

United States Department of the Interior
National Park Service

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National Register of Historic Places Multiple Property Documentation Form

This form is for use in documenting multiple property groups relating to one or several historic contexts. See instructions in Guidelines for Completing National Register Forms (National Register Bulletin 16). Complete each item by marking "x" in the appropriate box or by entering the requested information. For additional space use continuation sheets (Form 10-900a). Type all entries.

New Submission Amended Submission

A. Name of Multiple Property Listing

United States Second Generation Veterans Hospitals

B. Associated Historic Contexts

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

Changes in Health Care Offered by the Federal Government to Veterans of World War I
History of Government Sponsored Veterans Health Care
Disabled United States Veterans of World War I
Creation of Second Generation Veterans Hospitals, 1919–1950

C. Form Prepared by

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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 Part 60 and the Secretary of the Interior's Standards for Planning and Evaluation.

See continuation sheet

Signature of certifying official

Date

State or Federal agency and bureau

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 of the National Register

Date

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Provide the following information on continuation sheets. Cite the letter and the title before each section of the narrative. Assign page numbers according to the instructions for continuation sheets in How to Complete the Multiple Property Documentation Form (National Register Bulletin 16B). Fill in page numbers for each section in the space below.

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Paperwork Reduction Act Statement: This information is being collected for applications to the National Register of Historic Places to nominate properties for listing or determine eligibility for listing, to list properties, and to amend existing listings. Response to this request is required to obtain a benefit in accordance with the National Historic Preservation Act, as amended (16 U.S.C. 470 et seq.).

Estimated Burden Statement: Public reporting burden for this form is estimated to average 18.1 hours per response including time for reviewing instructions, gathering and maintaining data, and completing and reviewing the form. Direct comments regarding this burden estimate or any aspect of this form to the Chief, Administrative Services Division, National Park Service, P.O. Box 37127, Washington, DC 20013-7127; and the Office of Management and Budget, Paperwork Reductions Projects (1024-0018), Washington, DC 20503.

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United States Second Generation Veterans Hospitals, Nationwide

E. STATEMENT OF HISTORIC CONTEXTS

Second Generation Veterans Hospitals are significant as a tangible manifestation of the federal government's commitment to the health care of veterans of World War I. Constructed between 1919 and 1950, these medical facilities reveal a profound shift from the medical care offered to veterans at the federal level prior to World War I. Second Generation Veterans Hospitals built upon the mission of the National Home for Disabled Volunteer Soldiers (NHDVS), also known as First Generation Veterans Homes (which were built or acquired from 1866 to 1929). Whereas the eleven branches of the NHDVS, operated as long term domiciliary and hospital facilities for volunteer Union veterans of the Civil War, the Second Generation Veterans Hospital's mission was the rapid rehabilitation, healing, and return of veterans to their productive civilian lives through modern medical facilities, therapies, medicines, and surgical techniques. The growth of the number of Second Generation Veterans Hospitals was in part spurred by the continued liberalizing of admittance requirements that ultimately provided medical care to veterans for ailments unrelated to service injuries or disabilities. By 1950 the Veterans Administration was operating 136 hospitals, the nation's largest network of hospitals.¹ Standardized designs for these hospitals were developed and continued to evolve, creating large campuses with buildings grouped according to function. Although there are similarities among all of the Second Generation Veterans Hospitals, they can be divided based upon two periods of construction, Period I and Period II, and four hospital sub-types: neuropsychiatric, tuberculosis, general medical and surgical hospitals, and homes/general medical hospitals. Most of these facilities, especially neuropsychiatric hospitals, were constructed near rural communities able to accommodate the large tracts of land necessary for their campus settings and the agricultural operations utilized as occupational therapy. The majority exhibit nationally popular Colonial Revival architectural styles. The physical expression conveyed by these facilities honored ailing and injured veterans through a recognizably "American" or "Patriotic" language of architecture. While there are similarities, the built environment of Second Generation Veterans Hospitals can be distinguished from that of their predecessors: First Generation Homes built for veterans of the Civil War, and later hospitals that served veterans from turn-of-the-century conflicts and from the global combat of the middle decades of the twentieth century, such as that of World War II. Hospitals constructed in the second half of the twentieth century reflected a growing need for out-patient treatment rather than residential care and were known as Third Generation or Bradley Hospitals. Second Generation Veterans Hospitals have a distinct material culture that serves as a physical reminder of the prevailing and progressive medical care embraced by the federal government and offered to United States veterans who served in foreign theaters and to those suffering from ailments not associated with active duty situations. In many ways, veterans were offered medical care superior to that available to the civilian population. In an era prior to the widespread availability of comprehensive, insurance-funded health care, veterans hospitals provided the best available care at little or no cost to those who served in the U.S. military.

¹ *Administrator of Veterans Affairs Annual Report for Fiscal Year Ending June 30, 1950* (Washington, D.C.: U.S. Government Printing Office, 1951), 9.

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United States Second Generation Veterans Hospitals, Nationwide

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

History of Government Sponsored Veterans Health Care

The Second Generation Veterans Hospitals, created to serve the medical needs of veterans of World War I, built upon the mission of various government efforts that preceded them. Although the following discussion is organized into sections, many of the programs overlapped chronologically.

I. Revolutionary War to the Civil War, 1798–1865

The origin of medical care provided by the federal government to veterans dates back to the Revolutionary War when, recognizing the service of disabled soldiers, the Continental Congress provided pensions to those veterans who had service-related injuries. The United States Congress continued to offer monetary aid to disabled war veterans. The government expanded this pension system in 1818 to include any veterans who needed assistance, making clear that the pension was a reward for service, not charity. The number of disabled former soldiers receiving government pensions continually expanded, and in 1833, the Bureau of Pensions was created to administer the growing federal military pension program.²

One of the first pieces of national legislation toward the creation of a comprehensive medical complex for veterans of the United States, entitled the “Act for the relief of sick and disabled Seamen,” provided medical care to merchant seamen and was extended to those serving in the United States Navy in 1799.³ The act did not, however, result in the immediate construction of hospitals for the care of sailors, as existing facilities were utilized. By 1851 marine hospitals were located in New Orleans, Louisiana; Mobile, Alabama; Key West, Florida; Charleston, South Carolina; Ocracoke, North Carolina; Chelsea, Massachusetts; and Norfolk, Virginia.⁴ The construction of additional marine hospitals was undertaken during the mid-nineteenth century, coinciding with the expansion of maritime trade throughout the country, resulting in the creation of two dozen marine hospitals by 1861. Only seven marine hospitals were in use by 1872.⁵

² Suzanne Julin, “Draft: National Home for Disabled Volunteer Soldiers; Assessment of Significance and National Historic Landmark Recommendations” (2007), 7, completed under a Cooperative Agreement between the National Council on Public History and the National Park Service, Midwest Regional Office, and located on the World Wide Web on the National Park Service website at:

<http://www.nps.gov/history/nhl/Downloads/NHDVS/NHDVS%20Draft%20Two.pdf>. Accessed January 2009.

³ Benjamin J. Lewis, *VA Medical Program in Relation to Medical Schools* (Washington, D.C.: U.S. Government Printing Office, 1970; Washington, D.C.: Veterans Administration Department of Medicine and Surgery, 1984), 24. Citations are to the Veterans Administration edition; Bess Furman, in consultation with Ralph C. Williams, *A Profile of the United States Public Health Service 1798–1948* (Bethesda, MD: National Institutes of Health, 1973), 1–2.

⁴ Lewis, 25; United States Senate, *Report of the Secretary of the Treasury...information in relation to marine hospitals and the marine hospital fund*, 31st Congress, 2nd sess., S. Doc. 14, January 20, 1851, 4.

⁵ United States Senate, *Report of the Secretary of the Treasury, on the State of Finances for the Year Ending June 30, 1861*, 37th Congress, 2nd sess., S. Doc. 2, 1861, 98, 122–124; United States House of Representatives, *First Annual Report of the Supervising Surgeon of the Marine Hospital Service of the United States for the Year 1872*, 42nd Congress, 3rd sess., H. Doc. 131, 1873, 80.

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The United States Naval Asylum was established by Congress in 1811 and opened in 1831 in Philadelphia for elderly and disabled veterans of the Marines and Navy. The disabilities had to occur during military service for admittance to the Naval Asylum. The Naval Asylum was initially funded through fees paid by those serving in the Navy. The United States Military Asylum was established on the outskirts of the nation's capital in 1851. The Military Asylum became known as the United States Soldier's Home in the following decade. The United States Soldier's Home was created to serve elderly veterans and those who had served in the military with over twenty years of service. This establishment has been in continuous use and is currently known as the Armed Forces Retirement Home Washington, D.C. Another institution offering care to disabled soldiers was the Government Hospital for the Insane, created in 1852 and also located in Washington, D.C. This institution provided care to residents of the city and military personnel suffering from mental illnesses. The hospital also provided health care to soldiers and naval servicemen during the Civil War but returned to its original purpose of caring for those with mental diseases after the war. Admission was extended to veterans determined insane within three years of the termination of their military service. The name of the hospital was changed to St. Elizabeths prior to World War I, although patients had referred to the facility by its new official designation for many years. Because it served as a long term care facility, a cemetery was created for those patients who died while residing at the facility.⁶

II. National Home for Disabled Volunteer Soldiers (NHDVS)

Realizing disabled volunteer Union veterans of the Civil War often required long term care in excess of what their pensions and family members could afford, Congress created government-sponsored homes for disabled volunteer soldiers of the Civil War in March 1865. These were originally known as the National Asylum for Disabled Volunteer Soldiers. In 1873 the homes associated with the earlier legislation were renamed the National Home for Disabled Volunteer Soldiers (NHDVS), which reinforced the idea of a "home" as opposed to an "asylum."⁷ Governed by the Board of Managers, the NHDVS branches were to be homes for disabled veterans where they would receive lodging, food, clothing, and possible employment opportunities. These benefits were considered a reward for service rather than charity.⁸ The branches were operated using military protocols, including uniforms and regimented daily routines, and were constructed within campus settings with decentralized building arrangements. The NHDVS branches constructed during the last half of the nineteenth century contained buildings whose functions within the campus closely followed a military example, such as barracks, kitchen/mess halls, chapels, shops, power plants, hospitals, and administration buildings. Cemeteries were also associated with all of the branches, either on the grounds of the facility or in the local town. The NHDVS branches were located in rural areas on campuses often containing over 100 acres, which could include recreational facilities such as parks, lakes, theaters, and libraries. The

⁶ Gustavus A. Weber and Laurence F. Schmeckebier, *The Veterans Administration: Its History, Activities and Organization* (Washington, D.C.: The Brookings Institution, 1934), 70; Julin, 7–9.

⁷ National Park Service, "History of the National Home for Disabled Volunteer Soldiers," Veterans Affairs National Home for Disabled Volunteer Soldiers, "Discover Our Shared Heritage Travel Itinerary," http://www.nps.gov/nr/travel/veterans_affairs/History.html. Accessed January 2011; Weber and Schmeckebier, 73.

⁸ National Park Service, "History of the National Home for Disabled Volunteer Soldiers," Veterans Affairs National Home for Disabled Volunteer Soldiers, "Discover Our Shared Heritage Travel Itinerary."

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residents of the branches could earn additional funds by working in the various campus shops or laboring on the branch's farm, raising agricultural goods for the facility's kitchen. Buildings at the branches were constructed in various architectural styles popular from the second half of the nineteenth to early twentieth century, including Richardsonian Romanesque, Queen Anne, Stick, and Beaux Arts.⁹

Originally those eligible for admission to the branches of the NHDVS had to be a volunteer veteran of the Union forces whose illness or disability was directly related to military service during the Civil War. Over time the admission requirements were altered to include those who had served the United States in other conflicts by legislation such as the act passed in July 1884 (23 Stat. L., 120) that allowed entry to the branches for veterans of the War of 1812 and the Mexican War. This legislation opened the door for veterans that were disabled because of age or disease (not connected with military service) and therefore did not have the means to support themselves. Confederate veterans were still excluded from admission to the branches.¹⁰ While the homes offered medical care, many patients were indigents with long-term disabilities. The majority of patients from 1870 to 1922 were Union Civil War veterans, with veterans of the Spanish-American War gaining admittance to the homes beginning in 1900. The number of Civil War veterans residing at NHDVS branches reached its peak in 1905, with an average of 20,464 Civil War veterans. The peak year of average overall population at the NHDVS branches was 1906, when the average total population was 21,105 members. The majority of this figure included Civil War veterans, but it also included a growing number of Spanish-American War veterans. By 1932 an average of over 16,000 World War I veterans were utilizing the homes, whereas the average number of Civil War veterans had declined to slightly over 700.¹¹ According to Ronald Hamowy in *Government and Public Health in America*, the majority of benefits allotted to veterans before the Great War were paid as pensions, primarily to those injured in the Civil War or their widows. Access to the branches of the NHDVS was another benefit provided to former volunteer soldiers who did not serve with the Confederate forces. Passage of the Dependent Pension Act in 1890 greatly increased the number of eligible Civil War pensioners and their dependents and the outflow of payments from federal coffers.¹² The NHDVS continued offering domiciliary and medical care to veterans until its merger into the Veterans Administration in 1930. From that point, the former NHDVS facilities were under the control of the Veterans Administration and were referred to as Veterans Administration Homes, but they continued to provide the same domiciliary and medical care to disabled veterans.¹³

III. Creation of the Veterans Bureau

The First World War between the Allies and Central Powers began in 1914 in Europe and Russia. The United States remained a neutral party until its entrance into the war in April 1917. Hostilities

⁹ Ibid.

¹⁰ Esther M. Corzine, *Establishment of Veterans Administration Hospitals and Domiciliaries* (Washington, D.C.: Research Division, Coordination Service, Veterans Administration, 1951), n.p.; Weber and Schmeckebier, 73–81; National Park Service, "History of the National Home for Disabled Volunteer Soldiers," Veterans Affairs National Home for Disabled Volunteer Soldiers, "Discover Our Shared Heritage Travel Itinerary."

¹¹ Weber and Schmeckebier, 452–453; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1932* (Washington, D.C.: U.S. Government Printing Office, 1932), 90.

¹² Ronald Hamowy, *Government and Public Health in America* (Cheltenham, UK: Edward Elgar Publishing, 2007), 271–272.

¹³ Julin, 37–38.

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continued until November 1918, when the Armistice was signed.¹⁴ Excepting the brief Spanish-American War in the late nineteenth century, the United States' entry into World War I created a need for medical care of veterans not seen since the Civil War. The Bureau of War Risk Insurance was created as part of the Treasury Department in 1914. Initially the Bureau of War Risk Insurance insured American ships and their cargoes from losses during World War I, but in 1917, after the United States' entry into the global conflict, the bureau was charged with issuing death and disability insurance to servicemen, disbursing allotments to the veterans families, and with providing rehabilitation services and medical care to veterans.¹⁵ Public Law 90, passed in 1917, was the first occasion that medical care to veterans was specifically addressed by national legislation, whereas before this, domiciliary benefits with minimal medical care were offered to veterans. The medical care offered under the 1917 law was for injuries related only to military service.¹⁶

Because of the scale of the task and its lack of experience in health care, the Bureau of War Risk Insurance entered into a cooperative agreement with the United States Public Health Service (PHS) to handle the medical needs of the nation's returning disabled soldiers. The role of rehabilitation of disabled veterans was undertaken by the Federal Board for Vocational Education. Offering rehabilitation services to disabled veterans in order to return them quickly to productive civilian life was a dramatic shift from the long term domiciliary care provided by the branches of the NHDVS. After the Armistice in 1918, the Bureau of War Risk Insurance no longer wrote insurance policies for veterans, but since these policies were paid through payroll deductions during the conflict, a new accounting system was necessary to inform veterans of their insurance payments and premium collections. During the 1918 fiscal year, the Bureau of War Risk Insurance increased in size from 6,703 to 13,771 employees.¹⁷ Confusion among veterans increased as the bureaucracy grew, because different agencies and thousands of new employees were now managing veterans benefits.

The PHS, having been renamed in 1912, had been previously known as the Public Health and Marine Hospital Service (1902).¹⁸ Before taking responsibility for the medical care of disabled World War I veterans, the PHS maintained a number of small hospitals with a total capacity of approximately 1,500 patients. To address the imminent arrival of returning disabled veterans from Europe requiring medical care, actions were taken by the PHS to remedy the shortage of available government hospital beds. Civilian hospitals throughout the nation were contracted to accommodate returning veterans. Leases were assumed on existing government hospitals (such as Navy and Army hospitals), properties with existing structures that could be quickly retrofitted to serve as hospitals were leased (such as resorts), and existing hospitals were purchased, all in an attempt to meet the medical demands of the nation's returning disabled soldiers. In the second quarter of 1919, the PHS was able to establish ten

¹⁴ Tom Pendergast and Sara Pendergast, *World War I Almanac*, ed. Christine Slovey (Detroit, MI: Gale Group, 2002), xvii, 175; Byron Farwell, *Over There, The United States in the Great War 1917–1918* (New York, NY: W. Norton and Company, 1999), 35–36, 53, 257.

¹⁵ Weber and Schmeckebier, 212–214.

¹⁶ Corzine, n.p.; George E. Ijams and Philip B. Matz, "History of the Medical and Domiciliary Care of Veterans," *The Military Surgeon* 76, no. 3 (March 1935): 126.

¹⁷ Weber and Schmeckebier, 215–216; Amy W. Knight and Robert L. Worden, *Veterans Benefits Administration: An Organizational History, 1776–1994* (Washington D.C.: Veterans Benefits Administration, 1995), 16; James A. Tobey, *The National Government and Public Health* (Baltimore, MD: Johns Hopkins Press, 1926), 329.

¹⁸ Hamowy, 11.

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hospitals. The PHS also opened out-patient dispensaries, numbering fifty-five at their peak.¹⁹ As stated in a 1923 article by C. H. Lavinder, a surgeon with the PHS serving in New York, New York, "Many, if not most, of these institutions were unsatisfactory from a physical standpoint. Every attempt was made, however, to organize and operate a hospital system with high professional standards."²⁰

Rehabilitation was viewed as an important service for injured World War I veterans, and it was also hoped the training would reduce government subsidies to these former servicemen, who would be able to quickly return to the civilian workforce. The passage of the Vocational Rehabilitation Act in 1918 offered training to those discharged military personnel who were eligible for benefits from the Bureau of War Risk Insurance. The training was administered by the Federal Board for Vocational Education, although the Bureau of War Risk Insurance had to first determine the individual veterans compensation before any rehabilitation training could begin. The number of cases under review by the Bureau of War Risk Insurance to establish an individual's compensation created delays in both monetary compensation and rehabilitation training, since the Federal Board for Vocational Education could not accept individuals before their compensation was determined. Coordination within the three responsible governmental parties, the Bureau of War Risk Insurance, the PHS, and the Rehabilitation Division of the Federal Board for Vocational Education continued to be problematic. In numerous cases, once the rehabilitation training was completed, the veteran had to be examined by a physician who reported to the PHS and whose information was then sent to the Bureau of War Risk Insurance before compensation could be resumed. Steps were taken in an attempt to remedy such situations, but problems persisted.²¹

Inefficiencies were created by three government organizations dealing with World War I veterans, including overlapping functions and a lack of adequate hospital beds for returning injured veterans.²² President Warren G. Harding created a commission under the direction of Charles G. Dawes to address the issues faced by the nation's veterans of the Great War. Veterans organizations, such as the Disabled American Veterans (created in 1921) and the American Legion (organized in 1919), pushed for changes in the existing system. The Dawes Committee, following a similar suggestion offered by the previously-created Consultants on Hospitalization committee, proposed realigning the three major governmental entities that managed veterans benefits into a single agency. The Veterans Bureau Act of 1921 (42 Stat. L., 147), enacted in August 1921 and also known as the Sweet Act (or Sweet Bill), created the Veterans Bureau. The act merged the duties toward veterans of World War I held by the Bureau of War Risk Insurance (which ceased to exist), the vocational training of the Federal Board of Vocational Education, and the medical functions of the PHS, but not the hospitals under the PHS's control. The Veterans Bureau was an independent governmental agency, unlike the PHS and the Bureau of War Risk Insurance, which were both under the United States Treasury Department. Remaining separate governmental entities were the NHDVS and the Bureau of Pensions, which managed veterans assistance from earlier wars. In April 1922, fifty-seven hospitals of the PHS pertaining to the care of veterans were transferred to the Veterans Bureau by the authority of the president of the United States. Nine hospitals and sanatoriums that were under construction or being

¹⁹ C. H. Lavinder, "Hospital Activities of the United States Public Health Service During 1922," *The Modern Hospital* 20, no. 1 (January 1923): 31-32; C. C. Pierce, "Activities of the U. S. Public Health Service During 1921," *The Modern Hospital* 18, no. 1 (January 1922): 33-34; Hamowy, 31.

²⁰ Lavinder, 31.

²¹ Weber and Schmeckebier, 104-114; Knight and Worden, 16-17.

²² Tobey, 327-328; Weber and Schmeckebier, 153-156.

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remodeled by the Treasury Department were to be transferred to the newly created agency upon completion of the hospitals.²³ A number of the hospitals under control of the PHS had been closed prior to the transfer of the facilities to the Veterans Bureau, leaving approximately forty-four hospitals under the direct control of the Veterans Bureau.²⁴

In the spring of 1921, prior to the creation of the Veterans Bureau, an appropriation was made by Congress for the construction of new hospitals and expansion of existing government medical facilities. This appropriation for \$18.6 million was Public Act No. 384, also known as the first Langley Bill. The monies under this appropriation were under the control of the United States Treasury Department.²⁵ President Warren G. Harding appointed Charles R. Forbes, former Director of the Bureau of War Risk Insurance, as the first director of the Veterans Bureau. The director of the newly created agency apparently met opposition to the planned construction of new veterans hospitals from Dr. Charles Sawyer, the director of the Federal Board of Hospitalization and the president's personal doctor. President Harding established the Federal Board of Hospitalization in 1921. Its purpose was to coordinate the various federal agencies dealing with medical facilities, such as the Army, Navy, Veterans Bureau, and the PHS. In Sawyer's opinion, it was more economical to use available beds for disabled veterans in existing army cantonments in the United States than to construct new facilities.²⁶ In Bess Furman's *A Profile of the United States Public Health Service, 1798–1948*, Furman states that Dr. Sawyer "apparently was determined that all disabled veterans should be housed in old cantonment buildings and Army barracks. Forbes visited all these cantonment buildings which had been operated as hospitals under the Public Health Service and pronounced them all fire-traps."²⁷ Forbes served as director only a short time before the Veterans Bureau was under investigation for mismanagement. Forbes resigned in 1923, when the Senate started its investigation into the agency. General Frank T. Hines was appointed by President Harding in March 1923 to replace Forbes as director of the Veterans Bureau.²⁸

The Senate committee investigating the Veterans Bureau activities while under director Forbes produced recommendations for streamlining all of the various laws related to veterans benefits. Many of these recommendations were included in the World War Veterans Act (43 Stat. L., 607), enacted in June 1924. This act liberalized the standards for admission to hospitals for veterans of conflicts prior to World War I and also allowed the continued decentralization of the bureau throughout the nation.²⁹

²³ Knight and Worden, 18–19; Tobey, 329–330; Weber and Schmeckebier, 114, 161, 163–164, 217–218; Corzine, n.p.; Adkins, 110–111; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, (Washington, D.C.: U.S. Government Printing Office, 1922), 16; Hamowy, 34; Furman, 344–346.

²⁴ Adkins, 133–134; *Annual Report of the Surgeon General of the Public Health Service of the United States for the Fiscal Year 1922*, (Washington, D.C.: U.S. Government Printing Office, 1922), 224.

²⁵ C. C. Pierce, 33–35; John R. McDill, "A Development of Hospital Facilities for Disabled Veterans of the World War," *The Modern Hospital* 20, no. 1 (January 1923): 35.

²⁶ Furman, 344–346; Rosemary Stevens, "Can the Government Govern? Lessons from the Formation of the Veterans Administration," *Journal of Health Politics, Policy and Law* 16, no. 2 (1991), 294–295; Adkins, 120–121; Charles R. Forbes, "Inside the Harding Administration," in *Politics of the Nineteen Twenties*, ed. John L. Shover (Waltham, MA: Ginn-Blaisdell, 1970), 35–36.

²⁷ Furman, 346.

²⁸ Glover E. Hopson, *The Veterans Administration*, ([New York]: Chelsea House Publishers, 1988), 33–34; Knight and Worden, 19.

²⁹ Tobey, 23–24; Knight and Worden, 19–20.

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According to Hamowy, the World War Veterans Act provided government sponsored health care to veterans whether or not their disabilities or ailments were connected to their military service.³⁰

The Veterans Bureau built twenty-one hospitals designated as either tuberculosis, neuropsychiatric, or general medical and surgical hospitals, not including those erected or improved by the Treasury Department. The hospitals designed for and by the Veterans Bureau incorporated concepts derived from earlier federal examples set by the housing of large groups of men, such as Army reservations and NHDVS branches. Concepts utilized at these three federal institutions include a campus setting with buildings serving specific functions. While Army reservations, NHDVS branches, and Veterans Bureau hospitals all serviced the needs of military personnel, each had different missions. Veterans Bureau hospitals provided short-term rehabilitation and medical care to veterans, whereas Army reservations and NHDVS branches supported the long-term housing of soldiers and veterans while also offering medical care. The Veterans Bureau hospitals were focused on returning veterans to their families and the work force in a timely manner. The size of each Veterans Bureau hospital campus was dependent upon the sub-type of hospital that was to be erected at the site. The design of each of the three Veterans Bureau hospital sub-types shares similar characteristics with the others, but no two campuses are identical because of differences in the size of the property, topography, climate, architectural style of the buildings, and patient capacity. But even with these variations, the Second Generation Hospitals are clearly identifiable as a hospital type based on common elements of design.

The creation of the Veterans Bureau partially solved the earlier problems associated with separate government entities handling issues involving veterans health care. But veterans concerns continued to be managed in three different federal units: the Veterans Bureau, Bureau of Pensions, and the NHDVS. This arrangement, whereby multiple units administered veterans benefits, would soon change.

IV. Creation of the Veterans Administration

Congress enacted legislation in July 1930 (46 Stat. L., 1016) authorizing the president to merge the Veterans Bureau, the NHDVS, and the Bureau of Pensions into a single entity, the Veterans Administration. After its creation, the majority of benefits relating to veterans were overseen by the Veterans Administration. Veterans benefits not controlled by the Veterans Administration included the Naval Home at Philadelphia; the Soldier's Home and St. Elizabeths Hospital, both in Washington, D.C.; the American Battle Monuments Commission; and veterans benefits managed by the Army and the Bureau of Indian Affairs. In addition to veterans benefits, the Veterans Administration managed the federal government's civilian employees' retirement disbursements. Frank T. Hines, who had been director of the Veterans Bureau since 1923, was appointed administrator of the newly created Veterans Administration. Hines guided the agency until his departure in 1945.³¹

The Veterans Administration continued the medical facility construction design practices of its predecessor, the Veterans Bureau, as the three hospital sub-types and the functional building types continued to be erected by the Veterans Administration. In addition a fourth sub-type, veterans homes/general medical hospitals, was constructed in three locations: Mississippi, Florida, and Oregon. The three veterans homes/general medical hospitals were originally authorized as NHDVS branches, but with the consolidation of services, the three facilities were designed by the Veterans Administration.

³⁰ Hamowy, 276.

³¹ Weber and Schmeckebier, 226–227; Knight and Worden, 25; Darlene Richardson, Historian at the Department of Veterans Affairs, information provided to the author by email, August 25, 2010.

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These three facilities are unique to the Veterans Administration, having been constructed primarily for domiciliary care but also offering general medical hospital facilities. The designs for Second Generation Veterans Hospitals continued to evolve, just as they had under the Veterans Bureau. The hospitals of the Veterans Administration sustained the earlier design concepts of a campus setting, with buildings serving specific functions, and the grouping of buildings by function. The Veterans Administration also continued to modify building and site plans and develop further the modifications that were taking place at Veterans Bureau hospitals of the late 1920s. Included among these alterations is the use of less formalized landscape designs allowing picturesque and naturalistic patterns for drives, sidewalks, and plantings, when possible, and the development of the fully realized monumental Classical Revival-style main buildings.

In addition to meeting the health care needs of veterans, the Veterans Bureau and Veterans Administration began limited research programs starting in 1925. Most medical research in the United States at the time was conducted by a few prominent facilities, universities, or foundations, such as the Mayo Clinic. Veterans hospitals did not begin associations with medical schools until after World War II. Research conducted by the Veterans Bureau and Veterans Administration was not to be academic in nature but was expected to directly lead to better patient care in the veterans hospital system. Beginning in 1932, three laboratories were created by the Veterans Administration to address specific areas of medical research: tumor research at Edward Hines, Jr., Veterans Administration Hospital, Hines, Illinois; neuropsychiatric research at Northport, New York; and cardiovascular research at Washington, D.C. The research conducted at these three laboratories and other veterans hospitals led to improvements in veterans health care.³²

Disabled United States Veterans of World War I

I. Advances in Warfare During World War I

After the initial military thrusts, the Great War settled into a protracted campaign with nearly static fronts and opposing forces defending their positions from trenches while separated by the muddied, bomb-cratered, barbed-wired no man's land. The swift mechanization of the military forces, from cavalry to tanks and dirigibles to heavy airplane bombers, serves as an indicator of the many changes in warfare experienced by the combatants of the First World War, especially in comparison to the type of combat practiced and weaponry utilized during the American Civil War. This protracted conflict and the trench warfare so closely identified with the "war to end all wars" led to chemical and mechanical inventions and improvements clearly recognizable as modern warfare. The scientific innovations and their military applications unleashed destructive forces never before seen on the battlefield.

Guy Hartcup states in *The War of Invention, Scientific Developments, 1914–19*, "Never before in the history of warfare had so many guns been assembled or so many rounds fired as on the battlefields of the Western Front."³³ In addition to the great number of guns were shells filled with TNT and other

³² United States Department of Veterans Affairs, *A Historical Look at the Establishment of the Department of Veterans Affairs Research and Development Program*, (Washington, D.C.: Government Printing Office, 2010), 27, 41, 47, 51–57.

³³ Guy Hartcup, *The War of Invention, Scientific Developments, 1914–18* (London: Brassey's Defence Publishers, 1988), 44.

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high explosives that had not been utilized in such quantities before the First World War. Improvements were also made to grenades, mortars and armor piercing shells, artillery pieces, machine guns, torpedoes, submarines, and airplanes.³⁴ New devices unveiled during the conflict include the tank and flame throwers (both having marginal success), chemical gases distributed through shells and cylinders (including chlorine and mustard gas), and the associated protective masks and equipment.³⁵ These improvements and innovations of military hardware led to new types of wounds and injuries unimagined in the past, including victims suffering from gas attacks, psychological illnesses, shrapnel, chemical burns, bullet wounds (both rifle and machine gun), and wounds caused by shelling from heavy artillery and aerial bombing. These casualties presented a dramatic shift from the types of wounds treated by United States medical personnel in the Civil War and represent the basis of change in medical treatment necessitated after World War I from that offered previously by the NHDVS.

Concurrent with innovations that increased casualties were improvements in the medical care of wounded soldiers. Field hospitals were established to provide immediate attention and surgery, if necessary. Field hospitals were constructed as temporary structures, usually of wood. Hospitals of the European war theater were constructed on the pavilion plan, consisting of narrow wards attached to corridors that divided soldiers into small groups. Pavilion plan hospitals were constructed to allow breezes to pass through the wards to provide fresh air and remove stale and harmful air from the wards. New anesthetics and antiseptics were also produced to reduce the incidence of infections from shrapnel and surgeries, and improvements were made in the use of blood transfusions and the treatment of casualties of gas attacks.³⁶

II. United States Casualties During World War I

In April 1917 the United States declared war on Germany, thus entering the Great War on the side of the Allies. The drafting of men into the armed forces began in July 1917.³⁷ During World War I over 4.7 million men and women entered the various military services of the United States. After reaching training camps, over 740,000 potential soldiers were found to have mental or physical ailments precluding them from service although they had been processed by their local draft boards.³⁸ The Armistice was signed on November 11, 1918, thereby ending military actions among the combatants. The United States Army, including the National Guard, consisted of slightly over 200,000 men prior to the war. By the end of the Great War these two armed services commanded nearly 3.7 million soldiers.³⁹ During its brief active involvement in the war, the United States suffered 266,000 casualties from military operations. Of this total, 60,000 were killed, and the remainder suffered wounds. An additional 60,000 casualties died from diseases, approximately half in the United States during training before deployment overseas. Many of these deaths were caused by the 1918–1919 influenza epidemic that indiscriminately killed millions throughout the globe.⁴⁰

³⁴ Ibid, 45–49, 61–67, 122–123, 145–152, 156–157

³⁵ Ibid, 80–90, 94–103, 106–107

³⁶ Ibid, 167–170, 174–175.

³⁷ Pendergast and Pendergast, xvii, 175, 180, 182.

³⁸ Ijams and Matz, 125-126.

³⁹ Farwell, 35–36, 53, 257.

⁴⁰ Robert H. Zieger, *America's Great War, World War I and the American Experience* (Lanham, MD: Rowman and Littlefield Publishers, Inc., 2000), 108–109.

