property types for listing in the National Register of Historic Places under the multiple property submission *United States Second Generation Veterans Hospitals, 1919-1950*, along with the fourth for a transitional type – those hospitals approved and funded as National Homes but built after the second generation construction program went into effect, much like the expanded subtype considered in this cover nomination for the third generation of veterans' hospitals. The property types – i.e., type of hospital campus – were grouped into two periods of development, the first from 1919 through the mid-1920s and the second from the mid-1920s to 1950. The second time period represents the full expression of second generation design. Spurlock et al., Section F, 89-90.

veterans' hospital design, Montrose was built as a neuropsychiatric hospital and the architecture of the institutional campus reflects the Georgian Revival style. The campus contains numerous low-rise structures sprawling across the property. The admissions building is flanked by paired courtyards which are each surrounded by six patient buildings (Figure 27). Other buildings on the campus include a kitchen, a director's house, recreation facilities, a boat house, and a building designated solely for the care of female patients. The courtyard plan belongs to the second generation of veterans' hospital, but inside, the floorplan reflects the trends of modern hospital design that shaped the third generation of Veterans Administration hospitals. Even at the scale of Montrose – the largest of the third generation constructed – individual patient rooms and fewer large wards defined the floors (see Figure 18).[291] The stylistic elements also played a less important role on the buildings, with most detail applied to the main admissions building and virtually none on the ancillary buildings.

Figure 27. Aerial view of the Veterans Administration Hospital, Montrose, New York (VA).

[291] In terms of the number of beds, Montrose was the largest hospital of the third generation, originally designed for 1,984 beds for psychiatric patients, more than 600 beds larger than the next largest hospital planned for Pittsburgh, Pennsylvania.

Significance

The transitional hospitals are significant under the National Register of Historic Places Criterion A for their association with health care and medicine, particularly the advancement of research and development of therapies and treatment protocols by the Veterans Administration in the aftermath of World War II. The built expression of the Veterans Administration's postwar medical care was the urban, multistory main hospital building that technological advancements such as the elevator made possible. However dramatic the shift in location and form would be in the newly constructed hospital centers, the transitional facilities are lynchpins in the revolution led by the administrator of the VA, General Omar Bradley, in 1946. The Expanded Second Generation Hospital is an important part of the VA's modern medicine, modern medical center campaign that followed the Second World War. Like the cantonment hospital transferred from the military, these in-house transitional hospitals provided state of the art care on campuses initially conceived along the lines of the pavilion plan – low-rise and large acreage. Transitional hospitals are liminal by definition, yet the expanded second generation models proved integral to the VA's emerging hospital program as approaches to medical research and treatment evolved and in turn shaped the spaces in which medicine was administered during the postwar years.

The built form and style of the Expanded Second Generation Hospital subtype may make the individual medical center eligible for listing in the National Register of Historic Places under Criterion C for architecture as well, if distinctive characteristics for time and place or construction method exist, such as the West Roxbury hospital campus with its strong visual relationship to the architecture of the Harvard University campus. Campus architecture is a defining feature of the second generation of veterans' hospitals and so of this subtype; for significance under Criterion C, the Expanded Second Generation Hospital must have a revival style that unifies all the buildings of the campus in exterior detail and material and identifies them relationally by level of ornament or expression of the architectural style. Hierarchal cues were used in the colonial and early national periods, signaling which room or which building was the most important or which was a public space and which was service oriented by size, decoration, and material finish. The revival styles adopted for the hospital campuses followed suit – the degree of ornament corresponded to function and contributed to the cohesion of the architectural assemblage of the institution, as described for Montrose above. The hospital campus itself was made of a number of detached buildings placed within a naturalistic landscape design, and this site layout and landscaping must also be evident.[292]

[292] Spurlock et al., Section F, 99. Like Montrose, Tomah also has an architectural cohesion and was a second generation design completed and opened for World War II veterans, placing it within Bradley's campaign parameters. Its architectural character looked back to the second generation campus plan with a number of detached buildings grouped by function and built in the Classical Revival style of

Registration Requirements

The built form of modern medicine took longer to construct than the implementation of partnerships and research studies initiated under General Omar Bradley that would improve how medical care was provided to veterans. Thus, the transitional hospital, specifically the Expanded Second Generation subtype, is significant for its association with healthcare and medicine following World War II and its physical characteristics reflect that moment of transformation within the Veterans Administration as one hospital form gave way to another in the late 1940s. Planned under the design program for the second generation of veterans' hospitals, this property subtype aligns with those described under the multiple property submission, *United States Second Generation Veterans Hospitals, 1919-1950*, to the National Register of Historic Places and the registration requirements for the subtype are largely drawn from that study.

To be eligible for listing in the National Register of Historic Places, the properties must have been designed, constructed, and used by the federal government between 1919 and 1950 "for the primary purpose of providing general medical, surgical, respiratory, neurological, and extended care to veterans of the [nation's] armed forces."[293] The cohesion of the campus is especially important for National Register Criteria A and C and is the measure of integrity for the hospitals. All of the resources on the property must be related one another through a shared purpose and development, as well as visually in terms of design and materials (interpreted as architectural style). The use of the Colonial Revival style, or another derivative of classicism, for the aesthetic and massing of the hospital buildings was a deliberate choice to show patriotism through an affiliation with the architecture in vogue in the United States ca. 1800. The historicizing form and traditional building materials, such as brick, recalled the civic signature of the young democracy as well as the range of domestic architecture seen on the city streets.[294] The original details that identify the architectural style and materials used in the veterans' hospitals are, therefore, important characteristics of this property type, and especially for consideration of significance under Criterion C.

architecture. The buildings had an H-shaped footprint and were connected by corridors. The transitional phase bookended by Tomah and Montrose – as the VA's second generation gave way to the third – is referenced by Spurlock et al., and taken up in this nomination.

[293] The registration requirements are summarized from Spurlock et al., Section F, 98-107, quotation, 98.

[294] Given the time period (1919-1950) of the second generation of veterans' hospitals, regionalism was an important force in architectural design and in the choice of stylistic elements. In the southwest, details and materials taken from the Spanish Revival were used; whereas in Marion, Illinois, the Egyptian Revival was adopted for the campus. Here, the two properties of this subtype included in the survey, one located in New York and the other in Boston, it is the legacy of British Colonial America and the filtering of Italian Renaissance treatises through London that influenced the regional architectural landscape.

The arrangement of the buildings within the campus must be by function – historically and in the present – and the topographical features that enhanced the initial site selection must also be visible. The main building was typically placed on a hill, for example, and so its main elevation should still be a focal point from the internal drive. Neither additions to the building itself nor alterations to the surrounding landscape should obscure it. The number of buildings that are extant may vary, and not impact eligibility, as the numbers of buildings for each type of second-generation hospital varied at the time of construction and throughout the period of significance. The general medical and surgical hospitals were smaller in campus size and in building requirements, for instance. Regardless of size, landscaping elements such as mature trees and cultivated vistas must remain for a campus to be eligible for listing in the National Register; open space, initially green, may be altered for parking or converted to athletic fields as long as the viewsheds are intact. Surface coverings may change, in other words, making pavement more sympathetic than a multi-story parking deck as long as the cumulative effect of modernization and accommodation does not overwhelm the historic campus and so then its integrity in the period of significance.

For transitional hospitals of this subtype to retain integrity they must be in their original location and designed, built, and used by the federal government as veterans' hospitals during the period of significance. Moreover, a number of the buildings must be in-situ and retain their architectural style and proportion to convey the overall scale of the campus and the designed setting that defined hospital construction by the Veterans Administration after World War I. The main building of the hospital is essential to evaluating integrity. It must be recognizable in mass and form, and its primary elevation intact for the campus to be eligible for listing in the National Register of Historic Places. The integrity of design and setting is understood in terms of architectural and spatial relationships that include the detailing of and materials in the buildings of the Expanded Second Generation Hospital subtype as well as landscaping and circulation patterns and is evaluated by degree of change and how those alterations overlay the historic fabric and site plan. Here, the visibility of additions, parking lots, and utility buildings are considered, as well as the preservation of courtyards and other open spaces, of the character of the main entrance and vegetation, and if the buildings continue to be grouped by function in the campus plan. Materials and workmanship are also tied to physical characteristics, and integrity rests on the scope of replaced elements, such as windows, doors, and roofing, and in modernization efforts, such as the removal of cupolas and towers, enclosure of porches, changes to entrance awnings, and addition of ramps and elevators. If the main building of the hospital campus does not retain integrity of materials and workmanship, then the eligibility of the campus for listing in the National Register of Historic Places is impaired for the overall effect that building has on the integrity of feeling and association. In sum, the Expanded Second Generation Hospital subtype must retain:

-a focus on the main building, typically administrative in function;
-architectural cohesion in style (mass, form, ornament, material) and hierarchal detailing that corresponds to building function;
-buildings of the campus grouped by function, i.e., patient care versus power plant; and
-mature landscaping and open spaces that contribute to the campus-like setting.

The patient buildings typically had an H-shaped footprint, and the hospital campuses all had a flag pole placed in proximity to the entry. These should be present; however, changes to interior finishes, shifts in building use or in location of the flag pole, and the enclosure of porches or an addition of recreational facilities do not automatically make a property ineligible. A loss of land or of acreage held could impact integrity of the hospital campus and so should be considered along with other alterations to the architectural landscape for cumulative effect.

Subtype: Third Party Hospitals
Description

Transitional hospitals are those pressed into service by the Veterans Administration under the leadership of General Omar Bradley. As the administrator of the VA, Bradley reshaped how the government's hospitals for veterans developed between 1946 and 1958. While new Veterans Administration medical centers were designed and built, existing facilities were converted to use. These came from within the Veterans Administration as its in-progress, design and build hospital projects were completed, as happened in New York and Massachusetts, and from the military, including the cantonment-type hospital constructed during times of war from the nineteenth century through World War II and including those the military had impressed while it erected the cantonments. This last example is the subtype known as the Third Party Hospital for the purposes of this multiple property documentation form for the *United States Third Generation Veterans Hospitals, 1946-1958*. Three were included in the survey for this nomination: Butler, Pennsylvania; Sioux Falls, South Dakota; and Tomah, Wisconsin. The Butler campus was designed as a tuberculosis sanatorium in the 1930s, but never served as one before the army acquired it from Pennsylvania and passed it through to the Veterans Administration.[295] Similarly, the Tomah hospital campus was appropriated by the army from the Bureau of Indian Affairs, who operated the facility as a school since the 1890s. The Veterans Administration took it over in the mid-1940s and constructed additional buildings on the campus. The hospital in Sioux Falls, South Dakota, was created from a 1920s era collegiate campus. The college buildings were Gothic Revival in style as befitting the initial occupants, who were catholic.

[295] Just as an example of the one-off application of criteria for each campus, the Butler, Pennsylvania, veterans' hospital resonates on the state level because of its architectural form and for its service to Pennsylvania veterans.

The Veterans Administration added on to all three third-party hospital campuses and folded them into Bradley's modernization effort (Figure 28).

Figure 28. Architectural rendering of the main hospital building, Sioux Falls, South Dakota (top) and aerial view looking east to show the service buildings and rear of the main hospital during construction in 1948 (VA).

Significance

The transitional hospitals are significant under the National Register of Historic Places Criterion A for their association with health care and medicine after World War II. The built expression of the Veterans Administration's postwar medical care was the urban, multistory main hospital building that technological advancements such as the elevator made possible. However dramatic the shift in location and form would be in the newly constructed hospital centers, the transitional facilities are lynchpins in the revolution led by the administrator of the VA, General Omar Bradley, in 1946. The Third Party Hospital is an important part of the Veterans Administration's modernization campaign. Like the cantonment hospital transferred to the VA from the military, these transitional hospitals provided state of the art care on campuses initially constructed for another entity and purpose. Transitional hospitals are liminal by definition, yet the Third Party Hospital proved integral to the Veterans Administration's emerging hospital program as the spaces in which medicine was administered matured during the postwar years.

Third Party Hospitals may also be eligible for listing in the National Register of Historic Places under Criterion C for architecture as well as Criterion A, if distinctive characteristics for time and place or construction method exist, such as the Tomah hospital campus composed of buildings in the Classical Revival style or the Butler campus potentially as an example of the work of western Pennsylvania architect Edward B. Lee (Figure 29). The campus plan of the Third Party Hospital consists of a number of detached buildings linked by a common purpose – a new hospital in an older setting – and continuities in architectural style that reflect change in stewardship and the associated modernization efforts under Bradley. Physical characteristics of the Veterans Administration's imprint on the existing campuses of the Third Party Hospital subtype are reminiscent of those it created for the Expanded Second Generation Hospital, especially for building hierarchy and placement and for architectural form and ornament.

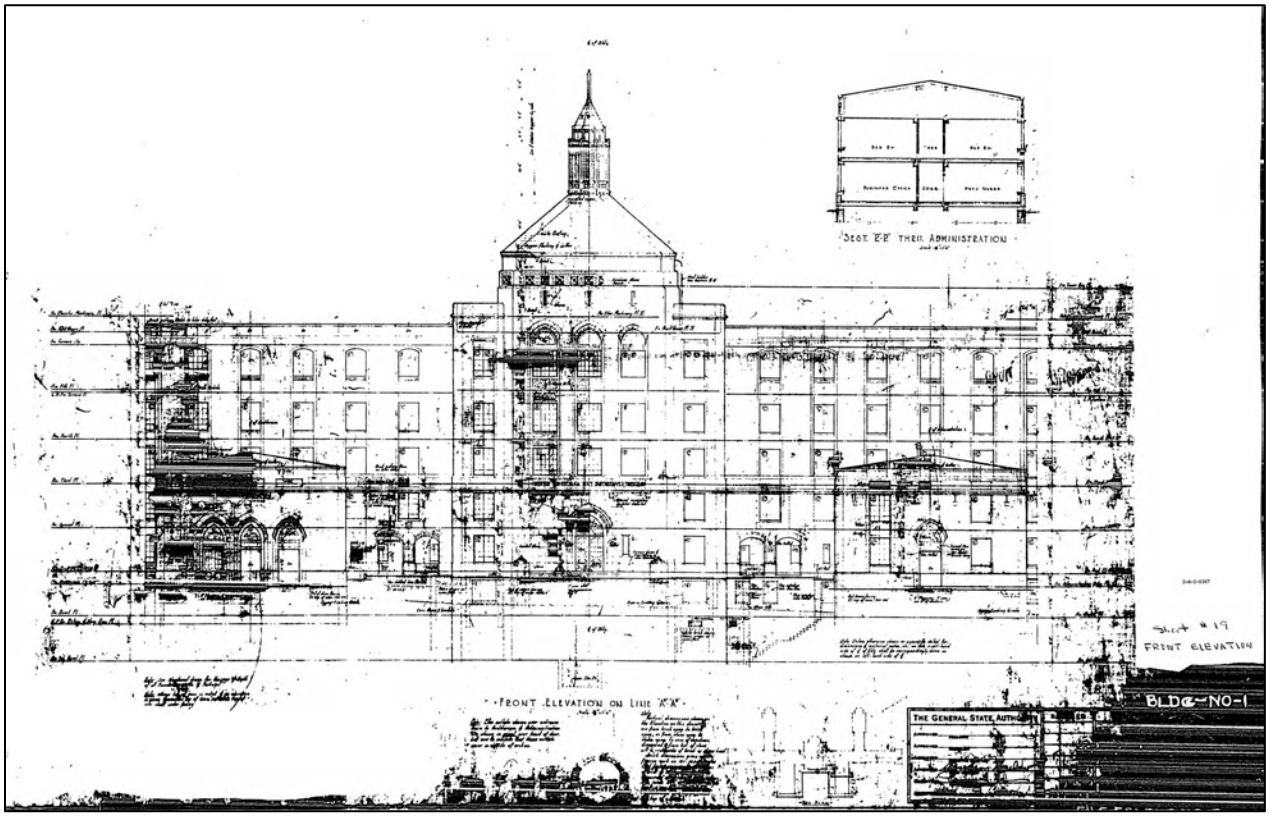


Figure 29. Front elevation, main hospital building, Butler, Pennsylvania (VA).

Registration Requirements

While the built form of modern medicine initiated under General Omar Bradley that improved how medical care was provided to veterans was constructed, transitional hospitals filled a need. The architectural interventions of the Veterans Administration in the existing campuses of the Third Party Hospital subtype belong to the larger dialogue about the appearance and plan of modern hospitals taking place throughout the healthcare industry nationwide at the time. Thus, the hybrid Third Party Hospital represents a pivotal moment in the transformation of one hospital format to another in the postwar era. Architects for the Veterans Administration planned additions to existing campuses using the design protocol for the government's second generation of veterans' hospitals. These hospital designs were developed after World War I and are described the multiple property submission, *United States Second Generation Veterans Hospitals, 1919-1950*, to the National Register of Historic Places.[296] Registration requirements for the Third Party Hospitals are derived from that study since the Veterans Administration drew from those ideals when repurposing campus installations for veterans' use as Bradley's campaign commenced.

[296] Spurlock et al., Section F, 98-107.

To be eligible for listing in the National Register of Historic Places, the properties must retain a cohesive building set from the period of significance that reflects the campus' initial architectural character and site plan. For example, in Sioux Falls, the Veterans Administration adopted the Gothic Revival for its additions to the college campus, choosing to complement the existing form and ornament for the overall integrity of design, feeling, and association of the campus rather than erect a modern tower in that context. In Tomah, the generous space between buildings gives the campus a more rural feeling that is in keeping with the post-World War I facilities and the roadways separate the school buildings from the classically derived Veterans Administration buildings erected for patient care. This effectively recreated the pattern of clustering buildings by function that was repeated throughout the second generation of veterans' hospitals. The survival of the campus setting, particularly the site layout and circulation patterns, is especially important for National Register Criteria A and C. It is also the primary measure of integrity. Architectural style of the buildings follows the revivals favored by the Veterans Administration for the post World War I hospitals and the modified pavilion – or the classically inspired building plan consisting of a central block and flanking wings – typical for the main building and focal point of the campus. The footprint of that building generally was an "H." Brick facing was used for the exteriors, in keeping with historical materials and revival architectural detailing. This main building of the Third Party Hospital must be extant and retain integrity for the campus to be eligible for listing under Criterion A or C. To be eligible for listing in the National Register, each hospital campus must retain:

-a cohesive campus plan and circulation patterns;
-the main building of the campus (typically with an H-shaped footprint); and
-a number of buildings from the period of significance, including the legacy buildings on the property transferred to the Veterans Administration and those for patient care.

Similar to the Army/Navy Hospital and Expanded Second Generation Hospital, the Third Party Hospital is evaluated in terms of cumulative effect of change over time on the architectural landscape and its integrity of design, setting, workmanship, materials, feeling, and association. However, each hospital campus must be in its original location to retain integrity and so be eligible for listing in the National Register under either criterion of significance. Integrity of workmanship and materials is impacted by change to the buildings, and eligibility can be impacted if additions obscure the primary elevations or if architectural details that convey style and time period are lost. If the modernization efforts overwhelm the historic fabric and massing through the introduction of unsympathetic materials in the whole-scale replacement of windows and doors and roofing, or in the placement of

equipment towers for mechanical needs, of towers for stairs and elevators, of ramps or emergency entrances, and of new entrance pavilions than these improvements negatively impact the integrity of the building. Similarly, infill between building wings impacts integrity because it alters the form, massing, and spatial relationships of the historic building and plan, whereas expansions to the rear of a building, specifically the main building with its H-shaped footprint, generally does not. This is because the rear additions are usually constructed with respect to the building's height and materials, and the H-shaped footprint remains visible in roofline and in monumental scale. The sliding scale of change is illustrated at Tomah, Wisconsin, where a new, small-scale entrance was constructed to the side and yet the primacy of the central block remains intact architecturally (Figure 30). Considerations of integrity of design, setting, feeling, and association are grounded in the campus plan and if the original site layout, circulation patterns, spatial relationships, and landscaping (whether mature trees or naturalistic features or water elements or minimal vegetation) are evident through the changes overlaid by time.

