United States Department of the Interior
National Park Service

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

B. Associated Historic Contexts

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

United States Second Generation Veterans Hospitals

Changes in Veterans Health Treatment During the Interwar Period

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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.

_____ _____ _____
Signature of certifying official Title Date

_____
State or Federal Agency or Tribal government

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 of the Keeper Date of Action

United States Department of the Interior
National Park Service

United States Third Generation Veterans Hospitals | Nationwide
Name of Multiple Property Listing | State

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 — Page Numbers

(If more than one historic context is documented, present them in sequential order.)

F. Associated Property Types

(Provide description, significance, and registration requirements.)

E. Statement of Historic Context

Through a combination of existing facilities and new construction, the Veterans Administration (VA), the forerunner to the modern day U.S. Department of Veterans Affairs, created a system to provide modern hospitals for primarily the Veterans of World War II, but also for all Veterans of previous conflicts. This massive hospital construction campaign occurred concurrently with nationwide construction of healthcare facilities, thus allowing VA to take advantage of the proliferation of architectural and medical knowledge regarding hospitals in the postwar period. This "Third Generation" of Veterans Hospitals are not a collection of identical buildings or architectural styles, yet the group, as a whole, represents the Federal response to the need for healthcare facilities for Veterans following World War II.

With the influx of 20,000,000 World War II Veterans added to the overall Veteran population, the existing VA hospital system was strained due to the pressing need for more beds in more facilities. Hospitals routinely had waiting lists, and as deployment accelerated, the need became even greater. VA's approach to hospital construction before World War II resulted in hospitals located in remote locations based on political pressure rather than on medical needs, with sizeable campuses of multiple low rise buildings housing large wards. VA discouraged its doctors from conducting research and medical organizations did not allow VA doctors to join, thus isolating them from new ideas in the medical field. Journalists and lawmakers became concerned that the previous approach VA had taken to hospital design and development was no longer suitable for these newly returning Veterans.

VA responded with a war hero, General Omar Bradley. During his tenure as VA's chief Administrator, Bradley initiated sweeping changes to the organization, including the creation of the Department of Medicine and Surgery that removed VA doctors from Civil Service and placed them under VA's purview for hiring and promotion. However, one of Bradley's biggest programs was the implementation of significant changes to the way VA built hospitals. Under the program that became the Third Generation Veterans Hospitals, newly constructed VA hospitals were sited near urban centers, associated with medical schools, and implemented the latest in hospital design, including stacking hospital services in a single skyscraper-type building.

Summary of Veterans Care up to World War II

The present day U. S. Department of Veterans Affairs is an agency that evolved from various colonial ordinances to a modern Federal organization responsible for providing health care, benefits, and other services to the Veteran. As early as 1636, the Pilgrims provided funds for disabled soldiers.[1] 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.[2] The War of 1812 also lead to the establishment of the first facility designated for the medical care of Veterans, the Naval Asylum in Philadelphia. The Civil War resulted in approximately two million Union Veterans, necessitating an expansion of the Veterans programs in the country. In 1862, the General Pensions Act provided for 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 his service.[3] In 1865, Congress passed legislation creating the National Asylum for Disabled Volunteer Soldiers, later known as the "National Home" to avoid the growing negative connotations associated with "asylum." The NHDVS Board of Managers was quick to explain the National Home was not charity, but a "reward to the brave and deserving."[4] The National Home system resulted in multiple branches across the United States, providing much needed care for volunteer Veterans ineligible for those benefits provided career military men. The National Home sites were modeled on military bases, with sizeable campuses and facilities to provide recreational and occupational activities including associated farms. Cemeteries for residents were located on the properties as well.[5] These campuses, including the National Soldiers Home and Naval Asylum, comprise the "First Generation" facilities.

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 either Public Health Service (PHS) hospitals or armed forces hospitals; these facilities operated at or over capacity, thus providing little in the way of convalescent care. As the number of Veterans increased, the PHS provided additional beds by leasing facilities from Federal partners, contracting with private hospitals for space,

[1] Paul B. Magnuson, "Medical Care for Veterans," *Annals of the American Academy of Political and Social Science* 273 (January 1951): 76.
[2] 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 16 November 2010), p. 3.
[3] Ibid., p. 4
[4] Board of Managers of National Home for Disabled Volunteer Soldiers, quoted in National Park Service, "Veterans Affairs National Home for Disabled Volunteer Service.," National Park Service, http://cr.nps.gov/nr/travel/Veterans_affairs/text_only.html (accessed 7 October 2010).
[5] Ibid.

and converting existing structures into medical facilities.[6] While the PHS covered medical care, the Bureau of War Risk Insurance handled pensions and life insurance while the Rehabilitation Division of the Federal Board for Vocational Education managed training and rehabilitation for Veterans. The three organizations created a labyrinth of services, and the frustrations with the lack of sufficient medical care led to Veterans advocacy groups, such as The American Legion and the Disabled American Veterans, calling to streamline the system.[7]

In 1921, the Veterans Bureau Act created one umbrella Federal organization to combine these segregated services, the Veterans Bureau. The Bureau handled pensions, vocational training, and medical care. Hospitals previously under the jurisdiction of PHS were transferred to the Bureau in 1922.[8] The Veterans Bureau embarked on a significant hospital construction program for the medical care of Veterans, resulting in 125 hospitals providing over 102,000 beds. These hospitals featured large rural campuses with multiple low rise buildings.[9] The hospitals were constructed in popular Revival styles of the period, including Spanish Colonial Revival and Georgian Revival, that referenced and reflected architectural styles of the past. The construction campaign continued under the Veterans Administration, which absorbed the Veterans Bureau in 1930, and well into the World War II period and is referred to as the "Second Generation" of Veterans hospitals.

Scandal rocked the Veterans Bureau during the Second Generation hospital construction program. Colonel Charles Forbes, appointed head of the Bureau by President Warren 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, after one of which, on a dare, Forbes and a woman jumped into Hayden Lake near Spokane."[10] In total, Forbes is believed to have absconded with a significant portion of the $250 million earmarked for hospital construction and supplies.[11] Forbes was found guilty of "conspiracy to defraud the Government in the building of hospitals for Veterans," leading to two years in the United States Penitentiary in Leavenworth and a $10,000 fine.[12]

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[6] 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, page 4; VA, *History in Brief*, 7.
[7] Spurlock, et al. *Second Generation*, Section E, p. 5.
[8] Ibid., Section E, p. 7.
[9] Ibid., Section E, p. 1.
[10] "Congress: A Pretty Mess," *Time*, 5 November 1923. http://www.time.com/time/magazine/article/0,9171,716844,00.html (accessed 1 April 2011).
[11] John Mack Faragher and others, eds., *Out of Many: A History of the American People, Volume II* (Englewood Cliffs, NJ: Prentice Hall, 1994), 722.
[12] "Political Notes: Forbes Punished," *Time*, 29 March 1926. http://www.time.com/time/printout/0,8816,729065,00.html (accessed 1 April 2011).

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. In addition, Veterans' services were further consolidated with the creation of the Veterans Administration in 1930. VA subsumed the Veterans Bureau, the National Homes, and the Bureau of Pensions into one entity, administered by Brigadier General Frank T. Hines, which provided multiple services for Veterans, including medical care.

Medical Care Arising from World War II

The new war brought advances in technology, both 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 advances in radio technology resulted in more reliable weapons and greater accuracy. The Pacific campaigns in the closing years of the war yielded high casualty rates, resulting in total casualties for American soldiers in World War II exceeding 290,000.[13] As a consequence of World War II, medical innovations expanded, resulting in greater survival rates for injured combatants. The widespread use of sulfa drugs and penicillin combined with rapid evacuation of wounded soldiers from the front achieved a high survival rate. The medical field also introduced improved surgical techniques for amputation, thus enhancing the survival of soldiers who likely would have likely perished from similar wounds during World War I.[14]

This increased survival rate necessitated the creation of a paraplegic program within VA. As bluntly stated in a VA report to President 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."[15] The survival of 2,400 paraplegics during World War II led to a pilot program to identify appropriate standards for care and treatment as well as to define appropriate facilities for rehabilitation. VA established designated centers for paraplegia care in seven hospitals, with the largest holding of 269 beds in Hines, Illinois.[16] While 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.

[13] Michael Gambone, *The Greatest Generation Comes Home: The Veteran in American Society* (College Station, TX: Texas A&M University Press, 2005), 38-39.
[14] Ibid., p. 39.
[15] 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.
[16] Ibid., p. 58

World War II amplified many of the diseases and disabilities handled by VA and its partners in Veterans care. The close quarters of the military life allowed diseases like tuberculosis (TB) to flourish among soldiers and sailors. TB is caused by a bacterium called *Mycobacterium tuberculosis,* with symptoms including coughing up blood, chills, fever, and night sweats. TB is spread through coughing, sneezing, and any activities that render the TB germs airborne.[17] Previous treatments for TB included traveling to warm climates, surgery to repair lungs, and isolation in sanatoriums where most patients were housed in large wards.[18] World War II increased the TB patient load cared for at VA hospitals, leading to delays in admission to designated TB hospitals.[19]

Mental illnesses were another focus of medical attention, supported by the general shift in perception prior to World War II that recognized that everyday people could suffer from psychiatric conditions. As a result, World War II Veterans often were more accepting and forthcoming when it came to mental illnesses. However the American psychiatric field did not necessarily have the wherewithal to provide care for the World War II Veterans.[20] VA utilized various treatments including insulin-shock therapy, electrical shock therapy and prefrontal lobotomies, all accepted treatments during the period, to care for psychiatric patients.[21]

VA and the Response to World War II

The massive scale and scope of World War II required an equally massive response from VA. Estimates placed the size of the Veteran population at 20,000,000, significantly larger than the comparable World War I Veteran population. VA recognized that the war necessitated revising existing plans for future expansion of its hospitals and healthcare for Veterans; as early as 1942, 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.[22]

At the close of World War II, VA faced the task of providing medical care to millions of returning Veterans. In 1945, 94 hospitals providing 75,967 beds operated under the auspices of VA in 45 states and the District of

[17] 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 18 April 2011).
[18] Trent Spurlock, et al, *Second Generation*, Section E, p. 13.
[19] Frances Brian Carroll, "Progress in the Medical Care of Veterans," *New England Journal of Medicine*, Vol. 244, No. 6 (8 February 1954): 214.
[20] Gambone, *Greatest Generation*, p. 40.
[21] Carroll, "Progress in Medical Care," p. 214.
[22] A.D. Miller, Executive Assistant to the Administrator to [Frank Hines], the Administrator, 19 August 1943, Entry 72, A1, Record Group 15, National Archives and Records Administration, Washington, DC.

Columbia; the majority of these hospitals (50) were designated general medical and surgical (GM&S), but the greatest number of beds (42,241) was located in neuropsychiatric (NP) facilities.[23] The majority of these hospitals had been built during the vast construction campaign following World War I. These facilities were designed following the prevalent medical theories of the day, featuring large wards that housed multiple beds located in rural areas far removed from large centers of population. The hospitals, particularly neuropsychiatric facilities, sprawled over hundreds of acres with large campuses comprising upwards of twenty buildings.

Within this framework of Veterans healthcare, African-American Veterans and women Veterans did not receive equitable care to their white, male counterparts. VA designated a single hospital exclusively for the care of African-American Veterans in Tuskegee, Alabama; by 1930, approximately 50 percent of African-American Veterans that had sought hospitalization benefits received healthcare at Tuskegee.[24] Segregated wards existed at other Veterans hospital for the care of African-American Veterans.[25] In 1947, VA identified 103 out of 127 of its hospitals as providing care for all Veterans, regardless of race. 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 VA to enforce a fully segregated hospital system. However, by 1953, 47 out of 166 Veterans hospitals functioned as segregated facilities.[26]

President Eisenhower forced integration of VA 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 as the dearth of female patients meant the hospital did not have a separate ward for women Veterans. Furthermore, according to A. W. Woolford, the Jackson VA hospital administrator, "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."[27] 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

[23] Frank Hines, "Medical Care Program of the Veterans Administration," *Annals of the American Academy of Political and Social Science*, 239 (May 1945), 74.
[24] Vanessa Northington Gamble, *Making A Place for Ourselves: The Black Hospital Movement, 1920-1945*. (New York City: Oxford University Press, 1995): 102.
[25] Ibid., p. 102.
[26] Alexander Bielakowski, ed., *Ethnic and Racial Minorities in the U.S. Military*. (Santa Barbara, CA: ABC-CLIO, 2013), 161.
[27] A. W. Woolford, quoted in David Barton Smith, "The Politics of Racial Disparities: Desegregating the Hospitals in Jackson, Mississippi," *Milbank Quarterly* 83 (June 2005): 247-269.

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 VA made it clear any new hospital would be integrated, proponents wriggled out of the conflict by admitting the hospital was needed desperately and the new design featured individual rooms, thus allowing patients to determine with whom he interacted. In 1962, the fully integrated new hospital opened in Jackson.[28]

Women Veterans of World War II also faced roadblocks in obtaining healthcare from VA hospitals in the post-War period. At the end of the 1945 fiscal year, VA had 71,229 total Veterans in hospital beds spread across its healthcare system. Women Veterans numbered only 755 of those patients, roughly 1 percent of the total patient population.[29] However, at the end of the war, approximately 280,000 women remained in the service to 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).[30] These units were viewed as auxiliary organizations with no military status and not fully part of the Armed Forces; therefore, the women could not avail themselves of Veterans benefits, including medical care.[31] These women were not recognized legally as Veterans, thus eligible for benefits, until the late 1970s and early 1980s.[32] The ineligibility of women Veterans combined with their significantly smaller piece of the total Veteran population resulted in limited spaces dedicated for the care of women Veterans in the hospitals of VA. Dedicated wards for women Veterans were rare in the general medical and surgical hospitals of the Third Generation. While a ward for female patients was included in the initial plans for the eighth floor at the hospital in Wilmington, Delaware, the ward was never activated. However, designated neuropsychiatric hospitals, such as those facilities in Montrose, New York and Topeka, Kansas did include dedicated buildings for women Veterans.