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Prior to the United States sending soldiers to the European theater, over 1,000 doctors visited field hospitals to study the military medical procedures and lessons previously learned by the British. As stated in Robert H. Zieger's *America's Great War, World War I and the American Experience*, British medical personnel were at first overwhelmed with the destructive effects modern military weapons caused soldiers, from physical trauma caused by gas attacks and high explosives to psychological disorders. The battlegrounds, formerly cultivated fields, were responsible for many of the deadly infections received by wounded soldiers.⁴¹ According to Zieger "31 percent of the wounded treated by the U.S. Army were gas victims."⁴²

Zieger also states that nearly 100,000 United States soldiers "were admitted to army hospitals with psychological or nervous ailments, and 42,000 gained disability discharges on the basis of these complaints."⁴³ These were not only shell shock cases (also known as war neurosis); men in Army camps in the United States and the European theater were found to suffer from mental illnesses. At the United States Army stations and hospitals of the Western Front, approximately 7,500 soldiers were treated for neuropsychological issues.⁴⁴

III. Neuropsychological Casualties of World War I

Even before the entrance of the United States into World War I, reports were issued from the frontlines of soldiers suffering from shell shock, also referred to as war neurosis. It was initially thought that the effects of shelling from modern high explosives were the cause of these casualties, as the violent force of the explosions appeared to affect the combatants' nervous systems. Continual gas attacks also provoked the onset of shell shock in soldiers. Many of the wounded had no physical injuries but suffered mental breakdowns leading to catatonic states, amnesia, tremors, nightmares, insomnia, blindness, paralyzed limbs, and/or hysterical moments. The victims of this neuropsychological illness included those of all ranks. It was later determined that rather than the concussive effects of artillery on the nervous system, these conditions were caused by the experience of soldiers facing the instruments and effects of modern warfare.⁴⁵

American doctors had observed the medical practices of the British and French in dealing with war neurosis patients from the front lines prior to the United States entering the conflict. One such observer was Dr. Thomas W. Salmon, who was the medical director of the National Committee for Mental Hygiene. Efforts were made to initially identify men with mental illnesses during induction into the United States Army in hopes of minimizing such cases later on, but many such recruits were still admitted to the military. Once medical personnel from the United States began to deal with soldiers suffering from shell shock, the preferred treatment was to quickly treat the men with food, rest, exercise, and quiet quarters in rear areas but not far from the front. Once positive progress was made, the soldier was sent back to the front lines to continue to serve alongside their comrades. The doctors

⁴¹ Ibid, 109.

⁴² Ibid, 110.

⁴³ Ibid, 111.

⁴⁴ Ibid.

⁴⁵ Zieger, 110; Pearce Bailey, Frankwood E. Williams, and Paul O. Komora, "Neuropsychiatry in the United States," in *The Medical Department of the United States Army in the World War, Volume 10*, edited by M. W. Ireland (Washington, D.C.: U.S. Government Printing Office, 1929), 1–3; Ben Shephard, *A War of Nerves, Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, MA: Harvard University Press, 2001), 1–3, 62–64.

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treating these men refrained from using the term “shell shock,” because it was not an accurate term, which provided some legitimacy to those suffering from the ailment. It was deemed imperative to return soldiers to action as soon as possible to keep others from falsely admitting to the illness in order to escape the front lines. Many soldiers did not respond to the immediate treatment and therefore required additional care in other facilities.⁴⁶

Prior to the war, the only hospitals providing treatment to soldiers with mental illnesses were St. Elizabeths Hospital, a few beds in Walter Reed General Hospital, both in Washington, D.C., and a few beds in Letterman General Hospital in San Francisco, California. After the United States’ entry into the Great War, the Army created psychiatric wards in camp, cantonment, and base hospitals to handle returning soldiers and to identify those suffering from mental illnesses before they were sent overseas. At first the Army placed these patients in “isolation-insane” buildings, heavily secured structures more like a stockade, but later they created psychiatric wards. The psychiatric wards were open wards with plentiful windows, in many cases with iron mesh over the windows rather than bars, and provided patients with medical care and activities. In cantonment hospitals, plans for psychiatric wards were derived from designs of the National Committee for Mental Hygiene. The wards could care for patients with varying degrees of illness, such as disturbed, semi-disturbed, and convalescent patients. The three classes of patients were separated from one another, and the wards contained special treatment facilities for the disturbed patients, including continuous baths, which were thought to calm patients. Special wards in certain Army general hospitals were adapted to care for these cases during the war. With the influx of soldiers suffering from war neurosis returning from Europe, additional hospitals were opened for the treatment of neuropsychiatric patients, such as at Fort Benjamin Harrison in Indiana (U.S. Army General Hospital No. 25) and at Fort Sheridan in Illinois (U.S. Army General Hospital No. 28). Occupational therapy was introduced in the Army hospitals for neuropsychiatric wards with almost immediate benefits to the patients. Occupational therapy included classes in typing, bookkeeping, vehicular mechanics, agriculture, drafting, basket making, and other activities.⁴⁷

In April 1919 the War Department issued Section VII, General Orders, No. 57, stating the procedures for transferring soldiers suffering neuropsychiatric disorders to the Bureau of War Risk Insurance and discharging the soldier from military service. The patient would be admitted to one of the PHS hospitals acting under the Bureau of War Risk Insurance and would then be discharged from the Army. Therefore patients received continuous treatment for their neuropsychiatric disorders. In many cases the patient was able to obtain treatment in close proximity to their homes.⁴⁸

Prior to the 1930s few drugs were utilized in the effort to cure neuropsychiatric patients. It was thought that the human body could best fight off diseases with little interference from drugs introduced into the patient’s system. According to Ben Shephard in *A War of Nerves, Soldiers and Psychiatrists in the Twentieth Century*, this was in response to the overuse of drugs to treat most any illness in the late nineteenth and early twentieth centuries. But the 1930s and 1940s began to see the introduction of new drug treatments, including penicillin. Insulin shock therapy (placing patients in an insulin coma) and electroshock therapy were both used as treatments for psychiatric patients during the 1940s and

⁴⁶ Zieger, 110–111; Shephard, 123–126.

⁴⁷ Bailey, etc., 39–41, 44, 95–96.

⁴⁸ Ibid, 148–149.

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1950s.⁴⁹ The 1950s was also the decade that saw the introduction of new psychotropic drugs in the treatment of psychiatric disorders.⁵⁰

The Veterans Administration was operating twenty-nine neuropsychiatric hospitals in 1940, including those at former NHDVS branches. The largest of these at Northport, New York had a bed capacity of 2,220 patients. Approximately 58 percent of the patients under the care of the Veterans Administration were being treated for psychiatric illnesses at the end of fiscal year 1940 (June 30).⁵¹ Albert Deutsch's 1944 article "III. Military Psychiatry: World War II, 1941–1943" states that by 1940, "Three out of every five beds in the seventy-nine Veterans Administration Hospitals were occupied by patients with nervous or mental disorders" and that each "psychiatric casualty of World War I had cost American taxpayers over \$30,000."⁵² Nearly 42 percent (45,723 beds) of the Veterans Administration's total bed capacity was utilized for patients suffering from mental illnesses in 1953. At the same time, an additional 3,000 veterans suffering from neuropsychiatric disorders were placed in contract hospitals by the Veterans Administration.⁵³

IV. Casualties of Gas Attacks

Two published articles from 1933 by Harry L. Gilchrist and Philip B. Matz in *The Medical Bulletin of the Veterans Administration* discuss the possible lingering effects of gas attacks on United States veterans of World War I. Over 70,700 United States casualties in Europe during World War I were caused by gas attacks. Only 200 died from the immediate effects of the gas attacks on the battle lines, but over 1,200 died in hospitals. Of the total number suffering the effects of gas attacks, 39 percent of casualties originated from mustard gas attacks, less than 3 percent from chlorine gas, just over 10 percent from phosgene and arsine gas, and over 47 percent of casualties suffered injuries from unknown types of gas, but possibly from those types already listed.⁵⁴ The gases utilized in World War I were divided up according to their physical effects on soldiers into groups including pulmonary irritants that affect the respiratory system, which could lead to death from asphyxiation (chlorine and phosgene); lacrimators, causing temporary irritation of the eyes (brom-benzylcyanide and chloracetophenone); vesicants, creating skin irritations and infections of both the skin and respiratory tract (mustard gas); sensory irritants, causing irritation of eyes, nose, and throat, as well as nausea, but normally not death (diphenylchlorarsine); and poisons of the central nervous system that can be lethal (hydrocyanic acid).

⁴⁹ Shephard, 206, 363–364.

⁵⁰ Rodney R. Baker and Wade E. Pickren, *Psychology and the Department of Veterans Affairs: A Historical Analysis of Training, Research, Practice, and Advocacy* (Washington, D.C.: American Psychological Association, 2007), 56.

⁵¹ Samuel W. Hamilton, "The History of American Mental Hospitals," in *One Hundred Years of American Psychiatry* (New York, NY: Columbia University Press, 1944), 145, 163–164; Baker and Pickren, 149; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1940* (Washington, D.C.: U.S. Government Printing Office, 1941), 7, 120.

⁵² Albert Deutsch, "III. Military Psychiatry: World War II, 1941–1943," in *One Hundred Years of American Psychiatry* (New York, NY: Columbia University Press, 1944), 424.

⁵³ Baker and Pickren, 56–57.

⁵⁴ Harry L. Gilchrist and Philip B. Matz, "The Residual Effects of Warfare Gases: The Use of Mustard Gas, With Report of Cases," *Medical Bulletin of the Veterans Administration* 9, no. 4 (April 1933): 339; Harry L. Gilchrist and Philip B. Matz, "The Residual Effects of Warfare Gases: The Use of Chlorine Gas, With Report of Cases," *Medical Bulletin of the Veterans Administration* 9, no. 3 (January 1933): 230.

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In all cases the effects were dependent on the weather conditions and the amount of exposure suffered by the soldier.⁵⁵

Germany first used chlorine gas as a weapon in April 1915. Soldiers suffering from a chlorine gas attack would normally recover if they survived after the first two days of exposure, although respiratory ailments such as bronchitis and emphysema would persist.⁵⁶

Mustard gas was first used by Germany in 1917 against British forces. The gas was delivered in artillery shells and was a very effective weapon. The mustard gas used by the combatants was not chemically related to actual mustard oils.⁵⁷ While mustard gas was probably the cause of most World War I casualties from gassing, mustard gas was lethal in only 2 percent of those exposed to the gas.⁵⁸ Initially the gas did not affect the exposed soldiers except for sneezing. But “in the course of an hour or two, the signs of mustard poisoning began to appear in the form of inflammation of the eyes and vomiting, followed by erythema [redness possibly caused by inflammation or infection] of the skin and blistering.”⁵⁹ By the time the affected soldiers reached the military health stations behind the lines they could be practically blinded by the attack. The effects of mustard gas are delayed and its potency is dependent on meteorological conditions, such as air pressure, temperature, and wind. Once exposed, mustard gas can cause inflammation of the eyes, possibly resulting in decreased vision or complete blindness; inflammation of nose, throat, and trachea that could lead to emphysema or pneumonia; or if swallowed, the gas could cause burns in the intestinal tract.⁶⁰ The resulting pneumonia caused by mustard gas could be lethal. The residual effects of mustard gassing included “Chronic bronchitis, emphysema, bronchial asthma, chronic conjunctivitis, and corneal opacities.”⁶¹ According to Sharon Reutter’s 1999 article “Hazards of Chemical Weapons Release during War: New Perspectives,” even a single exposure to mustard gas in a concentrated dose could cause recurring bouts with “skin and eye lesions...In addition, soldiers who had been gassed with mustard seemed to develop respiratory cancers more frequently than expected.”⁶² In the cases reviewed in both 1933 articles tuberculosis may have been present in the victims before the gas attacks. In their weakened condition, the dormant tuberculosis infection may have been reactivated in the veteran’s lungs, rather than being directly caused by the gas.⁶³ But each case had to be viewed individually, as stated by Gilchrist and Matz: “One must not generalize on the relationship of mustard gassing to the development of tuberculosis. Each

⁵⁵ Gilchrist and Matz, “The Residual Effects of Warfare Gases: The Use of Chlorine Gas, With Report of Cases,” 233.

⁵⁶ Ibid, 233, 238.

⁵⁷ Gilchrist and Matz, “The Residual Effects of Warfare Gases: The Use of Mustard Gas, With Report of Cases,” 340–341.

⁵⁸ Sharon Reutter, “Hazards of Chemical Weapons Release during War: New Perspectives,” *Environmental Health Perspectives* 107, no. 12 (December 1999): 985.

⁵⁹ Gilchrist and Matz, “The Residual Effects of Warfare Gases: The Use of Mustard Gas, With Report of Cases,” 341.

⁶⁰ Ibid, 342–343.

⁶¹ Ibid, 389.

⁶² Reutter, 985.

⁶³ Gilchrist and Matz, “The Residual Effects of Warfare Gases: The Use of Mustard Gas, With Report of Cases,” 389; Gilchrist and Matz, “The Residual Effects of Warfare Gases: The Use of Chlorine Gas, With Report of Cases,” 252–253.

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case must receive individual study for the purpose of establishing the part played by mustard gas in the inception of tuberculosis.”⁶⁴

V. Tuberculosis as a Continuing Illness Among Veterans

Tuberculosis is a disease that was misunderstood for centuries and killed indiscriminately among the social classes. Referred to as consumption and the “white death” during the last two centuries, deaths from tuberculosis peaked in the mid-nineteenth century. Tuberculosis remains a deadly malady in much of the world today, and treatment-resistant strains could create a revival of the dreaded disease.⁶⁵

Various curative treatments were adopted by the medical field and the general public during the nineteenth and early twentieth centuries. Many of these treatments, while purportedly successful, were never scientifically proven to eliminate the disease. In many cases the tuberculosis bacteria simply became dormant and in many of those cases never became active again.⁶⁶ Death rates associated with tuberculosis had been declining since the mid-nineteenth century, although a more pronounced reduction in deaths from the disease began in the early twentieth century. Numerous reasons could account for the decline in deaths from tuberculosis during the first half of the twentieth century, including isolating those suffering from the illness in sanatoriums, better diets and housing for the overall population, and radical medical treatments offered against the disease.

Tuberculosis remained a serious problem in the United States even with declining death rates. The NHDVS began to administer aid to a higher number of cases after veterans returned from fighting in tropical climates, such as Cuba and the Philippines, during the Spanish-American War in the late nineteenth century. Tuberculosis continued to affect soldiers returning from Europe after World War I. T. B. Kidner and Dr. H. A. Pattison both served as advisors to the United States Treasury’s committee Consultants on Hospitalization in the early 1920s, representing the National Tuberculosis Committee.⁶⁷ As reported in the *Journal of Outdoor Life*, the antituberculosis magazine, the two doctors “have been of assistance in determining the location of new hospitals; have visited many proposed sites; have inspected numerous institutions offered to the Government. They have scrutinized very carefully the plans prepared for these hospitals, and, acting for the Consultants, have offered many suggestions for improvements.”⁶⁸ The article also states that T. B. Kidner offered testimony during a hearing for the Langley Bill, probably the first Langley Bill.⁶⁹ The Consultants on Hospitalization also worked with representatives of the PHS, Bureau of War Risk Insurance, NHDVS, U.S. Army, American Legion, St. Elizabeths Hospital, Catholic Hospital Association, and the National Committee for Mental Hygiene.⁷⁰

⁶⁴ Gilchrist and Matz, “The Residual Effects of Warfare Gases: The Use of Mustard Gas, With Report of Cases,” 389.

⁶⁵ Mark Caldwell, *The Last Crusade: The War on Consumption 1862–1954* (New York, NY: Atheneum, 1988), 3–4, 9.

⁶⁶ *Ibid*, 11.

⁶⁷ “A Year’s Work, Medical Service,” *Journal of Outdoor Life* 19, no. 12, Section 2 (December 1922): 137-138; *Report of the Consultants on Hospitalization Appointed by the Secretary of the Treasury to Provide Additional Hospital Facilities Under Public Act 384 (Approved March 4, 1921)* (Washington, D.C.: U.S. Government Printing Office, 1923), 6.

⁶⁸ “A Year’s Work, Medical Service,” 138.

⁶⁹ *Ibid*.

⁷⁰ *Report of the Consultants on Hospitalization*, 5–7.

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The Consultants on Hospitalization's standardized plans for hospitals offered in their final report to the United States Treasury Department included plans for tuberculosis buildings in both warm and cold climates. The standardized plans also incorporated designs for a building to serve neuropsychological tuberculosis patients.⁷¹ The PHS transferred thirteen tuberculosis hospitals treating veterans to the Veterans Bureau in April 1922. Some of these hospitals were not of permanent construction. By June 30, 1922, the Veterans Bureau was operating thirteen tuberculosis hospitals including two newly opened facilities in Dawson Springs, Kentucky, and Walla Walla, Washington. Nearly 6,000 tuberculosis patients were being treated in Veterans Bureau hospitals in mid-1922, over 2,700 patients were admitted to civil hospitals under contract to the Veterans Bureau, and another 2,200 veterans suffering from tuberculosis were being treated in government hospitals not under control of the Veterans Bureau. Nearly 11,000 veterans were seeking care for tuberculosis in government hospitals in June 1922.⁷² The number of tuberculosis patients in veterans hospitals declined during the 1920s, which was similar to the national trend. By 1932 the number of ex-soldiers suffering from tuberculosis in veterans hospitals had declined to nearly 6,000 patients.⁷³ Approximately 5,000 tuberculosis patients were being treated in Veterans Administration facilities on June 30, 1939. This represented slightly over 9 percent of the patients served by the Veterans Administration at the time.⁷⁴ Slightly below 9 percent of the total number of patients in Veterans Administration hospitals, or 4,941 patients, were receiving treatment for tuberculosis on June 30, 1943. This represents a substantial decrease in the percentage of patients receiving medical care for tuberculosis in veterans hospitals from that of June 30, 1923, "when 41 percent of the patients were classed as tubercular."⁷⁵

It wasn't until the early 1940s that possible cures for tuberculosis were eventually discovered. The first new drug in combating tuberculosis was streptomycin, although it also had numerous side effects. The Veterans Administration began studies and research into effective drug therapies for tuberculosis in the mid-1940s. Other drug treatments followed, and the most successful drug treatment was isoniazid, which was first utilized in 1951. The new drugs required treatment over an extended period, since they only deterred the growth of the tuberculosis bacterium when it was active, but in most cases the results were almost immediate. In the mid-1950s tuberculosis continued to be a major medical issue with the Veterans Administration, as the agency was operating twenty-one tuberculosis hospitals in 1954 with approximately 14,000 patients. Additionally, tuberculosis wards were found in numerous instances in the Veterans Administration general medical and surgical hospitals.⁷⁶ This marked increase in the number of tuberculosis patients in veterans hospitals in the mid-1950s compared to the early 1940s can be attributed to the large increase in veterans eligible for health benefits that served in both World War II and the Korean War. This influx of veterans required a corresponding increase in veterans hospitals and bed capacity. The Veterans Administration was operating hospitals in eighty-six locations in mid-1940 with a capacity of over 59,600 beds. One hundred and thirty-six hospitals were in operation by the Veterans Administration at the fiscal year end of 1950, encompassing a capacity of

⁷¹ *Report of the Consultants on Hospitalization*, 88, 91–94.

⁷² *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 34, 36.

⁷³ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1932*, 12.

⁷⁴ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1939* (Washington, D.C.: U.S. Government Printing Office, 1939), 7.

⁷⁵ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1942* (Washington, D.C.: U.S. Government Printing Office, 1942), 9.

⁷⁶ Caldwell, 13–14; Baker and Pickren, 66.

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106,000 beds. Thirteen percent of beds were occupied by tuberculosis patients.⁷⁷ By the end of the 1954 fiscal year, the Veterans Administration was operating 170 hospitals with a capacity of 117,000 beds.⁷⁸ The new drug treatments for tuberculosis resulted in the closing of sanatoriums throughout the nation. Only those elderly patients who could not adapt to life outside the confines of the institutions occupied the few sanatoriums remaining in the late 1950s. By the early 1970s tuberculosis sanatoriums had nearly disappeared from the American landscape.⁷⁹

VI. Occupational and Recreational Therapy (Including Farm Operations)

Occupational and recreational therapies were important components in the recovery of disabled veterans, especially patients of tuberculosis and neuropsychiatric hospitals. The mission of the Second Generation Veterans Hospitals was to provide care and rehabilitation to patients and return them as quickly as possible to their communities as productive citizens. Occupational therapies at neuropsychiatric hospitals included more rigorous tasks, such as agriculture and landscaping, than those offered to tuberculosis patients because of the physical effort involved with such assignments. General medical and surgical hospitals offered few occupational therapies because of the short length of stay expected for patients at these hospitals. Recreational therapies were offered at all four sub-types of hospitals, as most campuses contained a recreation/auditorium building.

According to a 1926 article in the *United States Veterans Bureau Medical Bulletin*: "It has been suggested that occupational therapy is that form of treatment which includes any occupation, mental or physical definitely prescribed, and guided for the distinct purpose of contributing to and hastening recovery from disease or injury, and of assisting in the social and institutional adjustment of individuals requiring long and indefinite periods of hospitalization...The maximum benefits from occupational therapy may only be obtained when occupations are prescribed by medical authorities upon the basis of the therapeutic indications incident to the mental and physical condition, needs, interests, aptitudes, abilities, previous training, and experience of the patient."⁸⁰ The majority of the rehabilitation therapy took the form of vocational training and work programs on the hospital campuses. Vocational training could take many forms, including working in shops on the hospital's grounds (e.g., printing, shoe repair, automotive repair, and carpentry), or classes that included typing, bookkeeping, and stenography, among other activities. Occupational therapy also included work on the campus grounds, including working in the greenhouse, painting, grounds keeping, and minor repairs. Farming was also considered therapeutic, since many of the patients lived in rural areas, and raising crops, gardens, and livestock was viewed as a possible vocation or secondary form of income for the patient. One criterion for Veterans Bureau and Veterans Administration neuropsychiatric hospitals was that they be located on tracts with tillable acreage, so that produce and livestock raised on the hospitals' properties could be utilized in the kitchens to provide fresh meat and vegetables for the patients.

⁷⁷ *Administrator of Veterans Affairs Annual Report for Fiscal Year Ending June 30, 1950*, 9–10.

⁷⁸ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1940* (Washington, D.C.: U.S. Government Printing Office, 1941): 11; *Administrator of Veterans Affairs Annual Report for Fiscal Year Ended June 30, 1954* (Washington, D.C.: U.S. Government Printing Office, 1955), 16.

⁷⁹ Caldwell, 13–14.

⁸⁰ Harry J. Kefauver, "Agriculture as Occupational Therapy in the Neuropsychiatric Hospitals," *United States Veterans Bureau Medical Bulletin* 2, no. 6 (June 1926): 592.

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The St. Cloud, Minnesota, veterans hospital (Hospital 101) was opened September 15, 1924, as a neuropsychiatric hospital with a capacity of over 300 beds. In March 1926 it was reported that a root cellar with a capacity of 400–600 bushels of roots or potatoes was constructed by the patients and staff. The designs were provided by the Construction Division of the Veterans Bureau from plans originally produced by the Department of Agriculture. A poultry house was also constructed on-site using plans provided by the Construction Division.⁸¹ The following neuropsychiatric veterans hospitals were engaged in farming endeavors during 1926: Augusta, Georgia (41 acres under cultivation, 6 acres in hog pasture); North Little Rock, Arkansas (650 acres available for grazing, 6 acres for gardening, 250 acres to be cleared for cultivation); Gulfport, Mississippi (30 acres for cultivation); Sheridan, Wyoming (100 acres suitable for cultivation); American Lake, Washington (farm area includes 355 acres); Northampton, Massachusetts (24 acres for gardening and farming); Chillicothe, Ohio (approximately 1,700 acres available for various agricultural uses, including orchards, dairy operations, gardens, and crops); Camp Custer (Battle Creek), Michigan (210 acres for farming and gardens); and St. Cloud, Minnesota (156 acres available for pastures and 76 acres for orchards and gardens). The neuropsychiatric veterans hospitals also reported the value of their agricultural products for 1925. Chillicothe, Ohio, appears to have had the largest farming operation of these hospitals, as it reported over \$2,500 in dairy products, \$3,600 in vegetables, \$4,200 in corn, and \$1,200 in hay production. The remaining neuropsychiatric hospitals reported lesser amounts of agricultural products that included vegetables, poultry, dairy and egg production, and forage.⁸²

A 1929 article describes the occupational therapy activities offered at the Northampton, Massachusetts neuropsychiatric veterans hospital. During the milder months of the year, approximately 60 percent of the patients were engaged in outdoor activities, including agricultural production (raising poultry, bees, rabbits, sheep, and swine, as well as farming), road repairs, grounds keeping, construction, and clearing acreage. Indoor activities included making rugs and toys, repairing the hospital's furniture, working in the laundry, helping in the boiler plant, and clerical work in an office. The hospital also had an orchestra consisting of patients with an outside instructor.⁸³

The neuropsychiatric veterans hospital in Sheridan, Wyoming, listed twenty-four departments in which occupational therapy was offered in 1929. The occupational departments included metal shop; painting; wood shop; shoe repair; plumber's helper; office work such as a typist and stenographer; electrician's helper; garage helper; basket shop; leather shop; mattress making; barber shop helper; and engineer's helper. Agricultural and other outdoor activities were also offered as occupational therapy at the Sheridan, Wyoming hospital. Outdoor therapy activities included working in the greenhouse, general farm work, caring and working with the draft horses, repairing agricultural buildings, constructing roads, working in the vegetable cellars, and caring for the swine.⁸⁴

Similar occupational therapy activities were reported in 1929 at the Chillicothe, Ohio, neuropsychiatric veterans hospital. F. M. Rogers, a doctor serving at the hospital, states in a 1929

⁸¹ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1926* (Washington, D.C.: U.S. Government Printing Office, 1926), 53; E. W. Carr, "Section of Physiotherapy and Occupational Therapy," *United States Veterans Bureau Medical Bulletin* 2, no. 3 (March 1926): 329

⁸² Kefauver, 593–600.

⁸³ F. E. Steele, "A General Outline of Activities in Occupational Therapy," *United States Veterans Bureau Medical Bulletin* 5, no. 1 (January 1929): 71–72.

⁸⁴ E. D. Piper, "Occupational Therapy," *United States Veterans Bureau Medical Bulletin* 5, no. 4 (April 1929): 307–308.

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article: "Occupational work is one of the chief therapeutic measures used in this hospital, and is considered the ideal treatment for nervous and mental diseases."⁸⁵ Indoor therapeutic activities included a shoe shop; carpenter shop; the laundry, which handled approximately 5,000 articles daily; and an upholstery department that included constructing and restoring mattresses. Four single-story buildings constituted the arts and crafts department, which produced hooked rugs, table runners, pillow tops, lamp stools, baskets, and other items. Patients comprised the majority of the hospital's band members. Outdoor therapeutic activities included working on the hospital grounds crew and the numerous farming chores, such as working in the gardens and with crops, raising poultry, and the dairy operations. The Chillicothe facility also offered recreational therapy, including exercise classes, outdoor hikes through the hospital property, ball games, and relay races. An athletic field was under construction in 1929.⁸⁶

Recreational therapy was also offered at the American Lake, Washington, neuropsychiatric veterans hospital. At this hospital the patients built their own volleyball, basketball, and tennis courts, as well as horseshoe pits, and they helped in the construction of a running track. Other recreational activities included baseball, soccer, handball, hiking, and general exercise routines. The disturbed patients helped in the construction of their own athletic field.⁸⁷ The author of the 1929 article describing the therapeutic recreational activities at American Lake stated "that recreation has been beneficial not only from the physical standpoint but through its general appeal to patients' interest it has postponed deterioration and the state of helplessness, it has kept some more alert mentally, has improved their morale, increased their contentment, and made their relationships with one another and those caring for them more harmonious."⁸⁸

While the emphasis on occupational and recreational therapy normally occurred at neuropsychiatric veterans hospitals, some of the same activities were offered at tuberculosis and general medical and surgical hospitals. M. H. Axline, working at the general medical and surgical veterans hospital at Fort Harrison (Helena), Montana, in 1929 states that for "most of the patients, hospitalization is not a question of days or even weeks, but of months and years."⁸⁹ Axline indicates that in many tuberculosis and general cases doctors failed to recognize the importance of occupational therapy and did not order such treatment for the patient. Gradual exercise helped to increase the vitality of patients suffering from tuberculosis, recent surgery, and arthritis. Occupational therapy also provided a purpose for many patients who faced long-term stays in veterans hospitals.⁹⁰

Agricultural endeavors appear to have been limited or non-existent as occupational therapy at tuberculosis and general hospitals. Inside craftwork rather than outdoor occupations began to be emphasized at veterans tuberculosis hospitals. In 1930 the Central Office of the Veterans Bureau began to stress the importance of fully utilizing the agricultural programs at the neuropsychiatric hospitals to provide food products for the hospitals. Any buildings constructed for the farm operations were to meet the standards set by the United States Department of Agriculture. The emphasis on

⁸⁵ F. M. Rogers, "Methods of Administering Occupational Therapy," *United States Veterans Bureau Medical Bulletin* 5, no. 5 (May 1929): 388.

⁸⁶ *Ibid*, 388–391.

⁸⁷ Sigurd Grondahl, "Benefits derived by Mental Patients from Physical Recreation," *United States Veterans Bureau Medical Bulletin* 5, no. 6 (June 1929): 470, 474–475.

⁸⁸ *Ibid*, 476.

⁸⁹ M. H. Axline, "Occupational Therapy in General and Tuberculosis Hospitals," *United States Veterans Bureau Medical Bulletin* 5, no. 12 (December 1929): 1006.

⁹⁰ *Ibid*, 1004–1009.

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maximizing the farm operations of the neuropsychiatric hospitals appears to have been an expense/efficiency measure.⁹¹

The products created by patients taking part in occupational therapy at some of the veterans hospitals were entered into state and local fairs. These products often won awards and offered the general public a chance to view patients' talents and the fruits of their labors. Patients of the St. Cloud, Minnesota, veterans hospital entered twenty-three articles produced as occupational therapy in the 1931 state fair and won a total of fourteen first, second, and third prizes for their entries. Eleven entries harvested from the hospital's garden were shown at the county fair, with seven of the entries awarded prizes.⁹² Crafts, livestock, and garden produce raised at other veterans hospitals were entered at local county and state fairs, or booths were created to highlight the patients' crafts. The results were often similar to those experienced by patients of the St. Cloud veterans hospital.

An article from 1938 describes the changes in occupational therapy that had to be addressed as the population of veterans neuropsychiatric hospitals continued to age. Veterans neuropsychiatric hospitals dating to the period of significance were, by necessity, different than state operated mental institutions. State operated institutions cared for men, women, and children, and most patients were expected to remain at the institution for extended periods, if not years. In many cases little improvement was expected in patients of state mental institutions because of their deteriorated mental capacity. In contrast, the neuropsychiatric veterans hospitals initially treated young men, along with a small group of women veterans, that were expected to improve their mental health to the point where these patients were to rejoin the civilian workforce and become productive members of society. Men in their twenties and thirties are naturally more energetic and creative, willing to learn new skills, and use their abilities and knowledge in creating items in shops, growing crops, raising livestock, and working to beautify the hospital grounds. These young men enjoyed active sports, such as tennis, baseball, and basketball. By 1938 many of the long term psychiatric patients who were veterans of the First World War were in their forties. These patients were no longer interested in hard physical labor or sports that entailed strenuous activity. Their mental deficiencies continued to advance, leading to more habit training than expanded learning or skill therapy sessions. The prospect of these patients reentering society as productive citizens also continued to decline. Demanding physical sports were replaced by less taxing activities, such as croquet, indoor tennis, and billiards. A bird and wildlife sanctuary was being developed on the property of the Northampton, Massachusetts, neuropsychiatric hospital in 1938 to spur the patients' interests. Activities associated with greenhouses continued to provide a therapeutic benefit for patients, providing flowers for the grounds, dining rooms, and wards of the hospitals. Work in the hospital shops also continued to be of interest to many patients, as producing something of value or a feeling of personal usefulness was still a vital part of occupational therapy. In the near future, veterans hospitals would be hiring outside labor to take over occupations currently handled by patients, such as grounds keeping, farm labor, and staffing the hospital laundry.⁹³

⁹¹ Harry J. Kefauver, "Development of Agricultural Activities," *United States Veterans Bureau Medical Bulletin* 6, no. 7 (July 1930): 613–615; Harry J. Kefauver, "Physiotherapy and Occupational Therapy," *United States Veterans Bureau Medical Bulletin* 6, no. 11 (November 1930): 1009.

⁹² Hans Hansen, "Occupational Therapy at Veterans Administration Hospital, St. Cloud, Minn.," *Medical Bulletin of the Veterans Administration* 8, no. 2 (February 1932): 163.

⁹³ Frank E. Leslie, "Occupational Therapy for Psychotic Patients in Midlife," *Medical Bulletin of the Veterans Administration* 15, no. 1 (July 1938): 60–64.

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Occupational therapy/training was utilized by the four sub-types of veterans hospitals that included neuropsychiatric, tuberculosis, general medical and surgical, and the homes/general medical hospitals. The most widespread use of occupational therapy was at neuropsychiatric hospitals, where most of the patients' physical health allowed for strenuous activities, such as working in shops, raising agricultural products on the hospital farm, assisting with the hospital grounds, and engaging in recreational sports, including baseball, basketball, tennis, and soccer. Tuberculosis and general medical and surgical hospitals relied more on indoor activities and craft work as occupational therapies. By the late 1930s, the neuropsychiatric veterans hospitals were on the verge of becoming institutions caring for long term patients. The majority of these patients were World War I veterans in the mid-life years of their forties. Although it was a situation similar to that facing the branches of the NHDVS just prior to the United States entering World War I, the patients of the Second Generation Veterans Hospitals were younger than those of the NHDVS, since the Civil War had ended fifty years before the nation's entry into the Great War. But the Second Generation Veterans Hospitals would soon be receiving a new influx of patients, as disabled veterans of World War II would begin arriving in the early 1940s.