Figure 30. View of the façade of the main building in Tomah, Wisconsin, 2015 (VA).

New Hospitals

New construction under the federal government's third generation, veterans' hospital program defines the other two property types for this multiple property submission to the National Register of Historic Places. The first "New Hospital" property type is the architect-designed, U.S. Army Corps of Engineers-built hospital campus and the second is the Veterans Administration standard. Under the property type described as the "New Hospitals Designed by the Veterans Administration" are two subtypes: the VA Standard Plan and the Haun-type. The latter refers to neuropsychiatric hospitals. The distinction with the Haun-type references the property types identified in the contextual study, *United States Second Generation Veterans Hospitals, 1919-1950*, that highlighted the categories of hospital by patient focus, meaning either general medical and surgical or tuberculosis or neuropsychiatric, however, for the Veterans Administration's third generation hospitals, the registration requirements for new hospital construction are same. This is because the primary distinction of the new building campaign lies in its break with the World War I –era hospitals that the public associated with outdated facilities. Moreover, the guidelines the Veterans Administration created for its third generation hospital construction program in response to that perception framed all the new projects. The guidelines allowed for ingenuity in design, as represented in the partnership between private architects and the Corps of Engineers, well as through the collaboration between VA staff and medical personnel that produced standard plans to use as the program progressed. The Veterans Administration staff adapted the guidelines for a set of plans to be used as needed in multiple cities when costs of the new designs through the Corps of Engineers proved larger than anticipated. They also developed a plan for neuropsychiatric centers based on the recommendations from the medical field and by representatives from within the agency's branches of construction and medical services. The recommendations were presented by a committee spearheaded by Dr. Paul Haun, a well-known psychiatrist and proponent of recreational programs in patient therapies.[297] Committee members included Topeka, Kansas, based doctors Karl Menninger and Will Menninger. The Menninger family advanced psychiatric medicine and training for medical staff to treat patients in the early twentieth century and were involved with the VA hospital in Topeka for many years (Figure 31).[298]

[297] See the review of Haun's *Recreation: A Medical Viewpoin*t (New York: Bureau of Publications, Teachers' College, Columbia University, 1965) by I. Atkin in *British Journal of Psychiatry* 111, No. 477 (August 1965): 786 (online January 29, 2018, see https://doi.org/10.1192/bjp.111.477.786, accessed February 13, 2018).

[298] The Menninger family established the Menninger Foundation in the early twentieth century, and it consisted of a clinic, sanatorium and school. Karl Menninger was instrumental in the development of the Winter Veterans Administration Hospital in Topeka, that would become the largest psychiatric training center in the world, and was a force behind the building of the Haun-type hospital in 1958 to succeed Winter. For more information on Menninger, see "Karl Menninger, 96, Dies; Leader in U.S. Psychiatry," *New York Times*, July 19, 1990 (www.nytimes.com, accessed February 13, 2018), and "Karl Menninger," entry in *Kansapedia* (2011, rev. 2016) by the Kansas

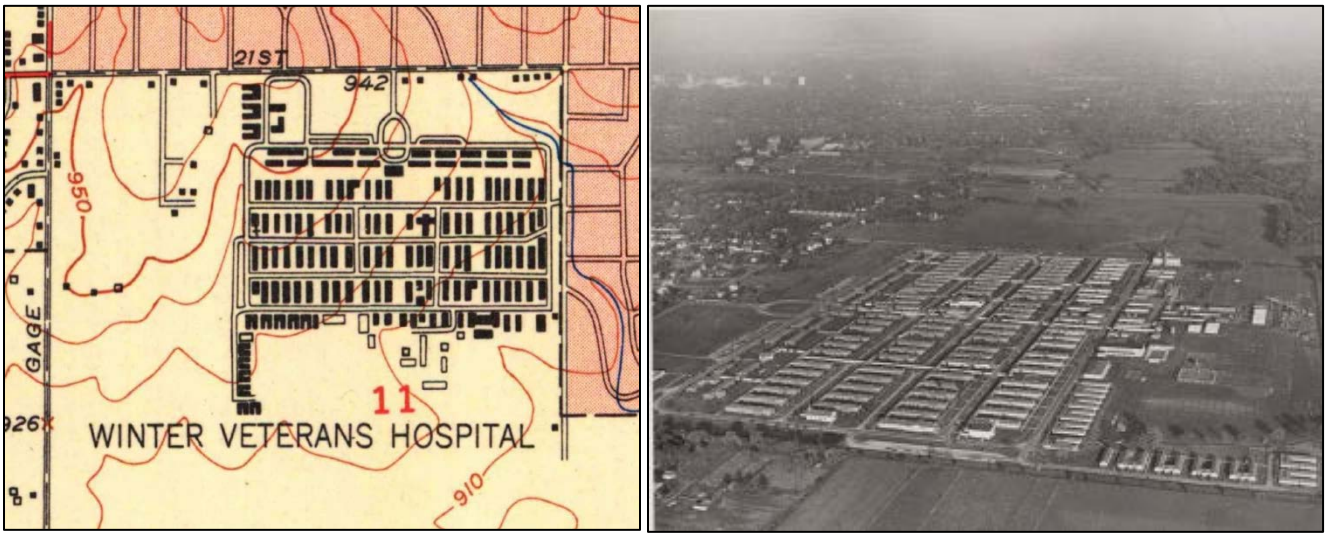


Figure 31. (left) Topographical map showing Winter Veterans Hospital in Topeka, Kansas, 1951 (VA), and (right) aerial view of the hospital (kansasmemory.org, Kansas State Historical Society, Copy and Reuse Restrictions Apply). This hospital was replaced by the third generation medical center in 1958.

The following characteristics are prevalent in the postwar hospitals built during the Veterans Administration's third generation of construction program and so are identifying markers of these medical centers.

Location

Demographics guided where the Veterans Administration's new hospitals were built and most were located in metropolitan areas with large veteran populations. Even so, local conditions influenced where the medical campuses could be constructed and site selection depended on where land for the medical campuses was available. Therefore some medical campuses were built in the established urban core of a city and some in postwar developments of primarily residential neighborhoods. Goals of the postwar hospital program contributed to this urban/suburban distinction, particularly in the association of the new veterans' hospitals with medical schools that effectively created medical districts such as that found in New Orleans, Louisiana.[299] In 1952, the 500-bed hospital was built on 5.6 acres in the city's downtown. The Veterans Administration created a compact campus, rather than rebuild on its Lake Pontchartrain property, to be close to the medical schools of Tulane University and Louisiana State University as well as the state-run teaching hospital, Charity Hospital. Together, the hospitals formed a center of modern healthcare. Specialized hospitals for the treatment of tuberculosis and

Historical Society (accessed February 13, 2018). Also, Lawrence J. Friedman, *Menninger: The Family and the Clinic* (Lawrence: University Press of Kansas, 1992).

[299] For historical context regarding the medical district and urban planning, see, for example, Jonathan Hughes, "Hospital-City," *Architectural History* 40 (1997): 26-88.

neuropsychiatric patients required larger parcels of real estate, and so, developing areas typically offered more choice even if those locations meant some of the new VA hospitals, like that in Kansas City, Missouri, were not always adjacent to other medical centers in the city. The Kansas City medical campus sat on 48 acres approximately 10 miles southeast of the urban core of the area. The 745-bed hospital was still within reach of transportation services and utilities, and yet distant enough to allay any fears of contagion from tuberculosis. In keeping with the Veterans Administration's third generation program, the Kansas City veterans' hospital was affiliated with the local medical school.

Building Plan and Materials

The showpiece of the new hospitals was the central hospital building. It was located prominently on the property and, from that focal point, rose from four to eighteen stories in height depending on budgeted size for the facility and treatment emphasis. The skyscraper emblem of the modern general medical hospital was a rejection of the politicized, and much criticized, multi-building, vast landscape of earlier Veterans Administration hospitals. The skyscraper form, quantified by bed count, combined patient wards and services in one main building of considerable size, often twelve to fourteen stories and up to 11,000,000 cubic feet, such as the hospital constructed in Pittsburgh, Pennsylvania (Figure 32).

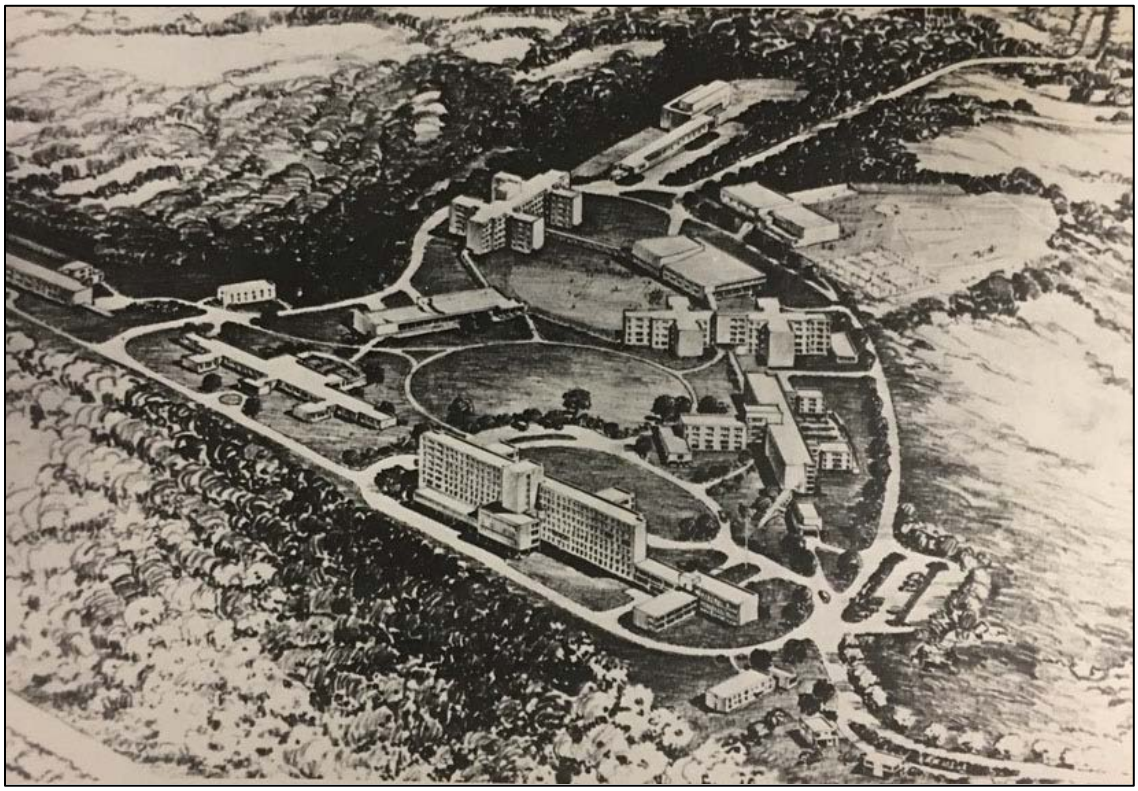


Figure 32. Rendering of the 1250-bed neuropsychiatric hospital planned for Pittsburgh, Pennsylvania (VA).

For the main building of the new veterans' hospitals, some basic organizational tenets prevailed across almost all of the designs for general medical and surgical hospitals, regardless of the architect or firm. The lowest floors, generally the basement and sub-basement, housed mechanical equipment and various support spaces, such as the morgue and storage. The first floor contained the primary spaces for interaction between the patients and the general public, whether they were family visitors, representatives from veterans' organizations, or performers in the auditoriums. Patient care dominated the upper floors. Traditionally, the topmost floors housed neuropsychiatric patients and this facilitated the patients' access to enclosed roof gardens if those amenities were included in the plans. And most of the neuropsychiatric hospitals did. Spatial arrangement of the floors dedicated for general medical services, i.e., not for psychiatric care, was identical in how space was allotted. The central core held the elevators, nurses' station, various offices, treatment rooms, and visitor lobbies. The rest of the central block routinely contained single patient rooms. Larger wards for anywhere from four to sixteen beds filled the end of the hospital wings. Patient rooms extended outward from this nucleus whether contained in a single linear block type building or forming Y-shaped wings in overall floorplan. The floors designated for neuropsychiatric patients tended to have more rooms designated as multi-bed wards and fewer single patient rooms. Many of the neuropsychiatric floors required specific treatment rooms identified within the architectural drawings as "Inhalation Therapy" or "Occupational Therapy" whereas corresponding spaces on the lower floors tended to only be identified as "Treatment and Exam."

The veterans' hospitals of this period focused on service-related medical care. Because the majority of veterans seeking medical treatment were men, the postwar hospitals lacked facilities specifically for the care of women, such as maternity wards. Civilian hospitals provided women with the needed resources, and the Veterans Administration encouraged female veterans to seek those services at their local medical centers. As a result, few of the VA's third generation of veterans' hospitals had designated spaces for the care of female veterans specifically. Those hospitals that did include such facilities often located them in the upper floors, adjacent to the neuropsychiatric wards and removed from the larger patient population. Occasionally, such as at the veterans' hospital in Wilmington, Delaware, the planned women's ward appears in architectural plans and drawings, but the VA never activated the ward.[300]

The Veterans Administration did not construct the postwar hospitals with overtly costly or ostentatious materials. For the most part, the hospitals were constructed using a steel-frame skeleton and faced in brick. Some variations

[300] Reference to this plan is made in Section E, above; a copy of the drawing was not available during the review and revise period (fall/winter of 2017) and so is not included as an illustration here.

in the exterior cladding exist, particularly in the first hospitals built under Bradley's program, and many featured a different material or fenestration pattern on the ground floor level of the main façade. This created a visual platform or base for the massive hospital structure that was visible from the primary approach drive. The main entrance for patients generally was an entrance pavilion that differed in its simplicity from the ornate monumental entrances of earlier generations of federally-sponsored architecture (Figure 33).

Figure 33. Detail view to show entrance pavilion, Veterans Administration Hospital, Ann Arbor, Michigan (VA).

While streamlined exteriors of midcentury modern architecture define the Veterans Administration's third generation of veterans' hospitals, local circumstances sometimes generated idiosyncrasies in the architectural program. For example, in Sioux Falls, South Dakota, the 1920s-era Catholic college designed in the Collegiate Gothic style became the nucleus for the Veterans Administration's new hospital center (see Figure 28). The VA incorporated many of the extant college buildings into the new hospital plan, and so the new buildings conformed to existing architectural style of the older campus. Political patronage also played a role in design decisions, as exemplified by the Veterans Administration hospital in East Orange, New Jersey, that was completed in 1952. The new medical center in East Orange followed the monolithic hospital design typical of the Veterans Administration's third generation program, but the main hospital building had bas relief panels, ornamental light fixtures, and other architectural features representative of the Art Deco style favored by local politicians supporting the project (Figure 34).

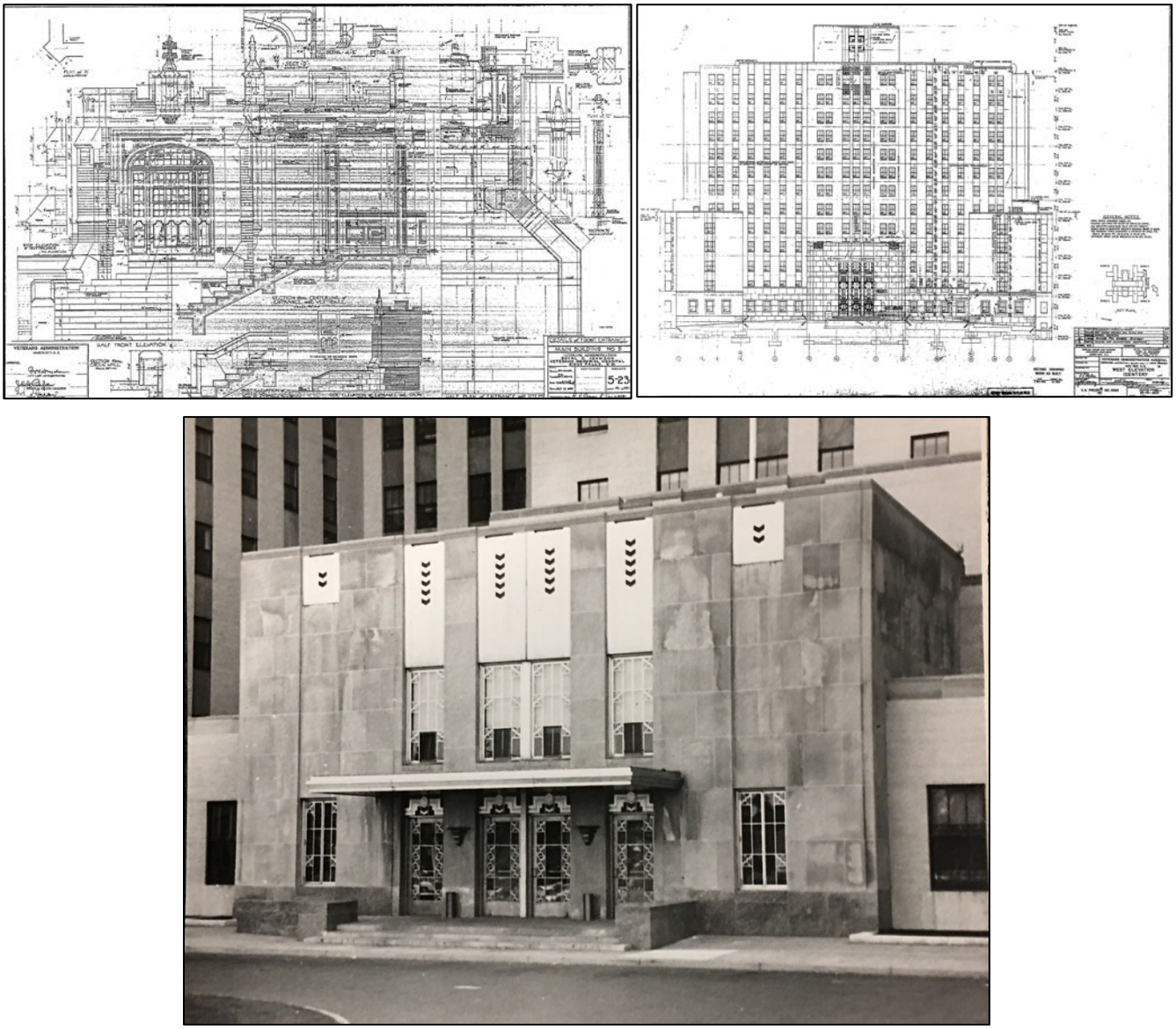


Figure 34. (top left) Detail drawing for the main building at Sioux Falls, South Dakota, reflecting the Collegiate Gothic style of the campus and (top right) elevation drawing for the main hospital building at East Orange, New Jersey; below, detail view of the main entrance, East Orange, New Jersey (VA).