Investigation into VA Practices

The condition of these VA 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 in the United States, published a series of articles in the New York City newspaper *PM* that criticized the medical care provided by VA. Deutsch conducted a survey of multiple VA

[28] Ibid.
[29] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1945*(Washington DC: Government Printing Office, 1945): 58.
[30] 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.
[31] Mary Lou Kendrigan. *Gender Differences: Their Impact on Public Policy*. (New York City: Greenwood Press, 1991): 176.
[32] *American's Women Veterans*, p. 6.

facilities and interviewed VA staff including General Hines, lower level VA staff, doctors, and members of Veterans groups. Deutsch identified multiple problems within VA, including a "medieval attitude towards medicine" that discouraged young doctors from joining VA, limited medical research, a massive bureaucratic system that restricted the time doctors spent with patients, and "undue kow-towing" to political pressures.[33] While Deutsch acknowledged that VA likely did not suffer from the same corruption that had triggered the scandal that led to the Hines appointment in 1923, he did condemn 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.[34]

Deutsch identified multiple ways to fix these problems, including creating a VA Medical Corps independent within VA, constructing new hospitals in urban areas near medical schools, forging connections with medical schools to ensure VA doctors were aware of the latest research and medical innovations, allowing young doctors to intern at VA hospitals, convincing the American Medical Association to permit VA doctors to join, hiring African-American doctors and nurses, and "break[ing] down the isolationist tradition in the VA system."[35]

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."[36] The *New York Times* summarized the complaints alleged "brutal treatment, unwarranted overcrowding, neglect, improper care, poor food, bad sanitation, and inferior medical care."[37] VA responded with denials, but acknowledged there may be isolated incidents that were the result of issues with under staffing rather than a systemic problem.[38]

Several investigations were launched, including those by the National Tuberculosis Association, the National Mental Hygiene Committee, and 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

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

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 VA.[39] 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.[40] 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."[41]

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 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 led to the matter moving to the floor of the House. If it passed, Deutsch could have received a $1,000 fine and a month in jail.[42] Journalists understandably decried the move, but Rankin found little support among his Congressional colleagues, either. Members of the House, including the Republican House Leader and the Democratic Whip, supported the reporter.[43]

The situation spiraled the investigation of VA to greater heights of national scrutiny, with radio commentator Walter Winchell condemning Rankin during his radio broadcast and former First Lady Eleanor Roosevelt supporting Deutsch in her syndicated column.[44] Meanwhile, Rankin's Committee accomplished little in terms of the investigation of VA. 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 Truman regarding legislation connected with Veterans.[45]

[39] Charles Hurd, "House Veterans Committee Deflects Inquiry on Medical Care of Soldiers," *New York Times*, 1 April 1945.
[40] "Will Soldiers Vote?," *Time*, 14 February 1944, www.time.com/time/magazine/article/0.9171,885334,00.html (accessed 4 April 2011).
[41] Hurd, "Committee Deflects Inquiry"
[42] Nathan Robertson, "Rankin Tries to Railroad Deutsch to Jail." *PM*, 20 May 1945, 3.
[43] Milton Murray, "Colleagues Condemn Rankin Action Against Newsman,," *PM*, 20 May 1945, 8.
[44] *PM*, 21 May 1945, 7; *PM*, 23 May 1945, 5.
[45] Elizabeth Donahue, "Vet Committee Still Kowtows to Boss Rankin," *PM*, 25 May 1945, 10.

Rankin sought to resolve the situation by introducing legislation that addressed some of the claims, mainly via establishing a medical corps within VA 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."[46] 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.[47]

The Committee's hearings continued, but matters had drawn to a head. In early June 1945, President Truman asked for the resignation of Frank T. Hines and announced the appointment of General Omar Bradley as the new Administrator for the Veterans Administration.

General Omar N. Bradley

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.[48] 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.[49] 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."[50] By his own admission, Bradley stood out more in athletics than in academic studies; nevertheless, he graduated in the top third of his class.[51] 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.[52] Besides Bradley, these notable graduates included Dwight David "Ike" Eisenhower, future commander of Allied

[46] Albert Deutsch, "Rankin's Stop-Gap Bill Sidesteps Main VA Issues," *PM*, 28 May 1945, 11; Charles Mitchie, "Rankin Still Opposes Hearing Truth on VA," *PM*, 31 May 1945, 7.
[47] Elizabeth Donahue, "Rankin Group Rebels, Clears Deutsch," *PM*, 30 May 1945, 3.
[48] Omar N. Bradley and Clay Blair, *A General's Life: An Autobiography* (New York: Simon and Schuster, 1983), 17-18, 31, 37.
[49] Ibid., 29-34.
[50] 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 3 December 3 2010).
[51] Bradley and Blair, *General's Life*, 34.
[52] "Notable USMA Graduates," United States Military Academy at West Point, http://www.usma.edu/notablegrads.asp (accessed 9 December 2010)

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.[53]

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 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.[54]

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.[55] 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."[56]

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.[57] 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

[53] Ibid.; Bradley and Blair, *General's Life*, 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 21 December 2010)
[54] Bradley and Blair, *General's Life*, 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 3 December 2010).
[55] Bradley and Blair, *General's Life*, 102-111; Kirkpatrick, *Centennial*; "Omar Nelson Bradley."
[56] "Omar Nelson Bradley."
[57] 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 (30 December 2010).

"felt that World War II Veterans should have a World War II Veteran to run the show."[58] By appointing Bradley (dubbed "The Doughboy's General" by *Time* magazine[59]), Truman "took out of the war one of his best field commanders" and "the top tactician in the European Theater."[60]

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 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.[61]

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.[62] 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.[63] 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.[64]

[58] "Inspired Choice," *Time*, June 18, 1945, http://www.time.com/time/magazine/article/0,9171,775886,00.html (accessed 8 December 2010).
[59] Bradley and Blair, *General's Life*, 241.
[60] "Inspired Choice."
[61] Bradley and Blair, *General's Life*, 467-470, 504-506, 552-553, 648, 662; Kirkpatrick, *Centennial*; "Omar Nelson Bradley."
[62] Bradley and Blair, *General's Life*, 461-462, 662-668; Kirkpatrick, *Centennial* ; "The History of Bulova," Bulova Corporation, last modified ca. 2002, http://www.bulova.com/about/history.aspx (accessed 4 January 2011).
[63] Bradley and Blair, *General's Life*, 665.
[64] Ibid., 670.

Bradley as VA Administrator

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 VA – "one of the biggest, hardest, touchiest jobs in the U.S."[65] At the time, it was anticipated that VA operations would "directly concern one out of every three U.S. families,"[66] and, therefore, Truman expected Bradley "to modernize the organization so that it could cope with the problems of the millions of Veterans."[67] During World War II, there were only an estimated five million Veterans registered with VA; by 1946, within a few months of the end of hostilities, the organization counted nearly 17 million Veterans in its records.[68] 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 [VA] gives me the chance to do something for the men who did so much for us."[69]

When Bradley took control of VA, it was "the largest independent agency within the [Federal] government" with over 65,000 employees and nearly 100 hospital facilities scattered throughout the country.[70] Under General Hines' tenure, all VA 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 war's end.[71] "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.'"[72] 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 operations, an "intensely controversial" move.[73] 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 VA hospitals."[74]

[65] Hurd, "Bradley Is Sworn As Veterans' Head;" "Inspired Choice."
[66] "Inspired Choice."
[67] Hurd, "Bradley Is Sworn As Veterans' Head."
[68] Kirkpatrick, *Centennial*.
[69] Bradley and Blair, *General's Life*, 440-446.
[70] Ibid., 447.
[71] Ibid., 450.
[72] Gambone, *Greatest Generation*, p. 34.
[73] Bradley and Blair, *General's Life*, 450-451.
[74] Kirkpatrick, *Centennial*.

The national press recognized the modern advances effected in the VA 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."[75]

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 Veterans population placed on VA programs. For the medical care of Veterans, Bradley focused on improving the quality of the VA medical staff and the construction of new, modern hospitals.

Between the announcement and his investiture, Bradley sought assistance from fellow military men and those outside the VA establishment. He first wanted the counsel of General Paul R. Hawley as VA's Chief Medical Director regarding the VA's 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.[76] While still on active duty, in September 1945, Hawley was appointed Acting Surgeon General, a position that would become 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 previous VA Administrator Hines with the proposal of embedding medical school staff and students in VA hospitals, but the concept gained little traction in the Hines administration.[77] Bradley, Hawley, and Magnuson recognized that linking VA hospitals and medical schools through consultations and residency training programs was of utmost importance to the success of its overhauls to the VA's medical program.[78]

Furthermore, Bradley, Hawley, and Magnuson sought to wrench the control of VA's medical staff out from the jurisdiction of the Civil Service Commission 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:

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[75] "Veterans' Medicine: Second to None!", *Reader's Digest*, vol. 51 (Sep. 1947), n. 305, quoted in Bradley and Blair, *General's Life*, 462.
[76] *Medical Care of Veterans (MCV)*, Washington, DC: U. S. Government Printing Office, 1967: 207.
[77] 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.
[78] Ibid, p. 208-209.

> 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.[79]

A bill was introduced before Congress to address these concerns, and it passed quickly 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, claiming it did not do enough to encourage hiring Veterans. The organizations dropped its objections when Bradley provided assurances that Veterans would receive full consideration during the hiring process.[80]

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.[81] The Department of Medicine and Surgery, authorized by Congress on 3 January 1946, was now free to hire the necessary doctors and nurses to provide modern medical care for Veterans.[82]

With the establishment of the Department of Medicine and Surgery, VA formalized relationships with medical schools across the country. These ties not only addressed staffing concerns but also emphasized research to be conducted jointly by VA and the medical schools. VA-funded research ranged across disciplines and focused on issues germane to Veterans healthcare. As catalogued by VA'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.[83] Dedicated research space was incorporated into plans for new VA hospitals and inserted into existing VA hospitals via the conversion of existing spaces, such as closets, bathrooms, and garages.[84] Additional research funds were spent on short term, intra-VA

[79] Major General Paul R. Hawley, quoted in *MCV*, p. 210.
[80] San Francisco *Chronicle*, 4 January 1946, reprinted in *California and Western Medicine*, Vol. 64, No. 1 (January 1946): 36.
[81] *MCV*, p. 212.
[82] PL 79-293, 59 Stat. 675, U.S. Statutes at Large, 3 January 1946.
[83] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1949* (Washington DC: Government Printing Office, 1950): 23 - 30.
[84] Hays, *A Historical Look*, 92, 97.

projects across multiple VA hospitals. As the research program expanded, VA also financed studies at nonprofit institutions that offered superior staff and facilities necessary for the research.[85]

In 1948, Public Law 729 authorized an annual $1,000,000 for VA solely "for prosthetic research, including all forms of prosthetic and orthopedic appliances and sensory devices," contingent on VA rendering the results available to the public.[86] Prosthetic research exemplified VA'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.[87] 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 VA.[88] Research conducted with International Business Machines Corporation, more commonly known as IBM, yielded developments for prosthetic arms powered by electricity. Via the Army Prosthetic Research Laboratory, VA funded exploration of prosthetics operated voluntarily through captured body movement and synthetic "skin-like" coverings.[89] In the 1970s, prosthetic research became its own department, newly christened the Rehabilitation Engineering Research and Development Service, within VA; VA continues prosthetic research to the present day.[90]

Tuberculosis became one of VA'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 VA's patient load in 1945.[91] VA also struggled with tubercular patients leaving VA hospitals before the completion of treatment, resulting in fears the contagion would spread to the civilian population.[92] In 1946, VA together with the Armed Forces began research on the effectiveness of streptomycin as a treatment of tuberculosis. Seven VA 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

[85] VA, *.Annual Report*, 1949, 30.
[86] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1948* (Washington DC: Government Printing Office, 1949): 88.
[87] Hays, *A Historical Look*, 419.
[88] Ibid., 425.
[89] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1951* (Washington DC: Government Printing Office, 1952): 62.
[90] Hays, *A Historical Look*, 431.
[91] VA, *Annual Report*, 1945, 3.
[92] William B. Tollen, "Irregular Discharge: The Problem of Hospitalization of the Tuberculous," *Public Health Reports*, Vol. 63, No. 45 (November 5, 1948): 1441.

conjunction with other drugs.[93] By 1950, chemotherapy for tuberculosis was the largest research program for VA.[94] Five years later, 46 VA hospitals were involved in testing of various treatment measures for tuberculosis, including testing of new drugs.[95] By 1960, sufficient advances in treatments were made to allow eight dedicated tuberculosis hospitals to be converted to general medical and surgical hospitals due to shorter tuberculosis hospitalization periods and dramatically smaller patient load.[96] VA continued tuberculosis research well into the 1960s.[97]

As with tuberculosis, VA directed research funds towards neuropsychiatric issues due to the prevalence of Veterans seeking treatment for post-War neuropsychiatric issues. In 1946, approximately 57 percent of the patients at VA hospitals nationwide sought care primarily for neuropsychiatric issues and an average stay for a neuropsychiatric patient at a VA hospital lasted 179.6 days.[98] The postwar period was a transitional era for neuropsychiatric care at VA. VA adopted frontal lobotomies as a method for treating schizophrenia, and by 1950, 47 VA hospitals had been approved to carry out the treatment.[99] Subsequently, VA initiated a three year study of 373 patients treated at six VA hospitals to determine the efficacy of lobotomies.[100] VA determined lobotomies were "not a cure," but did result in "recovery to a degree."[101] 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.[102] In 1956, VA launched a neuropsychiatric research center at its new hospital in Pittsburgh, Pennsylvania specifically to "correlate neuropharmacologic and neurophysiologic studies with clinical material."[103] Additional studies from that year included schizophrenia, efficacy of reserpine-based treatment, initiation of a 5-year evaluation of hospital design on recovery of neuropsychiatric patients, and a study on hereditary neurological diseases.[104] By 1957, VA had 933 different ongoing studies regarding neuropsychiatric issues.[105]

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[93] Hays, *A Historical Look*, 147, 150, 161.
[94] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1950* (Washington DC: Government Printing Office, 1951): 39.
[95] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1955* (Washington DC: Government Printing Office, 1956): 34.
[96] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1960* (Washington DC: Government Printing Office, 1961): 36.
[97] Hays, *A Historical Look*, 149.
[98] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1946* (Washington DC: Government Printing Office, 1946): 4-5.
[99] Annual Report 1950: 26.
[100] Hays, *A Historical Look*, 211.
[101] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1954* (Washington DC: Government Printing Office, 19455): 43.
[102] Hays, *A Historical Look*, 214.
[103] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1956* (Washington DC: Government Printing Office, 1957): 55.
[104] Ibid., p. 55-56.
[105] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1957* (Washington DC: Government Printing Office, 1958): 29-30.