VII. Health Care for Female Veterans of World War I

Women played a greater role in World War I than in previous conflicts, as approximately 35,000 women joined the various military services of the United States during the Great War, including the Army, Navy, and Marine Corps. These women served as nurses (the majority in the Army), yeomanettes, and approximately 300 in the Marine Corps served as marinettes.⁹⁴ A 1923 unattributed article in *The American Journal of Nursing* entitled "Disabled Ex-Service Women to Be Admitted to Soldiers' Homes" states that the Board of Managers (the governing body) of the NHDVS approved the designation of a separate building for the care of women permitted to receive disabled veterans benefits at the Danville, Illinois, branch of the NHDVS. Those ex-service women suffering from tuberculosis were to be housed at the Milwaukee, Wisconsin, branch of the NHDVS. According to the article, "ex-service women have been entitled to the same compensations as men in cases of disability arising from service. They were not allowed any assistance, however, unless their disability was at least ten per cent and directly traceable to service. Efforts were made by organizations such as the Women's Overseas Service League, to assist the Veterans Bureau in handling [these] cases."⁹⁵ The article also states that women veterans who are "in need of general hospital treatment or domiciliary care" will have housing and services "apart from the men as far as practicable with separate mess halls, gardens, and other features."⁹⁶ According to Suzanne Julin's draft report entitled *National Home for Disabled Volunteer Soldiers; Assessment of Significance and National Historic Landmark Recommendations*, few women took advantage of the opportunity; not more than five women were at the Danville branch of the NHDVS in 1924.⁹⁷

On March 19, 1928, the Committee on Military Affairs introduced a report to the United States Senate to amend the act of June 7, 1924, to include eligibility of women for benefits from the NHDVS.

⁹⁴ Charles M. Griffith, "Women Ex-members of the Armed Forces: Hospital Treatment and Domiciliary Care," *The American Journal of Nursing* 38, no. 7 (July 1938): 803–804.

⁹⁵ "Disabled Ex-Service Women to Be Admitted to Soldiers' Homes," *The American Journal of Nursing* 24, no. 2 (November 1923): 109.

⁹⁶ Ibid.

⁹⁷ Julin, 36.

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The report stated that women “have been admitted to the home for many years,” although a recent ruling by the Comptroller General indicated the original act did not include women as eligible for benefits derived from the NHDVS.⁹⁸ As stated in the *National Home for Disabled Volunteer Soldiers Report of the Board of Managers for the Fiscal Year Ended June 30, 1929*, “The act of Congress of date March 26, 1928, provides that honorably discharged officers, soldiers, sailors, or marines, including women commissioned or enlisted, and Army and Navy nurses who served in the regular or volunteer forces of the United States and who are disabled by disease or wounds and by reason of such disability are either temporarily or permanently incapacitated from earning a living may be admitted to the home.”⁹⁹

Encompassing a very small portion of the population eligible for receiving health care at Veterans Administration facilities, including both medical and domiciliary care at the former NHDVS facilities and existing hospitals, women veterans continued to utilize these benefits during the third and fourth decades of the twentieth century. A small number of beds were specified for use by women in many of the Veterans Bureau and Veterans Administration’s general medical and surgical hospitals. Usually a slightly larger number of women’s accommodations could be found in neuropsychiatric and tuberculosis hospitals, but with the small number of eligible women veterans and limited funding, few facilities were constructed specifically for women at veterans hospitals. A building exclusively for female veterans was constructed at Bedford, Massachusetts, and opened in 1947 (Resource 70). According to a newspaper article it was the first veterans hospital building to be constructed specifically for female veterans.¹⁰⁰ Civilian hospitals were often used by women veterans because of the limited number of beds available in veterans hospitals.¹⁰¹ As of June 30, 1932, 338 females out of 43,841 total patients were receiving treatment at Veterans Administration hospitals. The percentage of these female patients receiving various treatments included 18 percent for tuberculosis, 38 percent for neuropsychological illnesses, and 44 percent for general medical and surgical procedures.¹⁰² Over 300 women were receiving health care at Veterans Administration and civilian hospitals in 1937, and another 39 were lodged in domiciliary facilities.¹⁰³ Accommodations for female veterans were increased by the Veterans Administration by 1941, with women’s units then located in “nine general medical and surgical, seven tuberculosis, and three neuropsychiatric hospitals.”¹⁰⁴ Gwen H. Andrew’s 1941 article “Hospitalization Facilities for Women Veterans” states: “Three domiciliary homes now have accommodations for women. They are at Bay Pines, Florida, Dayton, Ohio, and Los Angeles, California. Additional accommodations are now being planned at Fort Washington, Maryland, and Salina, Kansas.”¹⁰⁵ The domiciliary facilities were for women veterans, like men, who suffered from long term health conditions

⁹⁸ Senate, Calendar No. 573, Prescribing Persons Entitled to the Benefits of the National Home for Disabled and Volunteer Soldiers, Etc., 70th Congress, 1st Session, Senate Report No. 560 (March 19, 1928), 1–2.

⁹⁹ *National Home for Disabled Volunteer Soldiers Report of the Board of Managers for the Fiscal Year Ended June 30, 1929*, 71st Congress, 2d Session, House Document No. 203 (Washington, D.C.: U.S. Government Printing Office, 1930), 31

¹⁰⁰ “Bedford’s New Building,” *Lowell Sun* (Lowell, Massachusetts), March 31, 1947.

¹⁰¹ Gwen H. Andrew, “Hospitalization Facilities for Women Veterans,” *The American Journal of Nursing* 45 (January–December 1945): 382.

¹⁰² *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1932*, 11.

¹⁰³ Griffith, 803–804.

¹⁰⁴ Andrew, 382.

¹⁰⁵ *Ibid*, 383.

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that were not expected to improve to the point of self sufficiency.¹⁰⁶ In 1945 women were able to continue to seek treatment in civilian hospitals if no Veterans Administration facilities were available to the former veteran.¹⁰⁷

VIII. Health Care for African Americans Serving in World War I

Many African Americans hoped enlistment in the Army during the Great War would improve their daily lives in this country through recognition of their military service leading to their acceptance as equals within the nation. African Americans were disproportionately drafted to serve in the Army for World War I, as 13 percent of draftees were African American, while this group composed only 10 percent of the United States population.¹⁰⁸ Included in the Consultants on Hospitalization report of 1923 is a section entitled "Problems of Race." The report indicates that 385,000 African-American soldiers served in the United States Army during World War I. The consultants concluded that a separate hospital should be constructed to serve African-American veterans of the Great War. The Tuskegee Normal and Industrial Institute at Tuskegee, Alabama, offered land for the hospital adjacent to the school's property. The Tuskegee Alabama Veterans Administration hospital is the only known federal veterans hospital constructed solely for the care of African-American veterans of World War I. It may also be the first Second Generation Veterans Hospital initially built with two designations, serving both as a tuberculosis and neuropsychiatric hospital.¹⁰⁹ On July 1, 1924, the Veterans Bureau was treating 21,730 patients in civilian, Navy, Army, Veterans Bureau and other hospitals. Of this total 1,162, or 5.3 percent, were African-American veterans located in hospitals throughout the country, with the largest concentration of patients (348) at the Tuskegee veteran's hospital.¹¹⁰ The male African-American veteran population increased to 1,637 patients by mid-1927, although this was a slight decline from the 1,791 patients in 1925.¹¹¹ According to the 1927 Veterans Bureau annual report, many of these patients were located at the Tuskegee veterans hospital. The annual report also indicates that wards for African-American patients were located "in 19 other United States veterans hospitals," indicating the segregated nature of medical care provided at the time by the Veterans Bureau.¹¹² By June 30, 1930, the Tuskegee veterans hospital accounted for 553 patients, or 26.5 percent, of all 2,086 African-American patients located in Veterans Bureau hospitals.¹¹³

In 1935 an appropriation of \$20 million (Public Law No. 260, Seventy-fourth Congress, approved August 12, 1935) was made to the Veterans Administration for construction at thirty-eight locations,

¹⁰⁶ Ibid.

¹⁰⁷ Frank T. Hines, "Medical Care Program of the Veterans Administration," *Annals of the American Academy of Political and Social Science* 239 (The Disabled Veteran, May 1945): 77.

¹⁰⁸ Jami Bryan, "Fighting for Respect: African-American Soldiers in WW I," accessed online at MilitaryHistoryOnline.com (originally published in *On Point*, 2003). Available on the World Wide Web at: <http://www.militaryhistoryonline.com/wwi/articles/fightingforrespect.aspx>. Accessed January 2011.

¹⁰⁹ *Report of the Consultants on Hospitalization*, 18–19, 53–54.

¹¹⁰ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924* (Washington, DC: U.S. Government Printing Office, 1924), 119–122.

¹¹¹ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1927* (Washington, DC: U.S. Government Printing Office, 1927), 30, 73.

¹¹² *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1927*, 30.

¹¹³ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1930* (Washington, DC: U.S. Government Printing Office, 1930), 9.

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mainly at existing neuropsychiatric facilities. Included in the appropriation were 844 additional beds for African-American patients to be constructed at Tuskegee, Alabama; Salem (Roanoke), Virginia; Alexandria, Louisiana; and Columbia, South Carolina. The total number of African-American veterans in domiciliary and hospital care on June 30, 1935, was 4,858, representing 9.3 percent of patients in veterans hospitals; this total increased to 7,175 on June 30, 1940, making up a total of 9.8 percent of all veterans in domiciliary and hospital care.¹¹⁴ The 1940 percentage is comparable to that of 1944, when African-American veterans comprised 11 percent of all veterans in domiciliary and hospital care on June 30, 1944.¹¹⁵

On July 26, 1948, President Harry S. Truman issued Executive Order No. 9981, which led to the desegregation of the United States armed forces. On that same day he also issued Executive Order No. 9980, stating that federal employment was not to be based on race, color, religion, or national origin. According to an article by David Barton Smith entitled "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda," these two executive orders also led to the desegregation of Veterans Administration facilities. Smith states that by 1954 Veterans Administration hospitals no longer segregated medical care for its patients.¹¹⁶

IX. Native Americans Serving in World War I

Native Americans of varying national and/or tribal affiliation served in the United States military during World War I and were eligible to receive medical care through the Veterans Bureau and Veterans Administration. According to Susan Applegate Krouse in *North American Indians in the Great War*, over "twelve thousand Indians served in the U.S. military in World War I."¹¹⁷ Additionally, the Army Nurse Corps included fourteen Native American women during World War I.¹¹⁸ In context of the total number of American military serving in Europe during the war, members of Native American nations and/or tribes were wounded or killed at a much higher overall rate than that experienced by the overall population of service personnel. While approximately 1 percent of all American soldiers were killed in action, Native Americans suffered 5 percent casualties during the

¹¹⁴ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1935* (Washington, D.C.: U.S. Government Printing Office, 1935), 11, 48; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1940*, 60.

¹¹⁵ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1944* (Washington, D.C.: U.S. Government Printing Office, 1944), 58.

¹¹⁶ Harry S. Truman Library and Museum, "Executive Order 9980" and "Executive Order 9981" located on the World Wide Web on the Harry S. Truman Library and Museum Website at <http://www.trumanlibrary.org/>. Accessed January 2011; David Barton Smith, "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda," *Health Affairs* 24, no. 22 (March/April 2005), accessed online on the World Wide Web on the Health Affairs website at <http://content.healthaffairs.org/content/24/2/317.full>. Accessed January 2011.

¹¹⁷ Susan Applegate Krouse, *North American Indians in the Great War* (Lincoln, NE: University of Nebraska Press, 2007), 5.

¹¹⁸ Lindsay F. Holiday, Gabriel Bell, Robert E. Klein, and Michael R. Wells, "American Indian and Alaska Native Veterans: Lasting Contributions," accessed online (Office of Policy, Assistant Secretary for Policy, Planning, and Preparedness, Department of Veterans Affairs, 2006), 3. Available from World Wide Web: <http://www1.va.gov/vetdata/docs/aianpaper9-12-06final.doc>. Accessed January 2010.

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Great War.¹¹⁹ Many of these Native Americans served during the conflict even though their United States citizenship was not clear. As disenfranchised residents they could not vote and did not have to serve during the war. This lack of governmental representation contributed to the disparity in economic status, education, and hospital care when compared to that available to the majority of the nation's citizens. In an effort to assimilate and provide citizenship to the Native American population, passage of the General Allotment Act of 1886 was aimed at diminishing tribal authority by allotting specific plots of land to individual owners.¹²⁰ Native Americans also gained United States citizenship through marriage to citizens, and in an act passed by Congress in 1901, citizenship was "extended...to the Five Civilized Tribes of Oklahoma."¹²¹ As stated in Thomas A. Britten's *American Indians in World War I, At Home and at War*, approximately "125,000 Native Americans in 1919 still did not possess American citizenship."¹²² Enacted during the first session of the sixty-sixth Congress on November 6, 1919, 41 Statute 350 Chapter 95 is entitled An Act Granting Citizenship to Certain Indians. The act granted United States citizenship to Native Americans that served in the military during World War I, subject to an honorable discharge and proof of identification before a "court of competent jurisdiction."¹²³ It is unclear how many of these veterans applied for citizenship through the 1919 Act, but the complexity of the requirements mandated by the Bureau of Naturalization probably kept many from seeking citizenship.¹²⁴ With citizenship, Native Americans who served in World War I were eligible for veterans benefits, including medical benefits at veterans hospitals. Although eligible for the same hospitalization benefits as other veterans of the Great War, the medical benefits of Native Americans were handled through the Office of Indian Affairs.¹²⁵

On June 2, 1924, Congress passed the Indian Citizenship Act (43 Stat 253), providing citizenship to all Native Americans born in the territorial United States. According to Charles J. Kapper, the passage of the Citizenship Act affected approximately one-third of the Native American population in the United States. The remainder had previously become enfranchised.¹²⁶ But citizenship did not automatically provide access to the voting booths, as some states continued to not recognize Native Americans' residency until the second half of the twentieth century.¹²⁷ Even with the disparity in the ability to vote, Native Americans who served in World War I were recognized as citizens and received the same benefits as other United States veterans of the conflict.

¹¹⁹ Thomas A. Britten, *American Indians in World War I, At Home and at War* (Albuquerque, NM: University of New Mexico Press, 1997), 82.

¹²⁰ Krouse, 5–6, 10; Tom Holm, "The Crisis in Tribal Government," in *American Indian Policy in the Twentieth Century*, ed. Vine Delora, Jr. (Norman, OK: University of Oklahoma Press, 1985), 145–146.

¹²¹ Britten, 176.

¹²² *Ibid.*

¹²³ Charles J. Kapper, ed., *Indian Affairs: Laws and Treaties*, Vol IV Laws (Washington: Government Printing Office, 1929), accessed online (Stillwater, OK: Oklahoma State University Library [produced by]). Available from World Wide Web: <http://digital.library.okstate.edu/kappler/index.htm>. Accessed January 2010; Krouse, 154.

¹²⁴ Britten, 179.

¹²⁵ James P. Rife and Capt. Alan J. Dellaplaine, Jr., *Caring and Curing: A History of the Indian Health Service*, Public Health Service Officers Foundation for the Advancement of Public Health (Terra Alta, WV: Pioneer Press of West Virginia, Inc., 2009), 22, 29, 70-74.

¹²⁶ Kapper, 1165.

¹²⁷ Daniel McCool, "Indian Voting," in *American Indian Policy in the Twentieth Century*, ed. Vine Delora, Jr. (Norman, OK: University of Oklahoma Press, 1985), 107–111.

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Creation of Second Generation Veterans Hospitals, 1919–1950

I. Appropriations and Expansion of Second Generation Veterans Hospital Program

Congressional legislation was enacted in March 1919 (40 Stat. L., 1302) to address the Bureau of War Risk Insurance and the PHS's shortage of hospital beds for veterans. This was the first federal legislation for the acquisition of hospital facilities for World War I veterans. The federal measure included over \$9 million for expansion of hospitals for veterans and the transfer of some military hospitals to the PHS.¹²⁸ As stated in Weber and Schmeckebier's 1934 publication *The Veterans Administration: Its History, Activities and Organization*, by fiscal year end 1919, the PHS was treating veterans "in twenty marine hospitals, the Fort Stanton sanatorium, and ten new hospitals, known as Public Health Service hospitals, which had been opened as a result of the act of March 3, 1919. Of the new hospitals, eight were at former army training camps."¹²⁹ By December 1919 the number of available beds for World War I veterans had increased to 7,200. The medical facilities of the Army, Navy, and NHDVS became available for World War I veterans after June 1920.¹³⁰ The majority of hospitals operated by the PHS for war veterans in 1920 were utilized as general medical and surgical facilities, although they also operated tuberculosis and neuropsychiatric hospitals.¹³¹

In March 1921 an appropriation of \$18.6 million was made by Congress for the purchase, alteration, and building of additional hospitals. This legislation was known as the first Langley Bill (Public Law 384, 66th Congress, 41 Stat. 1364). The expenditures were overseen by the United States Treasury Department with recommendations by the Consultants on Hospitalization. Upon completion of the projects, the hospitals were to be turned over to the Veterans Bureau, which was established five months after passage of the first Langley Bill.¹³²

Two months after the creation of the Veterans Bureau in August 1921 (42 Stat. L., 147), the PHS was caring for 13,773 disabled veterans in its facilities. The president of the United States in April 1922 transferred the PHS hospitals treating former soldiers to the Veterans Bureau. An article from January of that year, prior to the transfer of these hospitals to the Veterans Bureau, states that the PHS, through its Hospital Division, was continuing to develop and expand its hospital program. The Hospital Division of the PHS operated three categories of hospitals: general medical and surgical, neuropsychiatric, and tuberculosis hospitals.¹³³ The same categories of hospitals continued to be built by the Veterans Bureau and its successor, the Veterans Administration. General medical and surgical procedures were conducted in a limited manner at a number of Second Generation Veterans Hospitals specializing in neuropsychiatric care. Operating rooms were generally located on one of the upper floors of the campus's main/administrative building.¹³⁴

¹²⁸ Weber and Schmeckebier, 156–157; Tobey, 117.

¹²⁹ Weber and Schmeckebier, 157.

¹³⁰ Tobey, 118, 328.

¹³¹ Ijams and Matz, 127.

¹³² McDill, 35; "Committee of Eminent Physicians Hard at Work Providing Hospitals for Disabled Service," *Washington Star* (Washington, D.C.), July 2, 1922, Entry 164 Box 21, Record Group 121, National Archives and Records Administration; Adkins, 106.

¹³³ C. C. Pierce, 33–35; McDill, 35.

¹³⁴ United States Department of Veterans Affairs. Files of the Engineering Department at various hospital sites throughout the United States.

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Funds for the second Langley Bill, totaling \$17 million, were released in May 1922. Unlike the first Langley Bill, where the funds were under the control of the United States Treasury Department, the monies of the second Langley Bill were to be spent under the authority of the Veterans Bureau. The majority of the new hospitals under construction in the second Langley Bill were neuropsychiatric facilities. Operating in the hospitals were vocational training facilities to educate and motivate patients to become successful in an employment field once discharged from the facility. Often training continued after the patient left the hospital to ensure the successful transition into a vocational field.¹³⁵

One of the primary goals of the construction program was to have all disabled veterans of the First World War in government-owned, fireproof, permanent hospitals. The Veterans Bureau annually tracked the number of patients in temporary buildings and leased or contracted civilian hospitals. As new government-owned facilities were opened, leases were not renewed and temporary or non-fireproof buildings were closed. According to the 1922 Annual Report, the Veterans Bureau operated forty-eight hospitals: thirteen tuberculosis hospitals, with 25.5 percent of patients receiving treatment in civilian hospitals; ten neuropsychiatric hospitals; and twenty-five general hospitals. Fiscal year 1922 saw over 86,000 total admissions by the Veterans Bureau to government hospitals, with an additional 47,962 admittances to contract hospitals.¹³⁶ By the fiscal year end 1924, the forty-four Veterans Bureau hospitals had a capacity of 15,798 beds: 79 percent of total ex-service personnel patients (17,824 patients) were served in government hospitals (including Veterans Bureau hospitals), and the remainder were served in civilian hospitals. The total number of admissions during the 1924 fiscal year was slightly over 64,000, with over 51,000 admissions to government hospitals and the remaining 12,400 patients admitted to state and civil contract hospitals.¹³⁷ Congress enacted two appropriation bills, over \$6.8 million in June 1924 (43 Stat. L., 389) and \$10 million in March 1925 (43 Stat. L., 1212), for the Veterans Bureau to continue construction of hospitals to replace leased and temporary facilities and eliminate the use of civilian hospitals.¹³⁸ At the fiscal year end of 1926, the Veterans Bureau was operating fifty-one hospitals with 20,598 total bed capacity. Over the course of the fiscal year the number of beds in leased facilities declined by 835 to 1,750 beds. Over 69,000 admissions were approved by the Veterans Bureau during fiscal year 1926, with over 64,000 admissions to government controlled hospitals and only 5,162 (7.4 percent) admissions to state and civil contract hospitals.¹³⁹ By June 30, 1929, the Veterans Bureau was operating forty-nine hospitals with a capacity of 22,280 beds. Almost 95 percent of the beds were in government-owned structures of permanent construction and only 200 beds were in leased facilities. Of the 83,188 admissions approved by the Veterans Bureau during fiscal year 1929, slightly over 80,000 admissions were to government controlled hospitals and only 2,926 (3.5 percent) of admissions were to state and civil hospitals.¹⁴⁰

Created in July 1930, the Veterans Administration merged the Veterans Bureau, the branches of the NHDVS, and the Bureau of Pensions into a single agency. The branches of the NHDVS were

¹³⁵ McDill, 36, 38.

¹³⁶ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 34, 36, 38, 40, 75.

¹³⁷ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924*, 19–20, 45, 112.

¹³⁸ Tobey, 23–24; Knight and Worden, 19–20.

¹³⁹ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1926*, 21–22, 131.

¹⁴⁰ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1929* (Washington, D.C.: U.S. Government Printing Office, 1929), 13, 48.

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renamed Veterans Administration Homes under the newly created agency. By the end of the 1931 fiscal year, over 109,000 admissions of veterans were made to medical facilities. Of this total, 54 percent, or slightly over 59,000 veterans, were admitted to VA facilities. The remaining 46 percent of veterans were admitted to naval, army, marine, and state or civil hospitals. Growth in the numbers of hospitals and bed capacity continued, as the Veterans Administration was operating sixty-seven hospitals with a capacity of 36,572 beds (including hospital beds at Veterans Administration Homes) at the end of fiscal year 1932. Hospital beds at the former NHDVS continued to be utilized by World War I veterans. This increased the potential available beds for use by veterans. Through the fiscal year 1932 there were over 148,000 admissions by the VA, with 59 percent, or nearly 88,000 patients, admitted to VA hospitals. The remaining admissions of veterans for the year were made to naval, army, Public Health Service, and state and civil hospitals and institutions. Slightly over 6,000 veterans were admitted to state and civil hospitals and institutions during fiscal year 1932. The 1935 Annual Report of Veterans Affairs states that as of fiscal year end, the number of Veterans Administration hospitals had increased to eighty with a capacity of 44,793 beds. From March 1919, when medical care for veterans was first authorized by the Federal government for World War I veterans, through the fiscal year end of 1935, over 1.4 million veterans had been admitted to hospitals for medical care. During fiscal year 1935 the VA authorized the admission of nearly 107,000 veterans to hospital facilities and nearly 66,000 surgical procedures occurred during the year. Eighty-four hospitals were in operation at the end of fiscal year 1939 that had a capacity of 54,779 beds. There were over 165,000 admissions of veterans to hospitals during the fiscal year 1939, the largest number of admissions for any fiscal year through 1939. Nearly 85 percent of the admissions, or 140,000 veterans, were admitted to hospitals controlled by the VA. The 1939 annual report stated that slightly over \$200 million had been appropriated to the Veterans Administration and its predecessor agencies for enlarging and improving its facilities over the previous twenty years. The 1939 annual report also states that 77.5 percent of hospitalization cases handled during the fiscal year were not related to military service disabilities. This is a clear indication of the effect that liberalizing admission standards had on the Veterans Administration's continuing efforts toward the expansion of its hospital network.¹⁴¹ Tremendous growth in the number of hospitals operated by the Veterans Administration took place within the decade between fiscal years 1931 and 1941. At the fiscal year end of 1941 the Veterans Administration was operating ninety-one hospital facilities with a total bed capacity of 61,849. This compares to fifty-four hospitals in operation with 26,307 beds at the end of fiscal year 1931. During fiscal year 1941 the VA authorized the admission of over 187,000 patients, the largest single year number of admissions at that time. Nearly 2.4 million total authorized admissions had occurred since March 1919. Of the total number of admissions, 83.5 percent, or 156,512 patients, were to facilities under the control of the VA.¹⁴² By 1944 the Veterans Administration was operating thirty neuropsychiatric, twelve tubercular, and forty general medical and

¹⁴¹ Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1931 (Washington, D.C.: U.S. Government Printing Office, 1931): 15; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1932*, 13–14, 19; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1929*, 13; Weber and Schmeckebier, 356; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1935*, 6, 8–9; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1939*, 7–8, 11.

¹⁴² *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1941* (Washington, D.C.: U.S. Government Printing Office, 1942), 8–9, 11; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1931* (Washington, D.C.: U.S. Government Printing Office, 1931), 20; Adkins, 149.

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surgical hospitals. The 1944 fiscal year saw nearly 194,000 patient admissions by the VA, with over 169,000 admissions of patients to facilities under control of the VA. The remaining patients were admitted to other government controlled hospital and slightly over 3,000 patients admitted to civil and state operated hospitals. With the increased demand created by World War II, the Veterans Administration was operating 125 hospitals with a capacity of 102,200 beds by the end of fiscal year 1948, representing the largest assemblage of associated medical facilities operating in the nation. The number of admissions for the 1948 fiscal year ballooned to 549,300 patients.¹⁴³

The total number of hospitals continued to increase over the next two years. The Veterans Administration operated 136 hospitals in 1950 with a capacity of over 106,000 beds. For fiscal year 1950 the number of admissions climbed to over 577,715 while discharges were approximately the same number, at 577,275. Over 5.3 million out patient medical treatments took place during the 1950 fiscal year.¹⁴⁴

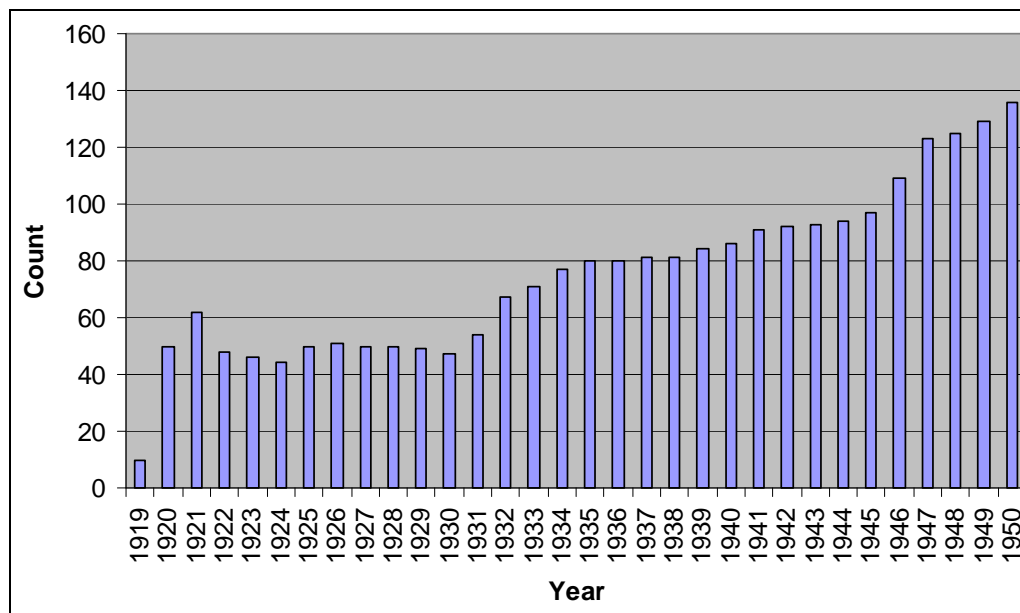


Figure 1. Number of veterans hospitals, 1919–1950 (Includes marine hospitals [1920–1921]; 1932 was the first year that includes hospital beds at Veterans Administration Homes).¹⁴⁵

¹⁴³ Edwin B. Morris, editor, "Hospital Planning by the Construction Service of the Veteran's Administration," *The Federal Architect* 13, no. 1 (October 1944): 16–17; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1944* (Washington, D.C.: U.S. Government Printing Office, 1944): 7; *Administrator of Veterans Affairs Annual Report for Fiscal Year Ended June 30, 1948* (Washington, D.C.: U.S. Government Printing Office, 1949), 8, 10.

¹⁴⁴ *Administrator of Veterans Affairs Annual Report for Fiscal Year Ending June 30, 1950*, 8–9.

¹⁴⁵ Data derived from Annual Reports of the Public Health Service, Veterans Bureau, and the Veterans Administration.

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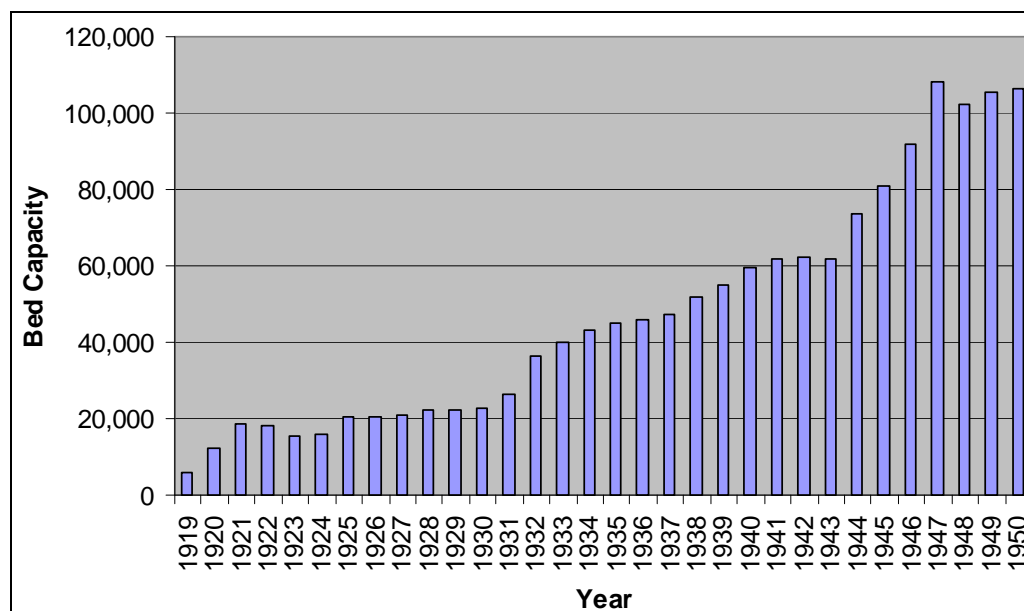


Figure 2. Veterans Hospitals bed capacity for years 1919–1950 (Includes marine hospitals [1920–1921]; 1932 was the first year that includes hospital beds at Veterans Administration Homes).¹⁴⁶

Weber and Schmeckebier address the monetary amounts allocated by Congress for new construction of hospitals and facilities and the expansion of veterans benefits from the creation of the Veterans Bureau through 1933. From fiscal years 1924 to 1932, the annual spending of the Veterans Bureau and Veterans Administration increased by \$356 million, or 66 percent, not including construction costs and insurance disbursements. Allocations for construction totaled \$72 million between fiscal years 1925 and 1932. Increases to the breadth of veterans benefits were kept in check by presidential vetoes and disagreements between the legislative and executive branches from 1921 to 1923. The World War Veterans Act (43 Stat. L., 607), enacted in June 1924, succeeded in initiating care for a much larger portion of the veteran population. The act conferred on all veterans from 1897 onward the benefits of travel expenses and hospitalization, whether or not their disabilities were incurred during military service, if space was available in the hospitals. Veterans who lacked the means to pay for hospitalization were to be given priority over those with available monetary resources.¹⁴⁷ By fiscal year end 1932, according to Weber and Schmeckebier, “the nonservice-connected cases numbered 23,472 or 60 per cent of the hospital load.”¹⁴⁸ Efforts were made during the 1920s and in 1930 to increase the presumption period, or the length of time after a soldier’s military service that certain diseases, once diagnosed, were assumed to have originated during military service. This would ensure the veteran would be eligible for benefits and treatment at a veterans hospital. Although the

¹⁴⁶ Data derived from Annual Reports of the Public Health Service, Veterans Bureau, and the Veterans Administration.

¹⁴⁷ Weber and Schmeckebier, 227–228; Stevens, 296.

¹⁴⁸ Weber and Schmeckebier, 234.