Figure 35. Interior view, elevator bank, Durham, North Carolina (left) and interior view, lobby, Grand Island, Nebraska, ca. 1950 (VA).

The interior finishes followed accepted hospital practices of the period that emphasized durability and ease of cleaning. The upper floors of patient rooms were plainly finished with plaster and painted walls stressing function over decorative features. Design details and ornamental elements were concentrated in the primary public spaces of the main hospital which were the lobby and chapel, and if included in the final plans, an auditorium. The lobby was the principal public space. It was where patients entered the hospital and were then guided to the correct floor via the information desk and nearby banks of elevators. The lobbies were the most formal and stylized spaces within the hospital and were fitted out accordingly. The floors were often terrazzo, rather than the standard asphalt tile, and other materials used included wood paneling and marble accents (Figure 35). The information desk could also be a statement piece, as seen in the extant curvilinear desk in the lobby of the Veterans Administration facility in Bonham, Texas. The desk once housed the hospital's switchboard. Material finishes common in the hospital lobbies were used in the chapels and auditoriums as well, and underscored visually the VA's understanding of the importance of the spaces to the general well-being of veterans, particularly those hospitalized for a length of time during treatment for tuberculosis or neuropsychiatric illnesses. Many chapels had a rotating altar, a feature developed so the space could truly be multidenominational, to ease the preparation for and transition between services for different faiths (Figure 36).

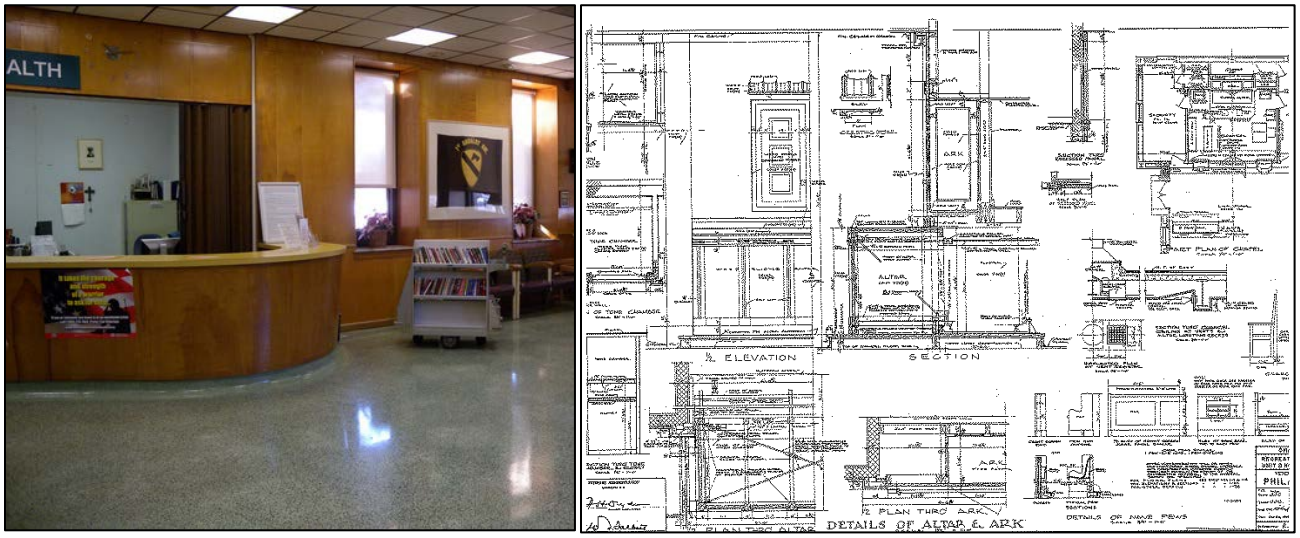


Figure 36. (left) Interior view, lobby area and curvilinear reception desk in the main hospital building at the Bonham, Texas, medical center and (right) details of the chapel, notably the altar and ark, for the Philadelphia hospital building (VA).

The associated support buildings of the medical centers were notably smaller in scale than the main hospital building and often did not exceed two stories in height. Depending on the size of the main hospital, the ancillary buildings almost always included a director's (or manager's) house, quarters for staff, laundry, and boiler plant. While the director's house, staff quarters, and nurses' quarters clustered together in a residential hub, attendants' quarters often were placed on the other side of the hospital campus from this housing enclave. The design of the smaller-scale residential buildings took architectural cues from the main hospital building, meaning the same exterior building materials and ornament were used throughout, albeit scaled down for domestic architectural reference (Figure 37). Similar to the housing enclave, laundries, warehouses, and boiler plants were grouped together around a central parking lot on the larger hospital properties. If the site was sufficiently large, these buildings would be well removed from the main hospital building. This trend tends to be more evident at the neuropsychiatric hospitals whereas, on more compact lots, they were grouped behind the main hospital building. Cladding of the utilitarian buildings corresponded to that used in the exterior treatment of the other buildings on the medical campus. Overall, the architectural emphasis was on functionality and featured little ornament.

Figure 37. Quarters (Building Nos. 7-8) on the medical campus in Shreveport, Louisiana; they are no longer extant (VA)

Figure 38. Converted stables, Fort Meade, South Dakota (VA).

Site Design

For the most part once the Veterans Administration acquired property for the new hospitals, the site was cleared of existing buildings and structures. In a few examples, however, the Veterans Administration repurposed the building stock for support services to push the opening of a facility up. Some of the resources on site that were reused are a home for elderly indigent men in Brockton, Massachusetts, and army stables in Fort Meade, South Dakota (Figure 38). Even in those examples, all medical facilities were housed in the newly constructed main hospital building. Expedited timetables for construction also left little resources for landscape design like that that had characterized the second generation of veterans' hospital campuses. This is reflected in the design and construction drawings, such as those prepared for the VA hospital in St. Louis, Missouri, wherein only one of

ninety drawings sheets is devoted to a planting plan and the majority of that sheet illustrates how to stake new trees. Whenever possible, the Veterans Administration incorporated existing trees and plantings into the overall site design (Figure 39). If landscaping was done, efforts were concentrated near the main entrance.

Figure 39. Architectural rendering of the site plan for the Veterans Administration Hospital in Manchester, New Hampshire (VA).

Internal drives ran through the campuses, without the ornamental plantings and vistas of the circulation patterns found in second generation hospital site plans; these roadways provided access to the main hospital and allowed for service deliveries at the loading docks to the rear of the main building. The main drive looped around a flagpole, often placed near the main entry point. A roadway leading into the campus looped around a flagpole placed near the main entrance. Surface parking lots were built close to the main hospital building to facilitate access by patients and visitors. Because the new hospitals were located in urban centers or public transportation outlets and because residential quarters for staff were included in the campus plan, larger parking garages or parking decks for commuters were unnecessary in the period of significance. Similar to landscape design under the third generation of veterans' hospitals, no aesthetic requirements were developed by the VA for parking, signage or benches beyond the minimalist tenor of midcentury modernism and administrative cost-consciousness.

New Hospitals Designed under the U.S. Army Corps of Engineers

Description

When the Veterans Administration partnered with U.S. Army Corps of Engineers for the new hospital construction program, it obtained access to private architectural firms knowledgeable and experienced in hospital design and construction. Each architect derived his own solutions to the Veterans Administration's program requirements which produced a set of hospitals with parallel features and no uniform appearance. Design commonalities include an emphasis on clean, linear qualities rather than ornamentation through the use of fenestration patterns and structural detail seen in building materials. Windows could heighten the building's verticality or, if banded, extend the horizontality. In the central section or primary elevation, windows often were framed out in contrasting materials to the surrounding wall. When this was done, along with spandrels in the same contrasting material, the height of the main hospital soared. In others, continuous narrow bands outlined windows of a single story which created defined horizontal lines and provided some shade to the interior spaces. Furthermore, the individual planes of the hospital were predominately flat in character, featuring few recessed entries, cupolas, or curved surfaces. Clean and rectilinear appearances are defining characteristics of the new Veterans Administration hospitals.

A series of smaller buildings accompanied the massive main hospital building. These support buildings historically provided utilities, housing for staff, and other services. Aesthetically, these buildings reference the overall design of the main hospital, using similar cladding and fenestration, in a visually cohesive campus (Figure 40).

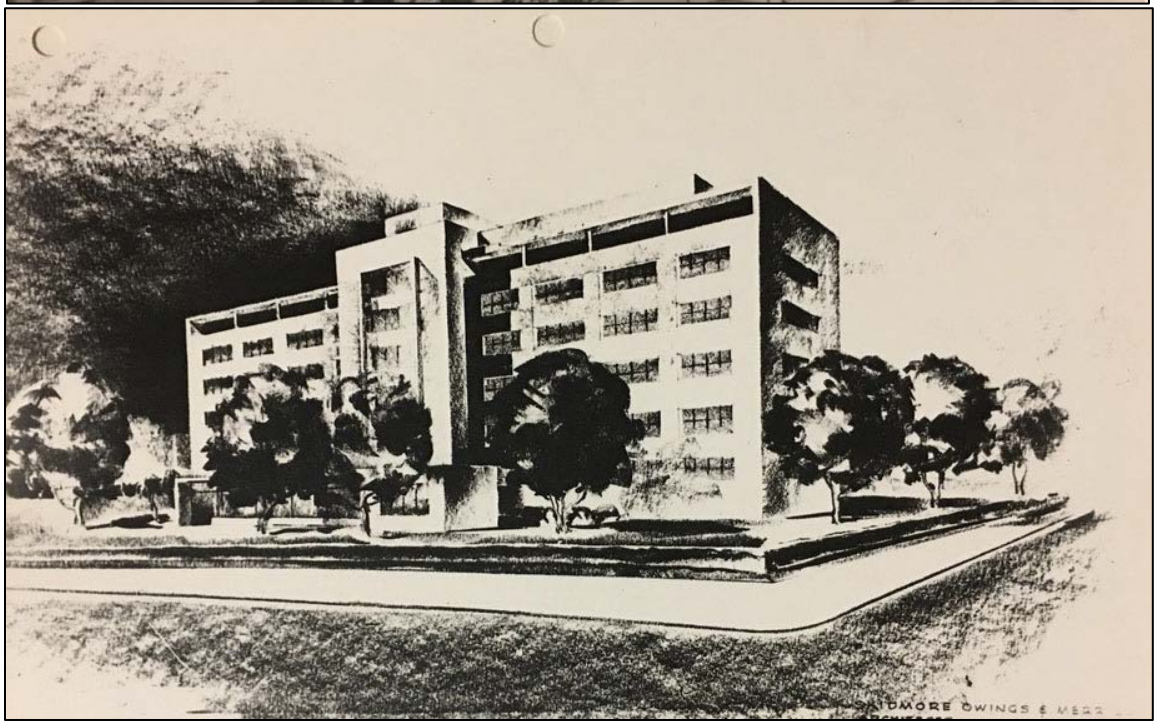
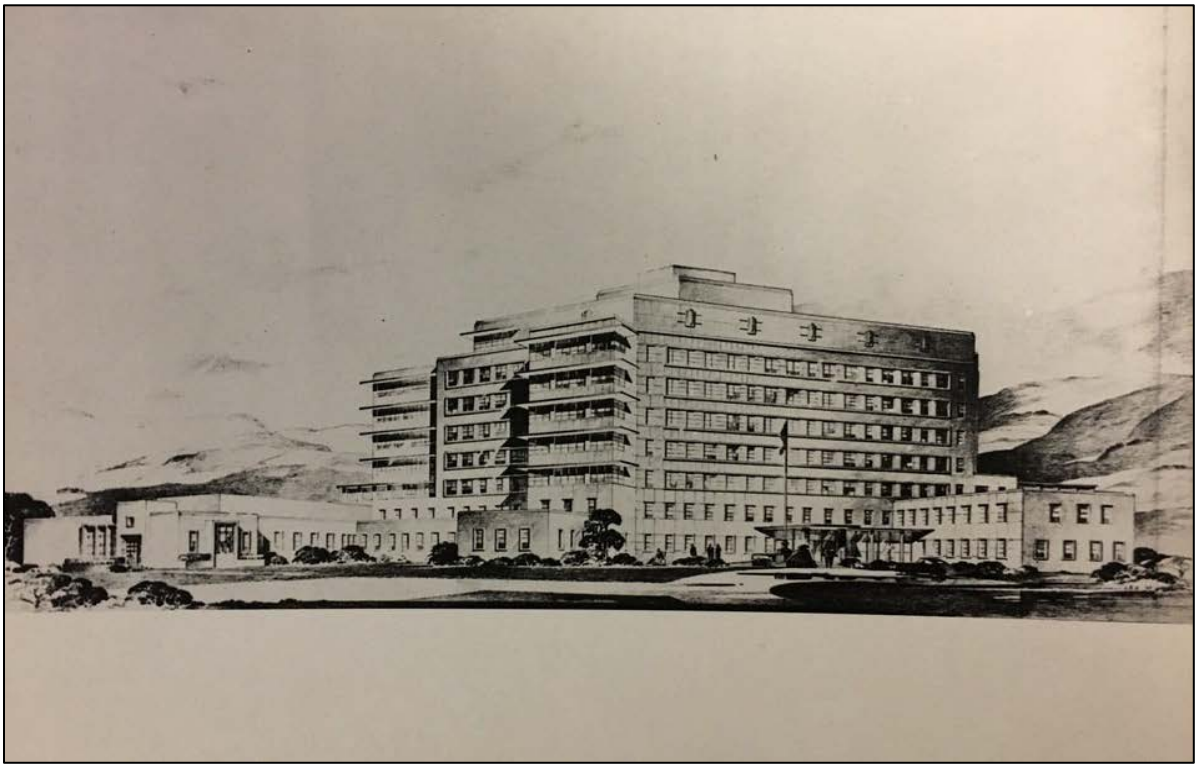


Figure 40. Presentation drawings for the Veterans Administration Hospital in Brooklyn (Fort Hamilton), for the main hospital and the nurses' quarters, SOM for the Veterans Administration (VA).

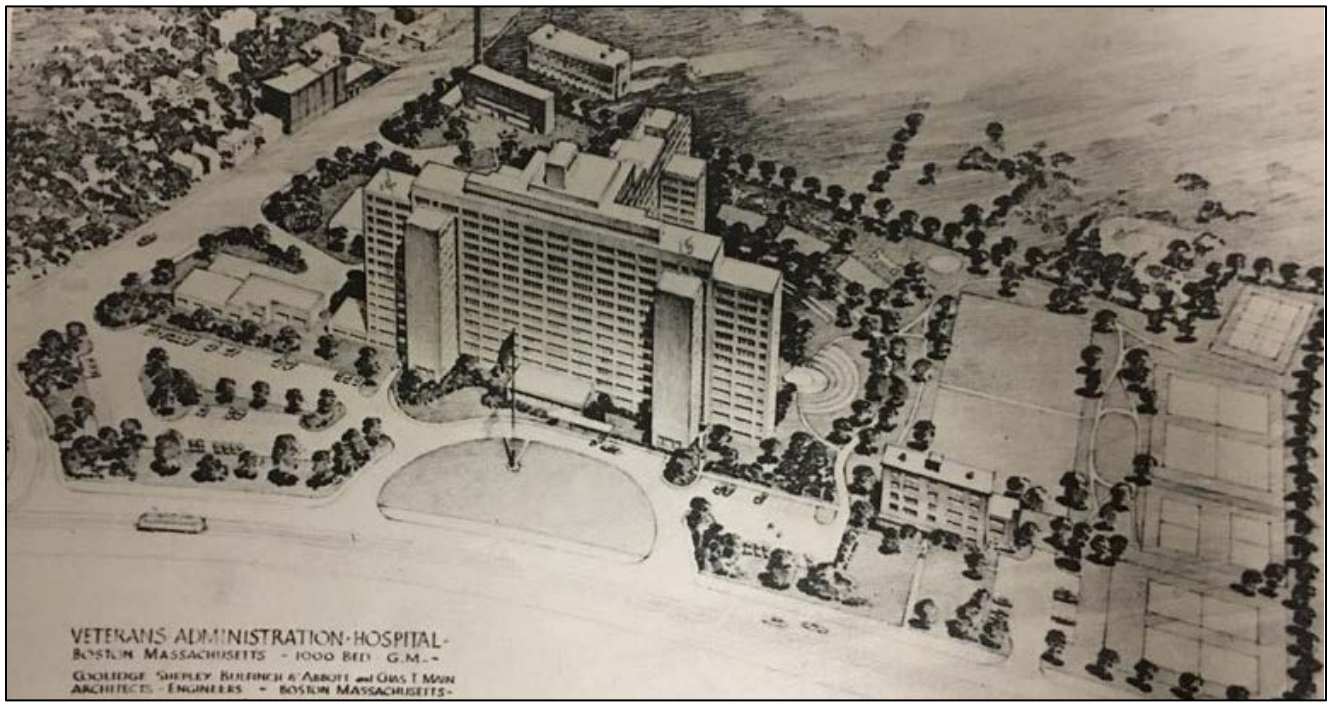
Examples of the private architect-designed hospitals include the veterans' hospitals in Brooklyn, New York, shown above; Grand Island, Nebraska; and Spokane, Washington (Figure 41). Different architectural firms designed these hospitals, thus the hospitals did not resemble one another in terms of plans, exteriors, or finishes. Yet each featured a large, prominent main hospital building that serves as the focal point for the campus surrounded by smaller ancillary buildings and structures. The various architects provided independent solutions to the programmatic requirements within the framework of postwar modern medical theory.

Figure 41. (top) Architectural rendering of the hospital campus in Grand Island, Nebraska, and (center) view looking east to the main hospital, 1950. *Below*: architectural rendering of the Veterans Administration Hospital in Spokane, Washington, designed by John Graham (VA).



The full list of properties of this type that were included in the survey and evaluation for the study *United States Third Generation Veterans Hospitals, 1946-1958*, are as follows:

Phoenix, Arizona; Wilmington, Delaware; Iowa City, Iowa; Fort Wayne, Indiana; Shreveport, Louisiana; Boston, Massachusetts (Figure 42); Iron Mountain, Michigan; Kansas City, Missouri; Poplar Bluff, Missouri; Durham, North Carolina; Grand Island, Nebraska; Omaha, Nebraska; Manchester, New Hampshire; East Orange, New Jersey; Albany, New York; Brooklyn, New York; Buffalo, New York; New York (Manhattan), New York; Altoona, Pennsylvania; Erie, Pennsylvania; Pittsburgh, Pennsylvania; Wilkes-Barre, Pennsylvania; Providence, Rhode Island; Big Spring, Texas; Bonham, Texas; Spokane, Washington; Madison, Wisconsin; Beckley, West Virginia; and Clarksburg, West Virginia. [301]



[301] See Section G, below.

Figure 42. Veterans Administration Hospital in Boston, Massachusetts: (top) architectural rendering by Coolidge, Shepley, Bulfinch and Abbot for the VA, (bottom left) view of the main hospital from the recreation area during construction (1951), and (bottom right) undated view of the main hospital (VA).