Temporary Hospitals

In order for these newly-minted VA doctors to provide modern health care for Veterans, modern hospitals were required. However, even Bradley's considerable drive to overhaul VA health care could not expedite the bureaucratic process necessary to construct a new hospital. Therefore, VA 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 VA and VA could assume control of existing facilities, primarily surplus Army and Navy hospitals.

By November 1945, General Hawley announced plans for providing medical care for Veterans at local facilities.[106] VA 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 of 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 VA 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.[107] In California, VA and physicians reached an agreement that outlined a very specific set of treatments available to the Veteran, 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.[108] 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 healthcare under these provisions if a local VA hospital was available to them.[109]

Another option utilized by VA involved taking over Army and Navy hospitals constructed and used during World War II, but considered surplus when the war ended.[110] During World War II, the Army and Navy insisted on

[106] "'Reforms' in Veteran Medical Setup," *California and Western Medicine*, Vol. 63, No. 6 (December 1945): 289.
[107] "Home-Town Medical Care for Veterans on Trial in Two States: Michigan and California," *California and Western Medicine*, Vol. 64, No. 4, April 1946, p. 265.
[108] "V.A. – C.P.S. Fee Schedule," *California and Western Medicine*, Vol. 64, No. 3 (March 1946): 144-147.
[109] "California Physicians' Service – Veterans' Administration Program," *California and Western Medicine*, Vol. 64, No. 4 (April 1946): 270.
[110] For the list of facilities transferred from the Armed Forces to VA, please see Appendix C.

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 built hundreds of no-frills structures designed for temporary use.[111] By spring of 1943, the Federal Board of Hospitalization (FBH), charged with preventing duplication of Federal hospital services, suggested the Army build hospitals using the standardized plans developed by VA for the Second Generation program with the intent of turning over those hospitals to 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 VA designs. Two Army hospitals were constructed in this manner, McGuire in Richmond, Virginia and Vaughan in Hines, Illinois.[112]

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 an army 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.[113] 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."[114] Halloran later became part of the surplussed facilities transferred to VA.

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 23 out of the 65 wartime hospitals would be available to be transferred to VA. Leased properties were to be returned to their pre-war owners.[115] While these

[111] 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.
[112] Ibid., p. 76.
[113] "Willowbrook's Halloran General: Largest Army hospital in the world," *Staten Island Advance*, 26 March 2011, http://www.silive.com/specialreports/index.ssf/2011/03/willbrooks_halloran_general.html (accessed 7 April 2011).
[114] "Quickly Converted for Casualties," *Architectural Record,* Vol. 95, No. 1 (January 1944): 77-78.
[115] "Army to Release 23 Hospitals by January 1," *California and Western Medicine,* Vol. 63, No. 6 (December 1945): 290.

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 VA leaders. Many hospitals were located in remote locations, making them difficult to staff and to access.[116] While many of these sites were to become permanent VA property, the temporary nature of these buildings did not lend themselves to providing modern healthcare in the long term.

While the beds in civilian and various armed services hospitals provided much needed relief to the thousands of Veterans seeking healthcare, the measures were mere stop gaps. One enterprising senator even suggested using surplus warships as hospitals, but there is no indication VA took him up on the idea.[117] VA needed new hospitals and a program to construct 80 new hospitals was underway shortly after Bradley took office as Administrator. This program allowed VA to demonstrate it was moving away from the perceived old-fashioned medicine provided in its existing hospitals and towards current healthcare offered in modern facilities. As a result, a VA hospital of this Third Generation period is one of three types: existing hospitals pressed into service, new hospitals designed by private architects, and new hospitals designed by VA architecture staff and based on standardized plans. VA was pressured further by a nationwide hospital construction program that not only amplified the differences between VA's existing hospitals and modern healthcare but also gave architects an opportunity to develop new standards for contemporary hospital architecture that would influence the Third Generation construction program.

Nationwide Hospital Construction Campaign

Following World War II, the United States experienced a revived interest in improving health care facilities throughout 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 700 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.[118]

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

[116] *MCV*, p. 201.
[117] "Ships Might Solve Hospital Shortage," Spartanburg *Herald-Journal*, 11 February 1946.
[118] V. M. Hoge, "Hospitals and Public Health Centers," *The Annals of the American Academy*, Vol. 273 (January 1951): 34-35.

associated health facilities between 1940 and 1945 at the cost of $100 million.[119] These facilities developed in areas experiencing population booms due to wartime production efforts and 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.[120]

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.[121] 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.[122] 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 2 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 TB.[123] 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.[124]

[119] Ibid., p. 35.
[120] Ibid., p. 36.
[121] Paul A. Brinker and Burley Walker, "The Hill-Burton Act: 1948-1954," *The Review of Economics and Statistics*, Vol. 44, No. 2 (May 1962): 209.
[122] Beds were generally considered unacceptable if certain issues were present, such as fire hazards, inappropriate design, or obsolescence.
[123] Vane M. Hoge, "The National Hospital Construction Program," *Journal of the National Medical Association*, Vol. 40, No. 3 (May 1948): 103.
[124] V. M. Hoge, "Progress Report on Hospital Survey and Construction Act," *American Journal of Public Health*, Vol. 39 (July 1949): 890.

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."[125] 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 bedroom arranged linearly along a corridor so that "the color line can be shifted one way or another as demanded by various patient loads."[126]

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, 16 tuberculosis hospitals, 26 mental hospitals, and 9 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 50 beds.[127] 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.[128]

What Makes a Modern Hospital?

The glut of cash available for hospital design and construction, both those funded by Hill-Burton and the VA hospital construction program, attracted the interest of medical professionals and architects alike. Revisiting these topics was appropriate, especially since many of the standard available texts dated to before 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.[129] The architecture field was particularly responsive to the rising need for modern hospital designs. Architects put forward articles in publications geared towards hospital administrators,

[125] Hoge, "The National Hospital Construction Program," p. 104.
[126] "Large Hospital for a Rural Area," *Architectural Record,* Vol. 103, No. 6 (June 1948): 96.
[127] Hoge, "Progress Report," p. 890-91.
[128] 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.
[129] Louise O. Waagen, "The Hospital Survey and Construction Act," *American Journal of Nursing,* Vol. 48, No. 6 (June 1948): 361; Ben John Small, "How to Read a Blueprint," *American Journal of Nursing,* Vol. 54, No. 5 (May 1954).

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. Articles and 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 hospital building to whether blinds or curtains were more appropriate for patient rooms. Multiple articles stressed the need for retaining a hospital consultant and an 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.[130] Every minute detail was examined and re-examined. PHS circulated numerous articles regarding components of hospital design. For example, in a discussion regarding a new site for a hospital, PHS identified the following areas of concern: accessibility, public utilities, nuisances, orientation, exposure, cost, dimensions, topography, and landscaping. As explained by PHS, 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."[131]

Modern Hospital Design

The architecture field identified hospitals as "the most important of all planning assignments now before architects and engineers."[132] 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

[130] Ibid., p. 50.
[131] Division of Hospital Facilities, United States Public Health Service, "The Functional Basis of Hospital Planning: The Hospital Site," *The Modern Hospital*, Vol. 68, No. 3 (March 1947): 50.
[132] Emerson Goble, "Hospitals," *Architectural Record*, Vol. 107, No. 2 (Feb. 1950): 99.

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.[133]

The Hospital Facilities Section of PHS circulated numerous plans and spatial requirements through architectural journals. The PHS 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 PHS provided among other designs, representative plans for a nursing unit with an offset corridor and southern exposure, a contagious disease nursing unit, open wards, 4-bed rooms, pediatric nursing units, a kitchen for a 100-bed hospital, and a combined doctor's office, examination and treatment room that also featured a waiting room.[134] The plans were accompanied with details on furnishing the rooms, down to the size of the bread box in the kitchen for a 50-bed hospital.[135] Generally, architects welcomed these articles, as the PHS provided a "valuable fund of planning information" that would assist architects in the successful completion of their hospital commissions.[136]

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.[137] 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.[138]

[133] "Frank Lloyd Wright on Hospital Design," *Modern Hospital*, Vol. 71, No. 3 (September 1948): 52.
[134] "Elements of the General Hospital," *Architectural Record*, Volume 106, No. 1 (July 1946): 76-90.
[135] Ibid., p. 83.
[136] Goble, "Hospitals," p. 99.
[137] Alfred Mufflen, "Operating Rooms on the Ground Floor," *Hospital Management*, Vol. 65, No. 1 (January 1948): 29.
[138] Charles Butler, *Hospital Planning* (New York: F. W. Dodge, 1946): 9.

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 the 1940s and 1950s. 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."[139] 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.[140] During the post World War II era, architectural heavyweight 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.[141] 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."[142]

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."[143] 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.[144] 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.[145] Orientation was also influenced heavily by the hospital's location. Emphasizing southern exposure and its 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.[146] As translated to modern hospitals of the post-World War II era, Atkinson's recommendations

[139] Alfred L. Aydelott, "The Hospital as Living Architecture," *Hospital Progress,* Vol. 30, No. 1 (January 1949): 4.
[140] 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.
[141] Spiro Kostoff, *A History of Architecture* (New York: Oxford University Press, 1985; reprint, 1995): 727 (page references are to reprint edition).
[142] "Architecture – not Style," *Progressive Architecture*, Vol. 29, No. 12 (December 1948): 49.
[143] Ibid, p. 5.
[144] William Atkinson, *The Orientation of Buildings of Planning for Sunlight*, (New York: John Wiley & Sons, 1912): 84.
[145] Ibid., p. 96.
[146] Butler, *Hospital Planning*, p. 5.

became a plan resembling a T, with support services along the cross and patients rooms in the stem. A number of Ts 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 Ft. 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."[147]

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 climes 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. [148]

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 TB 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 8 days, but the average stay at a tuberculosis hospital was 18 months.[149] 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.

Despite early treatments for TB that ranged from improving sanitary conditions to special diets and a "well regulated hospital life," TB remained a persistent health threat well into the twentieth century.[150] 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

[147] Nathaniel Owings, "Basic Considerations in Hospital Design," *Modern Hospital*, Vol. 70, No. 3 (March 1948): 59.
[148] Butler, Hospital Planning, p. 6-7.
[149] Peter N. Jensen, "Notes on Tuberculosis Hospital Planning," *Architectural Record*, Vol. 109, No. 4 (April 1951): 137.
[150] "A History of Tuberculosis Treatment," New Jersey Medical School, Global Tuberculosis Institute, Available online at umdng.edu/utbc/tbhistory.htm (accessed 27 July 2011).

it would demand and secure proper legislation and adequate provision for tuberculosis cases through hospitals, sanitoria, and dispensaries."[151] By 1911, 22,000 beds for TB patients were available, "a drop in the bucket compared with the necessities of the situation."[152] 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.[153] 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.[154] Tuberculosis hospitals in the 1940s began to be constructed as wings to general medical hospitals.[155] This trend provided TB 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. TB hospitals were not immune to governing forces beyond the medical community; in the early 1950s, Mississippi constructed separate TB facilities at its existing state sanatorium for its African-American population.[156]

While the core TB 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 TB 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 TB-caused lesions, needed to be housed near patient rooms for ease of caring for patients. Non-medical services that often were included in a TB hospital included an auditorium that could double as a chapel, barber/beauty shop, library, occupational and vocational therapy spaces, and activities areas for patients.[157]

[151] Dr. Livingston Farrand, "The National Association for the Study and Prevention of Tuberculosis," *Journal of the American Public Health Association*, Vol. 1, No. 5 (May 1911): 334.
[152] Ibid., p. 336.
[153] Spurlock, *Second Generation*, Section E, p. 13.
[154] Robert J. Anderson, "Tuberculosis Hospitals," *Architectural Record*, Vol. 109, No. 4 (April 1951): 135.
[155] Anderson, "Tuberculosis Hospitals", p. 136.
[156] "Tuberculosis Infirmary for Negroes," *Architectural Record*, Vol. 109, No. 4 (April 1951): 142.
[157] Jensen, "Notes," p. 137-138.