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executive branch worked against the efforts of increasing the presumption periods, compromise legislation was reached in 1930.¹⁴⁹

The Economy Act was enacted by President Franklin D. Roosevelt on March 20, 1933. This new legislation provided honorably discharged veterans with medical and domiciliary care for injuries suffered during military service and provided care for veterans with permanent disabilities, whether or not the disability occurred during military service. The Economy Act was passed to lower the federal government's annual expenditure to veterans, which was approximately a quarter of the government's annual budget. It was hoped the reduction of veterans benefits and other cost cutting proposals would decrease the annual federal budget by as much as 13 percent. The effect of the Economy Act was to decrease the number of veterans eligible for domiciliary and medical benefits and to reduce the amount of pensions. Veterans groups lobbied against the cuts in benefits, and President Roosevelt reduced the restrictions slightly by creating presumptive review boards to determine if disabilities that came to light during a specified period after discharge were related to a veteran's military service. Congress attempted to repeal the drastic cuts in veterans benefits the next year, but President Roosevelt vetoed the legislation. Both the House and Senate voted to override the President's veto and reinstated portions of veterans benefits that had been previously reduced. The Independent Offices Act, as passed by Congress in 1934, returned hospitalization benefits to veterans, whether or not the disabilities originated during military service, as long as the veteran could not afford treatment at a private hospital and depending on availability of beds at veterans hospitals.¹⁵⁰

The liberalizing of requirements for admission to veterans hospitals occurred in increments, with governmental factions differing on eligibility requirements for health care between the years 1919 and 1950. These differences arose partially from efforts to contain or reduce governmental expenditures pertaining to veterans benefits. By expanding veterans benefits from only domiciliary services to health care for any ailment, whether or not it originated from one's military service, broadened the scope of government-sponsored medical care for veterans and resulted in the necessary construction of hospitals to fulfill the government's commitment to these veterans. As stated by President Franklin D. Roosevelt at the dedication of the Roanoke/Salem, Virginia, Second Generation Veterans Hospital on October 19, 1934: "You see before you today a monument which is a very definite representation of the national policy of your Government, that its disabled and sick veterans shall be accorded the best treatment which medical and surgical science can possibly supply."¹⁵¹

II. Development of Standardized Designs for Second Generation Veterans Hospitals

i. National Homes for Disabled Volunteer Soldiers as a Model

The Civil War increased the number of veterans in the nation exponentially, with approximately two million soldiers having served in the United States military, or approximately 37 percent of males

¹⁴⁹ Ibid., 234–242.

¹⁵⁰ Corzine, n.p.; Adkins, 153–154; Mitchel B. Wallerstein, "Terminating Entitlements: Veterans Disability Benefits in the Depression," *Policy Sciences* 7, no. 2 (June 1976): 175–180; Frank T. Hines, "New Veterans Relief Policy Explained by General Hines," *New York Times*, July 30, 1933.

¹⁵¹ John T. Woolley and Gerhard Peters, *The American Presidency Project* [online] (Santa Barbara, CA: University of California (hosted), Gerhard Peters [database]). Available from World Wide Web: <http://www.presidency.ucsb.edu/ws/?pid=14765>. Accessed July 2009.

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residing in the Union states. This does not include those who served in the Confederate forces, as hostiles they were not eligible for federal veterans benefits. The General Pension Law of 1862 provided monetary support for veterans of the Union forces whose disabilities were attributable to injuries and illnesses suffered during military service. This was the first legislation that provided pensions for veterans disabled by disease. Congress created a government-sponsored home for disabled Union volunteer soldiers of the Civil War in March 1865 entitled the National Asylum for Disabled Volunteer Soldiers. By 1873 the name was changed to the National Home for Disabled Volunteer Soldiers (NHDVS), with the institution retaining this designation until the merger of the Veterans Bureau, NHDVS, and the Bureau of Pensions into the Veterans Administration in 1930.¹⁵² The care offered by the eleven branches operated by the NHDVS is significant, because it represents the first instance in which volunteer soldiers of the United States were offered domiciliary, medical care, and rehabilitation/educational opportunities by the federal government on a large scale. Prior to the creation of the branches, only career military personnel with over twenty years of service were provided domiciliary and medical care.

The plans for the NHDVS, with the individual locations referred to as branches, appear to have been influenced by the writings of Dr. Thomas Story Kirkbride, a noted authority on the treatment of those suffering from mental diseases in the mid-nineteenth century. Published in 1854 and again in 1880, Dr. Kirkbride's book *On the Construction, Organization and General Arrangement of Hospitals for the Insane* provided guidance for the location and construction of these institutions, some of which may have affected the design of the individual NHDVS branches. Dr. Kirkbride's recommendations for mental asylums included: their location in rural areas; that they would be situated adjacent to transportation corridors such as roads or railroads; acquisition of tracts of 100 acres or more for agricultural pursuits that would supplement the food for the patients; design of buildings that should "impress" both patients and visitors and in no way appear to be a prison; and landscaping of the campus that would provide picturesque surroundings for both patients and visitors.¹⁵³

Branches of the NHDVS were located in areas with concentrations of Union-affiliated Civil War veterans, including Maine (opened 1866), Wisconsin (1867), Ohio (1867), Virginia (1870), Kansas (1885), California (1888), Indiana (1888), Illinois (1898), Tennessee (1903), South Dakota (1907), and New York (1929).¹⁵⁴ According to Julin, "The specific designations of locations for these...branches were influenced by climate, terrain, availability of land, contributions of property and money from aspiring locations, and political interests."¹⁵⁵ Similar factors, including local politics and boosterism, continued to be important in the site selection for Second Generation Veterans Hospitals.

¹⁵² Julin, 6–7; Patrick J. Kelly, *Creating a National Home, Building the Veterans Welfare State 1860–1900* (Cambridge, MA: Harvard University Press, 1997), 3.

¹⁵³ Julin, 14; "Kirkbride Buildings" (2010), located on the World Wide Web at <http://www.kirkbridebuildings.com/index.html>. Accessed January 2010; Thomas S. Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* (New York, NY: Arno Press, 1973; originally published Philadelphia, PA: J.B. Lippincott and Company, 1880), 37–39, 52–53; Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840–1883* (New York, NY: Cambridge University Press, 1984), 6, 141, 143.

¹⁵⁴ National Park Service, "History of the National Home for Disabled Volunteer Soldiers," Veterans Affairs National Home for Disabled Volunteer Soldiers, "Discover Our Shared Heritage Travel Itinerary," http://www.nps.gov/nr/travel/veterans_affairs/History.html. Accessed January and August 2010.

¹⁵⁵ Julin, 14.

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At the Milwaukee, Wisconsin branch, a single, large building was constructed housing various facilities, such as offices, dormitories, medical care, kitchen, and other services. The Milwaukee building was constructed in the centralized manner favored by Kirkbride, with a substantial main block and receding linear wings extending from the side elevations. The Dayton, Ohio, branch was constructed in a decentralized pattern, with various buildings serving a single purpose arranged around a parade ground, similar to Army posts of the period. The Dayton branch included the main building, barracks, kitchen/dining rooms, shops providing minimal income and vocational training (for the production of brooms, cabinets, and clothing), a chapel and hospital, and a music hall.¹⁵⁶ Freestanding chapels and staff quarters were constructed at all NHDVS branches. The first permanent freestanding chapel was completed at the Dayton, Ohio, branch of the NHDVS.¹⁵⁷

The main building of the Milwaukee branch was designed by architect Edward Townsend Mix and the original buildings of the Dayton branch were created by architect C.B. Davis. Both branches employed Thomas B. Van Horne to design the landscaping. It appears later branches also employed various architects as they were established. This accounts for the variations in architectural styles at the eleven campuses and even between select buildings within a campus. The buildings of the NHDVS branches incorporated nationally popular architectural styles at the time of their constructions, including Richardsonian Romanesque, Queen Anne, and Stick styles. Standardized designs do not appear to have been utilized in the buildings of the various NHDVS campuses.¹⁵⁸

Both tracts for the Milwaukee and Dayton branches were located on elevated terrain to allow breezes of fresh air to cool and cleanse the facilities of perceived foul air. Author Patrick J. Kelly also indicates that the erection of institutions on elevated sites provided visitors and locals with a reminder of the federal government's resolve to provide care to Civil War Union veterans who were disabled during their service to the nation.¹⁵⁹

The NHDVS incorporated military practices, such as forming the residents into companies, issuing uniforms, providing passes to leave the property, and delivering punishment to those found disobeying the rules. The structured daily routine included awakening the members in their barracks each morning to reveille and lights were extinguished at a set time. Although a "home" in name, the military aspects of the NHDVS did not resemble characteristics of a family. The NHDVS followed Kirkbride's recommendation to include agricultural pursuits on the premises to provide food and activities for the members. Similar agricultural endeavors, such as raising gardens, crops, and livestock, were common at prisons and poor houses of the period. The NHDVS also provided vocational training to its members.¹⁶⁰ The vocational training utilized by the branches of the NHDVS, possibly one of the first instances of federally funded occupational training, may have served as an early model for the occupational training later offered by the Second Generation Veterans Hospitals, especially at neuropsychiatric and tuberculosis hospitals. Educational opportunities in the form of classes were also provided by the branches of the NHDVS. Judith Gladys Cetina's 1977 dissertation states that members

¹⁵⁶ Julin, 16; Kelly, 112–115, 117–119; Tomes, 141–142.

¹⁵⁷ Darlene Richardson, Historian at the Department of Veterans Affairs, information provided to the author by email, August 25, 2010.

¹⁵⁸ Julin, 16; National Park Service, "History of the National Home for Disabled Volunteer Soldiers," Veterans Affairs National Home for Disabled Volunteer Soldiers, "Discover Our Shared Heritage Travel Itinerary."

¹⁵⁹ Kelly, 111.

¹⁶⁰ Julin, 18–19; Kelly, 122; Judith Gladys Cetina, "A History of Veterans Homes in the United States, 1811–1930" (PhD diss, Case Western Reserve University, 1977), 413–415, 417.

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of the NHDVS “could receive instruction in reading, writing, arithmetic, geography, English grammar, history, natural philosophy, bookkeeping, telegraphing, and vocal and instrumental music.”¹⁶¹

In 1884, Congress agreed that eligible veterans included those that could no longer financially support themselves because of disability, whether or not the disability occurred while in military service. The disability could also be attributable to old age, thereby opening admittance to any veteran (except those of the Confederacy or dishonorably discharged) who was disabled.¹⁶² Prior to the liberalized admission policy of 1884, the Board of Managers realized the aging population of the NHDVS increased the need for additional hospital facilities at each of the branches. The Board of Managers requested additions to existing hospitals and for the erection of new hospital facilities to care for its aging members in the mid-1880s. According to Cetina’s dissertation, in 1886 “the board members emphasized their contention that the home was gradually becoming a great hospital.”¹⁶³

The Spanish-American War of the late nineteenth century provided additional members to the NHDVS, as Congress authorized admission of disabled veterans of the conflict in 1900 and 1901. The eligible veterans of this newest armed conflict brought with them the infirmities caused by tropical diseases, as many of the veterans had fought in the Philippines and Cuba. The NHDVS began having to focus more attention on medical care for veterans suffering from the effects of yellow fever, tuberculosis, and leprosy. The branches were able to treat tuberculosis patients in buildings separated from the regular barracks. This emphasis on extending medical care to eligible disabled veterans is particularly evident in the opening of two branches of the NHDVS: Mountain Home, Tennessee; and the branch in Hot Springs, South Dakota. The Mountain Home branch included a hospital for treating members with respiratory illnesses. The Hot Springs, South Dakota, branch was the first NHDVS planned as a medical facility from its initial design, treating veterans with intestinal and muscular problems.¹⁶⁴

With the nation’s entry into World War I, the NHDVS faced dramatic changes to its future as medical care became a more significant part of its mission. With the lack of adequate hospital facilities for returning soldiers from the European theater, the NHDVS stepped in to help the PHS to provide health care to these disabled veterans. Legislation was enacted in October 1917 that enabled veterans of World War I access to NHDVS branches for domiciliary or medical care. Funding was awarded to the NHDVS through the Bureau of War Risk in 1921 to increase capacity and provide additional hospital care for disabled World War I veterans. By 1923, 41 percent of all beds at NHDVS facilities were utilized for medical purposes. The vast majority of new patients, approximately 73 percent, admitted to the NHDVS in 1923 were disabled World War I veterans. This shift from an aging population to one of young men with aspirations of returning to their homes as productive members of society was truly profound. The demands of caring for a large number of neuropsychiatric patients also altered the original intentions of the NHDVS.¹⁶⁵

The creation of the Veterans Administration with Executive Order 5398 in July 1930 ended the separate authority of the NHDVS. The Veterans Bureau, NHDVS, and the Bureau of Pensions were merged together to form the Veterans Administration, placing health care and management of veterans

¹⁶¹ Cetina, 284.

¹⁶² Julin, 22; Cetina, 171.

¹⁶³ Cetina, 287–288.

¹⁶⁴ Julin, 30–33; Cetina, 355–358, 361, 367.

¹⁶⁵ Julin, 34–36; Cetina, 378–380; James A. Mattison, “The Development of the National Soldiers’ Home Service,” *The Modern Hospital* 20, no. 1 (January 1923): 59–61.

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benefits under the control of a single federal entity. Under the Veterans Administration the former branches of the NHDVS continued to evolve, as the requirements of the younger veterans of the Great War were different than those of aging Civil War veterans. Many of the new members suffered from neuropsychiatric illnesses. Vocational training was again offered to these youthful patients, as rehabilitation consisted of curing the patient and providing the means for self sufficiency once released from hospital care. The campuses of the former NHDVS branches continued to evolve under the authority of the Veterans Administration, as new medical facilities were incorporated into the landscapes of facilities initially designed for veterans of the Civil War.¹⁶⁶ With the creation of the Veterans Administration, the NHDVS branches were renamed Veterans Administration Homes. On June 30, 1932, the Veterans Administration Homes had 24,522 residents, with slightly over 5,800 in the Homes' hospital facilities and the remainder living in barracks. The 24,522 residents were composed of 22,096 white males, 2,383 African-American males, and 43 white females. African-American members could be found in all of the Veterans Administration Homes. The average age of the members of the Veterans Administration Homes on June 30, 1932, (distinguished by military conflict) was 85 years old for Civil War veterans, 58 years old for Spanish-American War veterans, and 39 years old for World War I veterans.¹⁶⁷

The final three homes/general medical hospitals that were funded under the NHDVS—Biloxi, Mississippi; Bay Pines, Florida; and Roseburg, Oregon—were not completed until 1933, after the establishment of the Veterans Administration.¹⁶⁸ Unlike their predecessors that were created primarily for long term care of Civil War veterans and offering limited medical care, the Veterans Administration initially designed these facilities to serve as both homes and general medical hospitals. As a result, these facilities have much more in common with Second Generation Veterans Hospitals than with their predecessor, First Generation Hospitals, and for that reason they are included here as sub-type 4 homes/general medical hospitals.

Cemeteries represent one of the principal landscape differences between the NHDVS branches and the Second Generation Veterans Hospitals. Cemeteries are affiliated with all branches of the NHDVS. The Bay Pines, Roseburg, and Biloxi homes/general medical hospitals are unique among the Second Generation Veterans Hospitals in that cemeteries are located on the grounds for members who

¹⁶⁶ Julin, 37; Cetina, 382–383; National Park Service, "History of the National Home for Disabled Volunteer Soldiers," Veterans Affairs National Home for Disabled Volunteer Soldiers, "Discover Our Shared Heritage Travel Itinerary."

¹⁶⁷ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1932*, 12.

¹⁶⁸ "Proud of the Past – Preparing for the Future," *VA Medical Center, Bay Pines, Florida: 50th Anniversary* (Bay Pines, FL: Veterans Affairs Medical Center, 1983), 2, located in the medical library of the Bay Pines Veterans Affairs Healthcare System, Bay Pines, Florida; United States Department of Veterans Affairs, *Bay Pines VA Healthcare System 75 Years of Healing: 1933-2008* (Bay Pines, FL: Bay Pines Veterans Affairs Healthcare System, 2008), 1, located in the medical library of the Bay Pines Veterans Affairs Healthcare System, Bay Pines, Florida; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1933* (Washington, D.C.: U.S. Government Printing Office, 1933), 14; United States Department of Veterans Affairs, National Cemeteries. "Roseburg National Cemetery." Located on the World Wide Web on the United States Department of Veterans Affairs website at http://www.cem.va.gov/cems_nmc.asp. Accessed February 2010; "Biloxi Soldier' Home Opened," *New York Times*, August 12, 1933; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1934* (Washington, D.C.: U.S. Government Printing Office, 1935), 16.

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died while residing in the dormitory or hospital facilities. All three cemeteries at these sub-type 4 facilities are currently designated as national cemeteries.

ii. Standardized Plans of the United States Army as a Model

The Context Study of the United States Quartermaster General Standardized Plans 1866–1942 discusses the use of standardized designs for buildings constructed for the United States Army. The context was completed by the United States Army Corps of Engineers, Seattle District to aid the Department of Defense in determining the eligibility of buildings and structures for the National Register of Historic Places. The study is divided into three time periods and includes numerous building types found at United States Army bases. Both veterans hospitals and Army bases shared a number of commonalities during the years between the world wars, such as housing a large number of men (active military and veterans) and providing shelter, food, and recreational activities within an enclosed campus to its temporary residents. While Army bases are composed of a number of unique structures and buildings, both veterans hospitals and Army bases also have buildings serving similar functions, including gatehouses, administration buildings, maintenance shops, laundries, power plants, hospitals, chapels, residential quarters, and recreation/theater buildings. The Army base layout evolved from a grid pattern, with the parade ground serving as the focal point, and was later modified after the First World War by utilizing the existing natural landscape patterns with curving lanes and designed plantings.¹⁶⁹ This evolution from formal to naturalistic landscape design is similar to the campuses of the Second Generation Veterans Hospitals.

The United States Quartermaster Department (later Corps) of the Army began to develop standardized plans in the 1860s, although the designs were not officially adopted. These designs were for permanent construction but could also be built of various materials. Many of the early designs were for temporary structures, but by the late nineteenth century, plans for both temporary and permanent buildings were developed by the Quartermaster Corps. The advantages of standardized plans included: reducing expenses in regards to construction, ease of construction if accompanied by material lists, the efficiency involved if the same contractor could produce the same buildings at different posts, and the ability to set a readily recognizable expectation of military architecture and post design for the civilian and military populations of the nation. These designs allowed for trends in regional architectural styles to be utilized. Many of the buildings designed by the Quartermaster Corps in the first half of the twentieth century incorporated nationally popular architectural styles, such as the Colonial and Spanish Colonial Revival styles.¹⁷⁰ Although the exteriors may exhibit architectural styles utilized at the time for both public buildings and residences, the Army base buildings were to impart “a military character, but it should be the character of its local and its natural traditions.”¹⁷¹ The Spanish Colonial Revival and

¹⁶⁹ Paul Chattey, Horace Foxall, Flossie McQueen, Cynthia Nielsen, Mary Shipe, Terri Taylor, and Jamie Tippet, *Context Study of the United States Quartermaster General Standardized Plans, 1866–1942* (Seattle, WA: U.S. Army Corps of Engineers Seattle District, Technical Center of Expertise for Preservation of Structures and Buildings, 1997), i–iii, 55–58. Located on the Defense Technical Information Center website, Accession Number ADA352432, <http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=ADA352432>, accessed January 2010.

¹⁷⁰ Chattey, et al., 6–7, 34; Alison K. Hoagland, “The Invariable Model,’ Standardization and Military Architecture in Wyoming, 1860–1900,” *Journal of the Society of Architectural Historians* 57, no. 3 (September 1998): 299, 302, 313.

¹⁷¹ Chattey, et al., 7.

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Colonial Revival architecturally styled buildings incorporated into the Quartermaster Corps' standardized designs exhibit minimal ornamentation, probably in an effort to restrain expenses and simplify construction. Also contributing to the economy of constructing standardized buildings was the introduction during the two decades prior to the Great War of construction materials with standardized dimensions. Similar to the standardized designs of the Second Generation Veterans Hospitals, those of the Quartermaster Corps are not necessarily identical, allowing for slight variations in the plans.¹⁷² Recreational buildings at many of the World War I camps constructed in the United States were funded by private sources, such as the Knights of Columbus, the Young Men's Christian Association (YMCA), the Jewish Welfare Board, and the Carnegie Corporation. These recreational buildings included theaters, libraries, auditoriums, and club buildings. In many instances the various purposes were incorporated into a single structure.¹⁷³

Strict landscape guidelines for Army posts prior to the First World War were not detailed in writing, other than to "be aesthetically pleasing."¹⁷⁴ It was during the quarter century prior to the Great War that landscape planning following the City Beautiful and Garden City movements began to be utilized at United States Army posts, including formal plans with very structured landscapes and others incorporating naturalistic designs with curving drives and greater use of the original topography.¹⁷⁵ The authors of *The Context Study of the United States Quartermaster General Standardized Plans 1866–1942* emphasize the guidance provided by architect and planner George B. Ford in the landscape design of Army posts in the 1930s. Ford was hired in 1929 along with a number of architects, planners, landscape architects, and engineers to review the development of posts by the Construction Division of the Quartermaster Corps. Ford was a proponent of the ideals proposed in the City Beautiful and Garden City movements. Landscape design standards for Army posts were issued by the Construction Division of the Quartermaster Corps in 1931. A landscape unit was created to provide assistance in the selection of vegetation for new post construction and also created standardized planting schemes for certain buildings, such as residential quarters and hospitals. The landscape unit suggested using vegetation to frame views, assist in erosion control, and separate various sections of the military post.¹⁷⁶ As stated in *The Context Study of the United States Quartermaster General Standardized Plans 1866–1942*: "The consistent application of master planning concepts such as functional, hierarchical arrangements of buildings and circulation systems [roads and sidewalks], incorporation of community areas and open space, standardized building setbacks, and the design of curvilinear roads and orientation of buildings to complement existing topography, allowed the ordered development of posts. While parade grounds were no longer always the central feature of the site as they were for earlier posts, they still served as important organizing features in the overall site plan."¹⁷⁷

It was also during this period that Victorian stylistic tendencies for post buildings began to be superseded by Colonial Revival and Spanish Colonial Revival styles. Buildings utilizing the Spanish Colonial Revival architectural style were constructed in the west and southwest portions of the country. Bungalows were also constructed for residential quarters of officers on Army bases.¹⁷⁸

¹⁷² Ibid, 10, 31, 39.

¹⁷³ Ibid, 12–13.

¹⁷⁴ Ibid, 39.

¹⁷⁵ Ibid, 39–40, 55.

¹⁷⁶ Ibid, 55, 57.

¹⁷⁷ Ibid, 56–57.

¹⁷⁸ Ibid, 39–40, 57.

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The United States' entry into World War I was the impetus for the construction of Army and National Guard training camps throughout the country. Each of the camps were filled with temporary structures of standardized designs. The sixteen Army cantonments had a capacity of over 600,000 men, while an equal number of National Guard camps could accommodate over 400,000 soldiers.¹⁷⁹ Included in these camps were hospitals, each originally with a capacity of 1,000 beds. These camp hospitals were originally designed by the Surgeon General's Office of the Army. Comprised of approximately sixty-five buildings, the structures of the camp hospital were of temporary wood construction with separated pavilions connected by covered corridors. Each of the wards had a porch at one end to provide greater comfort in southern climates and to help ambulatory patients. The chief of engineers of the United States Army designed the Army hospitals for the European theater during World War I to be prefabricated of standard widths to ensure ease of construction.¹⁸⁰

In the years immediately following the Great War, the Army was authorized to sell portions of its land holdings to pay for the construction of permanent buildings at its posts, many of which had deteriorating temporary structures. The monies provided by the sale of Army property led to new standardized designs in the late 1920s for post buildings such as hospitals and permanent quarters. These new designs were produced through the cooperation of both the Quartermaster Corps and practicing public architects. The Spanish Colonial Revival architectural style continued to be used in the West and Southwest and Colonial and Tudor Revival buildings were erected in other portions of the country. As stated in *The Context Study of the United States Quartermaster General Standardized Plans 1866–1942*, "The new designs were created to respond to regional, environmental and historic conditions. A consistently uniform architectural style was used at each post."¹⁸¹ By the early 1930s both the Army and the Veterans Bureau/Veterans Administration were utilizing similar architectural styles in comparable sections of the nation. With the war in Europe beginning in 1939, the Quartermaster Corps was under pressure to provide new and adequate buildings for the expanding United States Army. To meet these requirements, the Quartermaster Corps provided new standardized designs for numerous building types, including hospitals.¹⁸²

The Context Study of the United States Quartermaster General Standardized Plans 1866–1942 contains a number of examples of standardized plans and histories of various functional building types. Gatehouses were constructed in the general architectural style of the individual Army posts and became more numerous with the rise of the automobile as the major mode of transportation.¹⁸³ Gatehouses were also constructed at Second Generation Veterans Hospitals, especially those constructed in the later portion of the period of significance for these hospitals, the late 1920s through 1950 (which will also be referred to as Period II).

Army hospital designs evolved from the nineteenth-century design of pavilion hospitals and also included hospitals with a central, two-story main block with flanking wings and wrap-around porches. According to Alison K. Hoagland's article, "'The Invariable Model,' Standardization and Military Architecture in Wyoming, 1860–1900," in "the nineteenth century the [Army's] surgeon general exercised more control over hospital designs than the quartermaster general did over other types of

¹⁷⁹ Ibid, 41–47.

¹⁸⁰ Edward F. Stevens, "Development of the Hospital Ward Unit of the United States Army," *The Modern Hospital* 12, no. 6 (June 1919): 408–411.

¹⁸¹ Chattey, et al., 48.

¹⁸² Ibid, 51–52.

¹⁸³ Ibid, 76–77

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buildings, probably because the surgeon general represented a recognized profession.”¹⁸⁴ The pavilion hospitals, the first truly successful standardized building located within Army posts, consisted of numerous pavilions or open wards connected by long corridors and containing numerous beds. The pavilions could be one or two stories in height, and the connecting corridors were covered or enclosed. Pavilion hospitals were used as general hospitals by the Army from the Civil War through World War II. The pavilion plan was the accepted hospital plan in Europe and was based on the assumption that diseases were airborne, that “emanations from human bodies, not just exhalation, had a poisonous effect.”¹⁸⁵ It was believed that separated, narrow pavilions allowed fresh air to circulate and lowered the incidence of illnesses. With advances in medical treatment during World War I, it became accepted that germs were the cause of many diseases and infections, although pavilion hospitals continued to be constructed at Army cantonments throughout the United States’ involvement in the Great War.¹⁸⁶

As described by Frank W. Weed in *The Medical Department of the United States Army in the World War, Volume 5, Military Hospitals in the United States*, planning for Army hospitals began with sketch plans drawn by draftsmen in the Surgeon General of the Army’s office. These sketch plans were then examined by the surgeon general and other staff members before submitting them to the Quartermaster General’s Office. The final drawings were created and then approved by the surgeon general.¹⁸⁷ Upon the United States’ entry into World War I, preparations began for the stateside construction of National Guard and United States Army hospitals. Weed states that “In the preparation of these plans, medical officers, representing the various specialties, such as surgery, medicine, laboratory, were consulted, and, in so far as time, necessary construction, standardization, and funds permitted, plans were prepared to embody the essential features desired. These features were included with other usual hospital features and activities, and a general plan was evolved for the typical 1,000-bed hospital. A 500-bed hospital was planned by a similar process. In order to standardize equipment, materials, personnel, construction, and administrative requirements, it was thought best to accomplish this, and the 1,000-bed and the 500-bed hospital types were considered as more nearly approximating the majority of the proposed perfected features.”¹⁸⁸ The vast majority of military hospitals with a capacity of 1,000 beds or more constructed in the United States during World War I were of temporary construction. These hospitals were erected at Army camps, National Guard camps, and existing base, general, and tuberculosis hospitals. These large medical facilities included a number of buildings serving various functions, including quarters, kitchens and mess, wards, barracks, storehouses, garages, shops, laundries, operating rooms, mortuaries, chapels, and guardhouses. Ward buildings of various designs could be located at these hospitals, with patient capacity for each building varying from 12 to 122 beds, depending on the design and use of the building.¹⁸⁹ The expansion of military hospital construction during the war effort meant additional draftsmen were needed in the office of the surgeon general. Because of bureaucratic difficulties, “architects, versed in hospital design and construction, or in military procedure, were commissioned in the Sanitary Corps, for supervisory duties.”¹⁹⁰ With

¹⁸⁴ Hoagland, 307.

¹⁸⁵ Hoagland, 307.; Chattey, et al., 120–124.

¹⁸⁶ Chattey, et al., 120–124; Hoagland, 307.

¹⁸⁷ Frank W. Weed, prepared under the direction of M. W. Ireland, *The Medical Department of the United States Army in the World War, Volume 5, Military Hospitals in the United States* (Washington, D.C.: U.S. Government Printing Office, 1923), 27.

¹⁸⁸ *Ibid*, 29.

¹⁸⁹ *Ibid*, 39–52.

¹⁹⁰ *Ibid*, 29.

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approximately 250 hospital construction projects ongoing, a hospital section was created in the War Department's Construction Division.¹⁹¹

The standardized designs for Army hospitals of permanent construction in the mid-1920s no longer contained wrap-around porches, and quarters for medical personnel were constructed in close proximity to the hospital. Sun rooms took the place of the former porches in some of the designs. These hospitals are referred to as "pavilion-modified" within the typology of military hospitals discussed in the draft of *Military Hospitals Historic Context* from 2007. The draft of the study was completed by Adam Smith and Sunny Stone of the Construction Engineering Research Laboratory of the United States Army Engineer Research and Development Center.¹⁹²

The design of Army hospitals in the United States changed dramatically during the late 1930s with the acceptance of multiple-story buildings containing all the functions of the hospital in a single building, including clinics, administration, surgery, wards, and other medical services. With advancements in the understanding of the transmittal of diseases (they were not caused by human "vapors" but bacteria), the increasing use of antiseptics for wounds, the growing use of building materials that could be easily cleaned and disinfected, and improvements in elevator technology, the design of Army hospitals quickly changed. These new tower hospitals, organized around clusters of elevators, utilized smaller tracts of land with the consolidation of services. In 1938 construction began on a 610-bed Army hospital in Aurora, Colorado, that was completed in 1941. This hospital, the Fitzsimons Army Hospital, was the largest building constructed by the Army at the time. As with many large, public buildings of the mid-twentieth century, the exterior of this Army hospital exhibited a simplified version of the popular Art Moderne architectural style.¹⁹³

Chapels are a common building found at Army installations. Chapels were usually nondenominational and individually designed. Early chapels did not follow the existing architectural trends of the campus. According to *The Context Study of the United States Quartermaster General Standardized Plans 1866–1942*, chapels were first introduced onto Army posts as separate buildings in the late nineteenth century. Standardized designs for chapels were issued by the Quartermaster Corps in the early twentieth century, but it is unclear if these plans were ever used. Chapels at Army posts in the 1930s were constructed in the overall architectural style of the facility or continued to follow nationally popular architectural styles. Freestanding chapels at Second Generation Veterans Hospitals do not seem to appear on campuses until after World War II, and although numerous, they were not included on all Second Generation Veterans Hospital campuses. As with freestanding chapels at Second Generation Veterans Hospitals, private funding was utilized in the construction of the buildings at Army installations. While most Army posts of the post-World War II era have separate chapel buildings, many Second Generation Veterans Hospitals continue to have chapels incorporated into existing structures.¹⁹⁴

Of the building drawings and photographs included in *The Context Study of the United States Quartermaster General Standardized Plans 1866–1942*, those of the quarters for officers and nurses are most similar to those found at Second Generation Veterans Hospitals. Bachelor officers' quarters

¹⁹¹ Ibid, 29–30.

¹⁹² Adam Smith and Sunny Stone, Draft: *Military Hospitals Historic Context*, ERDC/CERL SR-06-DRAFT (Champaign, IL: Construction Engineering Research Laboratory, U.S. Army Engineer Research and Development Center, 2007 draft), 4–5.

¹⁹³ Chattey, et al., 124; Smith and Stone, 5.

¹⁹⁴ Chattey, et al., 204–206.

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(BOQs) and nurses' quarters were probably very similar in construction, although only the BOQs were discussed in the study. As stated in the study, "The military constructed bachelor officers quarters (BOQs) to house unmarried officers or those officers' stationed at an installation without their families. Bachelor officers' quarters usually were rectangular, two-story structures that contained living quarters and mess facilities for officers....During the early twentieth century, bachelor officers quarters were constructed to reflect the Georgian Revival and the Spanish Colonial Revival styles. The evolution of quarters design illustrates the military's interest in and adaption of contemporary civilian architectural trends to the military's construction program."¹⁹⁵ A similar correlation exists between Second Generation Veterans Hospital architecture of the first half of the twentieth century and nationally popular architectural styles. The study includes a photograph of a BOQ constructed in 1934 at Fort Lewis, Washington. From the photograph, the BOQ is very similar to large nurses' and attendants' quarters found at numerous Second Generation Veterans Hospitals from the early years of the period of significance dating from 1919 to the mid-1920s (also referred to within this multiple property documentation form as Period I). These similarities include symmetrical facade fenestration, a central projecting pavilion extending from the two-story main block, and minimal Colonial Revival ornamentation (oculus with swags in the gable, decorative door surround, and keystones over window openings).¹⁹⁶

As with other standardized building plans utilized by the Army, the architectural styling for non-commissioned officers (NCO) quarters changed from the late-nineteenth-century's Victorian tendencies to the Colonial and Spanish Colonial Revival styles of the 1920s and 1930s. Utilizing both two-story duplexes and detached bungalows and cottages, the Construction Service of the Quartermaster Corps developed entire neighborhoods of NCO housing at the expanding Army posts similar to civilian developments.¹⁹⁷ An architectural drawing of a two-story duplex NCO quarters for Fort Riley, Kansas, dated 1930, is very similar to duplex quarters found at Second Generation Veterans Hospitals dating to the same period. The NCO quarters duplex exhibits Colonial Revival characteristics, including symmetrical fenestration along the facade and rear elevations, pronounced facade entries with door surrounds and fanlights, gable-end chimneys, and single-story sun porches along the side elevations enclosed with windows and a balustrade along the roof line. A second version of the NCO duplex quarters is very similar to the previous example, except the facade entries include double doors and the side elevation porches are enclosed with brick and have tripartite windows with no roof balustrade. Although the previous two examples of NCO duplex quarters have side-gable roof configurations, another architectural drawing dating to 1935, again at Fort Riley, Kansas, exhibits a hip-roof over the main block of the duplex.¹⁹⁸

With the influx of building funds in the second half of the 1920s from the sale of excess Army property, new officers' quarters in the Colonial and Spanish Colonial Revival architectural styles were constructed at United States Army posts. These posts were larger than those of the past, and the officers' quarters were no longer situated adjacent to the parade grounds but were located in residential areas with winding drives and open public spaces. The officers' quarters were separated from the NCO quarters. Two-story and single-story residences were designed by the Construction Service of the Quartermaster Corps, as were duplexes, although single-family residences were more frequently

¹⁹⁵ Ibid, 227.