Significance

The new hospitals built for the Veterans Administration through a partnership with the U.S. Army Corps of Engineers from 1946 to 1958 are significant under National Register of Historic Places Criterion A for their association with health care and medicine. A multistoried, skyscraper-like central hospital building anchored the postwar medical campus, and midcentury modernism defined its architectural character. These postwar hospitals also may be eligible for listing under Criterion C at the national level if the design is a hallmark of the master architect's or architectural firm's oeuvre, or represents a shift in approach, and if the campus retains integrity to its period of significance. For example, the partnership with the Corps of Engineers engaged preeminent firms in architectural and engineering field, such as Skidmore, Owings & Merrill, John Graham, Jr., Favrot & Reed, and George Pepper, Jr., and they created truly modern hospitals, both in layout and appearance. Thus, individual properties may be eligible under Criterion C under this context.[302]

Registration Requirements

To be eligible for listing in the National Register of Historic Places, integrity must be evaluated for each property and fundamental to any assessment is the consideration of location. All hospitals must be located on their original site and the historic association with postwar healthcare and its shaping of *what* a modern hospital was to be must

[302] Typically the individual properties are significant at the state or national level under National Register Criterion A depending on the extent of the medical research at the site or singularity of type, such as Bonham, Texas, being the only domiciliary built in the third generation program or a pilot program in Albany, New York, whereas National Register Criterion C significance is more commonly recommended at a local or state level for the distinctive characteristics of the property type and place. For Brooklyn, however, the involvement of SOM recommends a national level. John Graham designed the Veterans Administration Hospital in Spokane, while Favrot & Reed provided plans for the facility in New Orleans, as Pepper did initially for Philadelphia. The distinction is noted here because a nationwide program does not automatically infer significance at the national level for the specific properties.

remain strong. This is most evident in the skyscraper form of the main building of the general medical and surgical hospitals that dominated the tight urban campuses; for the new neuropsychiatric hospitals or Haun-type, this is evident in a similar building-to-landscape relationship, just at a varying scale due to the larger campus size of those facilities. For all the new hospitals, regardless of patient focus, original design materials and workmanship should survive if they are to be eligible for listing under the *United States Third Generation Veterans Hospitals, 1946-1958*, multiple property documentation form. Evaluation of integrity is often relative – to change, to specific context – for the individual properties because the majority of the third generation of veterans' hospitals are operating as major healthcare centers today. Fulfilling General Bradley's vision for the Veterans Administration – ever modern, especially in its provisions for veterans' medical needs and wellbeing – makes change to the physical plant of the hospital campus inevitable. Some of the most common alterations include:

- Expansion of surface parking facilities and associated roadways;
- Construction of additional support buildings on the hospital property comparable in scale to the historic outbuildings;
- Additions to the main hospital building that reference the original historic hospital building in terms of scale, materials, and design aesthetic;
- Replacement of windows and doors;
- Alteration of interior spaces, including changes to interior finishes, shifts in usage, and subdivision of large open wards to private and semi-private rooms;
- Modification of the building from its original function; and
- Enclosure of roof gardens to house mechanical equipment.

Two interior spaces received special attention during the Veterans Administration's third generation program of hospital design: the chapel and the main hospital lobby.[303] Because of this, loss of those areas is likely to impact integrity of the main hospital and so, by extension, of the campus itself. The two spaces were significant to the third generation model of veterans' hospital design as places where visitors and families comingled with patients and medical professionals in an otherwise carefully orchestrated floor plan. The social element facilitated by the floor plan adds emphasis to these areas, more so than elevators and nurses stations, and the fitting out of the chapel and lobby was more luxurious than materials and workmanship found in other areas of the hospital as

[303] These spaces are discussed in Section E, above. Other common areas for patients and staff include the auditorium, libraries, and recreational facilities but these areas were not marked by material finish – given architectural preference in other words - as the chapel and lobby were. Likely because, while they were social spaces, these areas were not specifically public spaces.

prescribed by the minimalist ethos of modern design. The chapel served multiple faiths and the rotating altar developed to accommodate diverse needs was an important part of that space. The loss of the altar or the chapel altogether may negatively affect the eligibility of the hospital building. The lobby was the primary point of access to the facility, and a reorientation of floor plan to another main entry point shifts its role as the gateway to the patient care areas and administrative offices of the main hospital building. Such a change could, potentially, alter the historic character of the front façade and diminish its integrity to the period of significance. While disproportionate in scale to the hospital campus overall, the chapel and lobby signified key points of interaction for patients and their visitors. Thus their presence and integrity must be considered along with broader measures of design, setting, feeling, and association of the medical center overall. To be eligible for listing in the National Register, the new hospitals must retain:

- a cohesive campus plan that preserves sightlines relative to the main hospital's entrance and open space;
- the main hospital building(s), meaning either the skyscraper general hospital or the Haun-type multi-story building and a representative number of support buildings to convey the scale and proportion of neuropsychiatric hospital centers; and
-the elements of midcentury modernism that distinguish the medical center's architectural character and time of construction. These may include exterior form, massing, details, and fixtures associated with the building exteriors as well as the finishes of the chapel and lobby area(s).

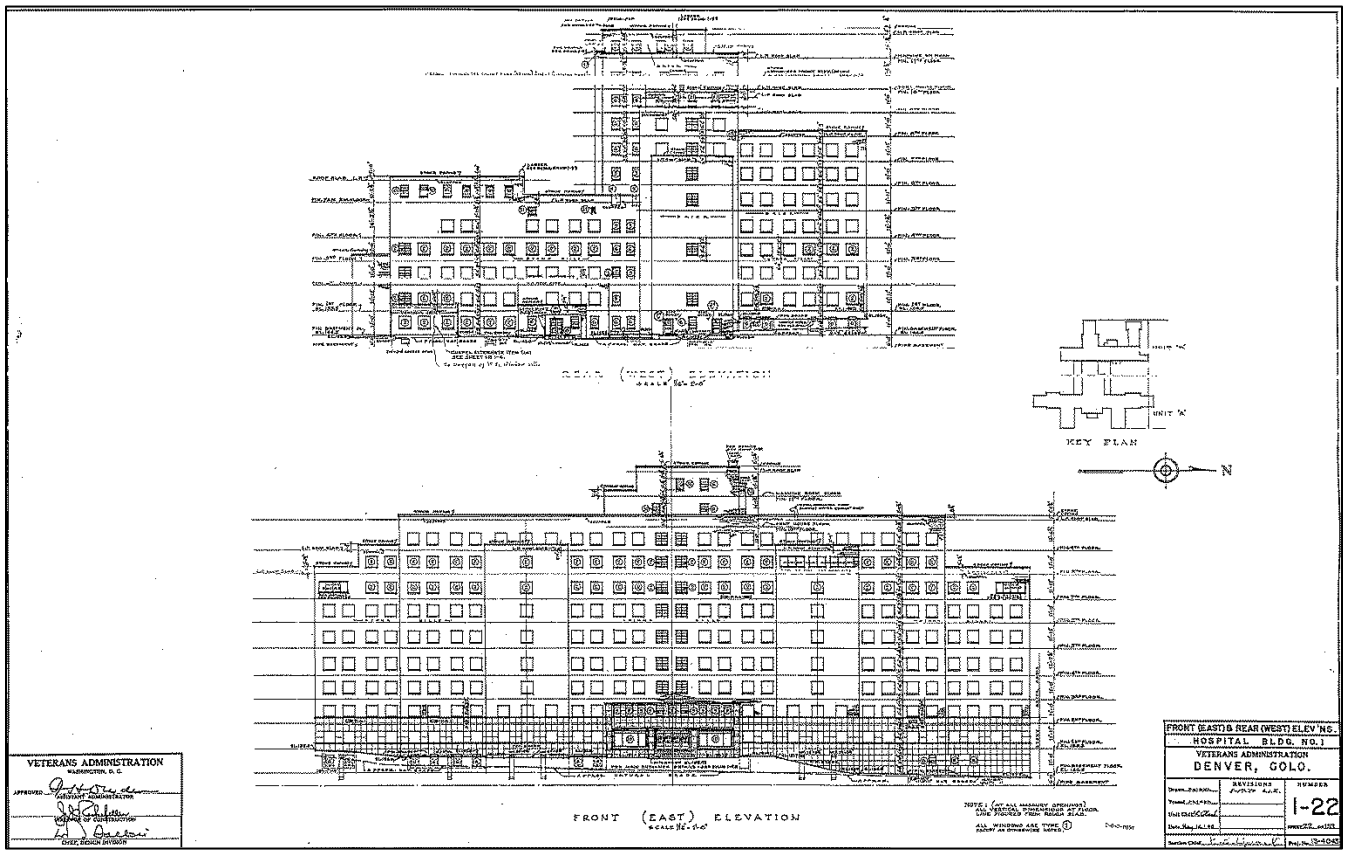
Similar to the transitional hospital property type, the new hospitals are evaluated in terms of cumulative effect of change over time on the architectural landscape and its integrity of design, setting, workmanship, materials, feeling, and association. Integrity of workmanship and materials is impacted by change to the buildings, and eligibility can be impacted if additions obscure the primary elevation or if the structural ornamentation of midcentury modernism is lost. If the modernization efforts overwhelm the historic fabric and massing through the introduction of unsympathetic materials in the whole-scale replacement of windows and doors and roofing, or obscure it in the placement of equipment towers for mechanical needs, of towers for stairs and elevators, of ramps or emergency entrances, than these improvements negatively impact the integrity of the building. Expansions to the rear of the main building of the hospital center generally do not adversely affect the overall integrity of the building or property as a whole. This is because the rear additions are usually constructed with respect to the building's height and materials. Considerations of integrity of design, setting, feeling, and association are grounded in the campus plan and if the original site layout, circulation patterns, and spatial relationships are evident through the changes overlaid by time.

New Hospitals Designed under the Veterans Administration

Subtype: VA Standard Plan

Description

The decision by the Veterans Administration to adopt a standard plan for its new hospitals grew out of fiscal concerns. Administrators at the VA feared that the agency would not be able to complete the outlined nationwide construction program if the cost overruns continued. Thus the new, VA standard plan hospitals were essentially copies of one another down to the red brick exteriors, regardless of site conditions or local building preference. The Veterans Administration's concerns over unruly costs and meeting its hospital goals triggered a shift of the design program from the Corps of Engineers to the VA's staff architects, resulting in the implementation of standardized plans that created an instantly recognizable veterans' hospital in a number of cities (Figure 43).



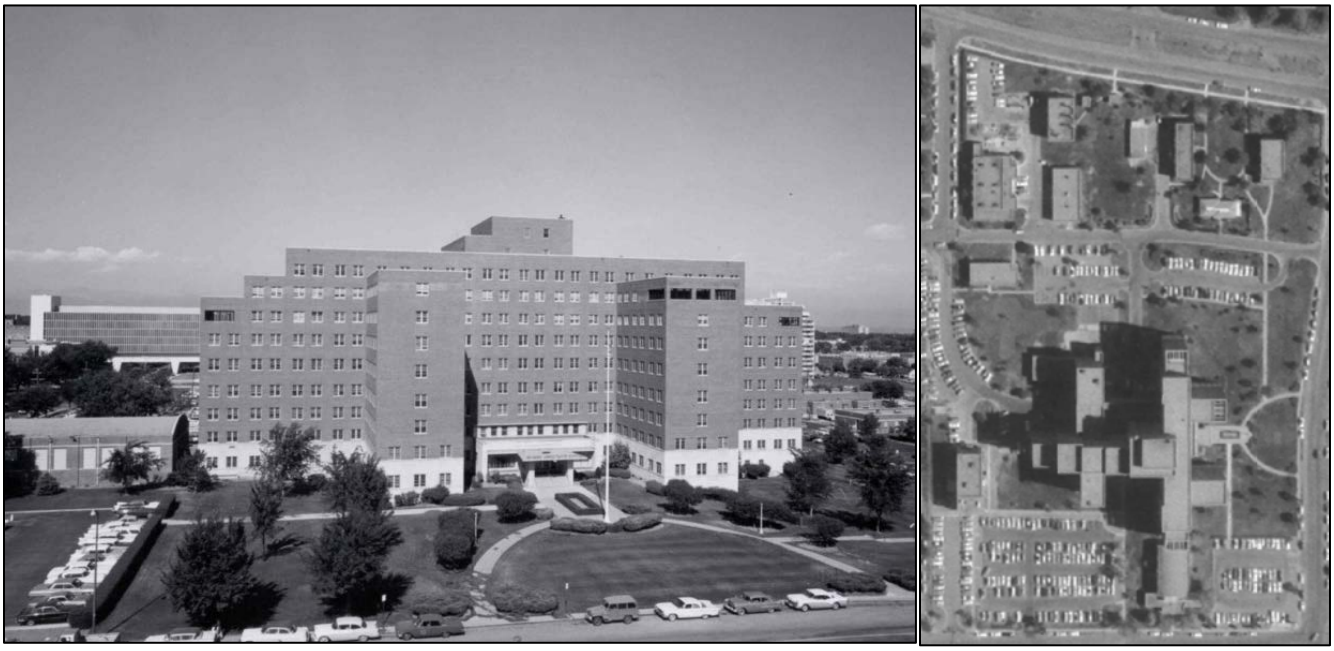


Figure 43.(top) Elevation drawing for the main hospital building, Denver, Colorado; Photographic views taken in the 1960s (bottom: left, 1965; right 1963) (VA).

In scale and massing, these VA standard plan hospitals resemble those third generation hospitals designed by architects in private practice rather than their World War I or second generation counterparts. This subset of new hospitals emphasized strict functionality in appearance, leaving nothing that could be considered extraneous. The exteriors were devoid of ornamentation. Plain panels of stone veneer often covered the exterior at the lower reaches of the building. Windows punctured the walls in rigid patterns based on the division of the interior space. The standard design placed emphasis on the activities taking place within rather than serving as a showcase of architectural innovation. The plan for the main hospital building consisted of a central block with projecting wings, with the main entrance in the center. The entry was stripped down as well and generally consisted of small pavilions and limited signage. A penthouse for mechanical equipment rose from the center of the main block (Figure 44).

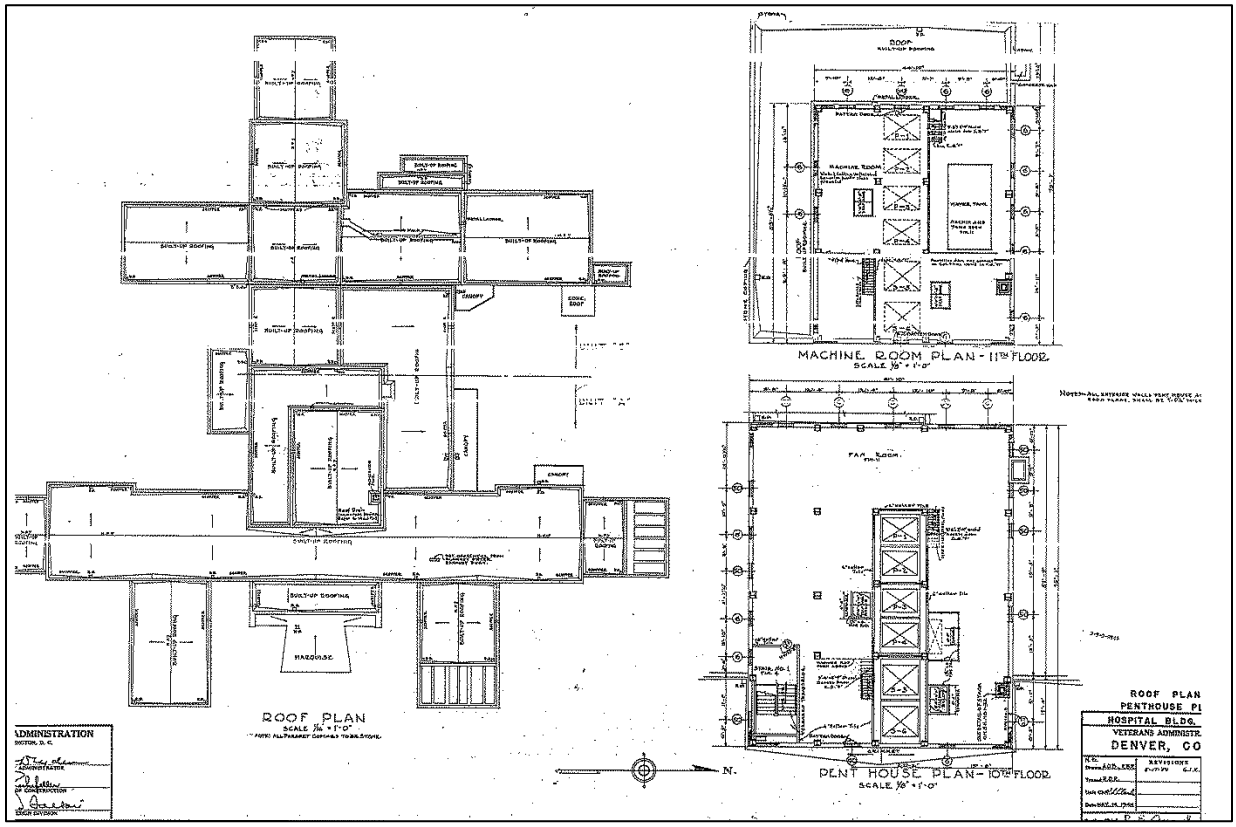
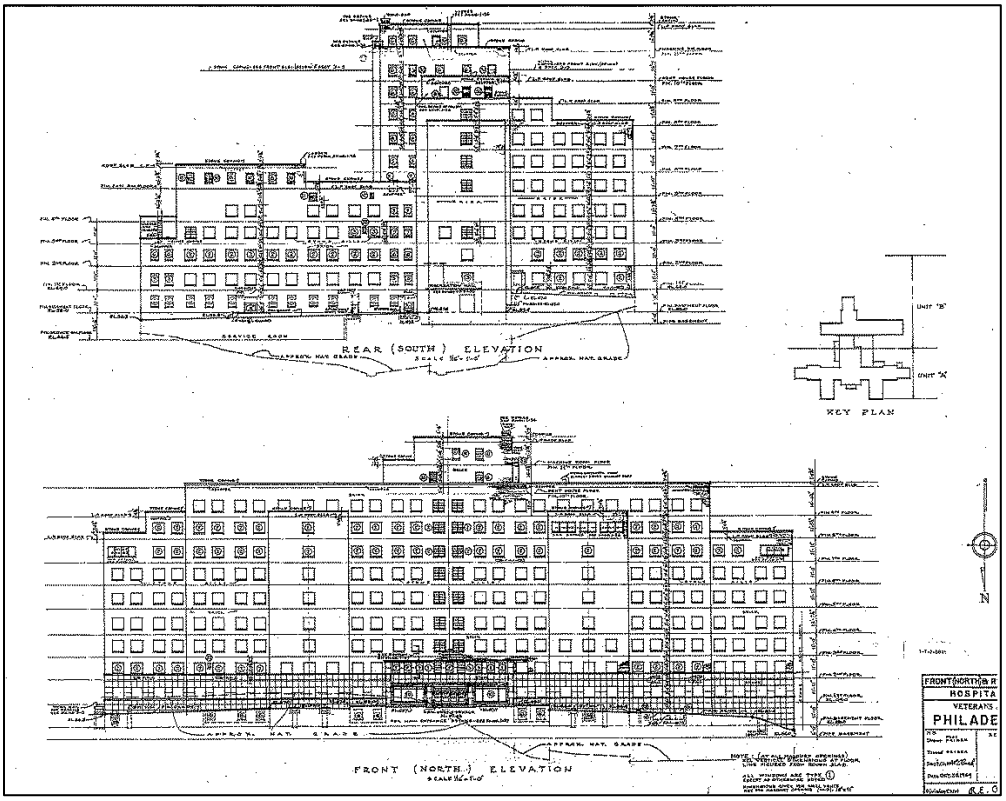