VA responded to the special needs of tuberculosis patients with the construction of designated TB hospitals, a trend that lasted well into the construction campaign resulting in the Third Generation hospitals. By 1944, VA operated 12 TB hospitals. VA elected to situate its TB hospitals in predominately rural locations, with the hospital sited on higher ground to provide fresh air to the patients. The TB hospitals followed the general design tenants of the VA hospital program of the period, with multiple buildings over a large campus with patients segregated by their condition.[158]

Hospitals designated for the care of psychiatric patients often had to wrestle with the same issues as TB hospitals, particularly extended patient stays. Therefore, psychiatric hospitals often featured extensive recreation facilities, agricultural components, auditoriums, chapels, libraries, and other amenities for patients. Frequently these hospitals were significantly larger than neighboring non-Federal medical hospitals, with beds numbering in the thousands. As with TB, 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.[159] 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."[160]

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.[161] 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.[162] 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."[163]

[158] Spurlock, *Second Generation*, Section E, p. 60.
[159] John W. Cronin and Wilber R. Taylor, "Environment for Mental Therapy," *Architectural Record,* Vol. 120, No. 5 (November 1956): 201.
[160] Owen A. Luckenbach, "Planning the Mental Hospital," *Architectural Record*, Vol. 101, No. 6 (June 1947): 107.
[161] Butler, *Hospital Planning*, p. 168-170.
[162] Isadore Rosenfield, *Hospitals: Integrated Design* (New York: Reinhold Publishing Corporation, 1947): 210.
[163] Ibid., p. 212.

As with TB hospitals, VA constructed specialized hospitals for the care of NP patients. On the eve of the Third Generation program, VA maintained 30 hospitals dedicated for NP patients. With these hospitals, VA emphasized rural locations that allowed for large campus-like hospitals comprised of multiple low-rise structures. The NP hospitals, much like the TB hospitals, segregated patients based on affliction.[164] VA would elect to retain many of these hospital trends in the construction of NP hospitals during the Third Generation hospital campaign.

Third Generation Veterans Hospitals

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, VA sought to meet ever increasing demand through the construction of new hospitals and additions to existing facilities. At the close of its 1944 fiscal year, VA had 36 construction projects in progress at existing hospitals and funding in place for another 26 construction projects including four new hospitals planned for Pennsylvania, New York, Wisconsin, and South Dakota.[165] Many of these construction projects appear to be located at existing VA facilities at the time, primarily Second Generation hospitals. By the end of June 1945, 26 new hospital projects were identified, including additional tuberculosis hospitals. While a majority of the hospitals were at least associated with a specific town or city, several were identified merely by their intended state.[166] In October 1945, Bradley announced preliminary locations for 19 of the 26 new hospitals, part of an expansion approved by President Truman in August of 1945 that would add over 29,000 beds to VA hospitals, an increase of 30 percent in total beds available within VA hospitals. This first announcement provided a preview of the new goals for the upcoming nationwide hospital construction program, as it emphasized association with medical schools and locations for hospitals that benefitted Veterans.[167] Congress had authorized funds for new hospital construction, but construction proceeded slowly.[168]

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

[164] Spurlock, *Second Generation*, Section E, p. 54.
[165] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1944* (Washington DC: Government Printing Office, 1944): 10-11.
[166] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1945*(Washington DC: Government Printing Office, 1945): 8.
[167] "Establishment of Hospitals for Veterans," *California and Western Medicine*, Vol. 63, No. 6 (December 1945): 292-293.
[168] *MCV,* p. 192.

had only begun on a few sites with many wallowing in the planning stages. Furthermore, VA did not overhaul its existing bureaucratic system; VA 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. VA had to find an efficient solution that expedited design and construction.

Given the patient need, VA focused on constructing hospitals that would offer primarily GM&S services. VA classified hospitals based on the preponderance of beds allocated for particular medical care, i.e. a TB hospital had the majority of its beds designated for the care and treatment of TB patients. However, medical treatments were not limited solely to those described by the hospital type. GM&S hospitals designated floors for the care of NP patients, despite the construction of eleven hospitals for the express purpose of caring for psychiatric patients. As TB remained a continuing concern for VA medical staff, five hospitals had a preponderance of beds designated for the care of TB patients. Only one hospital, the facility designated for Bonham, Texas, was identified as predominately domiciliary in purpose. Available beds and, therefore, hospital classification, changed based on VA's needs.

On February 16, 1946, VA announced its solution, "the most gigantic hospital building program in the history of the world," consisting of 80 new hospitals, including 3 already under construction and several already in planning stages.[169] The Gray Lady herself, the *New York Times*, announced breathlessly 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 $7,426,300. The article conceded that neighboring New Jersey and Connecticut would also receive hospitals.[170] The complete list of towns and cities selected to receive new hospitals, with the intended type of hospital and number of beds, reported in VA's *Annual Report* for 1946, follows as Appendix A.[171] Only seven states were not chosen for the site of a new hospital.[172]

As of June 1946, VA operated 91,675 hospital beds, 4,867 of those located in transferred Army hospitals.[173] The new hospitals announced in February would add a total of 38,923 beds, with 24,718 beds (64 percent) for general

[169] "Veterans Will Get 183 New Hospitals," *New York Times,* 17 February 1946.
[170] "Engineers, VA Open Talks on Hospitals," *New York Times*, 18 February 1946.
[171] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1946* (Washington DC: Government Printing Office, 1946): 176.
[172] Those states were Maine, Vermont, Kansas, New Mexico, Wyoming, Idaho, and Nevada. Alaska and Hawaii were not yet states in 1946.
[173] Ibid., p. 8

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, VA anticipated managing 163,476 beds upon completion of the construction program announced in 1946.[174]

Bradley publicized several key components of the plan that would mark significant departures from the Second Generation hospitals. These included constructing skyscraper hospitals that would require smaller parcels of land, partnering the new hospitals with local medical schools, and bringing in outside medical professionals to upgrade medical care for Veterans.[175] The program sought to retain private architectural firms, and not the VA architectural staff, to ensure VA was constructing fully modern facilities; as described by Bradley in an address to the AIA, utilizing the existing VA system would result in 1920 vintage hospitals being constructed in 1946.[176] Preliminary plans were to be drawn up by architects Addison Erdman, Slocum Kingsbury, and Carl A. Erickson.[177] 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 to the general architectural field on hospital construction.

Congress allocated $448 million for construction, as funding for the first 47 hospitals was in place and the additional 30 in progress.[178] Construction costs for the individual hospitals were to range from $2.5 million to $10 million.[179] While VA 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. VA hospitals were often located "in a remote district of a favorite legislative son."[180] 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 8,000 beds for Veterans in the state. The resolution was sent to Bradley, the Federal Board of Hospitalization (FBH), and all of California's congressional delegation.[181] In Nebraska, the Omaha Chamber of Commerce teamed up with The

[174] Ibid., p. 8, 46.
[175] "Veterans Will Get 183 New Hospitals," *New York Times,* 17 February 1946.
[176] Remarks of Cyrus E. Silling, AIA Convention, Salt Lake City, Utah, 23 June 1948, printed in *Bulletin of the American Institute of Architects*, July 1948: 40.
[177] "Veterans Will Get 183 New Hospitals," *New York Times,* 17 February 1946; if these plans are extant, they were not located during the course of research.
[178] "Veterans Will Get 183 New Hospitals," *New York Times,* 17 February 1946.
[179] "Army Will Help Build 80 Veterans Hospitals," *California and Western Medicine*, Vol. 64, No. 3 (March 1946): 154.
[180] Michael Gambone, *Greatest Generation,* p. 49.
[181] "Veterans' Hospital Facilities in California," *California and Western Medicine*, Vol. 63, No. 6 (December 1945): 296.

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.[182] Phoenix was particularly creative with its request, asking for a 3,000 bed hospital by presenting President Harry Truman with a 10-gallon hat.[183]

Despite mounting excitement over the new VA hospitals, the National Association for the Advancement of Colored People (NAACP) protested the decision to build a hospital in Mound Bayou, Mississippi solely for African-American Veterans. Calling it "a step backward," NAACP questioned why a segregated hospital was necessary when wartime government hospitals were integrated.[184] Shortly thereafter, planning for the hospital was stopped, but reasons were not given by VA.[185]

Location of New Hospitals

When Bradley became Administrator and the new hospital construction program was announced, political pressure came to bear when Hawley disregarded earlier plans by Hines for facilities to be built in specific locations across the United States.[186] 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.[187] 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 was to be the site of construction after the local chapter of The American Legion expressed concerns.[188] 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.[189]

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[182] "Vets' Hospital Plan Backed," *Omaha World-Herald*, 15 February 1945; "Vet Hospital 'U.S. Affair'," *Omaha World-Herald*, 11 March 1945.
[183] "10-Gallon Hat to Truman," *New York Times*, 29 August 1945.
[184] "Negroes Protest Hospital Plan," *New York Times*, 22 March 1947.
[185] "VA Ponders Setting up Separate Dixie Staffs," *Baltimore Afro-American*, 4 May 1946.
[186] "Veterans' Hospital Head Unmoved by 'Pressure'" San Francisco *Chronicle*, reprinted in *California and Western Medicine*, Vol. 64, No. 2 (February 1946): 96.
[187] Gambone, *Greatest Generation*, p. 49.
[188] "Vet Hospital Plans Same," *Omaha World-Herald*, 2 April 1945.
[189] General Omar N. Bradley to Honorable Homer Ferguson, 19 October 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.

Once a geographical area or city was chosen for a hospital, the specific site had to be selected and approved by the FBH through a resolution approved by the President. The FBH originated in 1921 to serve as an advisory board to the President regarding all hospitals operated by Federal agencies, from the armed forces to VA. During World War II, the FBH sought to co-ordinate efforts by the Army, Navy, and VA to minimize redundancy between efforts. The FBH consisted of representatives from the Army, Navy, PHS, Bureau of Indian Affairs, Bureau of Prisons, and VA.[190]

The FBH 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."[191] The specific type of hospital often governed why one site was more acceptable. For example, for the neuropsychiatric hospital designated for El Paso, Texas, VA recommended purchasing the "Sorenson Estate" as the property had irrigated land that would be appropriate for the farming component of the occupational therapy for the psychiatric patients.[192] Often the best site was located closest to the local medical school, as was the case in Durham, North Carolina where VA chose a 17.5 acre site adjacent to Duke University at a cost of $31,000.[193] Generally VA sought to purchase the chosen property and worked with local governments in the plans for development of the site. In St. Louis, VA reviewed 14 sites on which to build its hospital. The best one, also the site ultimately chosen, was located about a mile from the local medical school and consisted of 26 individual owners with "14 old mansion type houses and a number of commercial establishments."[194] 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."[195]

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

[190] National Archives and Records Administration, *Federal Records of World War II, Volume I* (Washington DC: Government Printing Office, 1950): 95.
[191] Resolution Adopted by the Federal Board of Hospitalization, 24 September 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.
[192] Resolution Adopted by the Federal Board of Hospitalization, 10 July 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.
[193] Resolution Adopted by the Federal Board of Hospitalization, 12 June 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.
[194] Resolution Adopted by the Federal Board of Hospitalization, 8 January 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.
[195] Ibid.

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."[196]

The Role of United States Army Corps of Engineers and Private Architects

Veterans needed open hospitals and not just empty parcels of land. To expedite construction, VA announced that building of the hospitals would be handled by the United States Army Corps of Engineers (USACE). [197] The USACE were attractive partners for VA as the War Powers Act of 1941 granted USACE the ability "to manipulate the contracting process favorably" to accelerate the purchase of supplies for wartime construction efforts.[198] At the time of the Third Generation hospital construction program, the War Powers Act was still in effect, and its subsequent Congressional extensions allowed USACE also to purchase supplies and services that would ultimately aid VA in hospital construction.[199] Furthermore, USACE already had contacts within private architecture and construction firms that further accelerated the construction process. With USACE on board, VA anticipated the hospitals would be completed in 18 to 24 months.[200]

The announcement that not only was VA 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 PHS, in June 1946, shortly after the hospital program was made public.[201] By April 1947, USACE had secured contracts with 52 independent private architectural firms, with several firms receiving more than one hospital contract. Five hospitals were to be designed by staff architects from VA.[202] Bradley was optimistic about retaining the private architects, as the size and scope of the program "would greatly outstrip the capacities of VA's own architect-engineer staff."[203]

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[196] Committee on Public Health Relations of the New York Academy of Medicine, "Hospitalization of Veterans," *Bulletin of the New York Academy of Medicine*, Vol. 25, No. 9 (September 1949): 594.
[197] "Veterans Will Get 183 New Hospitals," *New York Times,* 17 February 1946.
[198] James Ciment, ed., *The Home Front Encyclopedia* (Santa Barbara, CA: ABC-CLIO, Inc., 2007), 826.
[199] K.O. Shrewsbury to Assistant Administrator for Construction, Supply and Real Estate, Veterans Administration, 19 May 1948, Box, 1, Entry 72, Record Group 15, National Archives and Records Administration, Washington, DC.
[200] "Army Will Help Build 80 Veterans Hospitals," *California and Western Medicine*, Vol. 64, No. 3 (March 1946): 154.
[201] Kenneth K. Stowell, "What Are Essential Buildings?" *Architectural Record*, Vol. 99, No. 6 (June 1946): 71.
[202] List of Architect – Engineers and Construction Contractors, Hospital Branch, Construction Operations Division, Office of the Chief Engineers, Veterans Hospital Construction Program, 21 April 1947, Record Group 15, National Archives and Records Administration, Washington, DC.
[203] "Private Firms Predominate in V.A. Hospital Program," *Architectural Record*, Vol. 102, No. 4 (October 1947): 100.