¹⁹⁶ Ibid, 229.

¹⁹⁷ Ibid, 269–270.

¹⁹⁸ Ibid, 280, 282, 283.

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constructed. The Spanish Colonial Revival architectural style was utilized during the 1920s and 1930s in the Southwest and Southeast, and Colonial Revival style architecture for officers' quarters could be found throughout the remainder of the nation. In a few instances, Tudor Revival and French Provincial Revival architectural styles were also utilized for officers' quarters. Few examples of family housing were completed at Army posts during World War II, and those that were completed exhibited minimal Art Moderne architectural detailing.¹⁹⁹ Two architectural drawings of two-story, single-family officers' quarters in *The Context Study of the United States Quartermaster General Standardized Plans 1866–1942* have few similarities to the manager's/director's residences found at the Second Generation Veterans Hospitals. Dating to 1932 and 1933 and proposed for construction at Marshall Field, Kansas, both of the examples of officers' quarters have asymmetrical facades created by two-story sun porches along one side elevation. The only noticeable differences between the two officers' quarters are the door surrounds of the facade entries. The manager's/director's residences of the Period II Second Generation Veterans Hospitals may also feature asymmetrical fenestration along the facade, but the porches are usually single story and originally were open, not enclosed. The examples of the officers' quarters are also larger than the manager's/director's residence of the Second Generation Veterans Hospitals, exhibiting five bays extending across the facade of the main block of the house.²⁰⁰

Garages are another common building found at both Army posts and Second Generation Veterans Hospitals during the first half of the twentieth century. As early as 1913 the Quartermaster Corps had developed a standardized plan for a two-bay garage. Multiple-bay garages are commonly associated with officers' and NCO quarters, usually to the rear of the residences. Attached garages were incorporated into the designs for some residences in the 1930s. The garages usually exhibited the same architectural style as the residences, although with minimal decorative features.²⁰¹

Both United States Army posts and Second Generation Veterans Hospital campuses dating from the 1920s through mid-1940s share similarities in the evolution of their overall designs and in the architectural styles utilized for their buildings, especially during the 1930s. Many Second Generation Veterans Hospitals, especially those completed by the Quartermaster Corps of the Army and the Bureau of Yards and Docks of the Navy during Period I were constructed with minimal architectural ornamentation, and the campuses were more formally designed around circular, radial, or grid formations. These hospitals are very similar to Army hospitals constructed during the same period. But as the landscape designs and architectural styles of buildings located at Army posts began to evolve utilizing principles from the City Beautiful and Garden City movements, so too did the campus planning and building ornamentation of the Second Generation Veterans Hospitals. The Second Generation Veterans Hospitals and Army posts began to utilize naturalistic landscape plans incorporating curving drives and sidewalks, the existing topography, designed vegetation plantings to accentuate planned vistas or obscure certain views, and the formal entry drive, allowing the visitor/patient to travel through the landscape from the public highway to the facade of the imposing main building. The main hospital buildings also became larger and more ornate as elevators encouraged the vertical rise of buildings, and administration, medical clinics, and services were consolidated into a single building. Second Generation Veterans Hospitals located on smaller campuses, such as those originally constructed near urban areas as general medical and surgical hospitals, were limited in their ability to include many of the naturalistic landscape design characteristics found at the larger campuses of the neuropsychiatric

¹⁹⁹ Ibid, 293–296.

²⁰⁰ Ibid, 302, 305.

²⁰¹ Ibid, 321.

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hospitals and the homes/general medical hospitals, although formal entry drives and ellipses could still be incorporated into the smaller hospital campuses. Similarities also exist in the architectural styles found at both Second Generation Veterans Hospitals and Army posts of the 1920s and 1930s. The Colonial Revival architectural style was utilized throughout the United States regardless of local building traditions, including the Northwestern states. The use of Spanish Colonial Revival/Mission Revival style was relegated to the southeastern and southwestern portions of the nation. Other architectural styles in very limited use found at both Army posts and veterans hospitals of the period include Tudor Revival and French Colonial Revival. In addition to common landscape and architectural treatments, Army posts and veterans hospital campuses also have categories of building function in common, such as gatehouses, hospitals, chapels, residential quarters, and garages. The standardized designs of quarters constructed during the late 1920s through the early 1940s for both Army posts and veterans hospitals appear to be very similar, especially officers' duplexes. The standardized designs of these duplexes, similar in massing, fenestration, materials, and architectural styles, appear to have been derived from examples being built during the same period in urban residential developments throughout the United States. These similarities between the development of Army posts and veterans hospitals suggest that these common evolutionary traits in landscape design and architectural style were not an isolated government endeavor, but were part of a national movement in planning and architectural taste, especially the late 1920s through 1942.

iii. Standards for Veterans Neuropsychiatric Hospitals Offered by the National Committee for Mental Hygiene

One of the groups interested in the design and construction of neuropsychiatric hospitals for veterans was the National Committee for Mental Hygiene (NCMH). This national committee had studied the plans for recently constructed hospitals caring for those with mental illnesses and the current treatments for those patients. This study began before the United States' entry into the Great War. The Surgeon General of the United States Army requested in 1917 that the NCMH examine the possible hospital requirements for veterans returning from military combat.²⁰² In 1922 the NCMH gathered a group of professionals in the field of mental illness to produce a report for the Veterans Bureau that discussed the principles of hospital construction for the treatment of disabled veterans suffering from mental diseases. Professionals serving in the group included Dr. William A. White, superintendent of St. Elizabeths Hospital, Washington, D.C.; Dr. F. F. Hutchins, clinical director in neuropsychiatry, Veterans Bureau; and Dr. Thomas W. Salmon, formerly medical director, NCMH.²⁰³ As stated in the report by the NCMH, with the number of returning veterans and the passage of the Langley Bill's construction program, "it was obvious that a hospital designed primarily for active treatment rather than a custodial 'asylum' type of structure was required."²⁰⁴

The first paragraph of the report discussing the requirements of constructing a group of neuropsychiatric hospitals for the treatment of World War I veterans addresses the adoption of a standard design for such a medical facility:

²⁰² William F. Lorenz, chairman, *Standard Neuropsychiatric Veterans Hospital* (New York, NY: National Committee for Mental Hygiene, 1925), 3–4.

²⁰³ *Ibid*, 5–6.

²⁰⁴ *Ibid*, 5.

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The adoption of plans and general specifications for a standard type of neuropsychiatric hospital for ex-service men insures great saving of time where a number of such hospitals must be constructed, either completely or in part; promotes uniformity in medical administration and in the housing and distribution of personnel; saves time through furnishing concrete ideas based upon research to the architects charged with developing the construction, thus eliminating the necessity for expensive and time-consuming study on their part; tends to eliminate errors that might be costly to correct if they were discovered later on; effects economy in construction through standardization of construction members and mechanical and therapeutic equipment; makes for uniformly high standards in treatment through providing in various parts of the country facilities possessing equal advantages and insuring the most efficient use of medical, nursing, and other personal services.²⁰⁵

The report includes suggestions concerning the size of the hospital, selection of locations, design of the overall facility, and plans for buildings serving patients with various mental illnesses. Exact specifications were not included, since they were to be determined in final architectural drawings, but it was requested that the final drawings be re-inspected by medical professionals to ensure there were no major omissions.²⁰⁶

Plans submitted in the report for neuropsychiatric hospitals were limited to hospitals with a 500 bed capacity that could be doubled in size. It was suggested that hospitals with over 1,000 beds not be considered. It was recommended that hospitals be located on sites of not less than 500 acres, especially those with possible expansion to 1,000 bed capacity. Those that were not expected to expand beyond the original capacity of 500 beds could be erected on a site of 250 acres. Tracts available for agricultural pursuits should be included within the property, allowing patients the occupational therapy of raising gardens, crops, and livestock. The hospitals, according to the recommendations, should be located near large population centers, especially those with existing medical facilities housing specialists. The proximity to cities would allow for recreational opportunities beyond the medical campus and for relatives to easily visit patients, while also offering the practical necessities of municipal utilities and coverage by local fire stations.²⁰⁷

The report discusses the "Cottage Type" general layout, where smaller cottages are utilized for smaller groups of ambulant patients. It suggests that the separated cottages provide additional protection from communicable diseases and allow the patients to work in the kitchens, thus decreasing the workload for hired attendants. The suggested layout of the campus includes three groups of buildings creating three courtyards or quadrangles. The first group includes the diagnostic and intensive treatment facilities, convalescent cottages, and buildings for treating tuberculosis and disturbed patients. The buildings of the second two groups, continued treatment and re-educational groups, are arranged around quadrangles.²⁰⁸

Included in the report are sketch plans for a two-story standard neuropsychiatric hospital constructed in an H configuration. This plan, "slightly modified from plans of the United States Public Health Service," also "forms a part of the standard hospital planned by the Treasury Department Committee of Hospital Consultants, [and] is recommended with certain modifications that have been inserted on the attached sketches."²⁰⁹ These two plans are similar in overall exterior plan to H-buildings

²⁰⁵ Ibid, 7.

²⁰⁶ Ibid, 8.

²⁰⁷ Ibid, 8–9.

²⁰⁸ Ibid, 10–11, 19.

²⁰⁹ Ibid, 7, 20.

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found at many Second Generation Veterans Hospitals. The two plans depicted in the report for the first and second floors are both labeled: "Standard Neuro-Psychiatric Hospital for US Veterans Bureau, Disturbed Patients Pavilion." Other similarities include the central entry along the main block, porches on both floors and along the facade elevations of the return wings, a central projection along the rear elevation of the main block, and the main block extending beyond the return wings along the side elevations. The interior corridors of the standard neuropsychiatric hospital plan are not double loaded, as are many examples of Period II H-buildings at Second Generation Veterans Hospitals. The overall size of the standard neuropsychiatric hospital building plan appears to be smaller than H-buildings constructed during Period II by the Veterans Bureau and Veterans Administration.²¹⁰

Also included is a plan for a tuberculosis pavilion labeled "Standard Neuro-Psychiatric Hospital for U.S. Veterans Bureau." According to the report this is the same standard plan issued by the Consultants on Hospitalization for the Treasury Department. The plan includes a narrow building approximately 260 feet in length with a corridor extending along the length of one of the exterior walls. Facade projections include sleeping porches, and the kitchen/dining room is located in a central rear extension.²¹¹

The report did not include a recommended sketch for a main building, or one containing the "Reception Service, Medical and Surgical Service, Diagnostic and Clinical Laboratory Service, and Medical Administrative Service, but recommends the careful reconsideration of the plans already in the possession of the Veterans Bureau."²¹²

The report of the NCMH recommended the use of a plan for a cottage used at Whitby Hospital in Whitby, Ontario, rather than the standard cottage plan issued by the Consultants on Hospitalization. To date, no re-educational or continued treatment cottages similar to those proposed in the NCMH report have been surveyed at Second Generation Veterans Hospitals. The report did approve the standardized plan of the convalescent cottage issued by the Consultants on Hospitalization for the Treasury Department.²¹³

iv. Consultants on Hospitalization, 1921–1923 (Period I)

a. Recommendations of Consultants on Hospitalization

The Consultants on Hospitalization committee was created by the Secretary of the Treasury, Andrew W. Mellon, on March 16, 1921. The committee, also known as the White Committee after its chairman William Charles White, first met in March 1921. The Consultants on Hospitalization consisted of four experts in the fields of psychiatry, general medical and surgical medicine, and nervous disorders. The committee was comprised of Dr. William Charles White, chairman (medical director of the Tuberculosis League Hospital in Pittsburgh, Pennsylvania); Dr. Frank Billings (dean of the faculty of Rush Medical College, Chicago, Illinois); Dr. John G. Bowman (chancellor of the University of Pittsburgh); and Dr. Pearce Bailey (former director of the National Committee for Mental Hygiene). Dr. George H. Kirby was appointed to replace Dr. Bailey after his death. Dr. Kirby was director of the New York Psychiatric Institute at Ward's Island, New York. The consultants received no pay for their

²¹⁰ Ibid, 21–22.

²¹¹ Ibid, 20.

²¹² Ibid.

²¹³ Ibid, 26–27.

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services to the committee. The Consultants on Hospitalization soon created an advisory committee made up of representatives of the PHS, Bureau of War Risk Insurance, NHDVS, National Tuberculosis Association, and the National Committee for Mental Hygiene. Numerous hearings were held, as many states and communities were vying for the infusion of capital that would accompany the construction of a new federal hospital in their locales. The committee's final report in 1923 included recommendations for the continuing study of hospitals in the nation, the creation of an office to disseminate advice about the locations and standardized plans for hospitals and campus buildings, and cooperation between states and the federal government in standards for hospitals, among other recommendations.²¹⁴

The report of the consultants indicates that portions of the early funds appropriated by Congress to meet the needs of disabled veterans were spent for the maintenance of existing facilities, as the general thought was that existing available hospitals were adequate to meet the current and future requirements of returning disabled veterans. Funds were spent on repairing existing Army cantonments and portable buildings utilized by the Army during the war, although the buildings were originally built for temporary use. The Consultants on Hospitalization worked toward the development of standardized plans for federal hospitals that included buildings of a permanent nature to be constructed from fire proof materials. The report states that standardized plans were developed with input from numerous sources, including representatives of the Supervising Architect's Office of the Treasury, the National Tuberculosis Association, the National Committee for Mental Hygiene, PHS, and Harry I. Schenck, an architect representing the NHDVS. The report specifically mentioned members of the Supervising Architect's Office of the Treasury Department (James A. Wetmore, acting supervising architect; technical officer George O. Von Nerta; and superintendent of the drafting division, Louis H. Simon) and Harry I. Schenck of the architectural firm Schenck and Williams of Dayton, Ohio.²¹⁵

A memorandum from June 1921 by George H. Kirby (one of the committee members of the Consultants on Hospitalization) and Thomas W. Salmon (representative of the National Committee for Mental Hygiene) explains the motivations behind the development of standardized construction plans for neuropsychiatric hospitals. The same rationale for using standardized plans could also be applied to tuberculosis and general medical and surgical facilities. The incentives for developing standardized plans include judicious use of time; consistency of staff accommodations; efficient use of monetary resources and time in the study and development of individual plans; eradication of costly mistakes that could be made in the planning of structures if each individual hospital was designed by various entities; cost savings by purchasing standardized materials, elements, and equipment; and the ability to provide equal medical treatment to patients via standardized designs and equipment throughout the country. The memorandum also includes the following suggestions for choosing a site and its relative size: acreage that can be utilized for agricultural purposes as a therapeutic treatment for patients, a location near population centers and existing medical facilities (if possible) to take advantage of nearby specialists, and availability of municipal services, such as water, sewage, and fire protection.²¹⁶

²¹⁴ *Report of the Consultants on Hospitalization*, vii-viii, 4-7; Weber and Schmeckebier, 161; "Annual Report, The Secretary of the Treasury, Hospital Program Under Public Act 384 As Amended," n.d. (an apparent partial draft assumed to be from 1921 or 1922), Entry 164 Box 19, Record Group 121, National Archives and Records Administration.

²¹⁵ *Report of the Consultants on Hospitalization*, 3, 16-17.

²¹⁶ Memorandum by George H. Kirby and Thomas W. Salmon, "Plan For Standard Neuro-Psychiatric Hospital," 21 June 1921, Entry 164 Box 27, Record Group 121, National Archives and Records Administration.

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After the creation of the Veterans Bureau in August 1921, the Consultants on Hospitalization decided that the director of the Veterans Bureau should be included in their consultations, even though the disbursement of funds from the first Langley Bill (Public Act No. 384, enacted March 4, 1921) remained under the control of the Secretary of the Treasury. Once the plans for projects had been prepared and approved by the Supervising Architect of the Treasury and then approved by the Veterans Bureau, the Consultants on Hospitalization retained final approval of the plans and the bids for the projects. Some sites selected by the Consultants on Hospitalization were the locations of World War I (or earlier) cantonments. Besides new construction, funds were spent for remodeling and repairs to buildings at these existing sites.²¹⁷

Drawings for the standard neuropsychiatric hospitals to be constructed with the oversight of the Consultants on Hospitalization were forwarded to the acting supervising architect of the Treasury at the end of July 1921. The Acting Supervising Architect was to produce a "master set of plans which shall be used as the basis for the construction of the N. P. [neuropsychiatric] hospitals in different parts of the country contemplated by Bill 384."²¹⁸ The standardized plans for the neuropsychiatric hospitals were to be 40 percent complete, so that the templates could be altered to better serve specific sites. The plans were then to be forwarded on to the NHDVS for its building projects.²¹⁹ Architect Harry I. Schenck of Dayton, Ohio, was apparently producing plans for three branches of the NHDVS at the same time.²²⁰ Blueprint copies for typical tuberculosis hospitals for the NHDVS were submitted to the committee by the Dayton, Ohio, architectural firm of Schenck and Williams on July 19, 1921. These plans were discussed and approved by the interested parties.²²¹

In April 1923, a Kraft paper sketch of a "General Scheme for Psychiatric Hospital" for the PHS was delivered to the Consultants on Hospitalization. The sketch has the hospital buildings separated by function into five general groups. The grouping is similar to hospital campuses of the Veterans Bureau and its successor, the Veterans Administration, although the location of buildings on campus was determined by the size and topography of each individual site. The assemblage of buildings illustrated on the sketch includes the central group consisting of the administration building, clinic, housing for nurses and attendants, therapeutic services, and a separate building for the kitchen and dining room. Other groups include the officers' quarters (small buildings facing an oval drive), buildings housing the chronic group with separate kitchen facilities, the industrial group for patients that are classified for vocational training (this area also has the railroad siding adjacent to the storehouse and power house), and a grouping of convalescent cottages. Also indicated on the sketch is a gymnasium and recreation

²¹⁷ *Report of the Consultants on Hospitalization*, 28–30, 39–40, 65–66; McDill, 35.

²¹⁸ Consultants on Hospitalization, William Charles White, Chairman to J.A. Wetmore, Acting Supervising Architect, Treasury Department, 2 August 1921, Entry 164 Box 27, Record Group 121, National Archives and Records Administration.

²¹⁹ Memorandum, Dr. William Charles White to Dr. Kirby and Dr. Salmon, 9 July 1921, Entry 164 Box 16, Record Group 121, National Archives and Records Administration.

²²⁰ Memorandum, "T.B. Standard Plans, N.P. Standard Plans," n.d., Entry 164 Box 27, Record Group 121, National Archives and Records Administration.

²²¹ H. I. Schenck of Schenck and Williams to Miss Heffner, 19 July 1921, Entry 164 Box 4, Record Group 121, National Archives and Records Administration; Jas. A. Wetmore, Acting Supervising Architect of the Treasury Department to Dr. William Charles White, Chairman, Board of Consultants on Hospitalization, 19 July 1921, Entry 164 Box 16, Record Group 121, National Archives and Records Administration.

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hall, and indicated beyond the edge of the sketch are athletic fields and a farm colony serving those patients with tuberculosis.²²²

The final report of the Consultants on Hospitalization was published in 1923 and stated that standardized plans for twenty-seven categories of building function for neuropsychiatric and tuberculosis facilities had been developed, including quarters for housing personnel and service buildings, such as the laundry, boiler house, storehouse, and garage. Upon the selection of a site for a new hospital or enlargement of existing facilities, the master sets of standardized plans could be utilized to assist in accelerating the construction process at the site. The final pages of the report include samples of the standardized plans with photos beneath the plans of completed buildings at various hospitals. A number of the plans for patients' buildings were in the form of an "H" with return wings or in the shape of an "I," with rooms or wards aligned along one side of a corridor and having a central rear wing. Most of the buildings illustrated in the photographs are single or two story, although some of the larger patient buildings are three stories in height.²²³

The standardized plans of the Consultants on Hospitalization placed patients in various buildings dependent on the classification of their illness. Neuropsychiatric hospitals included buildings with diagnostic facilities to conduct a diagnosis of the arriving patient and separate facilities for those classified as disturbed, as needing continued treatment, or convalescent treatment. Standardized designs for tuberculosis hospitals offered a single building that included administration offices and an infirmary, and detached buildings constructed for ambulant or semi-ambulant patients. Buildings for both warm and cold climates were developed for tuberculosis facilities. Included in the designs submitted by the consultants were plans for housing medical officers, nurses, attendants, and for support buildings such as a laundry, storehouse, boiler house, and garage.²²⁴

b. Hospital Construction Overseen by Consultants on Hospitalization and Treasury Department

The majority of projects overseen by the Consultants on Hospitalization and the Treasury Department were for tuberculosis and neuropsychiatric hospitals. A number were located at former Army posts, such as at Fort Logan H. Roots in North Little Rock, Arkansas, where seven buildings were repaired, fifteen buildings and quarters were remodeled, and a new mess hall (including laundry and ice plant) and two garages were constructed. Twenty-five buildings were remodeled at Fort Walla Walla, Washington, and new construction included a laundry, boiler house, and ambulant and semi-ambulant wards. Fort Logan H. Roots became a neuropsychiatric hospital and Fort Walla Walla was designated a tuberculosis hospital. Other projects that included new construction along with remodeling/repairs were located at Lake City, Florida (tuberculosis); the Bronx, New York City (neuropsychiatric); Whipple Barracks, Prescott, Arizona (tuberculosis); Fort MacKenzie, Sheridan, Wyoming (neuropsychiatric); Augusta, Georgia (neuropsychiatric); and Rutland, Massachusetts (tuberculosis). The Augusta, Georgia; Bronx, New York City; and Rutland, Massachusetts, facilities were preexisting and purchased

²²² Memorandum by D. St. J. Sweitzer, Office of Superintendent of Construction Treasury Department, to Miss Heffner, of Dr. White's office, "pencil sketch of a general scheme for psychiatric hospital," 6 April 1923, and the pencil sketch of the hospital scheme on Kraft paper, n.d., Entry 164 Box 12, Record Group 121, National Archives and Records Administration.

²²³ *Report of the Consultants on Hospitalization*, 17–18, 83–99.

²²⁴ *Ibid*, 16–18.

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by the Treasury Department. New construction of various buildings at existing sites under the direction of the Consultants on Hospitalization occurred at Perryville, Maryland (neuropsychiatric); Oteen, North Carolina (tuberculosis); Fort Bayard, New Mexico (tuberculosis); Alexandria, Louisiana (tuberculosis); Dayton, Ohio (NHDVS, tuberculosis hospital); Milwaukee, Wisconsin (NHDVS, tuberculosis hospital); and Marion, Indiana (NHDVS, neuropsychiatric hospital). Larger construction projects creating new hospitals supervised by the Consultants on Hospitalization include Chelsea (Castle Point), New York (complete tuberculosis hospital of approximately twenty buildings); Tuskegee, Alabama (complete tuberculosis and neuropsychiatric hospital for African-American veterans consisting of approximately thirty buildings); Palo Alto/Menlo Park, California (approximately twenty-three new buildings for a neuropsychiatric hospital); and St. Louis (Jefferson Barracks), Missouri (approximately nine new buildings for a general hospital).²²⁵

At Fort Logan H. Roots in North Little Rock, Arkansas, only two new garages and a mess hall were constructed, while the remainder of the buildings were remodeled or repaired. A photograph of the building constructed under the supervision of the Consultants on Hospitalization as the mess hall (that also included an ice plant, bakery, and laundry) was located at the National Archives and Records Administration. The photograph is dated April 4, 1922. This building (Resource 26) was built with a walkout basement along three elevations and a gallery along the east-southeast elevation of the basement. The first floor gallery has a wood railing with a center decorative element similar to porches on many duplex quarters constructed during Period II. The stucco exterior appears to exhibit no other decorative details.²²⁶ At North Little Rock, no buildings were constructed with the standardized designs published in the 1923 report issued by the Consultants on Hospitalization.

At Tuskegee, Alabama, a number of the standardized designs illustrated in the Consultants on Hospitalization's 1923 report appear to have been used, including the re-educational building design, the ambulant patients' quarters for a warm climate, and the large attendants' quarters building. The officers' quarters at Tuskegee follow local building traditions, with frame construction, wood siding, brick foundations, and porches.²²⁷

The medical buildings of Tuskegee are generally two stories (except for the main clinical building) with brick exteriors. Few ornamental elements decorate the buildings, so they appear to have been built to simply serve their functions with a minimum of expense. The campus design is in a modified grid pattern with the medical and administration buildings in the center of campus, service/maintenance buildings to the rear, and the quarters to the northeast of the medical group of buildings. The medical buildings were all oriented in the same direction, to the south-southeast. With the administration building opposite the main medical building, the main entry drive does not directly approach the facade of the largest building on campus. Instead, the entry drive intersects a perpendicular lane southeast of the main campus building. This may indicate that formal entry drives were a later development for Veterans Bureau and Veterans Administration hospitals.

²²⁵ *Report of the Consultants on Hospitalization*, 39–40; Adkins, 117–118; McDill, 35.

²²⁶ *Report of the Consultants on Hospitalization*, 39; Photograph, 4 April 1922, Fort Roots, Arkansas, Records of Collaborating Boards and Committees – Board of Consultants on Hospitalization, General Correspondence and Related Records, 1921–23, Entry 164, Box 7, Record Group 121, National Archives and Records Administration; Charles Roper, "Six-Hour \$600,000 Blaze Hits Ft. Roots," *Arkansas Democrat*, June 15, 1954.

²²⁷ *Report of the Consultants on Hospitalization*, 85, 92, 98.

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v. Continued Development of Standardized Plans, 1923–1950

a. Veterans Hospitals Designed and Construction Supervised by Army and Navy (Period I, continued)

The initial hospitals built after the creation of the Veterans Bureau and specifically under control of the Veterans Bureau were designed and constructed under the supervision of the Quartermaster Corps of the Army and the Bureau of Yards and Docks of the Navy. These hospitals were constructed with funds appropriated under the second Langley Bill (Public Act 194, passed April 20, 1922): a general appropriation of \$12 million and an additional \$5 million that the director could obligate for additional construction. Charles Forbes, the first director of the Veterans Bureau, decided the construction departments of the Army and Navy should supervise the construction of facilities at seven locations under the second Langley Bill.²²⁸ According to the 1922 *Annual Report of the Director United States Veterans Bureau*, “there was considerable delay in carrying out the program for additional hospital facilities” under the first Langley Bill, and after ten months “the Supervising Architect’s Office had expended only \$437,682 out of the \$12,240,000 finally allotted to this service for construction purposes.”²²⁹ Because of these delays and the perception that hospitals were being placed in areas that were not fully servicing veterans, Director Forbes decided to utilize the Quartermaster Corps of the Army and the Bureau of Yards and Docks of the Navy to design and supervise construction of hospitals under the second Langley Bill, rather than the Office of the Supervising Architect of the Treasury. The construction arms of the Army and Navy were used because only 3 percent of the construction expense for the hospitals could be charged to design and construction supervision, whereas private architectural firms would supposedly have charged a greater percentage.²³⁰ A July 1922 newspaper article states that “Colonel Forbes has decided that time can be saved and better buildings can be secured through the supervision of the Army and Navy.”²³¹

In March 1922 the Office of the Supervising Architect of the Treasury Department was concerned that legislation under consideration would transfer the responsibility for the planning of hospitals from the Treasury Department to the Veterans Bureau. When the hospitalization program for World War I veterans began, the Bureau of War Risk Insurance was organized under the Treasury Department. James A. Wetmore’s testimony, representing the Office of the Supervising Architect of the Treasury before the House Committee on Public Buildings and Grounds, revealed that since 1919 the Treasury had supplied the architectural services for the construction of veterans hospitals. Beginning in 1921, with input from the Consultants on Hospitalization and other parties, the Office of the Supervising Architect produced hospital plans, according to Wetmore’s testimony, that “represent, we believe, the last word in proper hospital construction for the care of these classes of diseases. As a result of all this,

²²⁸ “Army and Navy to Build Hospitals for Veterans,” *Army and Navy Journal*, about July 1922, Entry 164, Box 21, Record Group 121, National Archives and Records Administration; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 16.

²²⁹ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 16.

²³⁰ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 15–16; F. Charles Starr, “The Design of Neuropsychiatric Hospitals for World War Veterans,” *The Modern Hospital* 20, no. 5 (May 1923): 433.

²³¹ “Army and Navy to Build Hospitals for Veterans,” *Army and Navy Journal*, about July 1922, Entry 164, Box 21, Record Group 121, National Archives and Records Administration.

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our plans which have been prepared for hospital treatment of nervous and mental cases and tuberculosis are standardized."²³²

According to the 1924 *Annual Report of the Veterans Bureau*, new construction under the second Langley Bill through late fiscal year 1923 had also been accomplished by the Quartermaster Corps of the Army and the Bureau of Yards and Docks of the Navy, with "those offices preparing plans and specifications for new construction and providing field supervision during the execution of the work."²³³ The Quartermaster Corps of the Army and the Bureau of Yards and Docks of the Navy designed and supervised the construction of seven hospitals.²³⁴ The hospitals designed and construction supervised by the Quartermaster Corps of the Army included Northampton, Massachusetts; Camp Sherman (Chillicothe), Ohio; Knoxville, Iowa; Camp Lewis (American Lake), Washington; and Camp Custer (Battle Creek), Michigan. Hospitals designed and construction supervised by the Bureau of Yards and Docks of the Navy included St. Cloud, Minnesota and Gulfport, Mississippi. All seven hospitals designed by the Quartermaster Corps and the Bureau of Yards and Docks were neuropsychiatric hospitals. The hospitals at both Gulfport, Mississippi, and Knoxville, Iowa, included the purchase and improvements to existing buildings. Also under the second Langley Bill, a hospital in Memphis, Tennessee, was purchased, and an architect from San Francisco was preparing plans for a tuberculosis hospital in Livermore, California.²³⁵

The buildings and campuses were to be completed in an expeditious manner and "void of all unnecessary adornment."²³⁶ According to an article by F. Charles Starr—who was in charge of the Veterans Hospitals Construction Service, Quartermaster Corps, U.S. Army—the buildings of the second Langley Bill under his supervision were constructed of reinforced concrete columns and floors, brick walls, slate roofs, and were two stories or less in height.²³⁷ Starr also states that "intensive study was given every phase of the requirements and the best medical specialists consulted. In planning the hospitals not only the grouping of the buildings, but the arrangement of rooms was so worked out as to function best toward the end of bringing patients back to normal condition as quickly as possible. They are not asylums but hospitals, where men with diseased or unbalanced minds can be treated sympathetically, yet scientifically, and nursed back to health just as for any other disease."²³⁸

Starr continues to describe the locations of the hospitals in rural settings and the plan of the campus. He states: "In general the buildings are grouped according to their functions. The officers' quarters and nurses' quarters are near enough to the hospital for privacy. The business of the institution usually is carried on in a separate building near the entrance to the grounds, while the utility group is located at one side."²³⁹

²³² House Committee on Public Buildings and Grounds, No. 16, *Hearings Before the Committee on Public Buildings and Grounds, House of Representatives, on H.R. 8791, Additional Hospital Facilities*, March 9 and 10, 1922 (Washington DC: U.S. Government Printing Office, 1922), 17, located in Entry 164 Box 4, Record Group 121, National Archives and Records Administration.

²³³ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924*, 494–495.

²³⁴ Starr, 433–435.

²³⁵ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924*, 79; Starr, 433–435; McDill, 36.

²³⁶ Starr, 435.

²³⁷ *Ibid*, 439.

²³⁸ *Ibid*, 436, 438.

²³⁹ *Ibid*, 438.

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While the overall plans of the early campuses constructed by the Quartermaster Corps of the Army have similarities, the individual designs are also dictated by the topography. For example, the Chillicothe campus (dedicated in 1924) is located on a gradual slope overlooking the flat floodplain of the Scioto River. The campus as originally constructed was compact, with the original main/administration building in an H-shape and patient buildings surrounding a quadrangle to the rear. The quarters are aligned along the main drive, which extends past the facade of the main building. The service/maintenance buildings are located to the east-southeast and slightly downslope from the central campus.

The central buildings of the Northampton, Massachusetts, hospital campus (dedicated May 1924) are compactly arranged on a flattened hilltop surrounding a courtyard. The courtyard was surrounded by enclosed corridors, which were in turn encompassed by the patient buildings. The officers' and nurses' quarters are aligned along the long, formal entry drive that extends to the state road at the bottom of the hill. The utility/maintenance buildings were located near the bottom of the hillside adjacent to a railroad spur, providing shipping for supplies and materials.

The Battle Creek, Michigan, hospital (opened October 1924) is situated on flat terrain adjacent to the former site of Camp Custer, a large World War I (and later World War II) Army camp. The overall layout of the campus is reminiscent of Army camps in that the buildings are aligned along two parallel crescent streets that if continuous would form a complete circle. The main entrance drive extends to the facade of the main building, and the patient buildings are aligned along the northeast lane flanking the main building. The quarters are aligned along the southwest parallel lane, and all are oriented in the same direction, opposite the patient buildings. The Battle Creek campus, unlike the two previous facilities, originally did not have a quadrangle or courtyard incorporated into its design.