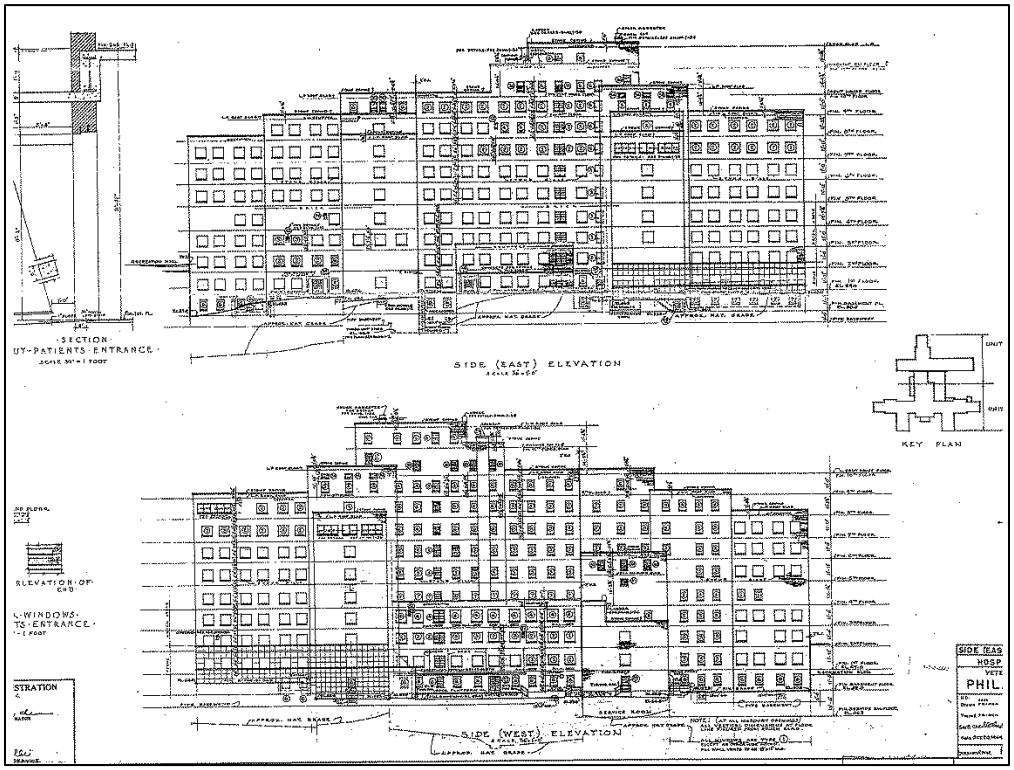
Figure 44. Roof plan, main hospital, Denver, Colorado (VA).

Thirteen VA standard plan hospitals were surveyed for the study. They are: Birmingham, Alabama; Denver, Colorado; West Haven, Connecticut; Chicago (Maywood), Illinois; Indianapolis, Indiana; Louisville, Kentucky; Saginaw, Michigan; Ann Arbor, Michigan; St. Louis, Missouri; Syracuse, New York; Cincinnati, Ohio; Oklahoma City, Oklahoma; and Philadelphia, Pennsylvania.[304]

Representative elevation drawings for the main hospital, here the one built in Philadelphia, are:

[304] Of the proposed nominated properties, Louisville, Kentucky, and Saginaw, Michigan, are both significant at the state level under Criterion A, while West Haven arguably has national levels of significance under Criteria A and C – it was the only tuberculosis-specific facility built under the third generation program and Beatrix Farrand designed its entrance.


REAR (SOUTH) ELEVATION
KEY PLAN
FRONT (NORTH) ELEVATION
N


SIDE (EAST) ELEVATION
KEY PLAN
SIDE (WEST) ELEVATION

Main Hospital Building, Veterans Administration Hospital, Philadelphia, Pennsylvania, ca. 1950 (VA).

Significance

The new hospitals built for the Veterans Administration to a standard design developed by staff architects are significant under National Register of Historic Places Criterion A for their association with health care and medicine. A multistoried, skyscraper-like central hospital building anchored the postwar medical campus, and midcentury modernism defined its architectural character. The new hospitals were faced in brick, and for the standard plan models, a red brick was used for the main hospital and ancillary, support buildings of the medical center. Austerity accompanied the skyscraper form and the resulting utilitarian character of the medical campus reinforced the priorities of the third generation program on healthcare provision rather than the designed landscape per se as costs were balanced. Similar to earlier Veterans Administration hospitals and to the new hospitals built through the Corps of Engineers, these VA standard plan hospitals had the main building as the campus focal point and, therefore, view sheds and sightlines to the main entrance were important to the site layout and spatial experience of the campus. Even so, the entrances themselves were modest and this sense of scale in

the pavilion, in the use of lighting, and in the signage is a distinguishing feature of the VA standard plan hospital along with the red brick exteriors and bands of fenestration.

Registration Requirements

The registration requirements for the new hospitals built to the VA standard plan are the same as those enumerated for the new hospitals designed by architects in private practice and constructed in partnership with the U.S. Army Corps of Engineers.

Subtype: Haun-type Neuropsychiatric Hospitals

Description

Similar to those neuropsychiatric hospitals developed for returning veterans of World War I, setting remained paramount to patient care in the neuropsychiatric hospitals constructed by the Veterans Administration between 1946 and 1958. Neuropsychiatric hospital design in this era followed recommendations of a committee of psychiatrists led by Dr. Paul Haun; the committee's findings were presented at the annual meeting of the American Psychiatric Association in 1947. Haun and the committee recommended discontinuing the use of rural locations for the medical centers as well as certain architectural features, such as porches and large wards, then popular. Instead, the committee supported the third generation protocol for urban or suburban locations for the new hospitals that were, ideally, sited near other medical centers. They also stressed that patient wellness relied on achieving comfortable, home-like surroundings rather than the "institutional" feel created by large patient wards. To create this atmosphere, the committee advocated a floor plan with smaller wards divided by partitions to achieve a simulacrum of privacy and with treatment rooms in proximity to patient rooms to minimize travel and waiting time (Figure 45). Providing secure exercise yards to encourage patients to go outside was another recommendation, and these features became characteristics of the "Haun-type" hospitals.

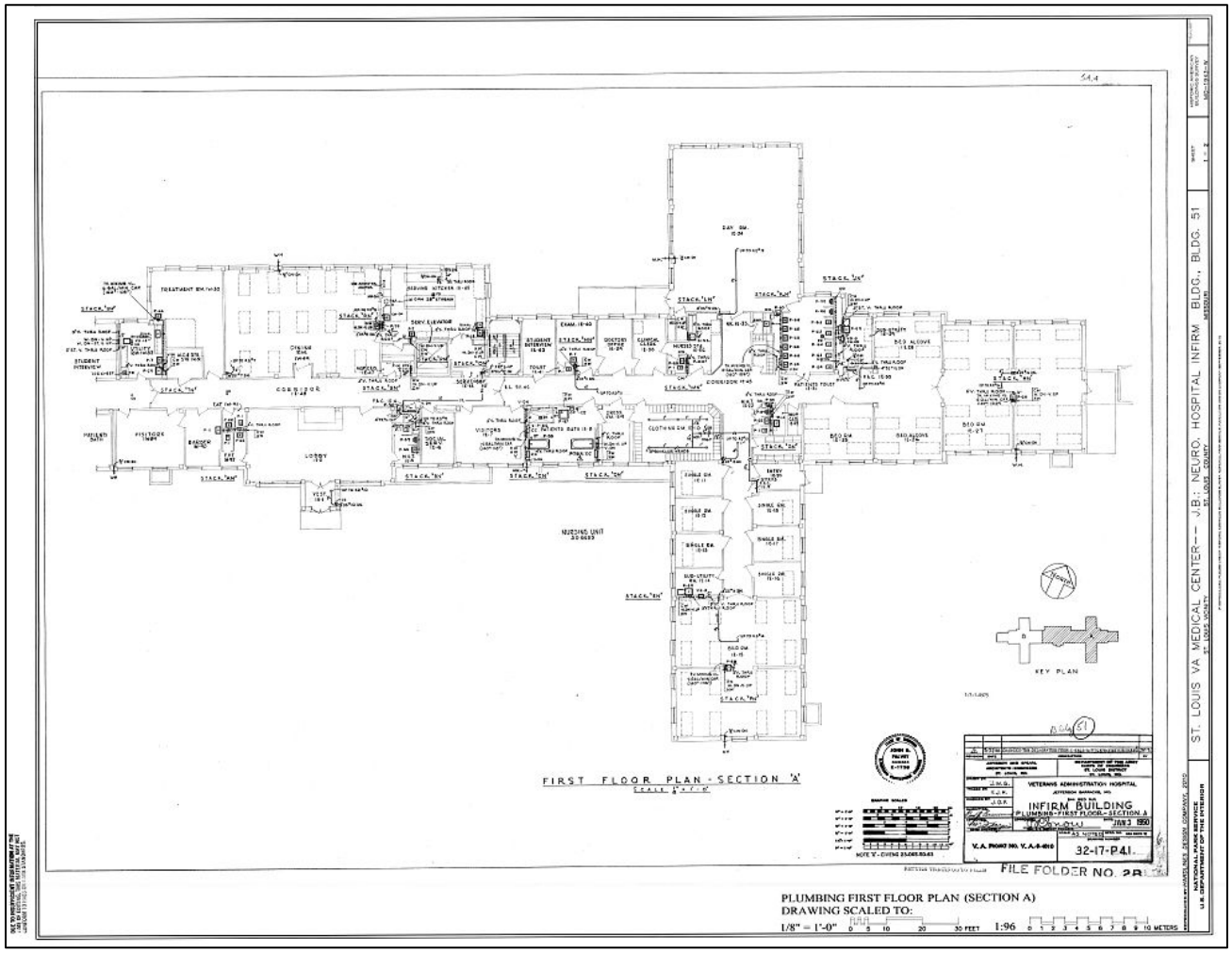


Figure 45. Plan of the neuropsychiatric hospital in St. Louis, Missouri, designed by Jamieson and Spearl, for the VA (Library of Congress).

While Haun's prescriptions defined the floor plan of the third generation neuropsychiatric hospital, continuities in site design and layout from earlier medical centers remained in place as these facilities were built, and those features remained viable in accommodating contemporary treatment plans. For example, a multi-story administrative building anchored the medical center campus, rather than the third generation's emblematic skyscraper, and ancillary buildings played a more visible role in healthcare in these addition to providing utilitarian spaces for warehouses and mechanical equipment. Haun's committee, in fact, recommended continuing the use of low-rise buildings for patient care. The campus plan, therefore, had multiple buildings of similar scale – each two to four stories in height – to house various hospital services. Patient buildings were organized around a courtyard or axial point. However, the architectural styles of earlier hospital campuses are absent, as is the rigidity

or formality of the plan itself. The main building – as was the skyscraper general hospital of other third generation campuses – was centrally located on the site and positioned near the main entrance to the campus (Figure 46).

Figure 46. Aerial view of the Veterans Administration Hospital, Salisbury, North Carolina (VA).

Patient buildings were placed in proximity to the administration building, and while similar in appearance and in building footprint, they differed by types of patients and treatment needs in accordance with Haun's committee recommendations. Moreover, separate buildings were designated for neuropsychiatric patients who also had tuberculosis. Like earlier hospital campuses, particularly the pavilion plan model, corridors connected the separate buildings of the Haun-type neuropsychiatric hospital. The support buildings, for utilitarian needs like boiler plants, were typically located to the rear of the campus or away from the patient building or buildings.

Given the average stay for patients at neuropsychiatric hospitals was significantly longer than those at general medical and surgical hospitals, neuropsychiatric hospitals of this era had amenities such as day rooms and visiting rooms and extensive recreational facilities. These facilities included buildings, such as theaters, indoor swimming

pools, and gymnasiums, as well as ball fields and basketball courts.[305] When combined with the other recommendations, the committee sought to create a hospital "where veterans can be treated not only with scientific skill but with human warmth and understanding attention."[306]

The Veterans Administration facilities at Topeka, Kansas, and Brockton, Massachusetts, represent the Haun-type of neuropsychiatric hospital. Both medical centers feature multiple, low-rise brick buildings linked via connecting corridors (Figure 47). Patient buildings are organized around the main administrative building. Extensive dedicated recreational facilities are present at both campuses, including ball fields, theaters, and enclosed exercise yards. The study included two other Haun-type hospital centers; they are located in Salisbury, North Carolina, and Salt Lake City, Utah.

Figure 47. Above: (left) Aerial view, looking northeast, of the Topeka hospital campus, ca. 1960, and (right) close up view of the Administration Building (main building) of the hospital, 1960 (kansasmemory.org, Kansas State Historical Society, Copy and Reuse Restrictions Apply).
Below: Salt Lake City Veterans Hospital, 1952 (VA).

[305] Planned landscape features were more characteristic of second generation, neuropsychiatric hospitals built in rural areas to accommodate a more sprawling campus plan and occupational therapies developed around agricultural activities. Overall, less emphasis was placed on landscaping in the third generation veterans' hospital designs, yet neuropsychiatric hospitals were larger by design and patients were encouraged to be outside.
[306] Paul Haun, M.D. and Z. M. Lebersohn, M.D., "New Trends in Hospital Design," *American Journal of Psychiatry*, 104 (February 1958): 555-64.

Significance

The new hospitals of the Haun-type designed by the Veterans Administration for the treatment of neuropsychiatric patients are significant under the National Register of Historic Places Criterion A for their association with health care and medicine, particularly the advancement of research and development of therapies and treatment protocols by the Veterans Administration in the postwar period. The guidelines for the plan of the neuropsychiatric hospitals were developed by the Veterans Administration with leading practitioners such as doctors Paul Haun, Karl Menninger, and William Menninger, and represent the most current of hospital design and healthcare administration trends. The design recommendations and development of the Haun-type hospital responded to the increased number of neuropsychiatric patients following the Second World War and to calls from the medical field for more trained personnel to care for the patients. The Haun-type hospital plan provided patients and caregivers with modern facilities tailored to specific needs and marked a pivotal moment in psychiatric medicine. Without the unifying architectural style of the earlier generation of Veterans Administration medical campuses, the significance of the Haun-type hospitals under National Register Criterion C is difficult to argue. They are seminal in plan – accommodating shifts in philosophy and protocol within the medical community – and the architectural character of the property type illustrates the association with healthcare

innovation. Medicine drove the design and the Veterans Administration adopted a standard planning approach in response.

Registration Requirements

The registration requirements for the VA-standard, Haun-type follow those enumerated for the new hospitals designed by the U.S. Army Corps of Engineers, with emphasis on the overall campus rather than on the singular skyscraper form of the other new hospital centers of the third generation program.[307]

Conclusion

Summary Statement of Significance

The *United States Third Generation Veterans Hospitals, 1946-1958*, collectively represent a revolution in medical care for veterans in the years following World War II. The Veterans Administration, predecessor of the U.S. Department of Veterans Affairs, responded to widespread charges of inadequate healthcare facilities by making sweeping changes to its approach to hospital design and construction. President Harry S. Truman appointed General Omar Bradley as Administrator of the VA with the expressed goal of modernizing the agency, including the hospital program. Under Bradley, the Veterans Administration created an interim system of surplus military hospitals and beds in private hospitals to provide immediate relief to the healthcare needs of the returning World War II veterans. This was concurrent to the proposed new hospitals that would concentrate healthcare services in a sleek skyscraper rather than in many buildings spread apart on extensive, and bucolic, campuses. The Veterans Administration placed its new hospitals near urban centers across the country, which allowed integration of the VA hospital with medical schools and other hospitals. At the close of the third generation initiative, the Veterans Administration managed over 120,000 beds in 172 hospitals, an increase of about 78 percent from 1945.

Period of Significance

At the end of World War II, the U.S. military transferred surplus properties for the Veterans Administration to use as veterans' hospitals and, in 1946, the VA's new hospital construction campaign was launched. The Veterans Administration built these hospitals well into the 1950s due to delays triggered by program changes, local politics, and the increased demands for additional hospital beds following the Korean Conflict. The last third generation

[307] For the properties recommended for listing in the National Register, the hospital in Topeka, Kansas, is significant at the national level under Criterion A because of its ties to the Menninger family and progress in the treatment of neuropsychiatric patients as well as shifts in design to accommodate those protocols. Hospitals in Salisbury, North Carolina, and Brockton, Massachusetts resonate on the state level.

veterans' hospital opened in Topeka, Kansas, in 1958. Therefore, the proposed period of significance for the *United States Third Generation Veterans Hospitals* is 1946 to 1958.

Criteria of Significance and Consideration of Integrity

Both property types, the transitional and new hospitals opened by the Veterans Administration during its third generation program, are significant under Criterion A for listing in the National Register because of their association with the evolution of healthcare and medicine. The properties may be significant at the state or national level depending on the specific facility's role in the veterans' healthcare network created after World War II and the medical center's impact on urban development of a city or region. Eligibility for listing under National Register Criterion C for architecture is also possible if the main hospital building or campus plan is associated with a master architect or firm. Materials are important under Criterion C; the minimalist aesthetic and brick-faced exteriors provided a uniformity that must remain evident despite change over time. Considerations of integrity hinge on more than location and historic association – design, setting, materials, workmanship, and feeling must also be assessed and the cumulative effect of change evaluated for each third generation hospital. For the postwar campus, structural ornamentation such as the planar elevations, fenestration patterns, and banding of the primary building created an overall effect of style and scale for what made a modern hospital. Measures of that effect guide eligibility of the properties today.

G. Geographical Data

The *United States Third Generation Veterans Hospitals* are located throughout the continental United States, although a naval hospital in San Juan, Puerto Rico, was transferred to the Veterans Administration at the end of World War II. That hospital has since been replaced and so is not part of the VA's third generation study set. *Reports of the Veterans Bureau* from the 1920s indicate there were facilities outside the continental United States, primarily for the administration of benefits through insular offices like those in Hawaii, the Canal Zone (Panama) and the Philippines, and contract hospitals provided any necessary medical care. The insular offices in Hawaii, Puerto Rico, and the Philippines remained open in 1945 to 1946, as the third generation of hospital design and construction began.[308] By the end of 1952, forty-three new hospitals were complete, with another sixteen under construction and planning drawings in development for five other sites. Another thirty-one had been expanded or had bed space converted for treatments, such as a paraplegic hospital reconfigured for general medical care in West Roxbury, Massachusetts, or adapted as tuberculosis ebbed, such as the Georgia medical centers located in Atlanta and Augusta. No new sites had been authorized since 1948 so the hospital construction program was capped at these sixty-four hospital locations at the time of the report for the congressional committee, and this provides a benchmark for measuring the Veterans Administration's third generation hospital program. None were located outside the continental United States (see Figure 49).[309]

[308] *Report of the United States Veterans Bureau*, 1922, 212, 546, 560; *Report of the United States Veterans Bureau*, 1926, 140, 347; Veterans Administration, Insular Offices, *Government Manual* 1946, 546; excerpts of reports courtesy of Darlene Richardson, VHA Historian, to Virginia B. Price, NCA Historian, November 15, 2017. This remained true into the 1950s. In the *Annual Report* by the Administrator of Veterans Affairs for fiscal year 1957 it was noted that 49 percent of patients in non-VA hospitals were those living outside the continental United States – Alaska, Guam, Hawaii, Puerto Rico, and the Philippines. Of those, 51 percent were neuropsychiatric patients. There were 1285 patients receiving benefits in this way, and 1010 (79 percent) lived in Puerto Rico and 65 percent needed tuberculosis or neuropsychiatric care. There was one VA hospital in Puerto Rico, as noted above and in Appendix C, for general medical and surgical needs. The report also noted the peak use of the non-VA operated hospitals occurred in 1948. *Annual Report* 1957, 3-8.