The architects under contract with USACE 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, 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 USACE, the Army, and Post Office. Several firms had designed hospitals, both for public and private clients, but few had completed projects that rivaled the dollar amounts being proffered by VA.[204]

The initial phases of design and construction went fairly smoothly for VA, USACE, and supporting architects. Architects understood that they would receive standards and programs from VA, would be expected to work at top speed, and would be paid via lump sum contracts with the USACE. 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."[205] However, there were to be no standardized plans.[206] Within a few months, VA and USACE 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.[207] USACE 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.[208]

New Hospitals – Second Generation as Model

When Bradley announced the new hospital construction campaign, VA had three hospitals under construction. A comparison of a VA-designed early Third Generation hospital with a Second Generation hospital built for the same purpose, care of neuropsychiatric patients, revealed several common characteristics but a few marked differences, suggesting VA's existing plans for Second Generation hospitals were adopted, and often expanded, for the early

[204] 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)
[205] Board of the American Institute of Architects, "Veterans Hospitals," reprinted in *Bulletin of the American Institute of Architects*, July 1948, 29.
[206] Stowell, "Essential Buildings," p. 71.
[207] "Progress Report: The Veterans Hospital Program," *Progressive Architecture*, Vol. 28, No. 8 (August 1947): 20.
[208] Lieutenant General R. A. Wheeler to General Omar Bradley, 7 June 1946, Record Group #15, National Archives and Records Administration, Washington, DC.; Brigadier General J. S. Bragdon to F. H. Dryden, 11 June 1946, Record Group 15, National Archives and Records Administration, Washington, DC.

Third Generation hospital construction project. The Franklin Delano Roosevelt Hospital, commonly referred to as "Montrose" after the nearby town in New York State, was constructed using drawings completed by VA in September 1946 and opened to receive neuropsychiatric patients in May 1950. The Salem Veterans Hospital, located in rural southwest Virginia, had its drawings completed in November 1933 and opened for patients in April 1935.[209] The exteriors of the respective hospitals appear markedly similar, as they are both constructed of red brick, feature limited architectural elements that refer to previous architectural styles, and the central entrances to the primary administration buildings feature a shallow colonnade that indicates the main entrance. The general layout of buildings designated for housing patients, as opposed to support services, reflect similar underlying theories towards patient care. The large wards, housing over twenty beds each, filled entire wings oriented perpendicular to a central corridor. The beds within these large wards are organized perpendicular to the windows with a central row of beds; there are no indications of partitions or other means of establishing privacy. Across the main corridor from the wards are generous day rooms leading to screened porches. The porches are available on every floor, unlike later Veterans hospitals that limit porches to the top floor. The main corridors contain smaller patient rooms, but only Montrose offers private rooms with a single bed. At the juncture of the ward wings and the main corridor, both Montrose and Salem offer dressing rooms and patient gang toilets. Doctor's offices, nurse's areas, treatment rooms, and visitor rooms fill the remaining spaces on the corridor. Both Montrose and Salem have elevators centrally located with stairhalls closer to the wards. Montrose deviated from Salem with its inclusion of private rooms, an additional elevator that suggests increase reliance on this mode of transporting patients, and smaller wards provided limited privacy via cubicle partitions and beds arranged parallel to the windows following then current hospital theory.

New Hospitals – Designed under USACE

For its new, modern hospitals to be built by USACE, VA developed general guidelines that would provide general program requirements. In these requirements, 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, VA did not intend "to standardize any particular type of architectural design or prototype building, but to standardize the components of particular

[209] Drawings for Building No. 8, Franklin Delano Roosevelt Hospital, obtained from Engineering Office, Montrose Campus, VA Hudson Valley Healthcare System, January 2011; Drawings for Building No. 6, Salem Veterans Hospital, obtained from Historic American Building Survey, http://memory.loc.gov/ammem/collections/habs_haer/ (22 April 2011).

facilities contained within the envelope of the building or buildings."[210] Thus VA's healthcare program drove the arrangement of interior space for the hospital, leaving the exterior appearance to the architect. 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 the enclosed roof garden.[211] 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 VA requirements. The requirements were vague when compared to recommendations put forth in the general hospital literature. Necessities were stated for the standard patient bedrooms, e.g. 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.[212] For example, the 300-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 Supervisor, and multiple other spaces with specific purposes.[213] But any direction the requirements gave to the project architect was imprecise, only utilizing descriptors such as "located near" and "adjoining."

Subsequently, the resulting plans developed by a variety of architects and architecture firms were not identical but shared certain commonalities that were reflections of the current theories that governed the design of hospital of the postwar period and VA's new 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 Ft. Hamilton facility in Brooklyn, dumb waiters 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.

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[210] U.S. Veterans Administration, *Requirements for 300 – Bed General Hospital (Revised)*, 12 June 1946: 1, Construction Subject Files, Record Group 15, A1, Entry 72, National Archives and Records Administration, Washington, DC.
[211] Ibid., p. 9.
[212] Ibid., p. 3.
[213] Ibid., p. 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 VA hospitals had chapels, usually located on the first floor, along with dedicated offices for Catholic and Protestant chaplains.

For patient rooms, the large wards had for the most part been abolished, with the largest typical ward housing 16 semi-private beds with curtained partitions. The majority of the bed spaces were single or double rooms. Patient spaces continued some trends followed in Montrose, with the larger wards located at the end of wings with smaller capacity rooms located closer to the center of the building. Beds were arranged parallel with the exterior walls and windows, with curtain partitions to provide limited privacy. Nurses' stations were centrally located to allow ease of access and supervision of all rooms.

These modern hospitals did not deviate from the Second Generation hospitals in retaining hospital management offices on the first floor. Generally located at the end of a corridor that led from the main lobby, the office of the hospital director was surrounded by administrative support staff and immediately adjacent to the finance division in the early hospitals of this period, such as Montrose, as well as the later hospitals, such as Louisville.

Hospital Program Matures

By early June 1946, VA had directed USACE to prepare plans and specifications for 17 hospitals, surveys for 15 additional sites, and studies for additions to 10 existing hospitals. VA had a total of 91 hospitals projects, comprised of new hospitals, additions to existing hospitals, and possible replacement of temporary hospitals obtained from the Army, that would be executed by USACE, leaving 49 still in planning stages. Four contracts had already been signed with architecture firms, exhausting the $1.5 million USACE had already received from VA. USACE was ready to sign contracts with an additional nine architectural firm, but lacked the funds to do so.[214] VA was held in check by congressional appropriations that limited funds for design, supervision, inspection and overhead to 3

[214] Wheeler to Bradley, 7 June 1946

percent of total construction funds.[215] By August of 1946, USACE required $43,650,000 to cover its technical services support provided to VA.[216]

While architects had been given the general program needs as developed by VA, they had not been limited to specific budgets.[217] 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.[218] Following the war, construction costs increased, partially due to shortages of steel, copper, and aluminum. As a result, construction bids for VA hospitals were coming back at almost $1.80 a square foot, adding another $150 million in construction costs across the program.[219] In April 1946, VA announced that these increased costs would balloon the budget to $900 million.[220] While budget numbers were made available to the public, those numbers included purchasing the site, designing the hospital and associated facilities, and constructing the final product.

New VA Hospitals – Third Generation Standard Plan

VA sought ways to cut costs for its hospitals. It recommended eliminating any non-essential parts of the hospital complexes, including auditoriums and recreation facilities. VA inserted itself more into the design and procurement process, rather than leaving it solely up to the discretion of USACE. VA also began to evaluate using standardized plans developed in-house by VA architects; thus, VA could save money by designing a building once then constructing it multiple times in different sites across the country.[221]

In February 1947, architects characterized USACE as essentially withdrawn from the process, leaving a VA-helmed board of review to evaluate the architects' drawings. The program ground to a halt, as VA decided whether or not to pursue additional funds and USACE "found the increasing interference…unbearably hampering, and about a month ago practically stopped the entire design program."[222] Finally the rift had grown too great, and, in early 1948, VA announced future hospital projects would be handled by its own architecture-engineering staff.

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[215] Bragdon to Dryden, 11 June 1946.
[216] F. H. Dryden to Assistant Administrator for Construction and Supplies, 8 August 1946, Record Group 15, National Archives and Records Administration, Washington, DC.
[217] "Progress Report," August 1947, p. 20.
[218] "VA Revises Plans for 61 Hospitals," *New York Times*, 2 August 1947.
[219] Wesley Gilbertson and Harold A. Kahn, "Construction of Hospitals, Health Centers, and Other Health Facilities, 1951-1952," *Public Health Reports (1896-1970),* Vol. 67, No. 12 (December 1952):1168; "Progress Report," August 1947, p. 20.
[220] "Cost of VA Hospitals May Rise Near Billion," *New York Times*, 17 April 1946.
[221] Extant standardized plans were not located during the course of research.
[222] "Progress Report," August 1947, p. 20.

The private architects resented the implication that their work had been unsatisfactory, thus requiring VA to take it over once again. Representatives from 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 VA architects. While VA 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. Furthermore, VA had increased its staff in the architect's office from 217 to 990 people. In response, AIA presented its claims in congressional hearings before an appropriation subcommittee of the House of Representatives. The main charges levied by 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 essentially 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.[223]

VA was probably not helped by the fact that its architects were not members of AIA, paralleling the charges rendered against VA regarding the isolation of its medical staff from the wider medical field during the Hines era. Of the 27 architects listed in *Federal Architect* in July 1945, not a single architect was a member of AIA while they were in service to VA. Two later joined, but only after they had moved to private practice.[224]

Gray testified at the same Congressional hearing, proffering that the VA's program had not changed. The original set of hospitals were circulated to private architectural firms and it was only the newly added 14 hospitals that were going to be handled in the manner most advantageous to the government, whether private firms or VA architects. As VA was going to implement the same plan for the 14 hospitals, it did not appear to be cost effective to retain outside architectural consultants. Furthermore, the upswing in VA 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.[225]

While the members of the subcommittee supported the AIA, 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. AIA continued to

[223] John Fugard speaking for the American Institute of Architects to the Subcommittee of the Committee on Appropriations of the House of Representatives, 25 May 1948, reprinted in *Bulletin of the American Institute of Architects*, July 1948: 32-33.
[224] Review of AIA Historical Directory of American Architects, http://communities.aia.org/sites/hdoaa/wiki/Wiki%20Pages/Find%20Names.aspx (8 April 2011)
[225] General Carl R. Gray speaking for the Veterans Administration to the Subcommittee of the Committee on Appropriations of the House of Representatives, 25 May 1948, reprinted in *Bulletin of the American Institute of Architects*, July 1948: 35-37

belabor the issue and met with VA, but by the close of VA's fiscal year of 1948, VA had contracts in place to construct 28 additional hospitals, with 61 hospitals still on the drawing board. USACE was charged with constructing 69 of the new hospitals, along with one addition, while VA would handle 18 of the new hospitals. At this point, VA had 125 hospitals in operation with 102,200 beds, with an increase in patient load still expected.[226]

Scaling Back the Program

Furthermore, VA 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 VA's hospital program be merged with Army, Navy and PHS 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.[227]

VA harbored its own concerns about staffing such a larger 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 22 hospitals, were removed from the budget plans for 1950; the complete list follows in Appendix B. In many cases, VA had already obtained land for these hospitals; these properties were now determined surplus and transferred to the government landlord, the General Services Administration. If no other Federal agency was interested, the property was disposed of according to Federal law.[228]

However, VA fought the other recommendations from the Hoover Commission. President Truman appointed a special committee, featuring prominent physician Howard Rusk, to review VA's hospitalization efforts. They submitted their findings in 1950 addressing the main charges of the high cost of operating VA hospitals and the need to subsume them into a larger Federal hospital system. The committee identified a dozen reasons that affected the cost of VA hospitals, many programmatic in nature, such as the dedicated stockroom required for storage of 90 days of supplies and the spaces designated for Veterans organizations, which were unique to VA.[229] The report detailed that VA provided unique hospitalization services, thus necessitating independent hospitals. One of the key

[226] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30,* 1948 (Washington DC: Government Printing Office, 1949): 5, 8, 80.
[227] Committee on Public Health Relations, New York Academy of Medicine, "Hospitalization of Veterans," *Bulletin of the New York Academy of Medicine*, September 1949, 592.
[228] "Giving Up Sites for Hospitals," Erie *Times-News*, 21 November 1952.
[229] Abramson, et al. *Report to the President*, p. 49.

arguments related to demographics: VA's patients were overwhelmingly adults and 98 percent male, thus eliminating the need for spaces designated for obstetrics and pediatrics, while Army and Navy hospital also cared for dependents.[230] VA succeeded in keeping its system independent, and several of the eliminated hospitals eventually were revived, notably New York and Houston, as the Korean conflict 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 VA control. For example, during VA's 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, VA closed its old Army hospitals in Phoenix, Ft. Logan (near Denver), and Louisville. The old hospital in Indianapolis was closed as its services were duplicated in the new hospital. Instead of being transferred, the hospital was renovated and reopened to serve tuberculosis patients.[231] This trend continued throughout the 1950s, with VA completing construction of new hospitals and closing those that became superfluous.