The Knoxville, Iowa, campus incorporated previously existing buildings constructed in the early twentieth century. The location was originally the site of the State Industrial Home for the Blind from 1892 to 1900. The location then contained the State Hospital for Inebriates beginning in 1902, but this facility operated for only a short time.²⁴⁰ The two preexisting buildings on the campus were designed by state architect H.F. Liebke of Des Moines for the State Hospital for Inebriates.²⁴¹ Both are three-story buildings with brick exteriors and banded brick along the foundations. Cottage No. 1 is a long, rectangular building, whereas the Administration Building is nearly square with a hip-roof. The Knoxville campus has Veterans Bureau buildings similar in design and function to the previously discussed facilities, but the buildings were not situated around a courtyard or quadrangle. The buildings are oriented to the major road along the front of the campus, and the terrain of the campus is relatively flat.

The buildings at Chillicothe, Ohio; Battle Creek, Michigan; Knoxville, Iowa; and Northampton, Massachusetts; all constructed by the Quartermaster Corps of the Army, are similar to those found at the Tuskegee, Alabama, campus, which was supervised by the Consultants on Hospitalization. The four Quartermaster Corps of the Army hospitals have two-story, H-shape main buildings with brick exteriors that are smaller than that found at Tuskegee, although the Tuskegee hospital was serving as both a tuberculosis and neuropsychiatric hospital. Otherwise the buildings of the four campuses are similar in massing, materials, and in the minimal decorative elements exhibited along the exterior elevations. As Starr states in his 1923 article, "In the detail design of the structures simplicity was

²⁴⁰ "The History of the Knoxville VA Medical Center," *Knoxville Journal-Express* (Knoxville, Iowa), November 6, 2009.

²⁴¹ United States Department of Veterans Affairs, files of the Engineering Department, Veterans Affairs Central Iowa Health Care System, Knoxville Veterans Affairs Outpatient Clinic, Knoxville, Iowa.

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sought, not only for its own merit, but because of limited funds which demanded it."²⁴² The only Colonial Revival decorative elements include formal entry surrounds, projecting pavilions with pediments, and occasionally a simple cornice detail. The officer's quarters of Knoxville, Iowa; Chillicothe, Ohio; and Northampton, Massachusetts were constructed in the Dutch Colonial Revival architectural style with brick exteriors, arched windows along the interior staircases, and gambrel roofs. The duplex officers' quarters of the Battle Creek campus exhibit rectangular massing covered by hip-roofs and also employ arched windows along the interior staircases.

The overall designs of the Second Generation Veterans Hospital campuses would continue to evolve along with the Colonial Revival and the Classical Revival architectural elements used in later veterans hospitals. But the grouping of buildings by function within the campuses would remain a constant through 1950.

b. Hospitals Constructed in the Late 1920s Through 1950 (Period II)

On June 10, 1923, the precursor of the Construction Division of the Veterans Bureau was created by a general order. The responsibilities of the Construction Division included the "preparation of plans, specifications and estimates covering construction, alteration and repair of plant and equipment, and the supervision of such work."²⁴³ Work underway by the Quartermaster Corps of the Army and the Bureau of Yards and Docks of the Navy was to be completed under their authority, whereas new construction and maintenance projects were begun under the authority of the newly created Construction Division of the Veterans Bureau, with bids being let to private contractors for the majority of the work.²⁴⁴ It was determined that costs could be better controlled with the consolidation of planning, design, and construction supervision within a single department of the Veterans Bureau.²⁴⁵

The Construction Division was later renamed the Construction Service, possibly after the creation of the Veterans Administration. As explained in Weber and Schmeckebier's 1934 publication, the Construction Service of the Veterans Administration was divided into three branches: the Office of the Director, Administrative Division, and the Technical Division. The Technical Division was responsible for "the preparation, plans, drawings, and specifications for new construction and alterations"²⁴⁶ and was further divided into the subdivisions for specifications, design, structural, and engineering. The architectural section, concerned with the construction of new buildings, was under the design subdivision.²⁴⁷ A 1933 memorandum by the Veterans Administration's director of construction, Louis H. Tripp, states: "Many standardized plans have been developed through the very close cooperation of the Construction and Medical Services" and that "The design and standardization of plans for hospitals must be entirely dependent on a thorough and intimate knowledge of the operating procedures and policies of the Medical agency which is to operate the institution. This situation exists at present to the fullest degree, and it would be exceedingly difficult to duplicate it in connection with an independent

²⁴² Starr, 439.

²⁴³ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924*, 497.

²⁴⁴ *Ibid*, 498–499, 506.

²⁴⁵ Memorandum, L.H. Tripp, Director of Construction, to Luther E. Ellis, Chief of Legislation and Regulations Division, 18 February 1933, MLR Entry A1 72 Box 9, Record Group 15, National Archives and Records Administration.

²⁴⁶ Weber and Schmeckebier, 322

²⁴⁷ *Ibid*, 321–322.

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construction organization.”²⁴⁸ As stated in a 1944 article, the Technical Division of the Construction Service for the Veterans Administration continued to work toward plans for hospitals that were both efficient and economical for the needs of both patients and staff. The staff of the Technical Division had experience working in various regions of the country and attempted to design the hospitals’ exteriors in keeping with the immediate vicinity’s historic building practices.²⁴⁹ While this may have been the intention of the Veterans Bureau/Veterans Administration construction divisions, in most instances this was not put into practice. As previously stated, the two most commonly utilized architectural styles for veterans hospitals during the years 1919 to 1950 were the Colonial and Spanish Colonial Revival/Mission Revival style, although most Third Generation hospitals constructed after 1945 utilized little if any ornamentation. Spanish Colonial Revival/Mission Revival styles, which are closely related architectural styles, tended to be utilized at veteran hospitals in the Southwest and deep South, including Tucson, Arizona; Palo Alto/Menlo Park and Los Angeles, California; and Bay Pines, Florida. The American Lake, Washington, campus in the Northwest also exhibits the use of the Spanish Colonial Revival architectural style. The Albuquerque, New Mexico, hospital exhibits a combination of Spanish and Pueblo Revival styles. Spanish Colonial Revival and Mission Revival architectural styles share characteristics such as exterior walls covered in stucco; arched window and entry bays; asymmetrical facade fenestration; unadorned exterior walls, or principal entries highly decorated with terra cotta surrounds; utilization of a tower or belfry; and roofs sheathed in clay tiles. Buildings exhibiting the Mission Revival architectural style, based on early Spanish missions in the Southwest, may also incorporate arcades surrounding interior courtyards. The Colonial Revival, with its symmetrical fenestration, red brick exteriors, and mixture of Georgian and Federal elements, was utilized in construction throughout the remainder of the nation, regardless of local building traditions. Examples of Colonial Revival style buildings are found at the campuses of Second Generation Veterans Hospitals in Lincoln, Nebraska; Batavia, New York; Fargo, North Dakota; Lyons, New Jersey; Lexington, Kentucky; Coatesville, Pennsylvania; and Tuscaloosa, Alabama, to name a few examples. Although the architectural styles of facilities in Cheyenne, Wyoming, and Lyons, New Jersey, may be different, the association between the two sites is evident through the similarities in massing and categories of building function, campus setting, and the grouping of similarly functioning buildings within the campus.

The planning for veterans hospitals was a collaborative effort between the Veterans Administration’s architects and doctors. Suggestions from medical professionals were utilized by the architectural staff in the continual updating of plans to provide efficient operations and medical care to the patients. The assemblage of detached buildings on a campus increased initial costs through the need to extend utilities underground and the construction of exterior connectors to provide weatherproof corridors to each of the buildings. It was determined that these initial costs, which put the infrastructure in place, were offset by the possibility of future expansion through the construction of additional buildings on the campus.²⁵⁰

²⁴⁸ Memorandum, L.H. Tripp, Director of Construction, to Luther E. Ellis, Chief of Legislation and Regulations Division, 18 February 1933, MLR Entry A1 72 Box 9, Record Group 15, National Archives and Records Administration.

²⁴⁹ Edwin B. Morris, editor, “Officials of the Veterans Administration,” *The Federal Architect* 13, no. 1 (October 1944): 19–20.

²⁵⁰ Edwin B. Morris, editor, “Hospital Planning in General,” *The Federal Architect* 13, no. 1 (October 1944): 37.

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Once the plans had been prepared by the Construction Division, or later the Construction Service, advertisements for bids were offered for the construction of a veterans hospital. The bids were examined by the Veterans Bureau and subsequently the Veterans Administration. The construction contract was usually let to a general contractor, who then may have dealt with numerous subcontractors. The Second Generation Veterans Hospitals were constructed by a number of general contractors, with a few of the hospitals initially constructed by the same general contractor. Examples of general contractors who constructed the initial buildings for a few of the Second Generation Veterans Hospitals include Morley Construction Company of Kansas City, Missouri (Batavia, New York²⁵¹); George A. Fuller Construction Company of Boston, Massachusetts (Northampton, Massachusetts²⁵²); Murch Brothers Construction Company of St. Louis, Missouri (Newington, Connecticut²⁵³; Lyons, New Jersey²⁵⁴); Ralph Sollitt and Sons Construction Company of South Bend, Indiana (Indianapolis, Indiana²⁵⁵); A. Bentley and Son of Toledo, Ohio (Battle Creek, Michigan²⁵⁶); L. Balkin Company of Chicago, Illinois, and Union Indemnity Company of New Orleans, Louisiana (Canandaigua, New York²⁵⁷); M.E. Gillioz of Monett, Missouri (Fayetteville, Arkansas²⁵⁸); National Construction Company of Atlanta, Georgia (Lexington, Kentucky²⁵⁹); Algernon Blair of Montgomery, Alabama (Roanoke/Salem, Virginia²⁶⁰); and James I. Barnes of Logansport, Indiana (Bay Pines, Florida²⁶¹). In many instances not all of the planned buildings were initially constructed, so different general contractors may have constructed later buildings, such as recreational buildings, quarters, connecting corridors, and patient ward/treatment buildings.

The late 1920s appears to have been a transitional period in the design of main buildings on the campuses of the Second Generation Veterans Hospitals. As stated previously, the main buildings of the early 1920s (Period I), especially those constructed under the supervision of the Consultants on Hospitalization, the Quartermaster Corps of the Army, and the Bureau of Yards and Docks of the Navy, were usually two-story, H-shape buildings with minimal ornamentation. The main buildings of the late

²⁵¹ "U.S. Government Hospital Site for War Veterans in Batavia Scene of Extensive Operations Despite Weather," *The Daily News* (Batavia, New York), December 12, 1932.

²⁵² John D. Kilpatrick and B. F. Vandervoort, Completion Report for U.S. Veterans Hospital No. 95 at Northampton, Mass., 1922–1924 (Northampton, MA: Office of the Constructing Quartermaster, War Department, Quartermaster Corps, Construction Service), 4, located in the Library of the Northampton Veterans Affairs Medical Center, Northampton, Massachusetts.

²⁵³ Bulkley S. Griffin, "New Hospital Contract Set At \$996,400," *Hartford Courant* (Hartford, Connecticut), February 5, 1930.

²⁵⁴ "Start Initial Work on Hospital," *Bernardsville News* (Bernardsville, New Jersey), July 11, 1929.

²⁵⁵ "Lowest Bid of \$487,000 by Ralph Sollitt and Sons Construction Company of South Bend," *Indianapolis Star*, January 22, 1931.

²⁵⁶ Tiffany B. Dzierman and Michael Stozicki. "Historic American Buildings Survey, United States Veterans Bureau Hospital No. 100," HABS No. MI-392. Giffels Consultants, Inc., Southfield, Michigan, 1993. Library of Congress, Prints and Photographs Division, Historic American Buildings Survey, Washington, D.C.

²⁵⁷ "New Complication Said Likely to Delay Opening of Hospital," *Ontario County Times-Journal* (Canandaigua, New York), January 13, 1933.

²⁵⁸ "Hospital Contract Is Awarded to Gillioz," *Fayetteville Daily Democrat* (Fayetteville, Arkansas), July 21, 1932.

²⁵⁹ "Contract Is Let for U.S. Hospital Here," *Lexington Leader* (Lexington, Kentucky), February 7, 1930.

²⁶⁰ "Five Contracts Used for Work," *Roanoke Times* (Roanoke, Virginia), April 28, 1935.

²⁶¹ "Barnes Awarded U.S. Contract on NHDVS," *St. Petersburg Advocate*, February 12, 1932, located in the "Bay Pines History: June 28, 1930 – Dec. 1932" archives binder at the medical library of the Bay Pines Veterans Affairs Healthcare System, Bay Pines, Florida, 1.

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1920s, those constructed in the Colonial Revival architectural style and utilizing Classical Revival design elements, appear to be a step in the design evolution of this category of functional building. These main buildings began to be constructed as larger monumental structures, and this period initiated the use of expressive, Classical Revival decorative elements, such as stone and terra cotta stringcourses and water tables; brick quoins; dormers; facade central projecting pavilions with pediments filled with oculus windows, terra cotta window surrounds, swags, and medallions; large porches with columns supporting entablatures; and prominent entry surrounds. Among the remaining examples of the evolving main buildings from the late 1920s are structures in Bedford, Massachusetts (1928), and Northport, New York (1928). These main buildings utilizing Colonial Revival architectural elements appear to be the precursor of the fully developed Classical Revival main buildings of the 1930s and early 1940s that continued to be monumental in size and incorporated terra cotta pilasters and panels; brick and terra cotta jack arches over the window openings; brick banding along the raised basements; large Doric columns supporting porticos; decorative wrought-iron railings and grilles; and cupolas featuring pilasters, balustrades, and urns. The main buildings of the 1930s reached the full expression of Classical Revival architectural style as it relates to Second Generation Veterans Hospitals.

The National Recovery Act of 1933 designated \$3 million and the Public Works Administration Appropriation Act of 1938 included over \$13 million in construction funds for Veterans Administration hospitals.²⁶² The Works Progress Administration (WPA) and the Public Works Administration (PWA), both New Deal initiatives of the 1930s, appear to have served a role in specific construction projects at several of the Veterans Administration campuses. A single-page, undated document located at the National Archives and Records Administration states the amount of WPA funds and "Sponsor's Contribution (PWA Funds)" that were apparently utilized for construction projects, or official projects, at Veterans Administration facilities. Twenty-three projects at eighteen veterans hospitals are listed on the document, with WPA monetary sums ranging from \$504 to \$150,428 per project. The WPA funding for the projects totaled \$557,694, and PWA funds totaled slightly over \$311,000.²⁶³ The types of projects funded by the WPA and PWA at the hospital campuses are not listed on the document, although a request for twenty common laborers through the WPA was placed in 1938 for construction projects at the Murfreesboro, Tennessee facility. The laborers were to be used for the placement of water, sewer, electrical, and steam lines, to construct sidewalks, and for the sowing of lawns.²⁶⁴

Forces outside the government sphere were emphasizing standardization of hospital care through a voluntary program of inspections. Created in 1912, the American College of Surgeons began inspecting and rating hospitals throughout the country in 1918. The organization established certain minimum requirements for rating hospitals in order to create a nationwide standardization of hospitals. The minimum standard was composed of five aspects, and hospitals voluntarily submitted to the inspection and rating. Prior to the American College of Surgeon's efforts, no comprehensive medical standards

²⁶² Committee on Veterans' Affairs, "History of Veterans' Administration Hospital Construction Programs," 83rd Congress, 1st Session, House Committee Print No. 5 (Washington, D.C.: U. S. Government Printing Office, 1953): 6.

²⁶³ Untitled document listing Veterans Administration stations, W.P.A. and P.W.A. funds expended on projects, undated, MLR Entry A1 72 Box 8, Record Group 15, National Archives and Records Administration.

²⁶⁴ J.M. Nixon, Manager, to William Oakes, Area Engineer, W.P.A. Office, 10 October 1938, United States Department of Veterans Affairs, Alvin C. York Veterans Affairs Medical Center Archives, Murfreesboro, TN.

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had been applied to hospitals in the United States.²⁶⁵ The Medical Council within the Veterans Bureau, created in 1924, suggested the bureau's hospitals be inspected by the American College of Surgeons. All fifty hospitals were inspected in 1925, with forty-five being fully accredited and two hospitals conditionally approved. The remaining three hospitals were soon accredited by the American College of Surgeons.²⁶⁶ The veterans hospitals, along with all government hospitals, continued to be surveyed by the American College of Surgeons. Twelve comprehensive surveys including government and civilian hospitals had been completed through 1936, with all government hospitals meeting the minimum standards from 1927 through 1936, including the seventy-nine facilities of the Veterans Administration surveyed in 1936.²⁶⁷

The use of standardized plans was viewed as both economically efficient and as an expedient method of construction. Whereas individualized buildings would be more time consuming to design and build and would increase the likelihood of errors, standardized buildings offered uniformity of design and health care that could be utilized throughout the nation.

vi. Four Sub-types of Second Generation Veterans Hospitals

Four sub-types of hospitals were designed, built, and/or operated from 1919 to 1950 within the purview of the PHS, Treasury Department, Veterans Bureau, and the Veterans Administration: neuropsychiatric, tuberculosis, general medical and surgical hospitals, and homes/general medical hospitals. Although the four sub-types of hospitals constructed for veterans during the years 1919 to 1950 share many similarities, they also have individual characteristics. The standardized designs developed by the Consultants on Hospitalization included specific buildings for neuropsychiatric, tuberculosis, and general hospitals. The Consultants on Hospitalization also established standardized designs for other buildings that continued to be modified by the Veterans Bureau and Veterans Administration. These evolving designs—such as for the administration building; quarters for staff; and support buildings, including a boiler house, garage, storehouse, and laundry—can be found at all four sub-types.²⁶⁸ The veteran's homes were originally branches of the NHDVS constructed primarily to offer domiciliary care and limited medical care to Civil War veterans. Funds were appropriated to the NHDVS for three additional facilities, but these three veterans homes/general medical hospitals were designed and operated by the Veterans Administration after its creation. All three of these homes/general medical hospitals opened in 1933 and are recognized as sub-type 4 within the Second Generation Veterans Hospitals. The three examples of sub-type 4 homes/general medical hospitals were constructed with both domiciliary and general hospital facilities. Although they utilize varying architectural styles, the main buildings of the Biloxi, Mississippi; Bay Pines, Florida; and Roseburg, Oregon; are similar, composed of multi-story, rectangular main blocks originally displaying open galleries along the upper floors. The patient/domiciliary buildings of the three campuses are also similar to each other. While the sub-type 4 facilities share commonalities with each other, they also have

²⁶⁵ W.B. Morse, "Standardization of Hospitals," *The American Journal of Nursing* 27, no. 2 (February 1927): 111–113; James S. Roberts, Jack G. Coale, and Robert R. Redman, "A History of the Joint Commission on Accreditation of Hospitals," *Journal of the American Medical Association* 258, no. 7 (August 21, 1987): 936–937.

²⁶⁶ Adkins, 134, 138.

²⁶⁷ "Nineteenth Annual Hospital Standardization Report," *Bulletin of the American College of Surgeons* 21, no. 4 (October 1936): 191–192.

²⁶⁸ *Report of the Consultants on Hospitalization*, 17–18.

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similarities with sub-groups 1, 2, and 3, such as conforming to the standardized campus designs of the Period II hospitals, with their detached buildings, buildings situated into three clusters serving similar functions, and similar functional building types within the campus. The other three sub-types, neuropsychiatric, tuberculosis, and general medical and surgical hospitals were designed and/or operated throughout the period of significance by the PHS, Treasury Department, Veterans Bureau, and Veterans Administration.

The October 1944 issue of *The Federal Architect* focused on the hospitals of the Veterans Administration in various articles describing the planning necessary for medical facilities; the location requirements; buildings found at neuropsychiatric, tuberculosis, and general medical and surgical hospitals; and floor plans of specific hospital buildings. This issue of *The Federal Architect* was especially beneficial in determining the sub-types of veterans hospitals. As stated in the conclusion section of the journal: "Successful hospital architecture is dependent on the realization by the architect that a hospital is a utilitarian building in which beauty, while present and always a factor to strive for, must of necessity be subordinated to the high purpose of a hospital, which is the alleviation of pain and suffering."²⁶⁹

a. Neuropsychiatric Veterans Hospitals (Sub-type 1)

In 1944 the Veterans Administration was operating thirty neuropsychiatric hospitals.²⁷⁰ Neuropsychiatric hospitals, like tuberculosis hospitals, were located in rural areas on large tracts of land. The Veterans Administration suggested in 1944 that neuropsychiatric hospitals should be located on tracts between 400 and 500 acres for a hospital with the capacity of 1,000 to 2,000 beds. The land should also accommodate agricultural pursuits for occupational therapy provided to the patients.²⁷¹ The buildings were constructed of fireproof materials, and sprinkler systems provided additional fire protection for the patients. The main building served as the focal point of the campus and by the 1930s consisted of a four- or five-story building containing clinical and administrative offices and a capacity of approximately 200 beds. Two-story ward/treatment buildings with a capacity of 100 to 200 beds were constructed on the campus to accommodate patients with varying degrees of mental illness. This separation of patients according to their level of illness was interpreted by the veterans hospitals as vital to the patients' recovery. Connecting corridors were constructed between buildings to shelter patients and employees from inclement weather conditions. The main and patient ward/treatment buildings, in many instances, were constructed in close proximity to one another surrounding a courtyard or quadrangle. The campus at Montrose, New York, exhibits the fully developed Period II design for a veterans neuropsychiatric Second Generation Veterans Hospital (Figure 3).²⁷² The development of the courtyard/quadrangle was dependent upon the topography of the site. The connecting corridors created an enclosed outdoor space for the patients that provided a safe environment but also confined the patients. The enclosed courtyards/quadrangles also provided

²⁶⁹ Edwin B. Morris, editor, "Conclusion," *The Federal Architect* 13, no. 1 (October 1944): 91.

²⁷⁰ Edwin B. Morris, editor, "Hospital Planning by the Construction Service of the Veteran's Administration," *The Federal Architect* 13, no. 1 (October 1944): 17.

²⁷¹ Edwin B. Morris, editor, "General Requirements for Hospital Sites," *The Federal Architect* 13, no. 1 (October 1944): 28.

²⁷² United States Department of Veterans Affairs, Engineering Department at the Veterans Affairs Hudson Valley Health Care System, Montrose Campus, Montrose, New York.

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patients with privacy from those visiting the campus.²⁷³ Buildings commonly associated with the campus of a veterans neuropsychiatric hospital include a main building, acute building, infirmary building, continued treatment building, parole building, kitchen/dining hall building, recreation building, residential quarters, connecting corridors, and the maintenance/utility buildings. The various treatment buildings allowed for the separation of patients according to their physical disabilities and neuropsychiatric symptoms, allowing patients to be surrounded by those with similar disabilities.²⁷⁴ One object located on each of the neuropsychiatric, tuberculosis, and general medical and surgical hospital campuses that should not be overlooked is the flag pole. The flag pole occupies a prominent position on each campus, usually directly in front of the main building. Many of the flag poles dating to the 1930s and 1940s have a large, decorative, octagonal poured concrete base. As stated in the 1944 issue of *The Federal Architect* that focused on Veterans Administration hospitals, during the daylight hours “flies the flag, a reminder of why the men are there and an eternal symbol of hope and rightness and confidence.”²⁷⁵

The Consultants on Hospitalization’s final report from 1923 included standardized designs for a re-educational building, continued treatment building, and disturbed patients building. All three were designed in a modified H-shape, although they were smaller than those constructed in later years (Period II).²⁷⁶ Similar buildings were constructed by the Quartermaster Corps of the Army at neuropsychiatric Veterans Hospitals between 1922 and 1924, but the majority of patient ward buildings constructed by the Quartermaster Corps of the Army were not full H-shapes. These buildings, which are not a fully articulated H-shape, had two projections along the facade flanking the main entry with return wings opposite the projections along the rear elevations. Similar building forms are also found at North Little Rock, Arkansas and Tuskegee, Alabama. The buildings at Tuskegee, Alabama, were completed under the supervision of the Consultants on Hospitalization. But the campuses completed by the Quartermaster Corps of the Army also included a few fully realized H-shape buildings. By the 1930s the majority of the acute, infirmary, continued treatment, and parole buildings on the neuropsychiatric veterans hospital campuses were constructed in H-shapes formed by main blocks intersected by return wings. Based on the exteriors the H-buildings are very similar, and currently it is not possible to identify their specific original function simply by an examination of the exterior of the building. Common features to all of the H-shape patient buildings and certain main buildings are two-story porches located along the facade or rear elevations or single story porches along the side elevations of the return wings. The majority of these porches have been enclosed with brick, but the original form of the porches remains visible. An example of a typical porch plan for an H-building is shown on the 1944 second floor plan of Building 68, a neuropsychiatric infirmary building at Tuskegee, Alabama (Figure 4).²⁷⁷

The initial costs for constructing neuropsychological veterans hospitals in campus settings appear to have been greater than similar facilities with centralized functions in a single building. With patients segregated in ward buildings based on the severity of their mental illness, a greater number of buildings had to be constructed for the facility, adding to the initial cost of the hospital. In many examples,

²⁷³ Edwin B. Morris, editor, “Hospital Planning in General,” *The Federal Architect* 13, no. 1 (October 1944): 37.

²⁷⁴ Edwin B. Morris, editor, “Design of the Neuropsychiatric Hospital,” *The Federal Architect* 13, no. 1 (October 1944): 39.

²⁷⁵ Edwin B. Morris, editor, “Editorial,” *The Federal Architect* 13, no. 1 (October 1944): 91.

²⁷⁶ *Report of the Consultants on Hospitalization*, 84–85, 87.

²⁷⁷ United States Department of Veterans Affairs, Engineering Department at the Central Alabama Veterans Health Care System-East Campus, Tuskegee, Alabama.

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expansion of the hospital was accounted for during the early design phase. The locations and functional types of buildings anticipated for future expansion were planned at the onset of the site design. Excess capacity in terms of the utilities, kitchens, and laundries were often included in the original plans. The decentralized design of the campus was costly at the onset because additional utilities, materials, and site preparation were necessary. The additional planning and site preparation allowed for reduced expenses once the expansion of the hospital took place.²⁷⁸

A general overview of a Veterans Bureau neuropsychiatric hospital is described in a 1928 address concerning the facility at Northport, Long Island, New York. The medical officer in charge of the hospital, which opened in that same year with twenty-four buildings, states that the campus included:

an administration building; a main hospital group comprising an infirmary building in which is located the admission ward, diagnostic clinic, various laboratories, the library, dental department and operating room, four continued treatment buildings, a building for acutely disturbed patients, recreation building and auditorium, and a building providing kitchen and congregate dining room facilities, all being connected by tunnels and surrounding a court comprising about eleven acres. The utilities group of buildings is composed of a laundry, warehouse, power house and garage. The personnel group consists of a nurses' home, two buildings for attendants, an apartment house and two duplex houses for medical officers, and a house for the medical officer in charge...[the campus] buildings are concrete, tile and brick, with slate roofs and stone trimmings.²⁷⁹

Rather than employing bars over the windows, the hospital utilized ornamental grilles over the lower half of the steel double-hung sashes and restricted the ability to open the upper sash. Areas with disturbed patients had windows with shatter-resistant glass, and porches were utilized on buildings housing patients.²⁸⁰

The main building of a second generation veterans neuropsychiatric hospital, serving as the focal point of the campus, commonly contained administrative and clinical offices. In some examples the regional veterans offices were located within the main building. The receiving wards of the hospital were located in the main building. The clinical offices included dentistry; x-ray; an ear, nose, and throat clinic; and therapy treatment for neuropsychiatric patients, such as hydro and electroshock therapies. The neuropsychiatric main building also contained facilities normally found in general and surgical hospitals, such as operating and recovery rooms (usually on an upper floor).²⁸¹

The acute building housed patients that were especially disturbed and at risk of endangering themselves or others. Those placed in the acute building were purposely separated so as not to hinder the recovery of other hospital patients.²⁸²

The infirmary building housed patients with both neuropsychiatric illnesses and physical deterioration to the point they could not care for themselves. The infirmary building often contains its

²⁷⁸ Morris, editor, "Hospital Planning in General," 37.

²⁷⁹ George F. Brewster, "Physical Features, Administration and Work of a U.S. Veterans Psychiatric Hospital," *The Psychiatric Quarterly* 3 (1929):42.

²⁸⁰ Ibid.

²⁸¹ Morris, editor, "Design of the Neuropsychiatric Hospital," 39.

²⁸² Ibid.

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own dining hall and serving kitchen, since many of the patients housed in this building type were often unable to leave their rooms or walk to the campus's kitchen/dining hall building.²⁸³

The continued treatment building housed neuropsychiatric patients that were physically fit and could join in occupational therapies on the campus. As stated in the 1944 issue of *The Federal Architect*, the continued treatment building "is for able-bodied patients suffering from chronic conditions without disturbing complications or who show a substantial degree of recovery but are still in need of restriction and observation."²⁸⁴

The parole building housed those patients who required little supervision and could care for themselves. The patients of the parole building also took part in occupational therapy programs and could use the facilities of the recreation building.²⁸⁵

The kitchen/dining hall building contained the kitchen and dining facilities for the employees and patients. Normally located directly to the rear of the main building and connected by an enclosed corridor, the kitchen facilities of the building could contain refrigeration and ice producing equipment, a bakery, food storage areas, and cooking capabilities to feed all of the patients three meals a day.²⁸⁶ Patients residing in the parole and continuing treatment buildings of the neuropsychiatric veterans hospital would take their meals in the kitchen/dining hall building. These patients would arrive either through the connecting corridors or by walking across the courtyards/quadrangles. Electrically heated carts could transport meals to patients residing in the infirmary buildings.²⁸⁷ In some examples, the kitchen/dining hall was combined with other services that might normally have been housed in separate facilities. Attendants' quarters were constructed on the second floor of some kitchen/dining hall buildings. The station garage and boiler house were appended to the kitchen/dining hall building at some locations, such as Tuscaloosa, Alabama, and Indianapolis, Indiana.

The recreation buildings of the Second Generation Veterans Hospitals constructed during Period II were usually second only to the main building in terms of exterior architectural decorative elements. Commonly constructed on a raised basement, the recreation buildings had an auditorium on the first floor. The auditorium had a stage for traveling shows and equipment for showing movies. The floor of the auditorium could be used for flower shows, banquets, parties, and other purposes. The basement often housed billiards and provided space for cards and other activities. Space for a library was also provided in many of the recreation buildings.²⁸⁸

The residential quarters on the neuropsychiatric veterans hospital campus housed the hospital's manager/director, officers, doctors, nurses, and attendants. Quarters were provided to assure that employees would be accessible when necessary. The manager/director usually lived in a detached single-family residence, while the officers or doctors were provided duplexes.²⁸⁹ The unmarried nurses and attendants lived in separate dormitory buildings that were usually rectangular in shape and two or three stories in height. The quarters were usually grouped together and distanced from the other buildings of the hospital campus. This distance from the neuropsychiatric hospital's patient and

²⁸³ Ibid.

²⁸⁴ Ibid.

²⁸⁵ Ibid.

²⁸⁶ Ibid.

²⁸⁷ Edwin B. Morris, editor, "Neuropsychiatric Hospital – Method of Feeding," *The Federal Architect* 13, no. 1 (October 1944): 61, 63–64.

²⁸⁸ Morris, editor, "Design of the Neuropsychiatric Hospital," 39.

²⁸⁹ Ibid.

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administrative buildings provided separation from the employee's work environment. In an attempt to provide additional seclusion, mature vegetation may also have been utilized to obscure employee quarters from the patient buildings.

Connecting corridors, as discussed previously, connect the patient buildings to one another and to patient services buildings, such as the main, kitchen/dining, and recreation buildings. Connecting corridors, also referred to as "tunnels" by some of the hospitals since they may be partially below grade, are normally not found in the quarters or maintenance/utility groups of buildings. Connecting corridors were not always included as part of the original construction, especially at neuropsychiatric hospitals of the early 1920s. Normally they extend from one building to another, but there are exceptions to the rule. The corridors of the North Little Rock, Arkansas, neuropsychiatric hospital (Veterans Bureau Hospital Number 78) are open-sided shelters constructed over the sidewalks of the facility. Designed and construction overseen by the Quartermaster Corps of the Army, the Northampton, Massachusetts, neuropsychiatric hospital (Veterans Bureau Hospital Number 98) was constructed on a hilltop with the connecting corridor surrounding the interior courtyard and the buildings located outside the connector with individual spokes extending from the oval-shaped connector. The original courtyard/quadrangle at the Chillicothe, Ohio, neuropsychiatric hospital (Veterans Bureau Hospital Number 97) has no connecting corridors.

The connecting corridors assist in the moving of patients for treatments, therapy, and meals, especially during inclement weather conditions. This is especially necessary in those portions of the country that experience severe winter weather. The courtyards/quadrangles formed by the connecting corridors and buildings created a secure and private environment for neuropsychiatric patients to enjoy outdoor activities. The corridors were constructed to be compatible with the architecture of the facility, and in many instances the corridors were built over trenches carrying utility and mechanical services for the campus buildings. Normally a single story or supported by a raised basement level, connecting corridors commonly have brick exteriors.²⁹⁰ Early examples of corridors are composed of brick supports, with stucco walls and windows filling the bays between the supports. Some corridors dating to the 1930s and 1940s have decorative arches or brick pilasters creating recessed bays. In some instances the bays were originally open, and in others they were filled with windows. Many of the corridors currently have replacement windows. Connecting corridors dating to the period of significance have been identified with gable, shed, and flat roofs. In some instances an additional story has been added to the corridors, providing direct access to the second floors of buildings, such as the main and kitchen/dining hall buildings. Corridors have been constructed on campuses to connect buildings built after the period of significance to the network of older structures.