[309] *History of the Veterans' Administration Hospital Construction Programs*, Report January 27, 1953, printed for the Committee on Veterans' Affairs (Washington, DC: Government Printing Office, 1953), 8-11. Also, in the *U.S. Government Organization Manual* for 1950, in the section for the Veterans Administration, there is a list, by state, of hospitals, domiciliaries, centers, and regional offices. See 450-54.

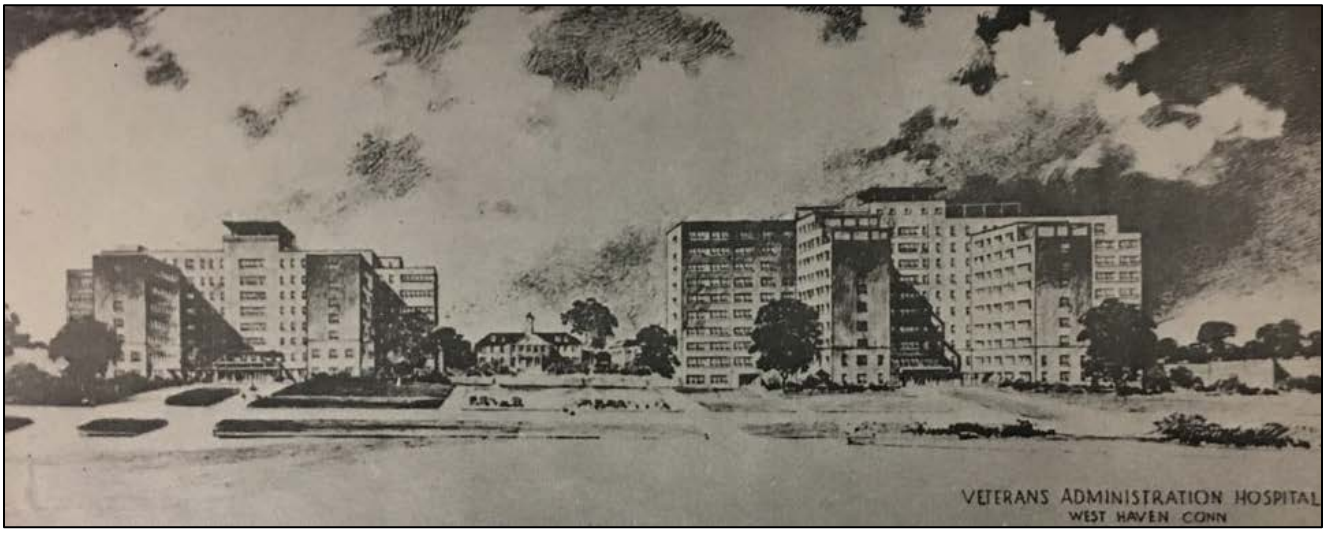
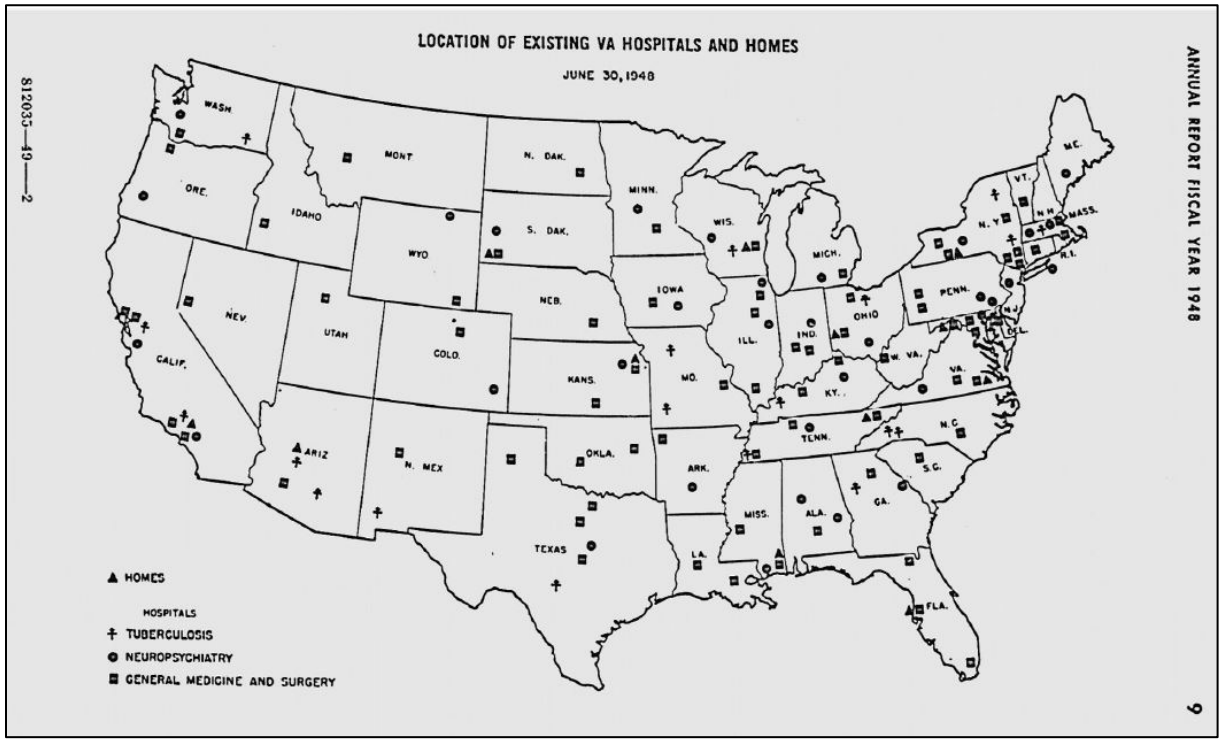


Figure 48. Architectural rendering of the Veterans Administration Hospital in West Haven, Connecticut (VA).

Hospitals then under construction included neuropsychiatric facilities in Brockton, Massachusetts; Sepulveda, California; Pittsburgh, Pennsylvania; and Salisbury, North Carolina. The hospital in West Haven, Connecticut was under construction for tuberculosis patients and general medical patients (Figure 48). The other eleven were classified as general medical and surgical hospitals: Ann Arbor, Michigan; Chicago, Illinois (2); Cincinnati, Ohio; Durham, North Carolina; New York, New York; Oklahoma City, Oklahoma; Philadelphia, Pennsylvania; Pittsburgh, Pennsylvania; St. Louis, Missouri; and Syracuse, New York. Projects with working drawings were in Cleveland, Ohio (2); San Francisco, California; Topeka, Kansas; and Washington, DC. Neuropsychiatric care defined the Cleveland (1 of the 2), San Francisco, and Topeka plans.[310]

[310] *History of the Veterans Administration Hospital Construction Programs*, 10.



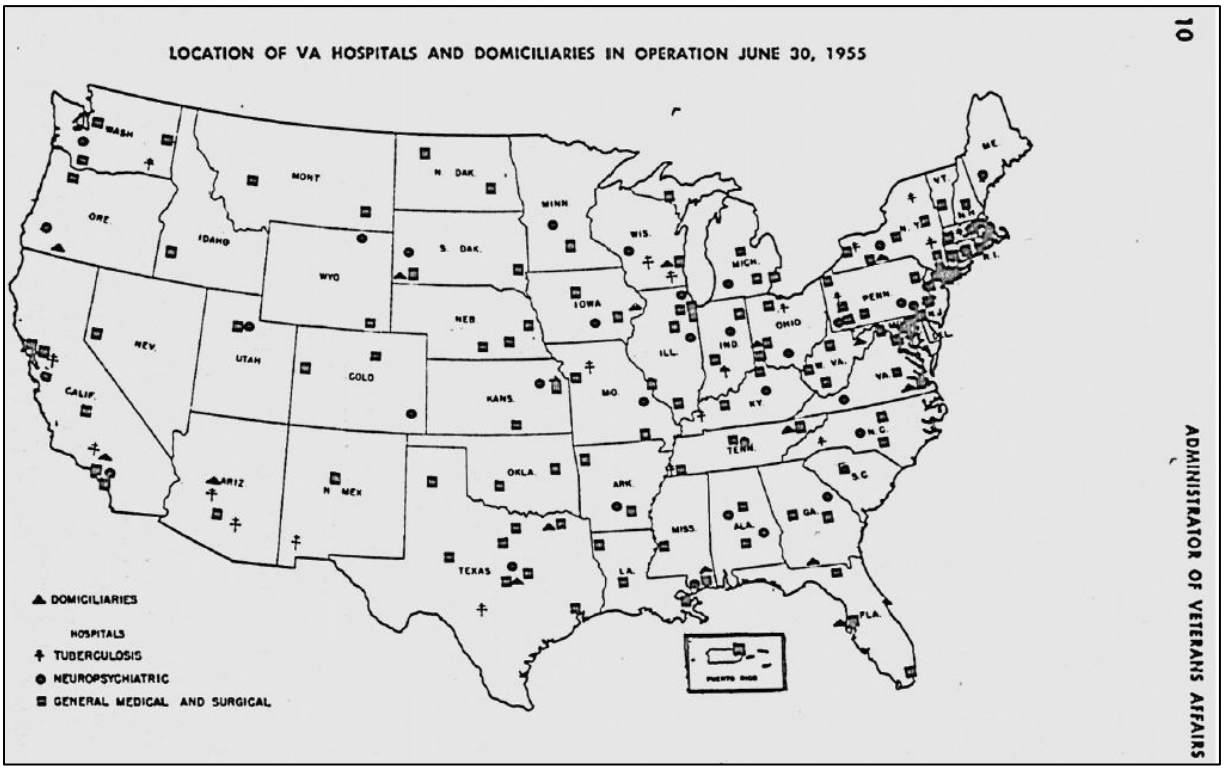
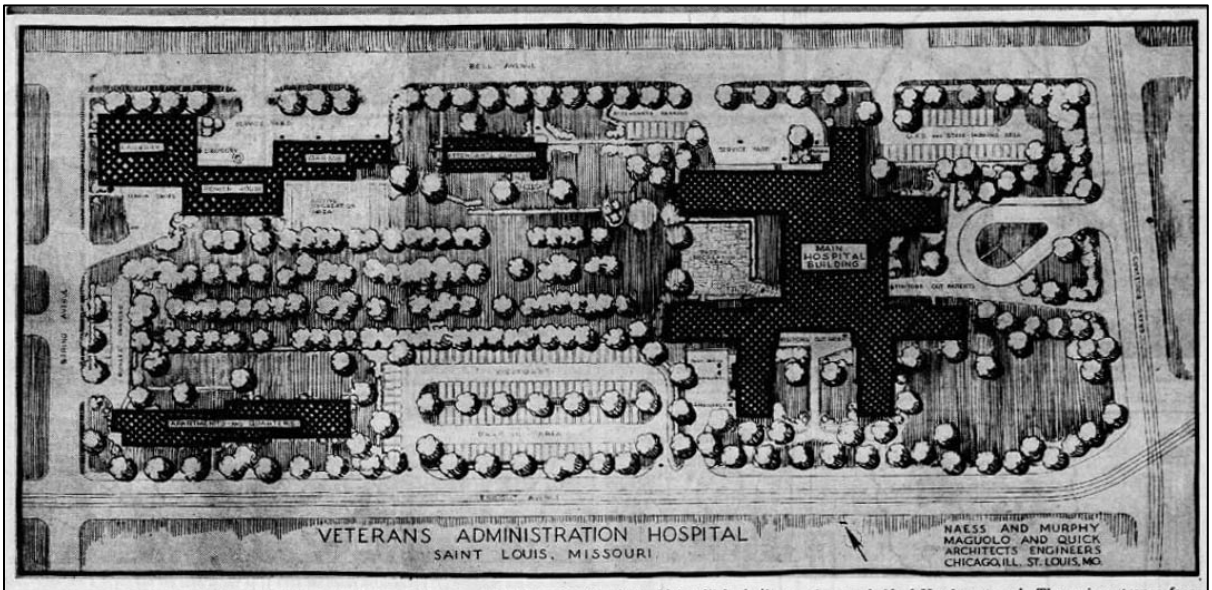


Figure 49. Comparative maps of veterans' hospital locations in 1948 and 1955 to illustrate expansion of the federal government's health care program. *Annual Report* 1948 and *Annual Report* 1955.

Third Generation Veterans Hospitals dating to the Period of Significance[311]

[311] In the table of Veterans Administration Medical Centers evaluated for the contextual study of the third generation of veterans' hospitals (1946-1958), five campuses noted as the third property type, that is built to standard plans produced by the VA, began under the purview of the second. Architects in private practice were initially associated with the hospitals in Birmingham, Alabama (Knight & Davis); Louisville, Kentucky, and Cincinnati, Ohio (S. Hannaford & Sons); Saginaw, Michigan (Giffels & Valet, Inc.); and St. Louis, Missouri (Naess & Murphy). This also appears to be the case with Syracuse, New York (see Figure 17 above). As described in the text above, cost saving measures caused the program to move away from the arrangement with the Corps of Engineers and private architectural firms to the VA staff (Figure 50).



DRAWING SHOWS GROUND PLAN for the 14½-story Veterans Administration Hospital which will be built on the east half of Vandeventer pl. The main entrance faces Grand blvd. The structure will cover 46,926 square feet. Three other buildings are included in the plan. The cost w ill be $15,000,000.

Figure 50. Here, the site plan prepared by a private architecture firm, through the Corps of Engineers, was presented in the St. Louis *Star Times* (May 12, 1948) but proved too costly to construct. This was also the case for the hospital initially planned in Syracuse, New York, as reported in the *Post Standard* in 1949 (see Section E, Figure 22, above). (Drawing of St. Louis (VA)).

In total, the Corps of Engineers developed sixty-one properties for the Veterans Administration, with another six (Fort Hamilton and Peekskill in New York; Fort Meade, Maryland; Medford, Oregon; Valley Forge, Pennsylvania; and Wilmington, Delaware) opening after 1954 and dissolution of the Corps' Hospital Branch. Ninety-five medical centers were identified as potential third generation hospitals from records of the Veterans Health Administration History Office and field histories of the U.S. Army Corps of Engineers. The end date for this list was 1954. Construction on the third generation of veterans' hospitals continued another four years and the most comprehensive count reaches one hundred at this writing. See Bianka Adams, *U.S. Army Engineer Veteran Hospital Program, 1946-1956*, Report February 2015, copy on file, VHA History. Thank you to Darlene Richardson, VHA Historian, for sharing this material.

Seventy-one of the medical centers were suggested for study at the beginning of the survey. Those lacking either a draft nomination or Determination of Eligibility report at the time of this contextual nomination, and so not listed in the table, include the hospitals in Little Rock, Arkansas; Fresno, California; Sepulveda, California; Grand Junction, Colorado; Baltimore, Maryland; Miles City, Montana; Minot, North Dakota; Batavia, New York; Lebanon, Pennsylvania; Pittsburgh (Highland Drive), Pennsylvania; and Seattle, Washington. Construction was directed by either the Corps of Engineers or the VA's staff architects or a combination thereof. The omissions include medical centers transferred to the VA from the military (i.e., Property Type I) in Oakland, California; Augusta, Georgia; Springfield, Missouri; Memphis, Tennessee; Nashville, Tennessee; Houston, Texas; and Richmond, Virginia. While the opening dates of these facilities suggest the medical centers fall under the auspices of the VA's third generation of hospitals, additional research needs to be done to determine if these are eligible for listing in the National Register under that context. See Section H, below.

State	City	Property Type	Date Approved	Date of Dedication	Architect/Builder	National Register Action
AL	**Birmingham**	III. New: VA Standard	1944	1953	VA	NRHP-DOE
AZ	**Phoenix**	II. New: USACE	1945	1951	Lescher, Mahoney & Lunden	NRHP-DOE
CA	**Long Beach**	I. Transitional: US Navy	1950	1950	Claud Beelman (1941 for Navy)	NRHP-DOE
CO	**Denver**	III. New: VA Standard	1947	1951	VA	NRHP-DOE
CT	**West Haven**	III. New: VA Standard	1946	1953	VA	NRHP-Draft Nomination
DE	**Wilmington**	II. New: USACE	1946	1950	Massena & DuPont	NRHP-DOE
GA	**Dublin**	I. Transitional: US Navy	1948	1948	Robert & Company	NRHP-Draft Nomination
IA	**Iowa City**	II. New: USACE	1945	1951	Ellerbe and Company	NRHP-DOE
IL	**Chicago**	III. New: VA Standard	1948*	1953	VA	NRHP-DOE
IN	**Fort Wayne**	II. New: USACE	1945	1950	Giffels and Vallet, Inc., with Alvin M. Strauss	NRHP-DOE
IN	**Indianapolis**	III. New: VA Standard	1946	1952	VA; J.L. Simmons Company, Inc., builders	NRHP-DOE
KS	**Topeka**	III. New: VA Haun Type	1947	1958	VA	NRHP-Draft Nomination
KY	**Louisville**	III. New: VA Standard	1945	1952	VA	NRHP-Draft Nomination
LA	**Shreveport**	II. New: USACE	1945	1950	Neild and Somdal	NRHP-DOE
MA	**Brockton**	III. New: VA Haun Type	1946	1953	VA	NRHP-Draft Nomination
MA	**West Roxbury**	I. Transitional: 2G	1941	1944	VA	NRHP-Draft Nomination
MA	**Boston**	II. New: USACE	1946	1952	Coolidge, Shepley, Bulfinch, and Abbot	NRHP-DOE
MI	**Iron Mountain**	II. New: USACE	1946	1950	Fugard, Olsen, Urbane, & Neiler	NRHP-Draft Nomination
MI	**Saginaw**	III. New: VA Standard	1946	1950	VA	NRHP-Draft Nomination
MI	**Ann Arbor**	III. New: VA Standard	1950	1953	VA	NRHP-DOE
MO	**Kansas City**	II. New: USACE	1945	1952	J. Gordon Turnbull, of Cleveland, and Wight & Wight	NRHP-DOE
MO	**Poplar Bluff**	II. New: USACE	1945	1951	P.M. O'Meara Associates Architects-Engineers	NRHP-DOE
MO	**St. Louis (John Cochran)**	III. New: VA Standard	1946	1954	VA	NRHP-DOE
NC	**Salisbury**	III. New: VA Haun Type	1944-45	1953	VA	NRHP-Draft Nomination
NC	**Durham**	II. New: USACE	1946	1953	Architect George Watts Carr, Sr., and the J.N. Pease Co.	NRHP-DOE
NE	**Grand Island**	II. New: USACE	1945	1950	P.M. O'Meara Associates Architects-Engineers	NRHP-Draft Nomination
NE	**Omaha**	II. New: USACE	1946	1953	Ellerbe & Company; Leo A. Daly	NRHP-Draft Nomination
NH	**Manchester**	II. New: USACE	1945	1949	James H. Ritchie and Associates	NRHP-Draft Nomination
NJ	**East Orange**	II. New: USACE	1946	1952	Ziegler, Childs & Paulsen	NRHP-Draft Nomination
NY	**Albany**	II. New: USACE	1945	1951	Eggers & Higgins	NRHP-Draft Nomination
NY	**Brooklyn**	II. New: USACE	1946	1950	Skidmore, Owings, & Merrill (SOM)	NRHP-Draft Nomination