By 1954, VA 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."[232] 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.[233] Furthermore, VA 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 VA hiring private architecture firms once again, in order to ensure that projects were completed in a timely fashion.[234] 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.

[230] Ibid., p. 51.
[231] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1952* (Washington DC: Government Printing Office, 1953): 11.
[232] Administrator of Veterans Affairs, *Annual Report for the Fiscal Year ending June 30, 1954* (Washington DC: Government Printing Office, 1955): 152.
[233] Ibid., p. 1.
[234] Ibid., p. 152-153.

The hospitals constructed as part of the Third Generation Veterans Hospital building campaign represent a significant change in the way VA provided healthcare 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, VA was able to provide stopgap healthcare during the period of swift demobilization immediately following the cessation of hostilities. However, to provide truly modern healthcare to Veterans, VA developed a plan to construct 80 new hospitals that represented the most current theories governing hospital operations and hospital design. These hospitals served as symbols that VA was no longer going to operate in isolation, as these new facilities were not constructed in rural backwater areas, but in cities that provided connections with medical schools and local hospitals. VA signaled the shift away from sprawling hospital campus by building sleek modern towers designed by architects in private practice. VA built hospitals based on projected Veterans' need, including hospitals specifically designated for tuberculosis and neuropsychiatric patients, from designs based on medical innovations. VA partnered with the USACE to expedite construction of the new hospitals, thus ensuring modern healthcare was provided quickly to the 20,000,000 Veterans of World War II.

F. Associated Property Types

Following World War II, VA faced surging medical care requirements due to an unprecedented number of Veterans entitled to healthcare. In order to meet the new demand, VA cobbled together a network of impermanent Armed Forces facilities and existing civilian facilities to provide treatment, while VA constructed its new modern hospitals designed especially for Veterans care. Together, these three types of resources constituted the Third Generation Veterans Hospitals.

Generally speaking, the transition hospitals were the first hospitals opened and operated by VA during the Third Generation program. The hospitals designed by architects in private practice followed. Budget constraints led to the utilization of in-house architectural staff, thus making those hospitals built based on a standard plan the third period hospital construction by VA during the Third Generation. However, clear temporal demarcations between these three phases cannot be drawn. Hospital construction was routinely delayed due to issues related to budget, site selection, availability of construction materials, or shifts in VA's programmatic requirements. These interruptions led to years elapsing between completed designs and open hospitals 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.

Transitional Hospitals

VA's postwar program utilized transitional hospitals to provide provisional measures for Veterans care prior to the completion of the massive hospital construction campaign. To expedite availability of hospital beds, VA utilized facilities that generally were already operating as hospitals. Thus, the transition from a third party to a VA facility required little more than new signage at the entrance. VA did not construct new, elaborate entrances or design new landscaping efforts. These facilities were appealing to VA because little to no intervention was required to open them up for Veteran care. While VA replaced some of these facilities during the course of the Third Generation construction program, many of these hospitals remain part of the VA network to the present day. These transitional hospitals do not have a singular plan or appearance as they originated from a variety of sources. All these facilities share the significance of serving an important means of providing health care to a growing Veteran population, while affording Bradley and VA enough breathing room to develop new, modern hospitals. These interim hospitals consisted of facilities constructed by the Army and Navy during World War II and transferred to VA after the cessation of hostilities; hospitals in planning or construction stages by VA that used Second Generation design

tenets expanded to meet surging patient loads; and existing hospitals built by various states and agencies that VA incorporated into its healthcare system.

Subtype: Army / Navy Hospitals

Description

One of the first types of hospitals utilized by VA following World War II was the cantonment-type hospital constructed during the war by the Army and Navy. Both the Army and Navy required hospitals that could be constructed quickly and adapted easily based on the number of needed beds; the final number of buildings constructed gave the hospital the flexibility to house anywhere from 25 to 2,000 beds, depending on anticipated patient load.[235] By World War II, negotiations between the Surgeon General and the War Department led to the development of the "Type A" hospital. This hospital template featured multiple one-story buildings designed to be erected quickly to meet urgent medical care needs; by spring of 1943, plans developed to transfer at least two of these hospital to VA after the War.[236] Frame construction was typical, but masonry buildings were not uncommon as wartime lumber shortages developed in portions of the country. The main administration building served as the central organizing fixture for the 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 in the remaining spaces. The Army constructed these types of hospitals throughout the United States as part of the greater war effort, and over twenty facilities transferred to VA when the Army began shedding surplus property after the war. World War II naval hospitals followed similar design tenets, but fewer hospitals shifted to VA after the war, since the Navy tended to construct hospitals as part of larger installations, not separate complexes. For the list of Armed Forces facilities transferred to VA after World War II, please see Appendix C.

A representative example of this Army/Navy subtype of Third Generation Veterans Hospital is the Carl Vinson VA Medical Center in Dublin, Georgia. The Dublin hospital 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. Patient treatment buildings are arranged in a chevron pattern behind the main building and linked via a series of connecting corridors. Support facilities, such as the boiler house and laundry, are

[235] Smith, *The Medical Department*, p. 14.
[236] Ibid., p. 76.

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.

Registration Requirements

In 2008, the Department of Defense developed a historic context describing military hospitals from the Revolutionary War era through modern day. This DoD context described briefly the World War II hospitals built by the Army and Navy and identified the components necessary to render the facility eligible for inclusion in the National Register of Historic Places as historic districts or individual historic properties; VA's properties that fall under this category will largely be historic districts. These components include the main administration building, a preponderance of the pavilion-type ward buildings, connecting corridors, and the surgery building. The survival of other buildings, such as mess halls and barracks, ranked of secondary importance to determining the eligibility of the complex.[237] The military hospitals historic context stated few of these buildings survived and "there does not appear to be an entire World War II hospital complex intact anywhere;" however, the context did not appear to review any extant former Army or Navy hospitals now within the purview of VA, such as the hospital in Dublin, Georgia or Martinsburg, West Virginia.[238] These requirements provide a sufficient framework for evaluation of VA's former Armed Forces hospitals. The VA facilities must include the majority of the original buildings remaining in their original configuration without extensive modern intrusions.

Subtype: Expanded Second Generation Hospitals

Description

When VA Administrator Omar Bradley announced the new construction program that would become the Third Generation, several VA hospitals were already in various stages of planning and construction. These VA-designed hospitals used existing plans and design tenets from the "Second Generation" of VA hospitals. Third Generation Veterans hospitals within this category were fairly rare; however, VA constructed a few hospitals during this transitional period between VA hospital generations. These hospitals vary in appearance from other facilities of the Third Generation, most notably in the utilization of revival architectural styles, but in more muted, limited applications than evident in the Second Generation hospitals.

[237] 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.
[238] Ibid., p. 280.

Second Generation hospital are those facilities constructed by VA between 1919 and 1948 and consisted of three primary types: general medical and surgical (GM&S), tuberculosis (TB), and neuropsychiatric (NP) facilities. Capacity for these Second Generation hospitals often was limited to 500 beds, as VA considered anything over 1,000 beds unwieldy to manage.[239] VA utilized these Second Generation hospitals as models for early, transitional Third Generation hospitals. The NP hospitals featured a main administrative building, multiple two-story buildings dedicated to specific types of patient care, kitchen and dining hall, recreation facilities, residential quarters, connecting corridors, and support facilities, such as the boiler house, water tower, and carpentry shops. Courtyards served as the organizing principle for the arrangement of hospital buildings. The TB hospitals included a main building housing both administrative and healthcare functions, as well as the complement of other buildings resembling the facilities found at NP hospitals of the period. The GM&S hospitals adopted an H-shaped central building, which accommodated the majority of the hospital functions, including administrative offices and clinical spaces.

VA utilized these existing designs for hospitals under construction during the waning days of World War II and the early post-War period. As a result, these early Third Generation, VA-designed hospitals consist of multiple buildings on a large campus featuring revival architectural styles in marked contrast to the sleek modern structures built on small urban footprints constructed elsewhere. The transitional campuses featured multiple low-rise structures often organized around a central greenspace. The most prominent building often housed the administrative offices and the buildings immediately adjacent housed patient care. Support services, such as carpentry shops and boiler houses, usually were located at the outer edge of the developed portion of the campus. As with the Second Generation Veterans Hospitals, seclusion and quiet were notable goals for the disposition of these hospitals, since many served predominately psychiatric patients. Furthermore, many of these hospitals retained the large wards containing 26 or more beds, rather than the combination of smaller wards and private rooms found in other VA hospitals of the same period. The most notable difference between this type of transitional hospital and later, private architect designed Third Generation hospitals is the utilization of revival architectural styles. While later Third Generation hospitals may have exhibited the same trends as Second Generation facilities, such as dedicated buildings for different types of patients at NP hospitals, the use of revival architectural styles in the newer facilities is rejected generally in favor of modern, contemporary architectural styles.

[239] Spurlock, et al., p. 41.

The VA hospital in Montrose, New York serves as an exemplar of the transitional type of early Third Generation hospital. Initial planning commenced in 1945, but delays resulted in the hospital's inclusion with the other Third Generation hospitals announced by Bradley in 1946. Montrose exhibits certain architectural characteristics of Second Generation hospital elements, notably a largely Georgian Revival campus with numerous low-rise structures sprawling across a campus located in a relative remote location. The neuropsychiatric hospital facility consists of one main admissions building flanked by paired courtyards. The courtyards are each surrounded by six patient buildings. 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. However, the scale of Montrose required stretching the Second Generation design tenets to almost unwieldy dimensions. In terms of the number of beds, Montrose was the largest hospital of the Third Generation campaign, originally designed for 1,984 beds for psychiatric patients, over 600 beds larger than the next largest hospital of 1,300 beds planned for Pittsburgh, Pennsylvania. As a result, Montrose features Georgian Revival details focused at the central portion of the administration building, limited architectural ornament on the patient buildings, and utilitarian appearances for ancillary buildings. The majority of the treatment buildings are configured in paired, mirrored courtyards ringed by connecting corridors. These building arrangements derived from Second Generation precedents, negate the verticality of the majority of the Third Generation hospital campuses and their central, high-rise hospital buildings. However, internal configurations, such as a majority of individual patient rooms and fewer large wards, reflect the trends of modern hospital design that guided Third Generation hospital plans.

Registration Requirements

In 2010, VA developed a historic context describing post-World War I Veterans hospitals, known as the "Second Generation" of hospitals, which included the identification of registration requirements and defining characteristics of these historic districts. These design elements are applicable to this subtype of Third Generation hospitals. The context identified sub-types based on hospital type (neuropsychiatric, general medical & surgical, and tuberculosis) and period of construction (Period I up to the 1920s and Period II to 1948). The context defines the registration requirements based on those subtypes, but several commonalities stretch across all the subtypes, most notably the use of revival architectural styles. The majority of the hospitals employed the Colonial Revival style, but Spanish Colonial Revival was popular in the south and southwest while other revival styles were utilized at hospitals on an individual basis, such as Egyptian Revival at Marion, Illinois. Other important attributes include elevation of the main building above surrounding terrain, organizing buildings by function, patient buildings constructed with an H-shaped footprint, and a campus-like setting. Alterations that do not affect eligibility include changes to interior finishes, shift in building functions, enclosure of porches, and addition of recreational facilities.

Subtype: Third Party Hospitals

Description

An alternate form of the transitional facility was the existing hospital building or hospital complex built by a third party, taken over by the Army or Navy during the war, and then shifted to VA following the cessation of hostilities. While these properties did not resemble the cantonment hospitals of the Army, their functions were identical: providing desperately needed medical care to Veterans. These facilities had construction dates that placed them within the Second Generation hospitals timeframe, but due to their adaption for World War II Veterans, they are considered part of the Third Generation hospitals. VA often erected multiple additions and outbuildings at these facilities, in order to conform more closely to its program needs. These hospitals encompassed a range of hospital designs, construction periods, and styles, given their construction by a variety of builders in uncoordinated efforts across wide geographies.

For example, at Butler, Pennsylvania, VA received a hospital constructed by the Commonwealth of Pennsylvania from the Army. Built as a tuberculosis facility, the state never activated the hospital before the war began. The Army annexed the facility and eventually transferred it to VA. The facility combines a late 1930s state tuberculosis sanatorium with a World War II Army hospital and additional modifications by VA; eleven buildings remain from the tuberculosis sanatorium. While the buildings of the state hospital exhibit more stylistic elements, particularly some Tudor Revival characteristics, and the Army buildings are strictly functional, the campus is unified by the use of brick as the common exterior treatment. As a result, the campus is a mix of building types, ranging from the massive main hospital building to utilitarian outbuildings, lacking a cohesive campus style. The Butler VA Healthcare facility is a rare Third Generation hospital, built as a new, specialized hospital by a State agency, converted to temporary wartime facilities by the Army, and eventually converted to a permanent tuberculosis hospital for Veterans after the war.

Registration Requirements

As this Third Party Hospitals subtype embraces a variety of hospitals, builders, geographies, and architects, registration requirements rely heavily on integrity of overall design and retention of original site configuration and circulation patterns. These historic properties will generally be historic districts. For the main hospital building, large additions that overwhelm the primacy of the main façade and relocate the primary entrance will negatively affect eligibility; however, minimally intrusive additions to the rear will not. Extensive alterations to the exterior, such as infill between wings or new entrance pavilions unsympathetic to the historic architecture of the original

hospital, will render the hospital ineligible. Substantive loss of the original buildings of the hospital complex, particularly those once dedicated to patient care, will render the facility ineligible as a historic district, but singular buildings may retain sufficient integrity to be individually eligible under this context.