The buildings of the maintenance/utility group are usually separated from the other campus buildings. If the topography allowed, the buildings of this group were located to the rear of the main and patient buildings. The maintenance/utility group of buildings at neuropsychiatric veterans hospitals include the storehouse; garage; boiler house and its associated stack; water tank/tower; fire station; laundry; and shops, such as the paint shop, carpentry shop, and metal shop. The hospital's farm buildings could also be categorized within this group, but were often distanced from the patient/ward buildings and maintenance/utility buildings.²⁹¹ The farm was an important component of the veterans neuropsychiatric hospital, providing occupational therapy to patients and fresh foodstuffs to the hospital

²⁹⁰ Edwin B. Morris, editor, "Connecting Corridors," *The Federal Architect* 13, no. 1 (October 1944): 90.

²⁹¹ Morris, editor, "Design of the Neuropsychiatric Hospital," 39.

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kitchen. Depending on the size of the farming enterprise, veterans neuropsychiatric hospitals raised gardens, crops, cattle, poultry (turkeys, chickens, and eggs), and swine, and operated dairies.

A long and narrow single-story building housing tuberculosis patients suffering from neuropsychiatric illnesses is often located on the campuses of veterans neuropsychiatric hospitals dating to Period I. These tuberculosis “cottages,” as they were referred to on early site plan maps, can be found at neuropsychiatric hospitals constructed by the Quartermaster Corps of the Army in the early 1920s.²⁹² A building constructed in a similar fashion but on a larger scale is located on the Tuscaloosa, Alabama, campus. This building, Resource 33, was completed in 1939 as a continued treatment building for neuropsychiatric patients. At approximately the same time as the completion of Resource 33, the Tuscaloosa, Alabama, facility’s designation was changed from a general medical and surgical hospital to a neuropsychiatric veterans hospital.²⁹³

An article in the 1944 issue of *The Federal Architect* describes some of the special features that were developed for neuropsychiatric patient buildings. In regards to the windows, decorative grilles were affixed on hinges to the exterior of the patient buildings’ windows. Steel double-hung sashes filled the windows of the patient buildings. The range of movement for the sashes was limited to provide a safe but secure environment for the patients. Examples of these steel window sashes can be found at a few of the veterans neuropsychiatric hospitals. Another safety and security feature found at veterans neuropsychiatric hospitals consisted of screens and grilles used for the two-story porches of the patient buildings.²⁹⁴ As stated previously, the majority of porches on these buildings have been enclosed, although a limited number of open porches exhibit woven wire screens.

b. Tuberculosis Veterans Hospitals (Sub-type 2)

According to an article in a 1944 issue of *The Federal Architect*, the Veterans Administration was operating twelve tuberculosis hospitals. These hospitals were located in California, Arizona, New Mexico, Texas, Missouri, Kentucky, New York, and Massachusetts. By 1944 the Veterans Administration required a tract of approximately 100 acres for the erection of a tuberculosis hospital with a capacity of 300 to 500 beds. This large amount of acreage was less than that necessary for neuropsychiatric hospitals, because the expected capacity was smaller for tuberculosis hospitals and the agricultural operations were less significant. The agricultural operations were smaller because the occupational therapy farming programs were not as extensive (or possibly even non-existent) in comparison to those of neuropsychiatric hospitals. Light outdoor activities such as walking were useful to ambulant patients that were beginning to recover from tuberculosis.²⁹⁵ The majority of occupational therapies for tuberculosis patients were practiced indoors.

The buildings of neuropsychiatric and tuberculosis hospitals were both constructed of fireproof materials and sprinkler systems provided additional fire protection for the patients. The main building served as the focal point of the campus and by the 1930s consisted of a four- or five-story building

²⁹² Starr, 434–436.

²⁹³ “Conversion of Facility at Tuscaloosa,” *Medical Bulletin of the Veterans Administration* 16, no. 2 (October 1939): 194.

²⁹⁴ Morris, editor, “Special Detention Features Neuropsychiatric Hospitals,” *The Federal Architect* 13, no. 1 (October 1944): 55, 57.

²⁹⁵ Morris, editor, “Hospital Planning by the Construction Service of the Veteran’s Administration,” 17; Morris, editor, “General Requirements for Hospital Sites,” 28.

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containing clinical and administrative offices and a capacity of approximately 200 beds. Two-story ward buildings with a capacity of 100 to 200 beds were constructed on the campus to accommodate patients with varying degrees of tuberculosis, a building practice similar to that of neuropsychiatric hospitals. Connecting corridors were constructed between buildings to shelter patients and employees from exterior weather conditions. The main and ward buildings in many instances were constructed in close proximity to one another surrounding a courtyard or quadrangle. The development of the courtyard or quadrangle was dependent upon the topography of the site.²⁹⁶

Similar to neuropsychiatric facilities, veterans tuberculosis hospitals were sited in rural areas on elevations higher than that of the surrounding terrain, if possible. While the elevated sites could provide the patients with improved ventilation within the buildings and expansive vistas, the prominent location also served as an expression to visitors and nearby communities of the Veterans Bureau/Veterans Administration's commitment to the physical rehabilitation and medical care of those who had made personal sacrifices by serving in the nation's military forces. Tracts with gradual slopes rather than steep inclines were favored, as were those that retained woodlands.²⁹⁷

As with the neuropsychiatric hospitals, the segregation of patients according to the degree of illness was observed at veterans tuberculosis hospitals. If possible, it was preferred that patients be separated into three categories of buildings according to the level of debilitation caused by the disease: infirmary, semi-infirmary, and ambulant. Standardized designs for the same building categories for tuberculosis hospitals were published by the Consultants on Hospitalization in 1923, although "semi-ambulant" was the preferred designation rather than "semi-infirmary."²⁹⁸

The infirmary building housed those patients suffering the most from the disease and contained numerous private rooms and small wards. The infirmary building by 1944 also included a substantial surgery department, as this type of treatment had been identified as useful in a number of tuberculosis cases. The surgical suite appears to have been placed on the top floor of the structure. In some examples the infirmary building may also have served as the campus's main building, housing the administrative and clinical offices similar to a general medical and surgical hospital. A general standardized floor plan of an infirmary for a veterans tuberculosis hospital is depicted in the October 1944 issue of *The Federal Architect*. The major difference between the tuberculosis infirmary building and patient buildings for neuropsychiatric hospitals is there are no return wings depicted in the floor plan. Dayrooms, normally located in the return wings, are not provided in the infirmary building, since most of the tuberculosis patients housed in these buildings were not capable of congregating for portions of the day in a single open space. Rather than providing two-story porches in the return wings, as in neuropsychiatric treatment buildings, the standardized infirmary plan illustrated in *The Federal Architect* has porches aligned along the facade and rear elevations. The patients' rooms, aligned along a double loaded corridor, open directly onto the porches. Although this mid-1940s plan probably evolved from earlier infirmary building designs, it continues to illustrate the reliance on fresh air and natural sunlight as a treatment for tuberculosis prior to the introduction of pharmaceutical therapies in the following decade. This same reliance on fresh air and sunlight is evident in the standardized plans

²⁹⁶ Morris, editor, "Hospital Planning in General," 37.

²⁹⁷ Morris, editor, "Hospital Planning in General," 37; Morris, editor, "General Requirements for Hospital Sites," 28, 30.

²⁹⁸ Edwin B. Morris, editor, "Tuberculosis Hospitals," *The Federal Architect* 13, no. 1 (October 1944): 85; *Report of the Consultants on Hospitalization*, 88, 91–91.

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for tuberculosis buildings published by the Consultants on Hospitalization in 1923, as porches and ribbons of windows were utilized, but on a smaller scale than the 1944 plan.²⁹⁹

The semi-infirmery building of the veterans tuberculosis hospital was for those patients who had progressed to the point that they could be relocated from the infirmary building. Patients requiring clinical care had to return to the infirmary building for these treatments. The semi-infirmery building by 1944 would contain small wards and dining halls. Dayrooms would also be included in the design of the semi-infirmery building. The “semi-ambulant” standardized building designs published by the Consultants on Hospitalization in 1923 for tuberculosis patients incorporated semi-private rooms, dayrooms (called sitting rooms), and small service kitchens. The ambulant, or convalescent, building of the tuberculosis hospital in 1944 was similar to the semi-infirmery building, but there was no kitchen included within the building. The patients were expected to take their meals in the dining hall building.³⁰⁰

Overall, the buildings found on a tuberculosis veterans hospital campus were very similar to those found at a neuropsychiatric hospital campus, other than the patient ward/treatment buildings. The buildings of the tuberculosis hospital would have been grouped together by function, just as those of the neuropsychiatric hospital.

c. General Medical and Surgical Hospitals (Sub-type 3)

The Veterans Administration was operating forty general medical and surgical hospitals throughout the nation in 1944, not including hospitals located at the Veterans Administration Homes. In that same year the Veterans Administration suggested that general medical and surgical hospitals be located on tracts of 50 to 100 acres, although hospitals located in downtown or urban areas could be placed on smaller parcels. Smaller acreage than was necessary for neuropsychiatric and tuberculosis veterans hospitals was acceptable because hospital stays for general and surgical patients were expected to be brief compared to patients of other types of hospitals. Larger tracts provided additional space for future development of the hospital. Rehabilitation therapy took place inside the hospital, and since turnover of patients was expected to be rapid, no outdoor occupational therapy programs, such as farming and landscape improvements, were utilized at general medical and surgical hospitals. Although the size of the campus was smaller than the other three sub-types of veterans hospitals, other determinants remained the same, such as location on elevated terrain, gradually sloping topography with no steep inclines, and a location adjacent to adequate transportation routes and generally removed from areas with noxious fumes and disturbing noises, such as industrial areas.³⁰¹

General medical and surgical hospitals, according to an article in the October 1944 issue of *The Federal Architect*, were usually constructed at the time as a single building in an H-shape with return wings housing the administration and clinical offices, wards, and surgical rooms. Figure 5 shows the various offices and clinics located on the first floor of the main building at Montgomery, Alabama.³⁰² The main building could possibly extend five stories in height. If possible, the main buildings of general medical and surgical hospitals incorporated porches for patients similar to those found on

²⁹⁹ Morris, editor, “Tuberculosis Hospitals,” 85; *Report of the Consultants on Hospitalization*, 88, 91–91.

³⁰⁰ Morris, editor, “Tuberculosis Hospitals,” 86; *Report of the Consultants on Hospitalization*, 88, 91–91.

³⁰¹ Morris, editor, “Hospital Planning by the Construction Service of the Veteran’s Administration,” 17; Morris, editor, “General Requirements for Hospital Sites,” 28, 30.

³⁰² United States Department of Veterans Affairs, Engineering Department, Central Alabama Veterans Health Care System-West Campus, Montgomery, Alabama.

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neuropsychiatric hospital buildings. Unlike neuropsychiatric and tuberculosis veterans hospitals, preference for the expansion of general medical and surgical hospitals was through wings added to the main building, rather than additional ward buildings constructed on the site.³⁰³ The buildings of the general medical and surgical hospitals were constructed of fireproof materials, and sprinkler systems provided additional fire protection for the patients. The main building served as the focal point of the campus.

The surgical suites were normally placed on the top floor of the general medical and surgical hospitals because it “insures quiet and less disturbance from the usual traffic within a hospital building and also minimizes the noise, dirt and other objectionable features, and often affords the opportunity for future expansion, if required”.³⁰⁴ Examples of operating rooms on the upper floors of general medical and surgical hospitals include those of Montgomery, Alabama, and Albuquerque, New Mexico (Figures 6 and 7).³⁰⁵ Air conditioning was only provided in the surgical suites in the mid-1940s. Additional patient facilities found in a general medical and surgical hospital in the mid-1940s included the canteen; pharmacy; post office; hydrotherapy; laboratories; x-ray facilities; ear, nose, and throat office; dental office; eye examination room; chief medical officer’s office; ward rooms; and showers and toilets.³⁰⁶

With fewer patients on a general medical and surgical hospital campus in comparison to neuropsychiatric and tuberculosis veterans hospitals, a reduced number of buildings are also located within this type of campus, such as at Albuquerque, New Mexico (Figure 8).³⁰⁷ Few general medical and surgical hospitals have H-buildings or other buildings constructed especially for patient care during the period of significance. The Newington, Connecticut, facility (dedicated in July 1931)³⁰⁸ was originally constructed with an additional general medical building in the form of a rectangular block with a central rear return wing. The Huntington, West Virginia, general medical and surgical hospital constructed an additional medical building in 1939.³⁰⁹ Additions to the general medical and surgical hospitals, especially large, flat-roof sections, were initiated in the 1950s. Original buildings located on the campus of veterans general medical and surgical hospitals are similar to those found at the other three sub-types of veterans hospitals of the same time period: kitchen/dining hall; recreation building; residential quarters; connecting corridors; storehouse; garage; boiler house and associated stack; laundry; water tank/tower; fire station; flagpole; and shops, such as the paint shop, carpentry shop, and metal shop. A separate administration building may have been constructed in certain cases, such as at Batavia, New York. The buildings were grouped together by function and would have been similar in design to veterans neuropsychiatric and tuberculosis hospitals.

³⁰³ Morris, editor, “Hospital Planning in General,” 37; Edwin B. Morris, editor, “Patient, Treatment, Service and Other Rooms in Neuropsychiatric, Tuberculosis and General medical and Surgical Hospitals,” *The Federal Architect* 13, no. 1 (October 1944): 89.

³⁰⁴ Edwin B. Morris, editor, “General Medical and Surgical Hospital,” *The Federal Architect* 13, no. 1 (October 1944): 75.

³⁰⁵ United States Department of Veterans Affairs, Engineering Department, Central Alabama Veterans Health Care System-West Campus, Montgomery, Alabama; United States Department of Veterans Affairs, Engineering Department, Raymond G. Murphy Veterans Affairs Medical Center, Albuquerque, New Mexico.

³⁰⁶ Morris, editor, “General Medical and Surgical Hospital,” 76–79.

³⁰⁷ United States Department of Veterans Affairs, Engineering Department, Raymond G. Murphy Veterans Affairs Medical Center, Albuquerque, New Mexico.

³⁰⁸ “Expect 5000 at Hospital Dedication,” *Hartford Courant* (Hartford, Connecticut), July 12, 1931.

³⁰⁹ “Progress of Major Construction Projects,” *Medical Bulletin of the Veterans Administration* 15, no. 4 (April 1939): 424.

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d. Veterans Homes/General Medical Hospitals Designed by the Veterans Administration (Sub-type 4)

With the passage of Public Law No. 536 on July 3, 1930, Congress authorized the combination of the Bureau of Pensions, the Veterans Bureau, and the NHDVS into a single agency. An Executive order dated July 21, 1930, created the Veterans Administration from the combination of the three previously autonomous governmental units.³¹⁰ Although the construction of the three veterans homes/general medical hospitals; located in Bay Pines, Florida; Biloxi, Mississippi; and Roseburg, Oregon; were funded through obligations approved prior to the creation of the Veterans Administration, they were designed and their construction was overseen by the new agency.³¹¹ These three facilities form a distinct sub-group within the Second Generation Veterans Hospitals, since they were designed as homes as well as general medical facilities. Domiciliary care was their primary purpose and substantial general medical facilities were also provided, illustrated by the 350 domiciliary and 191 hospital beds available at Roseburg, Oregon, on June 30, 1934.³¹² The three veterans homes/general medical hospitals were located on large tracts of land situated around ellipses (Figure 9).³¹³ The buildings were grouped into three clusters, similar to other sub-types of Second Generation Veterans Hospitals. The orientation of the buildings differs from facility to facility: at Biloxi many of the major buildings are oriented to the bay, with their rear elevation to the ellipse; at Roseburg the major patient buildings face the ellipse; and at Bay Pines, the buildings are oriented to either the adjacent bay or the ellipse. The buildings within the three campus settings are similar to one another, although different exterior stylistic treatments were utilized at each facility. The main buildings are multi-story, rectangular structures originally containing open porches along their upper stories. Kitchens and dining hall facilities were located in central wings to the rear of the main buildings. Commonalities shared by the four sub-groups include the use of architectural styles for buildings to create an architecturally cohesive campus scheme, similar functional building types, utilization of the natural terrain, and the campus plan with buildings of similar functions forming three groups. Cemeteries, a feature normally only associated with NHDVS branches, are also associated with the three sub-type 4 Second Generation Veterans Hospitals. While only a limited number of sub-type 4 facilities were constructed, their mission of providing domiciliary and general medical care to World War I veterans, and the architectural and landscape similarities connect this sub-type to the other three sub-types of Second Generation Veterans Hospitals.

III. Overview of Third Generation Veterans Hospitals

After World War II, the design of Second Generation Veterans Hospitals was modified, as newly designed buildings and landscapes reflected different philosophies in medical care for these new veterans. Some hospitals constructed through 1950, after the post-World War II design philosophies were adopted, continued to utilize design schemes developed for Second Generation Veterans

³¹⁰ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1931*, 9.

³¹¹ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1932*, 21.

³¹² *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1934*, 92.

³¹³ United States Department of Veterans Affairs, files of the Facilities Management Department, Roseburg Veterans Affairs Medical Center, Roseburg, Oregon.

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Hospitals. Because their built environment continues to embrace the Second Generation Veterans Hospitals' campus design, they are included in this context. Other veterans hospitals opening during the later years of the period of significance were designed with new ideas and visions for veterans health care, and their intra-campus spatial relationships varied dramatically from those of their predecessors. Third Generation Veterans Hospitals, or Bradley Hospitals, originated after World War II, when General Omar Bradley served as administrator of the Veterans Administration. General Omar Bradley, former Twelfth Army Commander in Europe during World War II, was sworn in as administrator of the Veterans Administration on August 15, 1945.³¹⁴ By February 1946 Administrator Bradley had embarked on a massive expansion of veterans hospitals through the construction of new facilities. Among the changes incorporated into the expansion of veterans hospitals after World War II, according to Bradley, was that "hospitals, wherever possible, will be built close to medical schools and centers, where doctors and other professional people can be brought into part-time association with VA's program for giving veterans a medical service second to none."³¹⁵ As early as 1923 in the Consultants on Hospitalization final report, it was suggested that the best health care was offered in medical teaching institutions and that the federal government should work with these teaching institutions in connection with providing health care for veterans.³¹⁶ Bradley's proposal for 183 new veterans hospitals included 49 neuropsychiatric hospitals, 105 general medical and surgical hospitals, and 29 tuberculosis hospitals.³¹⁷ To place the number of new hospitals in perspective, the Veterans Administration was operating 109 hospitals on June 30, 1946. Ten of these 109 hospitals appear to have been acquired during the previous twelve months from the United States Army for temporary use for veterans care. The impetus for this ambitious expansion program was the approximately 12.8 million World War II veterans that had been released from the military services and had returned to the nation's general population by the end of June 1946.³¹⁸

Bradley stated in a February 1946 newspaper article: "The new hospital planning program will bring a revised concept in the styles for new VA hospitals, of building vertically wherever possible, instead of constructing sprawling buildings which cover a good deal of ground...Especially in crowded cities, where land values are high, will the hospitals be built in the form of skyscrapers."³¹⁹ In another change from the previous leadership of the Veterans Administration, three outside architectural firms were "engaged to prepare plans" for the hospitals.³²⁰

Third Generation Veterans Hospitals were typically flat-roof, multi-story towers or H-shaped buildings built near existing medical schools, if possible. A large campus setting was no longer a prerequisite for the siting of the medical facility, because the multi-story tower could be constructed on a much smaller tract of land and within urban areas. The introduction of psychotropic drug therapy in the 1950s negated the need for large, rural campuses for neuropsychiatric patients. Agricultural pursuits and calming pastoral settings were no longer viewed as necessary treatment options for patients suffering mental illnesses. Some hospitals constructed after World War II and up to 1950 did

³¹⁴ Charles Hurd, "Bradley Is Sworn as Veterans Head," *New York Times*, August 16, 1945.

³¹⁵ "Veterans Will Get 183 New Hospitals," *New York Times*, February 17, 1946.

³¹⁶ *Report of the Consultants on Hospitalization*, 16.

³¹⁷ "Veterans Will Get 183 New Hospitals," *New York Times*, February 17, 1946.

³¹⁸ *Administrator of Veterans Affairs Annual Report for Fiscal Year Ended June 30, 1946* (Washington, D.C.: U.S. Government Printing Office, 1947): 1, 7–8.

³¹⁹ "Veterans Will Get 183 New Hospitals," *New York Times*, February 17, 1946.

³²⁰ *Ibid.*

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not incorporate the multi-story tower design. For example, the neuropsychiatric hospital at Montrose, New York, which opened in May 1950, continued to use Colonial Revival building designs, a campus plan, and H-buildings connected by corridors enclosing large courtyards. Incidences of tuberculosis continued to decline, and by the mid- to late 1940s this illness was beginning to be addressed by new pharmaceutical treatments. Therefore fewer tuberculosis hospitals were expected to be constructed. With air conditioning and other mechanical and medical improvements, the Third Generation Veterans Hospitals offered rooms and corridors designed around elevator shafts rather than focusing on plentiful natural ventilation, as had previously been the case.

While the Third Generation/Bradley Period introduced entirely new hospital complexes into the VA medical system, it also had significant impacts on existing Period I and Period II facilities. A transition in priorities from in-patient to out-patient medical care also prompted the VA to construct large clinics at numerous early-twentieth-century hospital campuses. The location and type of construction was dependent on the available space and topography of the targeted facility and could take several forms: sprawling, single-story buildings; multi-story towers, oftentimes occupying the open space of the original design; or large additions to existing buildings. This episode of new construction coincided with the increasing amount of paved surface for vehicle parking. Nationwide suburbanization trends in the post-World War II period created an increased dependency on personal automobiles, diminishing the utilization of public transportation. This applied to both staff serving at VA hospitals and visiting patients. New parking lots were introduced around existing buildings to support the limited time visits of new out-patient clinics. Internal roadways and entrances were improved to accommodate the increased vehicular traffic. Additionally, federal improvements to the public highway system, such as the construction of interstate highways, prompted the construction of new access points to intersect with the multilane roads. This forced the abandonment of original entries often connected to smaller local roads. An additional impact to Period I and Period II facilities associated with this trend was the reuse of on-campus residential buildings. As staff sought alternative living quarters, the need to house on-site attendants, nurses, and resident managerial personnel dwindled. The quarters originally built for this staff were converted into offices or storage, and modifications were frequently made to floor plans and original building materials, such as installation of energy-efficient replacement windows and enclosure of porches for additional offices. A third significant change during the Third Generation/Bradley period was the reduction of acreage once associated with several sub-types of VA hospital. Large tracts of land associated with agricultural endeavors were abandoned as therapeutic solutions shifted from active, outdoor endeavors to pharmaceutical and more passive, recreational pursuits due to the changing philosophies on occupation therapy for neuropsychiatric patients. This was so pronounced during the 1950s that virtually all farmland was transferred to other governmental or private entities. Similar trends are seen in tuberculosis hospitals. The drastic reduction of patients with this respiratory disease during the second half of the twentieth century reduced the demand for the construction of new patient wards, and land originally set aside for this purpose was no longer needed.

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F. ASSOCIATED PROPERTY TYPES

I. Name of Property Type: United States Second Generation Veterans Hospitals

II. Description:

Summary

The hospitals nominated as part of the United States Second Generation Veterans Hospitals Multiple Property Documentation form were created by the United States government between 1919 and 1950, principally for the care of veterans who served during World War I, but the care was eventually extended to veterans of other conflicts, such as the Spanish-American War and World War II. These were the first hospitals constructed on a nationwide scale by the federal government for the treatment of disabled veterans, leading to the largest hospital network in the nation. The hospitals were constructed over a thirty-one year period, including the boom years of the 1920s, the Depression era, and the years during and just after World War II. Hospitals dating to Period I (1919 to mid-1920s) were frequently added to former PHS hospitals, NHDVS branches, and Army posts and incorporated existing medical, domiciliary, and military buildings into their mission. The majority of those dating to Period II (late 1920s to 1950) were designed and constructed as entirely new veterans hospitals, although Second Generation Veterans Hospital buildings were also added to former NHDVS branches and military posts during Period II. The differences between the Period I and Period II Second Generation Veterans Hospitals demonstrate the evolution in both building and campus designs that occurred within the period of significance. Even though Second Generation Veterans Hospitals evolved over time they share similar design elements and as a result are recognizable health care facilities dating to this period. Some design elements, including the standardization of categories of building function and plans, were borrowed from earlier federal institutions, such as the NHDVS and/or Army posts. The campuses of the Second Generation Veterans Hospitals are easily differentiated from prior and later generations of medical facilities constructed for veterans care. The traits common to many of the Second Generation Veterans Hospitals include the four hospital designations (neuropsychiatric, tuberculosis, general medical and surgical, and home/general medical hospital); use of Colonial Revival and other nationally popular architectural styles; buildings serving similar functions at each facility; grouping of buildings by function; and landscape characteristics, including a campus setting.

Although no two campus plans are identical, owing to variations in topography, climate, and the parameters set to meet the needs of the hospital, similarities between the designs of the Second Generation Veterans Hospital campuses are evident. The hospitals can be divided into two construction periods and four campus sub-types; however, the overall characteristics of this group of federal hospitals serving the health care needs of the nation's veterans can be discussed in terms of hospital architectural styles, categories of building function, grouping of buildings within the campus setting, and characteristics of the campus landscape.

i. Periods of Construction

By analyzing information previously detailed in this nomination, the hospitals can be divided into two construction periods: the first period includes those hospitals that were constructed from 1919 to the

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mid-1920s; second period hospitals were constructed from the late 1920s through the end of the period of significance. Three of the hospital sub-types, neuropsychiatric, tuberculosis, and general medical and surgical hospitals, are found in both construction periods, but sub-type 4 (home/general medical hospital) hospitals were only constructed in the early 1930s. By design there are overlapping characteristics within the four sub-types of hospitals. But the evolutionary differences in the design of the hospitals constructed during the first period and those of the second construction period is clearly evident, as are the differences in the four sub-types that became the fully realized standardized designs for Second Generation Veterans Hospitals.

Period I: Hospitals dating from 1919 to mid-1920s

On March 3, 1919, Congress enacted the first appropriation to purchase or lease medical facilities for veterans of World War I. This legislation, Public Law, No. 326 of the 65th Congress (40 Stat. L., 1302), placed responsibility for medical care of World War I veterans with the PHS.³²¹ The legislation stated that the Treasury Department, which was over the PHS, was “to provide immediate additional hospital and sanitarium facilities for the care and treatment of discharged sick and disabled soldiers, sailors, and marines, army and navy nurses (male and female), patients of the War Risk Insurance Bureau.”³²² An appropriation of over \$9 million was included in the legislation for the Treasury Department to provide additional medical facilities for disabled veterans under the Bureau of War Risk Insurance. Five military hospitals were transferred to the PHS to provide additional medical facilities for veterans.³²³ In *Medical Care of Veterans*, author Robinson E. Adkins states “Public Law 326 was the first step toward what was to become the world’s largest hospital system.”³²⁴

The first facility obtained by the PHS under Public Law 326 was on April 1, 1919. This was the Camp Fremont post hospital in Menlo Park near Palo Alto, California, transferred by the War Department to the PHS.³²⁵ The initial Second Generation Veterans Hospital buildings were constructed from 1919 to the mid-1920s and included renovations to buildings at existing facilities, new individual buildings at existing facilities, and entirely new hospitals. The majority of these facilities were designed by the Consultants on Hospitalization in conjunction with the Office of the Supervising Architect of the Treasury, the Construction Service of the Quartermaster Corps of the Army, and the Bureau of Yards and Docks of the Navy. A number of the preexisting hospitals dating from 1919 to 1921 were originally under the control of the PHS, and buildings constructed on these campuses prior to the formation of the Veterans Bureau may have been designed by the Office of the Supervising Architect of the Treasury in conjunction with the Consultants on Hospitalization. Many of the PHS hospitals transferred to the Veterans Bureau were kept in service for only a few years. Buildings designed by the Office of the Supervising Architect of the Treasury in conjunction with the Consultants on Hospitalization were constructed at seven PHS hospitals and five NHDVS branches for tuberculosis and neuropsychiatric

³²¹ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1931*, 20; Adkins, 104; Weber and Schmeckebier, 156–157; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 4–5.

³²² Weber and Schmeckebier, 156–157.

³²³ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 4–5; Weber and Schmeckebier, 156–157; Adkins, 104.

³²⁴ Adkins, 105.

³²⁵ *Ibid*, 405.

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patients. Individual buildings were also constructed at former Army reservations that were being utilized by the PHS, such as Fort Logan H. Roots in North Little Rock, Arkansas, and Fort Walla Walla, Washington. These buildings normally follow the standardized designs developed by the Consultants on Hospitalization and the Office of the Supervising Architect of the Treasury.³²⁶

Seven of the hospitals constructed during Period I under the direction of the Veterans Bureau were designed and construction supervised by the Construction Service of the Quartermaster Corps and the Bureau of Yards and Docks. Five of the Period I hospitals were designed by the Construction Service of the Quartermaster Corps, and two additional hospitals were designed by the Bureau of Yards and Docks. All seven of these were neuropsychiatric hospitals.³²⁷ The hospitals designed by the Office of the Supervising Architect of the Treasury/Consultants on Hospitalization, the Construction Service of the Quartermaster Corps of the Army, and the Bureau of Yards and Docks of the Navy share common characteristics other than their period of construction. The buildings housing patients of varying degrees of mental illness at veterans neuropsychiatric hospitals designed by the Construction Service of the Quartermaster Corps appear to have been influenced by the Consultants on Hospitalization's standardized plans to a greater degree than those designed by the Bureau of Yards and Docks. Although these early hospitals and medical care buildings at existing facilities were designed by different federal agencies, similarities abound in the physical environment of the buildings and landscapes.

The veterans hospitals constructed during Period I, while sharing design similarities with the hospitals of Period II, are identifiable by the numerous distinctions in building and landscape design found within the earlier campuses. The majority of these hospitals were located in rural landscapes or within existing military posts, NHDVS branches, and PHS installations. The campus plans have similarities but are also dictated by terrain, climate considerations, and in the case of those located on former military posts, NHDVS branches, and PHS hospitals, existing site plans and buildings. Numerous preexisting military post buildings may be found within veterans hospital campuses of this period, such as North Little Rock, Arkansas; Walla Walla, Washington; and Fort William Harrison, Helena, Montana. The existing buildings at these locations may include former barracks, officers' quarters, kitchens/mess halls, and the post hospital. In certain examples the central core group of buildings is situated around a parade ground or courtyard, although more formal grid patterns of drives and buildings were also utilized. A courtyard may not have always been utilized in the design of the facility, as at Knoxville, Iowa, and Tuskegee, Alabama, where open spaces were left between the buildings, but no formal courtyard or parade ground is included in the overall campus design. The design of the Knoxville, Iowa, Chillicothe, Ohio, and St. Cloud, Minnesota, facilities utilized modified grid patterns, although Chillicothe also incorporated an oval drive with the central core buildings aligned along the edge of the oval. The Gulfport, Mississippi, facility featured the main building at the end of an oval drive and two large patient buildings situated to the front of the main building but on opposite sides of the drive. The campus layouts of the Period I hospitals, conceived as a complete entity, were normally linear in plan with modifications caused by topography, proximity to transportation routes (railroad and highway), and overall size of the property. There are exceptions to this rule, such as at Northampton, Massachusetts. Due to a lack of level terrain, the residences and maintenance/utility buildings were constructed along the slope or at the bottom of the hill at Northampton. Normally, the Period I hospitals also did not incorporate large courtyards enclosed by patient ward/treatment

³²⁶ *Report of the Consultants on Hospitalization*, 22–23.

³²⁷ Starr, 433–435.

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buildings connected by enclosed corridors or tunnels, as is often the case at Period II neuropsychiatric hospitals.

The spatial design of the Period I neuropsychiatric hospitals, in terms of building placement within the landscape, tends to be more compact than that of the same sub-type of hospital constructed during the Period II time frame. General medical and surgical hospitals were normally located on smaller tracts of land and consequently their three groups of buildings (central core, residences, and maintenance/utility groups) were constructed closer to one another. At Chillicothe, the residential quarters of the Period I neuropsychiatric hospital are constructed in close proximity to the central core group of buildings. At Knoxville, Iowa, the majority of the residential quarters were located across the public street from the central core buildings, although the female attendants' quarters were located directly to the rear of the kitchen/dining hall, and the maintenance/utility group of buildings was intermingled in the linear pattern of the central core group.