NY	**Buffalo**	II. New: USACE	1945	1950	Green & James; Eggers & Higgins	NRHP-Draft Nomination
NY	**Montrose**	I. Transitional: 2G	1944/1946	1950	VA	NRHP-Draft Nomination
NY	**New York (Manhattan)**	II. New: USACE	1946	1954	Alfred Hopkins Associates	NRHP-DOE
NY	**Syracuse**	III. New: VA Standard	1945	1953	VA Architect Walter Smith	NRHP-DOE
OH	**Cincinnati**	III. New: VA Standard	1946	1954	VA	NRHP-DOE
OK	**Oklahoma City**	III. New: VA Standard	1946	1953	VA; Robert McKee, General Contractor	NRHP-DOE
PA	**Butler**	I. Transitional: 3d Party	1946	1946	Edward B. Lee	NRHP-Draft Nomination
PA	**Altoona**	II. New: USACE	1945	1950	Marlier, Wolfe & Johnstone	NRHP-DOE
PA	**Erie**	II. New: USACE	1946/1947	1951	Marlier, Wolfe & Johnstone	NRHP-DOE
PA	**Philadelphia**	III. New: VA Standard	1946	1952	VA; John McShain, Inc., builder/contractor	NRHP-DOE
PA	**Pittsburgh (University)**	II. New: USACE	1945	1954	Mitchell & Ritchey	NRHP-DOE
PA	**Wilkes-Barre**	II. New: USACE	1945	1950	Kelly & Gruzen	NRHP-DOE
RI	**Providence**	II. New: USACE	1945	1949	VA; E. Turgeon Construction Company	NRHP-DOE
SD	**Fort Meade**	I. Transitional: US Army	1944	1944	US Army	NRHP-Draft Nomination
SD	**Sioux Falls**	I. Transitional: 3d Party	1944	1949	VA	NRHP-DOE
TX	**Big Spring**	II. New: USACE	1945	1950	Wyatt C. Hedrick	NRHP-Draft Nomination
TX	**Bonham**	II. New: USACE	1945	1951	Finger & Rustay	NRHP-Draft Nomination
TX	**Temple**	I. Transitional: US Army	1946	1946	US Army	NRHP-DOE
UT	**Salt Lake City**	III. New: VA Haun Type	1946	1952	Ashton, Evans & Brazier and McClenahan	NRHP-DOE
WA	**Spokane**	II. New: USACE	1945	1950	John Graham, Jr	NRHP-DOE
WI	**Tomah**	I. Transitional: BIA/Army	1945	1945	VA; Gust Newberg Construction Company	NRHP-Draft Nomination
WI	**Madison**	II. New: USACE	1946	1951	Holabird & Root	NRHP-DOE
WV	**Beckley**	II. New: USACE	1946	1950	Tucker & Silling	NRHP-DOE
WV	**Clarksburg**	II. New: USACE	1946	1950	Tucker & Silling	NRHP-DOE
WV	**Martinsburg**	I. Transitional: US Army	1946	1946	US Army	NRHP-DOE

Note: Abbreviations used in the table reference the National Register of Historic Places (NRHP); a Determination of Eligibility report (DOE) that surveys and evaluates each property for eligibility for listing in the National Register; and the U.S. Army Corps of Engineers (USACE). A DOE report does not infer the property is eligible, just indicates that the property was evaluated and a report compiled.

The fifty-six Veterans Administration Hospitals included here were evaluated as part of the resource study for the third generation of veterans' hospitals that underpins this nomination. Draft nominations were prepared for the properties recommended for listing under this context, and the DOE reports serve as updated documentation for the properties found to be ineligible for listing at this time.

Compilation
Veterans Administration Hospitals Opened 1946 and 1958[312]

State	City	Property Type	Date of Dedication or Opening	National Register Action under this Context
AL	**Birmingham**	III. New: VA Standard	1953	NRHP-DOE
AR	**Little Rock**	VA*	1950*	None
AZ	**Phoenix**	II. New: USACE	1951	NRHP-DOE
CA	**Fresno**	VA*	1950*	None
CA	**Long Beach**	I. Transitional: US Navy	1950	NRHP-DOE
CA	**Oakland**	Army*	1946*	None
CA	**Sepulveda**	VA*	1955*	None
CA	**Van Nuys**	Army*	1946-1950*	None
CO	**Denver**	III. New: VA Standard	1951	NRHP-DOE
CO	**Fort Logan**	Army*	1946-1951*	None
CO	**Grand Junction**	VA*	1949*	None
CT	**West Haven**	III. New: VA Standard	1953	NRHP-Draft Nomination
DE	**New Castle**	Army*	1946-1950*	None
DE	**Wilmington**	II. New: USACE	1950	NRHP-DOE
FL	**Coral Gables**	Army*	1947-1968*	None
FL	**Miami Beach**	Army*	1946*	None
GA	**Augusta**	US Army*	1951*	None
GA	**Chamblee**	US Army*	1946*	None
GA	**Dublin**	I. Transitional: US Navy	1948	NRHP-Draft Nomination
GA	**Thomasville**	US Army*	1946-1965*	None
IA	**Clinton**	Army*	1948-1965*	None
IA	**Iowa City**	II. New: USACE	1951	NRHP-DOE
IL	**Chicago**	III. New: VA Standard	1953	NRHP-DOE
IL	**Chicago/Vaughn**	Army/USACE*	1946*	None
IL	**Lawrence**	Navy*	1947*	None
IL	**McIntire**	Navy*	1947*	None
IN	**Fort Benjamin Harrison**	Army*	1946-1953*	None
IN	**Fort Wayne**	II. New: USACE	1950	NRHP-DOE
IN	**Indianapolis**	III. New: VA Standard	1952	NRHP-DOE
KS	**Topeka**	III. New: VA Haun Type	1958	NRHP-Draft Nomination
KY	**Louisville**	III. New: VA Standard	1952	NRHP-Draft Nomination
LA	**New Orleans**	VA*	1954*	None
LA	**Shreveport**	II. New: USACE	1950	NRHP-DOE
MA	**Brockton**	III. New: VA Haun Type	1953	NRHP-Draft Nomination
MA	**Framingham**	Army*	1946-1953*	None
MA	**West Roxbury**	I. Transitional: 2G	1944	NRHP-Draft Nomination
MA	**Boston**	II. New: USACE	1952	NRHP-DOE
MD	**Baltimore**	VA*	1952*	None
MD	**Fort Meade**	USACE*	N.D.*	None

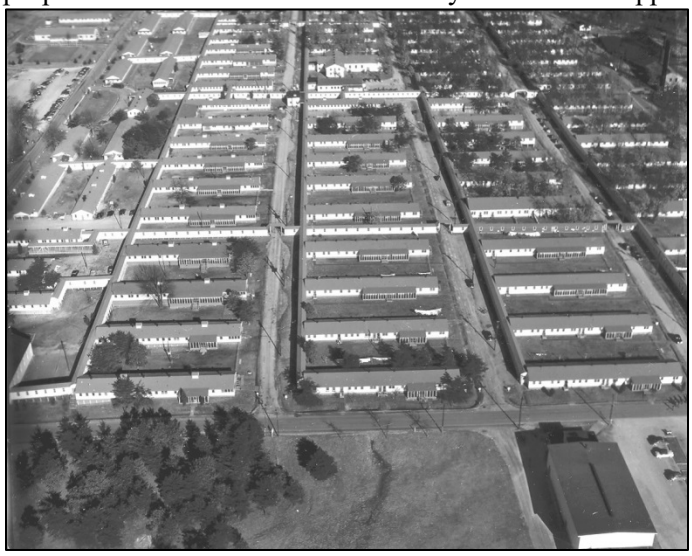
[312] This table is derived from the listing of veterans' hospitals that was generated in support of Dr. Bianka Adams' research on the U.S. Army Corps of Engineers Veterans Hospital Construction Program (1946-1956). There are one hundred medical centers included.

MI	**Iron Mountain**	II. New: USACE	1950	NRHP-Draft Nomination
MI	**Saginaw**	III. New: VA Standard	1950	NRHP-Draft Nomination
MI	**Ann Arbor**	III. New: VA Standard	1953	NRHP-DOE
MN	**Fort Snelling**	Army*	1947*	None
MO	**Kansas City**	II. New: USACE	1952	NRHP-DOE
MO	**Poplar Bluff**	II. New: USACE	1951	NRHP-DOE
MO	**St. Louis (John Cochran)**	III. New: VA Standard	1954	NRHP-DOE
MO	**Springfield**	Army*	1947	None
MS	**Jackson**	Army*	1946-1962*	None
MT	**Miles City**	VA*	1951*	None
NC	**Salisbury**	III. New: VA Haun Type	1953	NRHP-Draft Nomination
NC	**Durham**	II. New: USACE	1953	NRHP-DOE
NC	**Swannanoa**	Army*	1946-1960*	None
ND	**Minot**	USACE*	1950-1959*	None
NE	**Grand Island**	II. New: USACE	1950	NRHP-Draft Nomination
NE	**Omaha**	II. New: USACE	1953	NRHP-Draft Nomination
NH	**Manchester**	II. New: USACE	1949	NRHP-Draft Nomination
NJ	**East Orange**	II. New: USACE	1952	NRHP-Draft Nomination
NY	**Albany**	II. New: USACE	1951	NRHP-Draft Nomination
NY	**Batavia**	VA*	1951*	None
NY	**Brooklyn**	II. New: USACE	1950	NRHP-Draft Nomination
NY	**Buffalo**	II. New: USACE	1950	NRHP-Draft Nomination
NY	**Montrose**	I. Transitional: 2G	1950	NRHP-Draft Nomination
NY	**New York (Manhattan)**	II. New: USACE	1954	NRHP-DOE
NY	**Sampson**	Navy*	1946-1947*	None
NY	**Staten Island**	Army*	1947-1951*	None
NY	**Syracuse**	III. New: VA Standard	1953	NRHP-DOE
OH	**Cincinnati**	III. New: VA Standard	1954	NRHP-DOE
OH	**Cleveland**	US Army*	1946-1964*	None
OK	**Oklahoma City**	III. New: VA Standard	1953	NRHP-DOE
OR	**Medford**	USACE*	N.D.*	None
PA	**Butler**	I. Transitional: 3d Party	1946	NRHP-Draft Nomination
PA	**Altoona**	II. New: USACE	1950	NRHP-DOE
PA	**Erie**	II. New: USACE	1951	NRHP-DOE
PA	**Lebanon**	VA*	1947*	None
PA	**Philadelphia**	III. New: VA Standard	1952	NRHP-DOE
PA	**Pittsburgh (Leech Farm)**	VA/USACE*	1953*	None
PA	**Pittsburgh (University Drive)**	II. New: USACE	1954	NRHP-DOE
PA	**Valley Forge**	USACE*	N.D.*	None
PA	**Wilkes-Barre**	II. New: USACE	1950	NRHP-DOE
PR	**San Juan**	Navy*	1946	None
RI	**Providence**	II. New: USACE	1949	NRHP-DOE
SD	**Fort Meade**	I. Transitional: US Army	1944	NRHP-Draft Nomination
SD	**Sioux Falls**	I. Transitional: 3d Party	1949	NRHP-DOE
TN	**Memphis**	Army*	1946*	None
TN	**Nashville**	Army*	1946*	None
TX	**Big Spring**	II. New: USACE	1950	NRHP-Draft Nomination
TX	**Bonham**	II. New: USACE	1951	NRHP-Draft Nomination
TX	**Houston**	Navy*	1949*	None
TX	**McKinney**	Army*	1946*	None

TX	**Marlin**	VA*	1950-2008*	None
TX	**Temple**	I. Transitional: US Army	1946	NRHP-DOE
UT	**Salt Lake City**	III. New: VA Haun Type	1952	NRHP-DOE
VA	**Richmond**	Army*	1946	None
WA	**Vancouver**	US Army*	1946-1947*	None
WA	**Seattle**	VA*	1951*	None
WA	**Spokane**	II. New: USACE	1950	NRHP-DOE
WI	**Tomah**	I. Transitional: BIA/Army	1945	NRHP-Draft Nomination
WI	**Madison**	II. New: USACE	1951	NRHP-DOE
WV	**Beckley**	II. New: USACE	1950	NRHP-DOE
WV	**Clarksburg**	II. New: USACE	1950	NRHP-DOE
WV	**Martinsburg**	I. Transitional: US Army	1946	NRHP-DOE

*Note: Veterans Administration Hospitals marked with an asterisk were opened during the time of the third generation program but research needs to be done to determine if the properties are eligible for listing under this context. For example, the field histories include the earlier hospital at Brooklyn (opened in 1946, closed in 1950) as well as the existing one built on the Fort Hamilton site. This is also true of the Topeka, Kansas, hospital - the earlier military one (1946-1958) and the third generation hospital that opened in 1958. Only the latter is included here. So, too, for Louisville, Kentucky; Montrose (Peekskill), New York; Oklahoma City, Oklahoma; and Phoenix, Arizona. The Oklahoma City hospital was open from 1946 to 1953, while the Phoenix facility operated from 1946 to 1951 and that in Louisville from 1946 to 1952. A series of medical facilities served New Orleans, beginning with an army hospital transferred to the VA in 1946; a naval hospital in 1947; a hospital built by the VA in 1952 that closed in 2005, and another VA hospital that opened in 1954. The sites are counted once and number one hundred property locations in all. Sources include records of the Veterans Health Administration and field histories of the U.S. Army Corps of Engineers.

Those omitted from the 1952 report are the facilities transferred to the Veterans Administration, primarily from the armed forces during the demobilization following World War II, located in California, Colorado, Delaware, Florida, Georgia, Iowa, Illinois, Indiana, Massachusetts, Maryland, Missouri, Mississippi, North Carolina, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Texas, Virginia, Wisconsin, and West Virginia. The properties transferred from the military are listed in Appendix C.



Fort George Meade, Maryland, in 1952, view looking to the patient wards. This is an example of the cantonment type military hospital (NARA).

H. Summary of Identification and Evaluation Methods

Survey for the *United States Third Generation Veterans Hospitals, 1946-1958*, historic context and multiple property documentation form began with preliminary identification of those hospitals constructed in response to World War II.[313] Additional identification and information was provided by the Historic Preservation Office, Office of Construction and Facilities Management, Department of Veterans Affairs in Washington, DC. Publications authored by the Veterans Administration, such as the Administrator of Veterans Affairs *Annual Reports* and *Medical Care of Veterans*, were instrumental in culling out those properties that were constructed in the period of and immediately following World War II. Once identified, ten hospitals were chosen for the first round of survey, with additional hospitals surveyed subsequently.[314] These hospitals were selected as representative hospitals constructed by the Veterans Administration following World War II in terms of hospital type, location, and architectural style. Each site survey included photographic documentation of the exterior of the historic resources, limited photographic documentation of the interior of the main hospital, review of original and/or early architectural drawings, consultation with the hospital staff regarding the hospital history, and research at the local repositories regarding the development of the Veterans Administration hospital in the area.

Research for the historic context was conducted at the Washington, DC, and College Park, Maryland, facilities of the National Archives and Records Administration, particularly for Record Group #15, the records of the Veterans Administration (now U.S. Department of Veterans Affairs). Additional research was conducted at the archives of the American Institute of Architects in Washington, DC, and the Matas Health Sciences Library, the Architecture Library, and the Howard-Tilton Library, all located at Tulane University, New Orleans, Louisiana. Medical field journals, such as *Modern Hospital, Hospitals,* and *Hospital Administration* provided valuable information regarding modern hospital requirements during the period following World War II. Parallel information on modern hospital design was located in architectural journals such as *Progressive Architecture* and *Architectural Record*.

Property types identified as significant were based on the identification of those hospitals and their associated buildings constructed or managed by the Veterans Administration during the postwar period. These buildings were primarily the main hospital, but also included the buildings that provided support services, such as laundries

[313] The preliminary listing referenced here was unavailable during the review period (fall/winter 2017), and a compilation of the hospital centers constructed for Section G, above.
[314] Based on an internal progress-report in 2011, the first surveyed likely included the medical centers in Bonham, Texas; Kansas City, Missouri; Spokane, Washington; Brooklyn, New York; Montrose, New York; St. Louis, Missouri; Brockton, Massachusetts; and Louisville, Kentucky. – vbp, January 2018.

or power houses. Because the Veterans Administration instigated several temporary measures during the course of the postwar program, the significant properties also included those structures employed by the VA to provide health care even if they had been constructed initially by another organization.

Integrity requirements were based on site visits conducted of the representative hospital types and review of historic documentation including architectural drawings and photographs, combined with the VA's documentation regarding changes made to the historic structures.

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Appendix A

In 1946 the Veterans Administration identified seventy-six sites for the construction of a new third generation of veterans' hospital, with the projected number and type of beds: General Medical and Surgical (GM&S), Neuropsychiatric (NP), Tuberculosis (TB) and Domiciliary.[315]

The following list of proposed locations does not include those hospitals already under construction at the time of the *Annual Report*, such as Tomah, Wisconsin, or army hospitals that were later replaced with a modern facility, such as that in Topeka, Kansas (see Figure 31).[316] Nor does it include the two general medical and surgical hospitals, one in Batavia, New York, and the other in Montgomery, Alabama, that were slated to become tuberculosis hospitals and the twenty-two marked for expansion.[317]

Albany, NY	800 beds GM&S, 200 beds NP
Altoona, PA	200 GM&S
Ann Arbor, MI	500 TB
Baltimore, MD	300 TB
Beckley, WV	200 GM&S
Big Spring, TX	250 GM&S
Birmingham, AL	500 GM&S
Bonham, TX	50 GM&S, 300 Domiciliary
Boston, MA	1,000 GM&S
Brooklyn, NY	800 GM&S, 200 NP
Buffalo, NY	800 GM&S, 200 NP
Charlotte, NC	500 GM&S
Chattanooga, TN	500 GM&S
Chicago, IL	600 GM&S
Cincinnati, OH	750 GM&S
Clarksburg, WV	200 GM&S
Dallas, TX	500 GM&S
Decatur, IL	250 GM&S
Duluth, MN	200 GM&S
Durham, NC	500 GM&S
Eastern Connecticut	400 TB
El Paso, TX	500 NP
Erie, PA	200 GM&S
Fresno, CA	250 GM&S
Ft. Wayne, IN	200 GM&S
Gainesville, FL	1,000 NP
Grand Island, NE	200 GM&S
Grand Junction, CO	150 GM&S

[315] *Annual Report for the Fiscal Year ending June 30, 1946* (Washington, D.C.: Government Printing Office, 1946): 176.
[316] The *Annual Report* listed Kansas City twice, once for the general medical and surgical facility and once for the smaller tuberculosis one (250 beds). Here the city is listed only one time.
[317] Thus the twenty-four projects that were additions (rather than new hospitals) announced in the *Annual Report* (p. 46) include hospitals in Batavia, New York, and Montgomery, Alabama, plus: Bedford and Northampton in Massachusetts; Bath, New York; Atlanta, Georgia; Bay Pines, Florida; Columbus, South Carolina; Mountain Home, Tennessee; Tuskegee, Alabama; Brecksville and Dayton in Ohio; Downey, Illinois; Lincoln, Nebraska; Minneapolis, Minnesota; Alexandria, Louisiana; Biloxi and Gulfport in Mississippi; Portland and Roseburg in Oregon; Livermore and San Fernando in California; and Salt Lake City, Utah.