New Hospitals
Description

Accelerated demobilization rates of armed forces of the size and scope of World War II quickly demonstrated to VA that its Veteran population required an expedited construction program. The decision to build new hospitals provided VA an opportunity to deliver the latest in modern healthcare to Veterans, thus addressing many of the concerns regarding substandard healthcare raised by an alarmed public. As a result, VA engaged the USACE to oversee construction of new hospitals designed by private architecture firms rather than relying on its in-house architecture staff responsible for the much-criticized older facilities. However, concerns over cost forced a reduction in the overall program, leading to the development of a standard hospital plan by VA architects based on the same programmatic requirements. As a result, the new hospitals built during the Third Generation Veterans Hospitals can be subdivided into two categories: those designed by architects in private practice under USACE direction and those designed by in-house VA architects. Despite the differences in appearance, the new Third Generation Veterans Hospitals embraced several similar characteristics based on the goals for creating a modern hospital as envisioned by VA. Both types relied on specifications developed by VA that accommodated specialized medical care for Veterans. These requirements, combined with modern hospital design tenets of the period, led to similarities between these two categories.

The new Third Generation hospitals tended to be sited near metropolitan areas of states with large Veteran populations; however, the availability of land and local concerns unique to each city guided the exact location. Therefore, a VA hospital could be located very close to the urban core or in an area of postwar development surrounded by predominately residential neighborhoods. VA's goal of locating its hospitals in proximity to local medical schools often created concentrated medical districts, but available land suited for a hospital of this scale, especially when combined with the programmatic needs for specialty TB or NP hospitals, often pushed VA to select properties not immediately adjacent to the other hospitals in the city.

For example, VA sited the hospital in New Orleans, completed in 1952, on a relatively small piece of property for comparable VA hospitals, only 5.6 acres for 500 beds, in downtown New Orleans. Despite the size, the site was preferable to rebuilding on the previous hospital site along the shores of Lake Pontchartrain, since the new property

sat in close proximity to the medical schools of Tulane University and Louisiana State University, along with the state-run teaching hospital, Charity Hospital. By locating VA downtown, New Orleans created a medical district featuring modern healthcare. Conversely, in Kansas City, VA opted to construct a 745-bed hospital on 48 acres, approximately 10 miles southeast of the urban core. This site placed the hospital in a developing area of the city, yet kept the associated medical school, transportation services, and utilities within reach. The decision by VA to locate the Kansas City facility at this property was likely due to the initial intent to build a TB hospital, a type of facility often located in less populated areas due to prevailing medical theories and fear of contagion.

For the most part, the showpiece of these hospitals was the central hospital building, ranging anywhere from 4 to 18 stories, sited prominently on the property. These hospitals rejected previous Veterans hospital design of multiple low-rise buildings spread over vast properties. The intended services and beds to be provided by each hospital necessitated the construction of large buildings, with many facilities designed to enclose 12 to 14 stories and up to 11,000,000 cubic feet, such as the hospital constructed in Pittsburgh.

For the new main building, some basic organizational tenets prevailed across almost all of the designs for general medical and surgical hospitals, regardless of architect. 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 Veteran 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 to facilitate patient access to the enclosed roof gardens. The floors dedicated for general medical services, i.e. not for psychiatric care, tended to have identical plans as to distribution of space. The center 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 4 to 16 beds filled the end of the hospital wings. 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."

As Veterans hospital of this period focused on service-related medical care and the preponderance of Veterans seeking care were men, these hospitals generally did not include facilities found routinely at civilian hospitals for care of women, such as maternity wards. Rather than include these facilities within its own hospitals, VA

encouraged female Veterans to seek those services at their local civilian hospitals. As a result, few Third Generation hospitals have designated spaces for the care of female Veterans. Those hospitals that did include such facilities often located them at 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 VA never activated the ward.

VA did not construct these hospitals with overtly costly or ostentatious materials. For the most part, the hospitals, regardless of size, started with a steel frame skeleton. The majority of the hospitals are clad in brick, but some variations in exterior cladding are found among the earlier hospitals. Often the lower floors had a different treatment on the exterior, distinguished by material or fenestration, which created a platform or base for the massive hospital structure. This variation tended to be located only on the portion of the structure readily visible from the primary approach and did not necessarily extend to all elevations. The main entrance for patients tended to be constructed of the same material, usually with a simple modern entrance pavilion featuring none of the ornate monumental entrances of government architecture of earlier generations.

While the majority of these hospitals featured the streamlined exteriors of midcentury modern architecture, idiosyncratic responses based on local situations resulted in architectural anomalies within the Third Generation program. For example, at Sioux Falls, South Dakota, VA chose a site once home to a 1920s Catholic college designed in the Collegiate Gothic style. As VA opted to incorporate many of the extant buildings into the new hospital complex, it designed the new construction to conform to the predominant architectural style of the campus. Political patronage also played a role in design decisions, as exemplified by the VA hospital in East Orange, New Jersey. When constructed in 1952, the hospital conformed to the single monolithic hospital design typical of the Third Generation, but the main building features bas relief panels, ornamental light fixtures, and other architectural features representative of the Art Deco style. These anachronistic design elements were the result of a local politician giving the plum design contract to his favorite architect who worked in the Art Deco style.

The interior finishes followed accepted hospital practices of the period, emphasizing durability and ease of cleaning. The upper floors of patient rooms were rather simple, stressing function over decorative features. Any emphasis on architectural design tended to be placed on the primary public spaces of the lobby, chapel, and auditorium, provided the hospital had the latter. The lobby for these Third Generation Veterans Hospitals was the principal public space, where patients would enter to be guided to the correct floor via the nearby banks of elevators. These lobbies tend to be the most formal and stylized spaces within the hospital, represented by unique finishes and treatments not

found in the more private spaces in the rest of the building. The floors were often terrazzo rather than the standard asphalt tile. The lobbies featured interiors finished in wood paneling, marble, or other more formal finishes as opposed to the plaster of the patient rooms. The lobby at the VA facility at Bonham, Texas retained its curvilinear information desk that once housed the hospital switchboard. These types of finishes often extended to chapels and auditoriums as recognition of the importance of these spaces to the general well-being of the Veterans. Many chapels even featured a rotating altar, providing an easy way to transition between services for different faiths.

The associated outbuildings were notably smaller in scale, often not exceeding two stories in height. Depending on the size of the hospital, the outbuildings 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 often clustered together in a residential hub, attendants' quarters often sat on the other side of the hospital from this housing enclave. The design of these outbuildings took architectural cues from the main hospital building, often utilizing the same exterior building materials and scaled down ornamentation. Director's houses filtered these elements through a domestic lens, creating buildings that may have incorporated certain design elements from the main hospital building on the exterior but favored residential rather than institutional architecture.

Support services, such as laundries, warehouses, and boiler houses, often 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 NP hospitals. Smaller urban lots often required these support buildings be located to the rear of the main hospital building. The buildings would be clad with the same exterior treatment as the other buildings on campus. The exteriors of these buildings emphasized functionality and featured little ornament.

For the most part, VA did not retain any extant buildings on the property; usually these buildings and structures were demolished in the course of site preparation. However, in the push to open up healthcare facilities as quickly as possible, VA often repurposed existing building stock for support services but ensured all medical facilities were housed in the newly constructed main hospital building. These extant reused facilities ranged from a home for elderly indigent men at Brockton, Army stables at Fort Meade, to a former tuberculosis hospital at West Haven.

As with the designs for the new hospital buildings, VA did not develop aesthetic requirements for the landscape, parking, signage, benches, and the like. Unlike the Second Generation Veterans hospitals, for which landscape considerations were a point of emphasis, landscape treatments were not part of the Third Generation construction

program. The variation in hospital sites resulted in corresponding distinctions in landscape treatments. Those hospitals constructed on larger tracts could indulge in more extensive landscape designs than their confined urban counterparts. Generally, VA sought to use existing trees and plantings to the extent feasible with the overall design for the site. For the most part, the emphasis on expedited construction and modern facilities tended to leave landscaping less consideration. For example, of the over 90 extant available architectural drawings for the construction of the St. Louis VA hospital, only one is devoted to a plan for plantings for the site; a portion of that single drawing is devoted to the correct method for staking the new trees.

These above-noted characteristics are found throughout the majority of the Third Generation Veterans Hospitals, whether designed by VA or private architects, as they manifested some of the primary goals of the new hospital program. However, the specific manner each architect chose to design his specific VA hospital resulted in a range of solutions to a single problem.

Subtype: New Hospitals - Designed under USACE

When VA partnered with USACE for the hospital construction program, it obtained access to private architectural firms knowledgeable and experienced in hospital design and architecture. These architects, well trained and familiar with large scale government construction, provided new and modern facilities markedly different in design and appearance from those hospitals constructed by VA architects. The architects received general program requirements, but were given a free hand on the design of the final facilities. Each architect derived his own solutions to the VA program requirements, resulting in a collection of hospitals that have some parallel features but no uniform appearance. While some identical hospitals exist, they are the product of a single architectural firm executing designs for more than one hospital. However, given the overarching theories prevalent in hospital design of the day, many of the hospitals have similar features reflecting these planning principles.

The hospitals designed under USACE usually reflected a modern aesthetic, rather than revival architectural styles popular with the previous generation, that placed these Third Generation Veterans Hospital squarely within the postwar period. As a result, this subset of hospitals had some design commonalities. The hospitals designed by private architects have limited extraneous ornamentation, choosing to emphasize the clean linear qualities of the buildings. Given the lack of ornament, fenestration patterns and materials played important roles in the aesthetics of the building. Architects used windows to emphasize the verticality or horizontality of the structure. Many of the structures featured a central projecting portion with windows often framed out in contrasting materials, along with

spandrels in the same contrasting material, to emphasize the vertical quality of this section of the hospital. For other hospitals, continuous narrow bands outlined windows of a single story not only creating defined horizontal lines, but also 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 served as defining characteristics.

The private architects executed designs for the outbuildings concurrently with the design for the main hospital. Therefore, the associated outbuildings, such as the staff quarters and power plants, referenced the design of the main hospital structure, often through identical exterior cladding or fenestration patterns. The outbuildings featured elements of the main hospital scaled down to be more suitable for these smaller two- or three-story structures.

Examples of the private architect-designed hospitals include the Veterans hospitals in Brooklyn, New York; Grand Island, Nebraska; and Spokane, Washington. Different architectural firms designed these hospitals, thus the hospitals did not resemble one another in terms of plans, exteriors, or finishes. Yet all of the above hospitals 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.

Registration Requirements

The majority of the Veterans hospital complexes designed by architects in private practice will be eligible as historic districts. However, individual buildings may be individually eligible, particularly the main hospital building if ancillary buildings have been lost and the facility is no longer a cohesive historic property.

All hospitals must be located on their original site.

Since these architects all worked from the same set of programmatic requirements, and since many were sited on small, urban sites, there are some similarities in form. These hospitals feature a massive skyscraper-type structure often located in a position of prominence within a larger property, such as at the crest of a hill. The main buildings range from 4 to 18 stories. The majority of the hospitals feature a central block with elevators, offices, and the like with patient wings projecting from the central core. However, a variety of floor plans sprung forth during the Third Generation, including linear blocks without projecting wings and joined Ys. Almost all hospitals included roof gardens at the uppermost floors for NP patients. The main building housed support services as well, such as kitchens

and storage on the basement and lower floors, the lobby, offices, and chapels on the ground floor, and patient rooms filling out the rest of the space. NP wards traditionally filled the uppermost floors, including specialized treatment rooms.

The overall architectural style of these hospitals reflects design elements of Mid-Century Modern and International Style architecture, but some local, idiosyncratic responses, such as the Art Deco facility in East Orange, were constructed.

These massive hospitals are surrounded by a series of smaller outbuildings that historically provided utilities, housing for staff, and other services better suited outside the walls of the main hospital building. These outbuildings reference the overall design of the main hospital, using similar cladding and fenestration, for instance, thus rendering the campus visually cohesive.

In the Third Generation, VA emphasized modern medical care in sleek facilities sited on urban lots, particularly for its general medical facilities. This focus emphasized the buildings and the activities within those buildings over the sweeping grounds and extensive recreational facilities commonly found at VA hospitals of previous eras, particularly as budgetary concerns led to a scaling back of facility designs. VA occasionally elected to retain extant plantings on the property, but rarely devoted much time or effort for landscaping at the majority of these facilities. The minor landscaping efforts that did take place were often clustered near the entrance to the hospital or near the main entrance to the hospital building. Internal roadways were either for direct access to the main hospital building by patients or staff or for delivery vehicles to reach loading docks at the rear of the main hospital building and other service areas. VA did not design elaborate entrances or signage for its modern hospitals. The main access point for these facilities often consisted of a plain sign and main drive that looped around a flag pole near the primary entrance to the hospital building.

In selecting sites for these facilities, VA considered the availability and proximity of public transportation. VA also constructed multiple residential units for staff at the majority of the Third Generation hospital complexes. As a result, VA did not need to devote extensive space or considerable funds to the construction of parking lots or decks during the Third Generation. Surface parking lots were constructed routinely near the main entrance, but these were often small and intended for a handful of staff and a few visitors.

Original design materials and workmanship should survive for these hospitals if they are to be eligible for listing under the Third Generation Veterans Hospitals. However, since the majority of these hospitals remain under the purview of VA and continue to provide healthcare services to Veterans, alterations to the campuses are common, and many will not render the district ineligible. 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;
- 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 as a hospital or hospital support; and
- Enclosure of roof gardens to house mechanical equipment;

Finding alterations to the interiors of these hospitals is not unusual as the facilities have been changed to meet modern medical standards and needs. However, two interior spaces received particular attention during design and thus may affect the eligibility of the individual structure: the chapel and the lobby. If the chapel has been altered to the point that key elements are no longer extant, particularly if the hospital had a rotating altar but it has since been removed, eligibility may be negatively affected. Additionally, as the lobby served an important role as the primary point of access to the facility, its replacement or relegation to a secondary or tertiary entrance may affect eligibility.

Taken individually, these alterations have a minimal effect on the integrity of the historic hospital campus. Cumulatively, these alterations can have a major impact. For this reason, each hospital has to be evaluated carefully to determine whether it retains enough of its appearance during its period of significance to be eligible for inclusion in the National Register of Historic Places under this context.

The presence of new construction at a Third Generation hospital is practically inevitable, given changing requirements to meet modern healthcare standards. New construction affects the eligibility of the facility if it is not comparable in scale, materials, and general appearance. Rear additions tend to be less problematic than additions on the primary elevations. If the addition replaces the original entrance to the main hospital building, obscures the

historic facade from the main access point to the facility, or is unsympathetic to the original historic character of the hospital, the eligibility of the hospital may be affected.

Finally, the integrity of feeling and association for the Third Generation Veterans Hospitals will be affected by changes over time that sever the link to the post World War II period in the United States. Many of these Third Generation hospitals remain part of the VA healthcare system and continue to evoke the connection to Veterans healthcare even if surface parking lots and additions have altered the original appearance. A key determinant of integrity of feeling and association for these hospitals is whether the site retains its focus on the main hospital structure. Generally this trend will be exhibited via direct access to the structure from the main entrance and the absence of any taller buildings on the campus.

Subtype: New Hospitals - Designed under VA

An alternate type of VA hospital developed when VA adopted a standard architectural plan in the interest of economy. The standard plan grew out of cost concerns that arose during the first rounds of construction. VA feared that they would not be able to complete the outlined nationwide construction program if the cost overruns continued. The new standard plan hospitals were more modest facilities, but were essentially identical copies of one another down to the red brick exteriors, regardless of site conditions or local situation. The plan for the main hospital building consisted of a central block with projecting wings. A penthouse for mechanical equipment rose from the center of the main block. Then main entrance for the hospital building was located in the center of the main block between the two projecting wings. The design minimized the main entrances for patients and consisted of small pavilions and limited signage.

In scale and massing, these VA-designed hospitals resemble those Third Generation hospitals designed by architects in private practice rather than their Second Generation counterparts. This subset of hospitals, however, emphasized strict functionality in their appearance, leaving nothing that could be considered extraneous. The exteriors were devoid of virtually all 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 resulting design reduced the hospital to its most fundamental components and placed emphasis on the activities taking place within rather than serving as a showcase of architectural innovation.

Examples of VA-designed hospitals include facilities in Louisville, Kentucky; Philadelphia, Pennsylvania; and St. Louis, Missouri. Despite the diverse locations, the main hospital buildings at these various hospitals are practically identical, including red brick cladding, no architectural ornament, and plain ancillary buildings.

Registration Requirements

As with the hospitals designed by architects in private practice, the VA facilities based on the standard plan will most likely be historic districts; these districts follow the same registration requirements. However, the austere exteriors of these standard plan hospitals can sustain little in the way of alterations before the eligibility is compromised. The entrances to the main hospital buildings have been subjected particularly to numerous changes over the years to accommodate accessibility requirements. When constructed, these entrances were routinely modest in appearance and lacked any of the elaborate doors or lighting elements found at architect-designed facilities. As a result, these entrances cannot sustain any significant accumulation of changes before the historic character is lost.

Additional parking lots, window replacements, and rear additions to the main hospital building are the more frequent alterations to standard plan Third Generation hospitals. If these alterations follow the general scale and character of the facility and do not significantly alter the circulation patterns of the facility, these changes will not affect eligibility.

Subtype: Neuropsychiatric Hospitals

Designed by either architects in private practice or VA's own architectural staff, Third Generation Veterans Hospitals designed predominately for neuropsychiatric patients vary from their general medical and surgical counterparts in design and organization. These hospitals were influenced heavily by the findings of the recommendations of a committee of psychiatrists led by Dr. Paul Haun. As presented at the annual meeting of the American Psychiatric Association in 1947, the committee recommended neuropsychiatric hospitals reject the common architectural features such as porches, large wards, and rural sites. The committee advocated that patient wellness relied on achieving comfortable, home-like surroundings and a degree of privacy. Thus avoiding the "institutional" architecture of the past, including smaller wards divided by partitions to achieve a simulacrum of privacy, ensuring secure exercise yards to encourage patients to go outside, and locating treatment rooms near patient rooms to minimize travel and waiting times became characteristics of these "Haun-type" hospitals.

As NP hospitals had different program needs than GM&S hospitals, these new Haun-type NP facilities broke with the typical Third Generation hospital model of a monolithic building surrounded by a scattering of much smaller buildings for support. Instead, services in these new NP hospitals spread across multiple buildings of similar scale, generally two to four stories in height, and hewed more closely to Second Generation precedents. However, the revival style architecture favored during the earlier era of Veterans hospital is absent in the Third Generation NP facilities. The administration building remained the most prominent on campus, centrally located and near the main entry point to the facility. Patient buildings clustered near the administrative building; these buildings often were similar to one another in appearance and footprint, but differed as to types of patients housed within. Separate buildings housed neuropsychiatric patients also suffering from tuberculosis. While a central courtyard or axis served as an organizing principle for many of the primary patient buildings, the strict formality and rigid orientation of the Second Generation hospitals was not present. Connecting corridors, either below or above ground, commonly link the buildings of these facilities. Support buildings, housing boiler plants and warehouses, generally sat isolated from patient care buildings at the rear of the hospital campus. Given the average stay for patients at NP hospitals was significantly longer than those at GM&S hospitals, Third Generation NP hospitals tended to have extensive recreation facilities. These facilities included buildings, such as theatres, indoor swimming pools, and gymnasiums, as well as ball fields, basketball courts, and the like. Often the sprawling neuropsychiatric hospitals located in predominately rural areas devoted the most acreage to planned landscape features, particularly if agricultural activities functioned as part of the occupational therapy program.

The VA facilities at Topeka, Kansas and Brockton, Massachusetts represent the Haun-type of NP facility of the Third Generation. Both these hospitals feature multiple, low-rise brick buildings linked via connecting corridors. Patient buildings are organized around the main administrative building. Extensive dedicated recreational facilities are present at both campuses, including ball fields, theatres, and enclosed exercise yards.

Registration Requirements

As with the other hospitals of the Third Generation, the NP hospitals will largely be considered eligible for the NRHP as a historic district.

Many of the registration requirements for general medical facilities apply to NP facilities. All hospitals must be located on their original site. Circulation patterns, particularly in relation to how patients would enter the primary entrance, must remain consistent with historic use patterns. The overall historic appearance of the complex must

remain evident and not be obscured by new construction. The Mid-Century Modern architectural elements should be retained and not compromised by unsympathetic alterations or additions. The loss of spaces where the public and patients interacted, such as the lobby or chapel, may also affect eligibility. Particularly since these NP hospitals often had separate chapels and auditoriums, given the longer patients stays common to these facilities.

However, because these NP hospitals reflect a different development pattern than their general medical counterparts, the registration requirement are somewhat different. Instead of the lynchpin element of a single, central main hospital building, Third Generation NP hospitals contain multiple low-rise building with no single individual building dominating the campus. Thus, the loss of one patient building may not affect eligibility as long as the overall configuration of the buildings retains the original Haun-influenced plan.

As with the other Third Generation hospitals, replacement of windows, expansion of parking, and minor rear additions and new construction that are in scale with the original buildings are acceptable alterations. The loss of recreational facilities will not affect eligibility, unless the areas that were once recreational fields or open greenspace has become the site for incompatible new construction that has severely compromised the overall historic integrity of the campus.

Significance

The Third Generation Veterans Hospitals represent a revolution in medical care for Veterans in the United States in the years following World War II. The Veterans Administration, predecessor of the Department of Veterans Affairs, responded to widespread charges of inadequate healthcare facilities by making sweeping changes to its approach to hospitals. Instead of continuing the practice of multi-building campuses designed in revival architectural styles housing patients in large wards that characterized Veterans hospitals after World War I, VA constructed sleek skyscraper hospitals that housed the majority of their functions within a single structure. VA sited these new modern hospitals near urban centers across the United States, which allowed integration of the VA hospital with medical schools and other hospitals rather than in isolated, rural areas. General Omar Bradley's term as Administrator for VA achieved these changes. President Truman appointed Bradley head of VA with the expressed goal of modernizing the agency, including the hospital program. VA therefore announced a plan for constructing 80 new hospitals throughout the United States. Meanwhile, VA created an interim system of surplussed Army and Navy hospitals and beds in private hospitals, as had been done after World War I, to provide immediate relief to the healthcare needs of the returning World War II Veterans while construction was underway on the new

hospitals. At the close of the Third Generation period, VA managed over 120,000 beds in 172 hospitals, an increase of about 78 percent from 1945. The majority of the Third Generation Veterans Hospitals remains under VA supervision and continue to provide healthcare to Veterans today.

VA implemented this program through the construction of new hospitals. USACE constructed many of these facilities utilizing plans developed by architects in private practice. Architectural firms and architects like Skidmore, Owings & Merrill, John Graham, Jr., Favrot & Reed, and George Pepper, Jr. all jumped at the opportunity to provide architectural services to VA. These firms created truly modern hospitals, both in layout and appearance. These hospitals embraced linear appearances with little ornamentation while still housing all the requirements of the VA hospitals program. As a result, while certain core characteristics remain consistent throughout these buildings, they do not necessarily resemble one another.

VA's concerns over unruly costs and meeting its hospital goals under the proscribed budget triggered a shift of the design program to VA architects, resulting in the implementation of standardized plans that created an instantly recognizable Veterans hospital.

Therefore, VA hospitals constructed as a response to the surge in the Veteran population following World War II are significant under criterion A, as representative of the theme of health/medicine, with some of the hospitals also eligible under criterion C, given their association with significant architects. The Third Generation Veterans Hospitals may be significant on a nationwide level as they represent the overarching Federal response to the issue of appropriate Veterans health care implemented on a nationwide scale; however, individual hospitals may also be significant regionally or locally given the construction often spurred development of urban areas adjacent to the newly constructed hospital.

At the end of the war, the U.S. military began transferring surplus properties to VA for use as hospitals, followed shortly thereafter by the boom in new hospital construction. VA built these hospitals, developed specifically in response to World War II, 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 hospital opened in Topeka in 1958, following a lengthy bid at replacing a temporary hospital obtained from the Army in 1946. Therefore, the proposed period of significance for the Third Generation Veterans Hospitals is 1946 to 1958.

G. Geographical Data

The Third Generation Veterans Hospitals are located throughout the United States.

H. Summary of Identification and Evaluation Methods

Survey for the Third Generation Veterans Hospital historic context and multiple property listing began with preliminary identification of those hospitals constructed in response to World War II. 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 VA, 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 an additional 20 hospitals surveyed subsequently. These hospitals were selected as representative hospitals constructed by VA following World War II in terms of hospital type, location, and architectural style. Each site survey included extensive photodocumentation of the exterior of the structure, limited photodocumentation of the interior of the 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 VA hospital in the area.

Research for the historic context was conducted at the Washington, DC and College Park, MD facilities of the National Archives and Records Administration, particularly for Record Group #15, the records of VA. 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 VA during the postwar period. These buildings were primarily the main hospital, but also included the buildings that provided support services, such as laundries or power houses. As VA instigated several temporary measures during the course of the response, the significant properties also included those structures employed by VA in a long term means of providing health care to Veterans following World War II, even if they had been constructed initially by another organization.

Integrity requirements were based on site visits conducted of 10 representative hospital types and review of historic documentation including architectural drawings and photographs, combined with VA documentation regarding changes made to the historic structures.

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Appendix A

Sites identified for the construction of a new Third Generation Veterans Hospital, with the projected number and type of beds; General Medical and Surgical (GM&S), Neuropsychiatric (NP), Tuberculosis (TB) and Domiciliary.[240] The following list does not include those hospitals already under construction at the time of the report, such as Tomah, Wisconsin, or Army hospitals that were later replaced with a modern facility, such as Topeka, Kansas.

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
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

[240] *Annual Report for the Fiscal Year ending June 30, 1946* (Washington, D.C.: Government Printing Office, 1946): 176.

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.[241]

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

[241] *MCV*, p. 224-225.

Appendix C: Armed Forces facilities transferred to the Veterans Administration after World War II.[242]

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)

[242] Smith, *United States Army in World War II,* p. 304-313; *MCV*, p. 395-409.

Appendix D: Commonly used acronyms in the preceding report.

AIA	American Institute of Architects
FBH	Federal Board of Hospitalization
GM&S	General Medical & Surgery
NP	Neuropsychiatric
PHS	Public Health Service
TB	Tuberculosis
USACE	United States Army Corps of Engineers
VA	Veterans Administration (became U.S. Department of Veterans Affairs in 1989)