Grand Rapids, MI	200 GM&S
Greenville, SC	200 GM&S
Harrisburg, PA	200 GM&S
Houston, TX	1,000 NP
Indianapolis, IN	500 GM&S
Iowa City, IA	500 GM&S
Iron Mountain, MI	250 GM&S
Kansas City, MO	495 GM&S, 250 TB
Klamath Hills, OR	200 GM&S
Little Rock, AR	500 GM&S
Louisville, KY	750 GM&S
Madison, WI	500 TB
Manchester, NH	150 GM&S
Miles City, MT	100 GM&S
Minot, ND	150 GM&S
Miss – Ala Area	200 GM&S
Montrose, NY	1,984 NP
New Haven, CT	500 GM&S
New Orleans, LA	500 GM&S
New York, NY	800 GM&S, 200 NP
Newark, NJ	1,000 GM&S
Oklahoma City, OK	1,000 NP
Omaha, NE	500 GM&S
Philadelphia, PA	1,000 GM&S
Phoenix, AZ	200 GM&S
Pittsburgh, PA	1,248 GM&S
Poplar Bluff, MO	200 GM&S
Providence, RI	400 GM&S
Saginaw, MI	200 GM&S
Salisbury, NC	921 NP
Salt Lake City, UT	500 NP
Seattle, WA	300 GM&S
Shreveport, LA	450 GM&S
Sioux Falls, SD	300 GM&S
Southwest Georgia	250 TB
Southern Minnesota	200 GM&S
Southern Missouri	1,000 NP
Spokane, WA	200 GM&S
St. Louis, MO	500 NP
Syracuse, NY	800 GM&S, 200 NP
Tallahassee, FL	200 GM&S
Toledo, OH	1,000 NP
Tupelo, MS	200 GM&S
Washington, DC	750 GM&S
Western Pennsylvania	1,300 NP
Wilkes - Barre, PA	475 GM&S
Wilmington, DE	300 GM&S

Appendix B: Hospital projects cancelled as part of the 16,000 bed cutback for 1950.[318]

Americus, GA
Charlotte, NC
Chattanooga, TN
Columbia, SC
Decatur, IL
Detroit, MI
Duluth, MN
El Paso, TX
Gainesville, FL
Grand Rapids, MI
Greenville, SC
Harrisburg, PA
Houston, TX
Klamath Falls, OR
Memphis, TN
Mound Bayou, MS
New York, NY
Norman, OK
Salisbury, NC
San Diego, CA
Tallahassee, FL
Thomasville, GA
Toledo, OH
Tupelo, MS

Note: In 1949 President Truman recommended reducing 16,000 beds from the Veterans Administration hospital construction program which resulted in either the elimination of projects altogether or a smaller-scale facility. Initial references to the President's order are consistent in the reference to beds, which eliminated twenty-four from the plans. Another fourteen hospitals were reduced in size, and those planned for St. Louis, Missouri; Cleveland, Ohio; and two in Pittsburgh, Pennsylvania, were among them. [319] The veterans' hospital construction program continued nonetheless, with the cancellation of the hospital in Houston, Texas, offset by the transfer of the naval facility there to the VA, and another twenty-eight scheduled to be completed – though not activated – in

[318] *MCV*, 224-25. The list here was taken from a news release by the VA on January 10, 1949. In the report, Memphis is incorrectly noted as located in "Tex.". See p. 225.
[319] "28 New Veteran Hospitals Planned," *Tucson (Arizona) Daily Citizen*, December 2, 1949, 6; Truman Felt, "Proposed 1000-Bed VA Hospital Here Reduced by Half," *St. Louis Star and Times*, January 10, 1949, 1; "Truman Asks Veterans Hospital Cut," *Tampa Daily News*, January 11, 1949, 3; "Veterans Fight Cut in Hospital Program," *Battle Creek Enquirer*, January 27, 1949, 6; ""State Committee Will Investigate Vet Hospital Cut," *Bradford Era* (Pennsylvania), January 20, 1949, 6; "Tennessee Congressmen Fight Cancellation of Veterans Hospitals," *Kingsport Times*, March 29, 1949, 9; "Fewer Hospitals," *Portland Press Herald*, March 29, 1949, 1 .

1950. At the close of the fiscal year in June 1950, the construction branch had fifty-eight projects, including forty-six new hospitals. Five of those were completed (Tomah, Wisconsin; Lebanon, Pennsylvania; Grand Junction, Colorado; Providence, Rhode Island; and Sioux Falls, South Dakota), and forty-one were under construction. The remaining twenty-one hospitals were not yet under contract, making a total of sixty-seven on the VA's docket. Of the thirty-seven new hospitals, the Corps of Engineers was responsible for twenty-eight; of the twelve additions, the VA staff took eleven and the Corps one project. At the time, the VA had 136 hospitals in its network, with eighteen tuberculosis, thirty-four neuropsychiatric, and eighty-four general medical and surgical hospitals across the country. Staffing shortages were responsible for 40 percent of the system's unused beds (Figure 51).[320]

Hospitals mentioned specifically were those located in Big Spring, Texas; Denver, Colorado; Fresno, California; Marlin, Texas; Miles City, Montana; Seattle and Spokane, in Washington. Nine were activated, including several previously enumerated in the VA's *Annual Report* as complete such as the hospital centers in Sioux Falls and Fresno. The others were in Delaware and New York, where two existing facilities were then closed; plus one each in Indiana, Michigan, and New Hampshire. Twenty projects were scheduled for completion in the fiscal year 1951 and another seventeen in fiscal year 1952.[321]

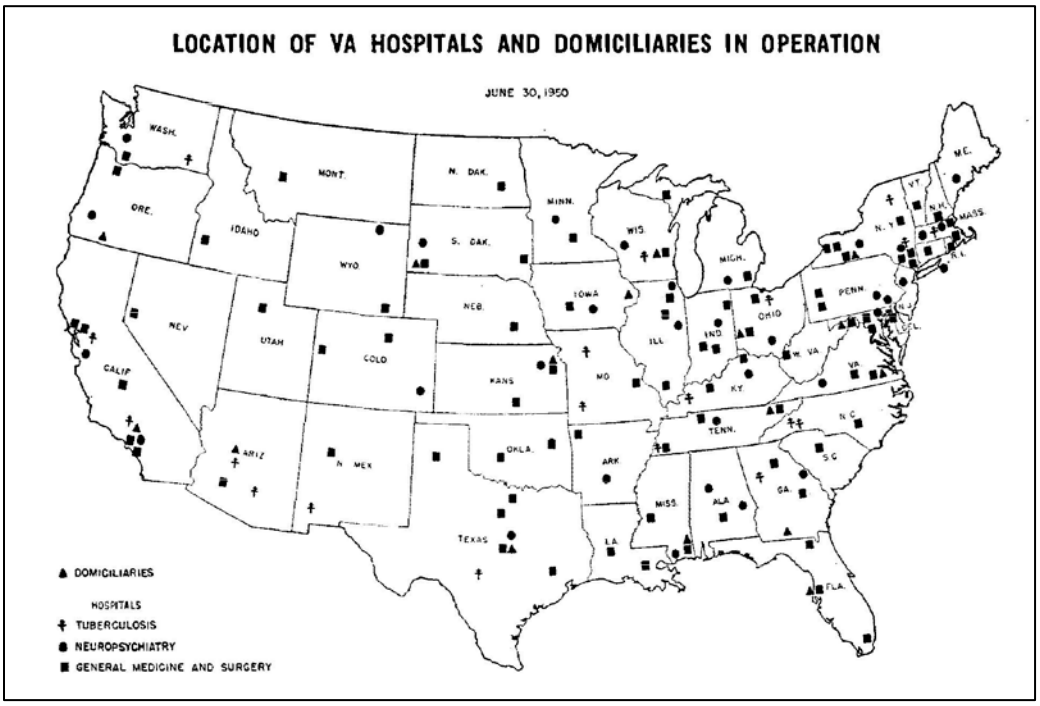

Figure 51. *Annual Report* 1950.

[320] *Annual Report* 1950, 1, 9-10, 99. See also Sections E and G, above.
[321] *Annual Report* 1950, 1, 9-10, 99.

Appendix C: Armed Forces Facilities Transferred to the Veterans Administration after World War II.[322]

Ashburn General Hospital (Army), McKinney, TX (closed 1965)
Barnes General Hospital (Army), Vancouver, WA (replaced)
Baxter General Hospital (Army), Spokane, WA (replaced)
Billings General Hospital (Army), Indianapolis, IN (closed 1953)
Birmingham General Hospital (Army), Van Nuys, CA (closed 1950)
Camp Lawrence (Navy), Lawrence, IL (returned to Navy ca. 1961)
Camp McIntire (Navy), McIntire, IL (returned to Navy ca. 1961)
Crile General Hospital (Army), Cleveland, OH (closed 1964)
Cushing General Hospital (Army), Framingham, MA (closed 1953)
Deshon General Hospital (Army), Butler, PA (open)
Dublin Naval Hospital (Navy), Dublin, GA (open)
Finney General Hospital (Army), Thomasville, GA (closed 1965)
Fort Logan (Army), Denver, CO (closed 1951)
Fort Meade (Army), Fort Meade, SD (open)
Fort Snelling (Army), Minneapolis, MN (open, part of Minneapolis VAMC)
Foster General Hospital (Army), Jackson, MS (closed 1962)
Halloran General Hospital (Army), Staten Island, NY (closed 1951)
Houston Naval Hospital (Navy), Houston, TX (replaced)
Kennedy General Hospital (Army), Memphis, TN (closed 1967)
LaGarde General Hospital (Army), New Orleans, LA (closed 1947)
Lawson General Hospital (Army), Atlanta, GA (closed 1966)
Long Beach Naval Hospital (Navy), Long Beach, CA (open)
McCloskey General Hospital (Army), Temple, TX (open)
McGuire General Hospital (Army), Richmond, VA (replaced)
Moore General Hospital (Army), Swannanoa, NC (closed 1960)
Nautilus General Hospital (Army), Miami Beach, FL (closed 1947)
New Castle Airfield (Army), Wilmington, DE (closed 1950)
New Orleans Naval Hospital (Navy), New Orleans, LA (closed 1952)
Newton D. Baker General Hospital (Army), Martinsburg, WV (open)
Nichols General Hospital (Army), Louisville, KY (closed 1952)
Oakland Army Regional Hospital (Army), Oakland, CA (closed 1963)
O'Reilly General Hospital (Army), Framingham, MA (closed 1953)
O'Reilly General Hospital (Army), Springfield, MO (closed 1952)
Papago Park Prisoner-of-War Camp (Army), Phoenix, AZ (closed 1951)
Sampson Naval Training Base (Navy), Sampson, NY (closed 1947)
San Juan Naval Hospital (Navy), San Juan, PR (replaced)
Schick General Hospital (Army), Clinton, IA (closed 1965)
Thayer General Hospital (Army), Nashville, TN (closed 1963)
Vaughan General Hospital (Army), Hines, IL (part of Hines VAMC, likely demolished)
Camp White (Navy), White City, OR (open)
Will Rogers ADF Station Hospital (Army), Oklahoma City, OK (closed 1953)
Winter General Hospital (Army), Topeka, KS (closed 1958)

[322] Smith, *United States Army in World War II,* 304-13; *MCV*, 395-409.

Appendix D: Biographical Sketch - General Omar Bradley (1893-1981)

General Omar Nelson Bradley served as the first post-World War II chief of the Veterans Administration. Born on February 12, 1893, Bradley grew up in the hardscrabble farming and coal mining country of central Missouri. Upon graduating with the fabled West Point class of 1915, he entered the U.S. Army as a second lieutenant of the 3rd Battalion, 14th Infantry Regiment, based near Spokane, Washington, at Fort George Wright.[323] These early years of military study and training led to a stellar career with the U.S. Army during wartime and in postwar service.

In August of 1911, Bradley entered the United States Military Academy at West Point. While there, he excelled in sports, particularly baseball and football.[324] In fact, according to one biographer, Bradley "believed that sports taught the art of group cooperation and took pride in the fact that every member of the 1914 [baseball] team who remained in the Army became a general officer."[325] By his own admission, Bradley stood out more in athletics than in academic studies; nevertheless, he graduated in the top third of his class.[326] This class of 1915 became known as "the class the stars fell on" because 59 of its 164 graduates reached the rank of brigadier general or higher – a West Point record.[327] Besides Bradley, these notable graduates included Dwight David "Ike" Eisenhower, future commander of Allied forces during World War II and 34th President of the United States, and Joseph M. Swing, commander of the 11th Airborne Division during World War II and the Occupation of Japan.[328]

Following graduation from West Point, Bradley served the U.S. Army in numerous capacities, including infantry duties in several American locations, mathematics instructor at West Point, instructor in tactics and other operations at various military schools, and officer in charge of the National Guard and of Reserve/ROTC affairs for the U.S. Territory of Hawaii. Over the decades between World Wars I and II, Bradley continued to move upward in his infantry career. By the time Britain and France declared war on Nazi Germany on September 3, 1939, he was serving on the U.S. War Department General Staff in Washington, D.C., as an assistant secretary to the Chief of Staff, General George C. Marshall. In February 1941, Bradley was ordered to assume the command

[323] Omar N. Bradley and Clay Blair, *A General's Life: An Autobiography* (New York: Simon and Schuster, 1983), 17-18, 31, 37.
[324] Bradley and Blair, 29-34.
[325] Charles E. Kirkpatrick, *The Centennial: Omar Nelson Bradley* (Washington, D.C.: United States Army, 1992), http://www.history.army.mil/brochures/Bradley/Bradley.htm (accessed December 3, 2010).
[326] Bradley and Blair, 34.
[327] "Notable USMA Graduates," United States Military Academy at West Point, http://www.usma.edu/notablegrads.asp (accessed December 9, 2010)
[328] "Notable USMA Graduates"; Bradley and Blair, 31; "World War II Divisional Combat Chronicles: 11th Airborne Division," U.S. Army Center of Military History, last modified June 24, 2010, http://www.history.army.mil/html/forcestruc/cbtchron/cc/011abd.htm (accessed December 21, 2010)

of both Fort Benning (Georgia) and its Infantry School. As commandant, he was promoted to the temporary rank of brigadier general, the first of his West Point class to achieve that rank.[329]

Several months after Bradley took command at Fort Benning, Japan attacked Pearl Harbor on December 7, 1941, prompting a drastic turn in his military career track. With the Army activating (or re-activating) additional infantry divisions, Bradley received a temporary promotion to major general and command, first, of the 82nd Infantry Division and, then, the 28th National Guard Division, both of which trained in the Alexandria, Louisiana, region.[330] As World War II continued, Bradley was promoted to permanent ranks, successively, of brigadier general and major general. He commanded forces in North Africa and Sicily in 1943, and he "commanded the [U.S.] First Army and the 12th Army Group in the [Normandy] invasion and final campaigns of western Europe, 1944-1945."[331]

While still in command of the 12th Army Group in Europe, Bradley was appointed by President Harry Truman in June 1945 to take over as head of the Veterans Administration.[332] The previous administrator, Brigadier General Frank Hines, had held that office for 22 years, but, as noted above, he faced growing criticism as hundreds of thousands of World War II Veterans entered an antiquated system that was ill-equipped to handle the ever-increasing needs of returning military personnel. As hostilities were drawing to a close, the Commander-in-Chief "felt that World War II Veterans should have a World War II Veteran to run the show."[333] By appointing Bradley (dubbed "The Doughboy's General" by *Time* magazine[334]), Truman "took out of the war one of his best field commanders" and "the top tactician in the European Theater."[335]

On November 21, 1947, President Truman announced Bradley's appointment as U.S. Army Chief of Staff, succeeding General Eisenhower. Bradley stepped down from VA on November 30, but he did not assume his new position until February 7, 1948. He served as Chief of Staff until August 16, 1949, at which time he became the first Chairman of the Joint Chiefs of Staff (as officially established), 1949-1953. Bradley also was appointed first Chairman of the Military Committee of the North Atlantic Treaty Organization (NATO), 1949-1950, and he

[329] Bradley and Blair, 59, 79-86, 94; Kirkpatrick, *Centennial*; "Omar Nelson Bradley," U.S. Army Center of Military History, last modified October 3, 2003, http://www.history.army.mil/faq/brad_bio.htm (accessed December 3, 2010).
[330] Bradley and Blair, 102-11; Kirkpatrick, "Omar Nelson Bradley."
[331] Kirkpatrick, "Omar Nelson Bradley."
[332] Charles Hurd, "Bradley Is Sworn As Veterans' Head," Special to *The New York Times*, August 16, 1945, http://www.nytimes.com/ref/membercenter/nytarchive.html (December 30, 2010).
[333] "Inspired Choice," *Time*, June 18, 1945, http://www.time.com/time/magazine/article/0,9171,775886,00.html (accessed December 8, 2010).
[334] Bradley and Blair, 241.
[335] "Inspired Choice."

continued as the U.S. representative to that body until August 1953. On September 22, 1950, President Truman and Congress promoted Bradley to the rank of General of the Army – the only officer promoted to that five-star rank since World War II.[336]

Nearly four decades following his graduation from West Point, General Omar Bradley retired from active military service in mid-August of 1953, although, by law, he remained on the Army rolls as an "active" five-star general for the remainder of his life. In 1954, he entered the civilian sector as Chairman of the Board of the Bulova Research and Development Laboratories, a company he had grown to respect for its Veterans' rehabilitation program; four years later, he became Chairman of the Bulova Watch Company (he also served as a director to a few other companies in the private sector). Bradley retired from Bulova in 1973, although he maintained ties to the corporation as a consultant and honorary chairman.[337] Throughout his years of civilian service and retirement, he maintained his Army interests and contacts, becoming "a sort of senior military statesman" for the nation.[338] General Omar Nelson Bradley died on April 8, 1981, at the age of 88 years; he was buried at Arlington National Cemetery with full military honors.[339]

[336] Bradley and Blair, 467-70, 504-06, 552-53, 648, 662; Kirkpatrick, "Omar Nelson Bradley."
[337] Bradley and Blair, 461-62, 662-68; Kirkpatrick, *Centennial* ; "The History of Bulova," Bulova Corporation, last modified ca. 2002, http://www.bulova.com/about/history.aspx (accessed January 4, 2011).
[338] Bradley and Blair, 665.
[339] Bradley and Blair, 670.