In terms of design, little formal landscaping was developed in the early 1920s for Period I hospitals designed by the Treasury Department, Construction Service of the Quartermaster Corps, or the Bureau of Yards and Docks. The primary goal was to quickly and efficiently construct the hospitals and transfer patients to the new permanent, fireproof buildings. Developing the landscape with formal planting plans to beautify the campus was not an important consideration at the time. It wasn't until later that the condition of the grounds was addressed and improved, usually with patient labor, especially at neuropsychiatric hospitals. The grounds of the Battle Creek, Michigan, neuropsychiatric hospital were improved through the planting of 9,400 trees between 1927 and 1930, whereas only 15 trees had been on the grounds at the time construction began on the facility.³²⁸ Although dedicated in July 1924, improvements to the grounds at the Chillicothe, Ohio, facility did not begin until the next year with the planting of nearly 600 trees in an orchard and the filling of ditches dating to the site's prior use for World War I military training³²⁹

The main buildings of Period I campuses were usually larger than patient ward/treatment buildings but only in massing. Most main and patient ward/treatment buildings were two stories in height, but the main building contained large return wings. The main block of the patient ward/treatment buildings was smaller than the main building and exhibited short projections along the facade with larger return wings containing porches along the rear elevations. The kitchen/dining room building, normally constructed to the immediate rear of the main building for Period II veterans hospitals, was often constructed along the courtyard or to the side of the Period I main building. The main building of the Period I hospital lacks the monumentality and massing of those found at Period II hospitals. Period I main buildings were the focal point of the campus primarily because of their location at the end of the linear main drives and the fact that they were the largest campus building. The buildings constructed for the Period I veterans hospitals exhibit limited exterior decoration, owing to the time constraints to open the hospitals and budgetary concerns. The decorative elements were normally confined to entry surrounds, keystones over facade window openings, and decorative brickwork usually found on the theater/recreation buildings. In certain examples the exteriors of the buildings are clad in stucco and the only visible ornamentation is the entry surround and a simple cornice. The main buildings at St. Cloud and Gulfport,

³²⁸ Barbara L. Hill, *The Quiet Campaign. A History of the Veterans Hospital, Battle Creek, Michigan*, 2nd ed. (Veterans Administration Hospital, Battle Creek, Michigan, 1973), 7.

³²⁹ *The Price of Freedom...A Brief History of the Chillicothe VA Medical Center*, VA Pamphlet 528-89 (Chillicothe, OH: VA Medical Center, 2004), n.p.; *Veterans Administration, Serving Veterans for 50 Years, 1930-1980* (Chillicothe, OH: VA Medical Center, 1980), 5-6.

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Mississippi, exhibit ornamental entry pavilions with stringcourses and pilasters, although the St. Cloud buildings are Colonial Revival while those at Gulfport are clad in stucco and have Spanish Colonial Revival exteriors. Both the St. Cloud and Gulfport buildings were designed by the Bureau of Yards and Docks of the Navy. The relatively simple architectural decoration of the buildings is a common trait among buildings dating to Period I. The majority of Period I veterans hospitals appear to have been constructed as neuropsychiatric hospitals, resulting in facilities built on large tracts of land to allow substantial farming operations as a form of occupational therapy. Neuropsychiatric hospitals of both construction periods I and II are comprised of a larger number of buildings to house patients than is found at the other three sub-types of hospitals, tuberculosis, general medical and surgical, and home/general medical hospital. New patient ward/treatment buildings continued to be constructed at Period I hospitals during Period II as the need for additional facilities arose. These new patient ward/treatment buildings were normally H-shape buildings that are very similar to those found at Period II veterans neuropsychiatric hospitals. Although these later H-buildings are larger than the original patient ward/treatment buildings with raised basements and fully articulated return wings along both the rear and facade elevations, the Period II H-buildings continued to exhibit similar exterior materials and Colonial Revival design elements.

A sampling of examples of veterans hospitals dating from 1919 to the mid-1920s includes Palo Alto/Menlo Park (Camp Fremont), California; Prescott (Whipple Barracks), Arizona; North Little Rock (Fort Logan H. Roots), Arkansas; Helena (Fort William Henry Harrison), Montana; Chillicothe, Ohio; Boise (Fort Boise), Idaho; Tuskegee, Alabama; Walla Walla (Fort Walla Walla), Washington; American Lake, Washington; Northampton, Massachusetts; Knoxville, Iowa; St. Cloud, Minnesota; Gulfport, Mississippi; Sheridan (Fort MacKenzie), Wyoming; and Battle Creek (Camp Custer), Michigan.

Period II: Hospitals dating from the Late 1920s to 1950

The Second Generation Veterans Hospitals constructed in the late 1920s through 1950 were designed and their construction supervised by the Construction Division of the Veterans Bureau and the Construction Service of the Veterans Administration. The majority of veterans hospitals constructed during Period II originally served as neuropsychiatric and general medical and surgical hospitals. As in the past, the primary purpose of a veterans hospital could be changed, therefore a general medical hospital could later be designated as a tuberculosis hospital or vice versa. The designation of a veterans hospital was fluid and could be changed dependent upon the patient load at the time.

The hospital campuses of Period II evolved from the designs implemented during Period I, incorporating many of the same building and landscape design elements but expanding the size of the main and patient ward/treatment buildings and increasing the exterior ornamentation of the most public campus buildings. The first change from the Period I buildings is the evolution in the design of the main building. By the late 1920s the main buildings became monumental in size compared to other buildings found on the hospital campus, with the main block rising three or four stories and a central pavilion possibly rising an additional floor. The central pavilion of these late 1920s main buildings dating to Period II could have flat roofs, whereas those of the 1930s displaying the Classical Revival architectural style often have front-gable or hip-roofs. The late 1920s main buildings also began to exhibit Colonial Revival and Classical Revival architectural details, such as elaborate facade entry surrounds and stairways, window surrounds, banded brick pilasters, brick banding along the raised basements, quoins, wide cornices or cornices composed of modillions, and the tympanum of the central facade filled with decorative elements. These decorative features were often composed of stone, concrete, or

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terra cotta. Administration buildings could also be located adjacent to the main building of the Period II hospital campuses of the late 1920s. Categories of hospital buildings began exhibiting a hierarchy of ornamentation within the hospital campus during Period II, with the main buildings displaying the most decorative elements, followed by the recreation building (an example of which is Building 4 at Des Moines, Iowa, Figure 10), quarters, and the patient ward/treatment buildings. The kitchen/dining building normally had little ornamentation, and the maintenance/utility group of building displayed little or no decorative elements.³³⁰

The evolution of the main building in the late 1920s was not the sole apparent change in the hospital campuses of Period II. The residence for the manager and duplexes for the officers' families also began to display the nationally popular Colonial Revival architectural style. While the manager's residence may be slightly different at Period II hospitals, constructed in the red brick Colonial Revival style, the duplexes at the various hospitals can be nearly identical. The same is true for the recreational buildings at the campuses utilizing Classical Revival and Colonial Revival stylistic influences, as this category of building is easily recognizable. While each recreation building is not identical and variations exist, the overall form and decorative elements are similar to one another in most examples. The H-buildings, although displaying limited architectural elements at those campuses with buildings utilizing the Classical Revival and Colonial Revival aesthetic, incorporate arched porches within the return wings or along the side elevations of the return wings. Flat-roof porches extending from the facade or rear elevation of the return wings are also found on certain examples of H-buildings.

Although the majority of Period II veterans hospital campuses were constructed with red brick buildings consistent with the Colonial Revival and Classical Revival architectural styles utilized for many federal buildings, a few of the Period II hospitals interpreted other nationally popular styles that were tied in some cases to local or regional building traditions. Period I similarly used locally popular building forms and styles for residence quarters, such as the cottages at Tuskegee, Alabama, or the bungalows and stucco covered buildings with Spanish tile roofs at Palo Alto/Menlo Park, California. The few Period II veterans hospitals that utilize other contemporary nationally popular architectural styles, such as Mission Revival and Spanish Colonial Revival architectural styles, have similar categories of buildings, but the building's form and footprint may not correspond to buildings with similar functions at Colonial Revival/Classical Revival buildings. Such is the case at Albuquerque, New Mexico, where the main buildings were built in the Spanish Colonial/Pueblo Revival; and Cheyenne, Wyoming, which utilized the Italian/Tuscan Revival architectural style. The irregular massing and asymmetrical fenestration of the main building is quite unlike the symmetrical massing and fenestration of the rectangular Classical Revival main buildings with their return wings. Other examples of campus buildings constructed in the Spanish Colonial Revival style that do not match the massing of their Classical Revival counterparts include single-story residential quarters (resembling bungalows), recreation buildings, and kitchen/dining hall buildings. Patient ward/treatment buildings constructed in an H-shape are very similar, utilizing various architectural styles. The maintenance/utility buildings are utilitarian structures and are also similar in massing, despite the use of different architectural ornamentation, although those exhibiting the Spanish Colonial Revival styles may have flat roofs. Although the public buildings and residences may not be physically similar, the campuses using the various architectural styles are identifiable as Period II veterans hospitals because of the campus setting; the monumental main building and flag pole serving as focal points of the campus; the buildings serving common specific

³³⁰ United States Department of Veterans Affairs, Engineering Department, Veterans Affairs Central Iowa Health Care System, Des Moines, Iowa.

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functions for groups of patients; the clustering of the buildings by function; the similarity of massing in H-buildings and maintenance/utility buildings regardless of the architectural style exhibited by the buildings; the creation of large courtyards encompassed by H-buildings and enclosed connecting corridors at neuropsychiatric hospitals; and the naturalistic use of the site's topography within the campus.

The treatment of the hospital's campus landscape also appears to have evolved during Period II from the earlier hospitals. Formal drives utilizing curves and the existing natural landscape appear to have been in greater use during Period II than previously, creating a more picturesque landscape. The topography and size of the hospital's campus played a determining factor as to the extent a curving, formal drive could be accommodated at the site. General medical and surgical hospitals, with their smaller tracts of land and locations closer to urban areas, often were prevented from having a long, curving drive, as many appear to have short, straight drives leading directly from the main entrance to the front of the main building. But even small campuses have curving drives and sidewalks that appear to make use of the natural topography, and rigid, straight grid patterns are rarely utilized unless dictated by the original tract. The veterans hospitals of Period II provide the impression of collegiate campuses through their mature trees and landscaping, numerous two-story patient ward/treatment buildings and quarters, spatial design between the buildings, setbacks from the adjoining streets and roads, and curving sidewalks and drives. Although the Period I hospitals may also share many of these qualities, the fully realized building designs of the 1930s and Period II provide a clear distinction between the two construction periods.

a. Sub-type 1: Neuropsychiatric Hospitals

The neuropsychiatric veterans hospitals can be treated as a separate sub-type among the four veterans hospital categories constructed during this period, which also include tuberculosis, general medical and surgical hospitals, and veterans home/general medical hospitals. While the four hospital sub-types share numerous common characteristics, there are also specific differences between each sub-type.

Neuropsychiatric veterans hospitals were located in rural landscapes on the outer fringes of a city or town. Situated on large tracts of land, neuropsychiatric hospitals normally contained the largest number of buildings and patients of the four sub-types of veterans hospitals. A primary reason for the larger tracts associated with neuropsychiatric hospitals, besides providing insulation from the diversions of the outside world, was the agricultural operations conducted as a form of therapy. The patients participated in the raising of gardens (both flower and vegetable), livestock, and crops, as well as working in greenhouses. Meat and vegetables produced by the patients were utilized by the hospital kitchens. With the sub-type 1 hospital located in pastoral settings and many of the patients from similar rural areas, the farming operations were seen as a therapeutic method of preparing patients to return to productive lives after treatment and also served as a way to subsidize operation of the hospital by supplying the kitchens with fresh food. With the introduction of psychotropic drugs for the treatment of neuropsychiatric patients in the 1950s and the increased availability of prepackaged foods, the agricultural operations at the sub-type 1 hospitals began to decline. Most farming endeavors at the hospitals appear to have ended by the 1960s. Few sub-type 1 hospitals retain any structural vestiges of the farming operations within their existing campuses. The Roanoke/Salem, Virginia, medical complex retains a barn and at least two other outbuildings associated with its former agricultural endeavors and Bedford, Massachusetts, retains a large barn predating the hospital.

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Neuropsychiatric hospitals contained the largest number of patients in comparison to the other three hospital sub-types. Distinctive, two-story H-shape buildings were built to house and treat the patients of the neuropsychiatric veterans hospitals. These H-buildings, built during Period II, were larger in size than the earlier patient ward/treatment buildings constructed during Period I. These patient ward/treatment buildings served specific patients according to their debilitation, and were broken up into acute, infirmary, continued treatment, and parole buildings. The larger H-buildings continued to be erected at neuropsychiatric hospitals dating to both Periods I and II through 1950. Few H-buildings were constructed at sub-type 3 hospitals (general medical and surgical hospitals), and there were none constructed at the homes/general medical hospitals (sub-type 4). The H-buildings were often built around courtyards/quadrangles with a number of the larger neuropsychiatric hospitals having two courtyards. In other examples, the H-buildings of Period II could be placed outside the original cluster of patient buildings, such as at Knoxville, Iowa, and Chillicothe, Ohio.

Examples of Period I neuropsychiatric hospitals either constructed originally or remodeled to serve that purpose include Knoxville, Iowa (opened 1920 as PHS hospital); Camp Custer, Michigan (later renamed Battle Creek, opened 1924); American Lake, Washington (opened 1924); Chillicothe, Ohio (opened 1924); and Northampton, Massachusetts (opened 1924). A sample of veterans hospitals originally constructed as neuropsychiatric hospitals during Period II includes Northport, New York (opened 1928); Bedford, Massachusetts (opened 1928); Lyons, New Jersey (opened 1930); Coatesville, Pennsylvania (opened 1930); Waco, Texas (opened 1932); Canandaigua, New York (opened 1933); Roanoke/Salem, Virginia (opened 1935); and Murfreesboro, Tennessee (opened 1940).³³¹

b. Sub-type 2: Tuberculosis Hospitals

Tuberculosis hospitals were located on large tracts of land but required a smaller area than neuropsychiatric hospitals. Located in rural areas on the outskirts of towns or cities, tuberculosis hospitals were commonly placed on tracts of approximately 100 acres for a hospital with a capacity of 300 to 500 beds.³³² Farm operations, it seems, were not utilized as occupational therapy at tuberculosis hospitals because of the physically debilitating effects of the disease on the patients.

Originally tuberculosis hospitals were constructed with three categories of buildings serving three specific categories of patient: infirmary, semi-infirmary (or semi-ambulant), and ambulant. As stated previously, the infirmary building housed veterans most disabled by the disease, and the prototype design depicted in the 1944 issue of *The Federal Architect* was a long, rectangular building without the return wings synonymous with the patient ward/treatment buildings in the H-shape found at veterans neuropsychiatric hospitals of the period.³³³ These infirmary buildings could often serve as the hospital's main building. The east wing of the Tuskegee, Alabama, main building served as the infirmary building for veterans suffering from tuberculosis. The Tuskegee campus was unique because it was constructed to serve African-American veterans and was originally a combined neuropsychiatric and tuberculosis hospital. The west wing of the main building served neuropsychiatric patients. An early drawing of the west elevation of the tuberculosis infirmary, dated March 10, 1922, was completed by the Office of the Acting Supervising Architect of the Treasury Department. This drawing depicts the elevation facing the

³³¹ Adkins, 395–399, 402–404, 406, 408.

³³² Morris, editor, "General Requirements for Hospital Sites," 28.

³³³ Morris, editor, "Tuberculosis Hospitals," 85.

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courtyard of the main entrance to the building and the neuropsychiatric wing.³³⁴ The three-story wing is a large rectangular building with windows lining the west and east elevations. Porches may have been located on the third floor of the east elevation, because the third floor is set back from the lower two floors of the building. The Tucson, Arizona, facility opened as a veterans tuberculosis hospital in 1928. This hospital was constructed in the locally popular Spanish Colonial Revival/Mission Revival architectural style. The main building of the Tucson campus is denoted as the infirmary building on an early elevation drawing dated June 30, 1927. It is a long, narrow, rectangular structure with the northern portion slightly angled. The asymmetrical building originally exhibited open galleries along the first floor of the facade and rear elevations and numerous open porches along the second and third floors.³³⁵ Other buildings located on the campus of a tuberculosis veterans hospital would have been similar to those of sub-types 1 and 3, although H-buildings apparently were not a common building form.

Tuberculosis cottages were constructed during Period I at neuropsychiatric hospitals to treat those with mental disabilities suffering from the disease. These cottages were normally long, narrow, rectangular, single-story buildings like those found at Knoxville, Iowa, and Northampton, Massachusetts. Period I tuberculosis hospitals, such as Walla Walla, Washington, may have buildings constructed for both ambulant and semi-ambulant patients. These two-story buildings, pictured in the Consultants on Hospitalization report, were also long and narrow with large window openings along the facade.³³⁶

While a number of tuberculosis hospitals opened between 1919 and 1950 to serve veterans, the majority had been closed or re-designated neuropsychiatric or general medical and surgical hospitals by the 1960s, as medicines had been developed to treat the disease. Because former tuberculosis veterans hospitals were reclassified to sub-type 1 and 3 hospitals as early as the 1930s, few intact examples remain. In addition, general medical and surgical hospitals were often re-designated tuberculosis hospitals or vice versa to serve the changing needs of the Veterans Bureau and Veterans Administration, as in the case of Indianapolis, Indiana, which was re-designated a tuberculosis hospital from a general medical and surgical hospital in the early 1950s.³³⁷ Twenty-two known examples of Second Generation Veterans Hospitals were originally constructed or operated to serve tuberculosis patients between 1919 and 1926. Of the twenty-two hospitals, only ten remain in operation. Since few Second Generation Veterans Hospitals originally constructed to serve as tuberculosis hospitals remain in operation, and those that do have re-designated missions, it is difficult to determine characteristics specific to this sub-type of hospital other than the three building categories designed for tuberculosis patients, which are normally located at Period I tuberculosis veterans hospitals.

Tuberculosis hospitals opened during Period I include (with opening and closing dates) Greenville, South Carolina (1919–1924); Alexandria, Louisiana (1919–1928); New Haven, Connecticut (1919–1927); Prescott, Arizona (1920–present); Tucson, Arizona (1920–1928); Fort Bayard, New Mexico (1920–1965); Tacoma, Washington (1920–1929); Oteen, North Carolina (1920–present); Lake City, Florida (1920–present); Camp Kearney, California (1921–1926); Dawson Springs, Kentucky (1922–1962); Las Animas, Colorado (1922–2001); Walla Walla, Washington (1922–present); Rutland,

³³⁴ United States Department of Veterans Affairs, files of the Engineering Department, Central Alabama Veterans Health Care System, East Campus, Tuskegee, Alabama.

³³⁵ United States Department of Veterans Affairs, files of the Engineering Department, Southern Arizona Veterans Administration Health Care System, Tucson, Arizona.

³³⁶ *Report of the Consultants on Hospitalization*, 91–94.

³³⁷ Adkins, 401.

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Massachusetts (1923–1965); Tuskegee, Alabama (1923–present, originally served as both a tuberculosis and neuropsychiatric hospital); Legion, Texas (1923–present); Tupper Lake, New York (1924–1965); Castle Point, New York (1924–present); Livermore, California (1925–present); Aspinwall, Pennsylvania (1925–present); and San Fernando, California (1926–1990s). Only one veterans hospital designated as a tuberculosis hospital appears to have been constructed during Period II (Tucson, Arizona).³³⁸ The hospital at Albuquerque, New Mexico, opened in 1932 with a main building serving general medical and surgical functions and a tuberculosis building having a capacity of 100 beds.³³⁹

c. Sub-type 3: General Medical and Surgical Hospitals

Numerous general medical and surgical hospitals were constructed during the period of significance by the Veterans Bureau and Veterans Administration. General medical and surgical hospitals did not rely on outdoor occupational therapies, and patients' length of stay was relatively short in comparison to patients at sub-type 1 and 2 veterans hospitals. The sub-type 3 hospitals, by not serving long-term patients that resided on campus, required fewer patient treatment buildings. Partially because of these factors, general medical and surgical hospitals could be placed on relatively small lots in urban areas or on the edge of towns and cities.

The buildings of the general medical and surgical hospitals served similar functions and were grouped together in the same way as those of the other three sub-types, into groups such as administration/central core, residence quarters, and maintenance/utilities (an example of this type of grouping can be seen on the Wichita, Kansas, site plan, Figure 11).³⁴⁰ But the number of buildings specifically serving patients was greatly reduced from those of sub-types 1 and 2. It appears that many of the general medical and surgical hospitals of Period II originally only had a large main building housing administration and patients (such as at Albuquerque, New Mexico, Figures 12 and 13).³⁴¹ Other examples had a separate administration building, although some of these were built after the initial construction. Additional patient buildings for Period II general medical and surgical hospitals were constructed as necessary, although they usually do not appear to have been built as H-buildings but with multi-story rectangular main blocks. In certain instances these rectangular main blocks also have rear central wings. Because of the smaller campus and workforce required for general medical and surgical hospitals in comparison to sub-types 1 and 2, fewer residential quarters buildings are located at the Period II hospitals. The proliferation of the automobile may also have created less need for housing employees on campus. Even though the patient treatment spanned a shorter length of time at general medical and surgical hospitals than hospitals of sub-type 1 and 2, many Period II hospitals of sub-type 3 have auditorium/recreation buildings. These recreation buildings are very similar to those found at other Period II veterans hospitals and were usually in close proximity to the main building. The smaller campus and fewer buildings also meant the physical plant could be smaller. The Period II

³³⁸ Ibid, 395, 397, 401–402, 406, 408.

³³⁹ 50th Anniversary Program Committee, *50th Anniversary Veterans Administration Medical Center, Albuquerque, New Mexico 1932–1982* (Albuquerque, NM: VA Medical Center, 1982): 9–10.

³⁴⁰ United States Department of Veterans Affairs, Engineering Department, Robert J. Dole Veterans Affairs Medical Center, Wichita, Kansas.

³⁴¹ United States Department of Veterans Affairs, Engineering Department, Raymond G. Murphy Veterans Affairs Medical Center, Albuquerque, New Mexico.

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general medical and surgical hospitals at Indianapolis, Indiana, and Tuscaloosa, Alabama, have boiler plants incorporated into the kitchen/dining hall building to the rear of the main building.

The smaller tracts of land on which the Period II sub-type 3 hospitals were located required the buildings of the separate groups, in a number of instances, to be situated more closely together. The quarters though were still located some distance from the main hospital building, such as at Huntington, West Virginia; Newington, Connecticut; and Fayetteville, Arkansas. But the maintenance/utility buildings were often in close proximity to the central core group of buildings. This configuration is found at the following examples of Period II hospitals: Newington, Connecticut; Huntington, West Virginia; Batavia, New York; Indianapolis, Indiana; and White River Junction, Vermont. The prerequisite that the Second Generation Veterans Hospitals be located on elevated terrain along with the requirement that smaller tracts of land be used for the sub-type 3 hospitals culminated in small tracts of land on hilltops in a number of examples. The slopes of the hillsides created a natural obstacle for incorporating later buildings and additions. Examples of sub-type 3 hospitals located on hilltops include Huntington, West Virginia; Montgomery, Alabama; and Des Moines, Iowa.

d. Sub-type 4: Veterans Home/General Medical Hospitals designed by Veterans Administration

The three home/general medical hospitals constructed by the Veterans Administration are located in Bay Pines, Florida, Biloxi, Mississippi, and Roseburg, Oregon. These sub-type 4 facilities were originally funded to serve as NHDVS branches, but they were designed and construction was overseen by the Veterans Administration, and although they include domiciliary functions not seen at other Second Generation Veterans Hospitals, they incorporate many of the design principles associated with the Second Generation Veterans Hospitals dating to Period II. The three facilities form a distinct sub-group within the Second Generation Veterans Hospitals. The sub-type 4 facilities were initially constructed to include general medical hospitals. By June 30, 1934, each of the three facilities had a capacity of 350 domiciliary beds and between 191 and 207 general hospital beds. The capacities of these three examples of Second Generation Veterans Hospitals were much smaller than the majority of First Generation facilities at the same date; for example, Los Angeles, California, had over 5,500 domiciliary and 1,200 hospital beds, and Dayton, Ohio, had over 3,100 domiciliary and 1,100 hospital beds.³⁴² These three homes/general medical hospitals were originally located on large tracts of land and incorporated cemeteries into their campus designs. Cemeteries are a common design element of NHDVS branches but not of the other sub-types of Second Generation Veterans Hospitals. At Roseburg the new facility was constructed on land adjacent to an existing state soldiers' home with a preexisting cemetery. The preexisting buildings of the Roseburg facility were initially utilized by the Veterans Administration.

Commonalities between all four sub-groups of hospitals include the campus design with detached buildings serving specific functions. The single architectural style utilized for the sub-type 4 buildings creates a cohesive campus setting that is also a characteristic of the other three sub-types of veterans hospitals. The campuses of First Generation Veterans Hospitals often incorporated various architectural styles as buildings were added to the facilities. The use of the natural attributes of a site, curvilinear drives and sidewalks, and open spaces provides a picturesque landscape found at both sub-type 4 homes/general medical hospitals and at many of the other three sub-type Period II hospitals. A

³⁴² *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1934*, 91–92.

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large central ellipse is a common landscape element of the three sub-type 4 facilities. The major buildings of the campus built to serve patients during the period of significance are situated along the edge of the ellipse. Both Bay Pines and Roseburg were expected to expand by continually adding patient buildings after the initial construction phase. Bay Pines was expected to ultimately house 4,000 patients, while a 1932 plot plan of Roseburg indicates that future buildings were envisioned to encompass the ellipse.³⁴³ Along with the ellipses and curving drives, the landscapes of the three sub-type 4 facilities include mature vegetation that adds to the natural setting. Both Bay Pines and Biloxi are situated adjacent to bays that contribute to the picturesque qualities of the veterans homes/general medical hospitals.

The monumental main building and flag pole originally served as the focal points of the sub-type 4 campus, a common trait with Period II veterans hospitals. Additional similarities between sub-type 4 and the other three sub-types of veterans hospitals include the clustering of buildings into three groups according to common functions. The three groups are the same as those found at the other three sub-types of veterans hospitals and include the central core buildings, residential buildings, and the maintenance/utility group of buildings. The main buildings of sub-type 4 facilities are of similar design, although they utilized different architectural styles, originally incorporating open porches along the upper stories of their facades and rear elevations. The porches provided areas for the patients and members to cool themselves in the summer months, especially in Biloxi and Bay Pines, where they benefited from breezes off the Gulf of Mexico. The other patient buildings exhibit rectangular massing but no return wings, as would be found on patient buildings at neuropsychiatric hospitals or main buildings at other Second Generation Veterans Hospitals. The manager's residence, duplexes, and maintenance/utility buildings at the Roseburg facility are nearly exact copies of similar examples at other Period II veterans hospitals utilizing the Colonial Revival and Classical Revival architectural styles. The maintenance/utility buildings of all three facilities are arranged along a common lane similar to many Period II hospitals.

The sub-type 4 facilities are small in number in comparison to the other three sub-types of Second Generation Veterans Hospitals. The mission of all four sub-types of facilities was to serve the medical needs of veterans, primarily those who served in World War I. The sub-type 4 facilities initially served as general hospitals and also offered domiciliary care to veterans. Sub-type 4 homes/general medical hospitals also incorporate many of the characteristics of the other three sub-types, including large tracts of land similar to sub-type 1 hospitals; campus designs with detached buildings serving specialized functions; the picturesque design of the campus incorporating the existing natural qualities of the sites, similar to other Period II hospitals; cohesive stylistic campus scheme created through the use of a single architectural style; monumental main building and flag pole serving as focal points of campus; similarities in the functional types of buildings to those found within the other three sub-types; placement of buildings serving similar functions into three clusters of buildings within the campus; the use of standardized designs for certain campus buildings (such as the duplex residences, maintenance/utility buildings, and the main buildings found within the three sub-type 4 campuses); and the placement of the maintenance/utility buildings along a common lane. These shared characteristics

³⁴³ "Room to Accommodate 4,000 Veterans," unknown newspaper, October 1931, located in the "Bay Pines History: June 28, 1930 – Dec. 1932" archives binder at the medical library of the Bay Pines Veterans Affairs Healthcare System, Bay Pines, Florida, 1; United States Department of Veterans Affairs, files of the Facilities Management Department, Roseburg Veterans Affairs Medical Center, Roseburg, Oregon.

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indicate the commonalities among all four sub-types of facilities and the basis for the inclusion of sub-type 4 facilities within the Second Generation Veterans Hospital typology.

e. Summary

The above generalizations are applicable to many of the Second Generation Veterans Hospitals constructed during Period II. Exceptions to the rule are to be expected since no two facilities are identical, even though standardized buildings were constructed on their campuses. Variations are common on the exteriors of buildings, and differences exist among the functional building types. Recreation buildings are an example of a functional building type that evolved through a number of incarnations dating from those of Period I to only a few variations of known designs by the early 1930s. The architectural style utilized for the campus, size of the property, climate, topography, and the hospital designation (tuberculosis, neuropsychiatric, general medical and surgical, and home/general medical hospital) all played a role in the design of buildings constructed on a Second Generation Veterans Hospital campus. It should also be noted that once a facility was constructed, it was never a static campus. Expansion of the campus through new permanent or temporary buildings or additions was continually being assessed by the Veterans Bureau and its successor, the Veterans Administration. With these reevaluations came new buildings to the campuses to meet changing requirements, which was a constant at the facilities throughout the period of significance. The annual reports of both veterans agencies include ongoing construction projects at the end of each fiscal year. It should also be noted that buildings associated with Second Generation Veterans Hospitals were also constructed during the period of significance on the campuses of the NHDVS branches.

ii. Building Functions and Architectural Styles

The Colonial Revival architectural style is utilized at the majority of Second Generation Veterans Hospital campuses. The use of decorative elements evolved throughout the period of significance, as time and financial constraints allowed minimal ornamentation for the Period I hospitals. The use of ornamentation expanded among the main and recreation buildings of the Period II hospitals, until the main buildings became monumental in size and prominently served as the focal points of the campuses. Other nationally popular architectural styles were also included among the Period I and II hospitals. The campuses entirely designed by the Veterans Bureau and Veterans Administration continued the original cohesive architectural style even with later additions to the campus through the late 1940s. The evolution of the decorative architectural exteriors and design of the buildings is clearly evident in the modifications made between Periods I and II, although there were overlapping design tendencies in the mid-1920s.

The majority of building functional types found at Second Generation Veterans Hospitals are similar, irrespective of the construction date or the sub-type. Specialized patient ward/treatment buildings are found at neuropsychiatric and tuberculosis veterans hospitals. Typical buildings/structures found at Second Generation Veterans Hospitals, according to function, include the main/administration building, kitchen/dining hall, recreation building, flagpole, patient ward/treatment buildings, connecting corridors, residential quarters, and maintenance/utility buildings. Commonly included within the maintenance/utility group are the laundry, boiler house and the associated stack, garage, fire station, warehouse, shops, and the water tower/tank. Agricultural buildings and outbuildings related to farm activities were often distanced from most of the other campus buildings, such as quarters, patient

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ward/treatment, and maintenance/utility buildings.³⁴⁴ Exterior corridors normally connect the central core group of buildings to one another, including the main/administration, kitchen/dining hall, recreation, and patient ward/treatment buildings.³⁴⁵

Administration/main buildings are commonly constructed in an H-shape and are closely associated with the kitchen/dining hall, recreation, and patient ward/treatment buildings, which normally constitute the core group of buildings. But not all administration/main buildings were constructed in an H-shape: those constructed in the Spanish Colonial Revival/Mission Revival/Pueblo Revival architectural styles are often rectangular in shape with asymmetrical fenestration. In many examples this central core group of buildings is situated around a courtyard/quadrangle that is enclosed by the connecting corridors. While normally two or three stories in height in examples from Period I, by the beginning of Period II these buildings had become monumental in size and noticeably ornamented, serving as the visual focal point of the campus.

The flag pole is a common object found at many Second Generation Veterans Hospitals, usually in a prominent position in front of the main/administration building. The substantial base is often constructed of poured concrete in an octagon shape.

In a number of examples, the hospital administration functions were located in a separate building within the central core group. The administration building may have been constructed initially with the original buildings or as a later campus addition. When constructed as a separate entity, the administration building is normally a two-story, multi-bay, rectangular structure. As with all buildings on the campuses of Second Generation Veterans Hospitals, the functions housed in the administration buildings have usually changed during the ensuing years, depending upon the needs of the hospital complex.

The kitchen/dining hall is a common building found at nearly all of the Second Generation Veterans Hospitals. These buildings could originally contain various support services, such as the kitchen/dining area, attendants' quarters, and storage space. In certain instances at general medical and surgical hospitals the boiler plant and garage are incorporated into the kitchen/dining hall building. These multi-story buildings may have a mixture of roof forms, including gable, hip, and flat. The kitchen/dining hall building will have restrained decorative detailing, with Colonial Revival examples usually limited to dormers, a cornice, simulated chimneys, stringcourse, water table, and windows with double-hung sashes. Vehicular entries with overhead doors and loading docks are also common to these buildings.

The recreation building, normally found in the central core group, is usually one of the most architecturally detailed structures on the hospital campus, second only to the main/administration building. This building, when constructed in the Classical Revival style, exhibits decorative elements such as simulated chimneys, roof balustrade, dormers, prominent cornice, columns supporting a portico, pilasters, quoins, jack arches over the windows, projecting pavilions, prominent entries with surrounds and pediments, and decorative railings. The recreation building will often have an auditorium with a stage area and recreation services that could include billiards, ping pong tables, and other leisure activities for the patients. Religious services may also have been conducted in the recreation building.

Patient ward/treatment buildings found at Period I veterans hospitals are often two stories with a rectangular main block and projections along the facade and rear elevations. The projections along one elevation are usually shorter than the return wings along the opposite elevation. Period I patient

³⁴⁴ Morris, editor, "Design of the Neuropsychiatric Hospital," 39.

³⁴⁵ Morris, editor, "Connecting Corridors," 90.

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ward/treatment buildings display little decorative treatment, such as an entry surround and simple cornice. The exteriors of the buildings are usually finished in brick or stucco. The patient ward/treatment buildings of Period II are commonly H-shape buildings with masonry exteriors and larger massing than buildings serving similar functions from Period I. Sub-type 1 hospitals commonly have the greatest number of H-shape patient ward/treatment buildings of the four sub-types. In a number of instances two or more enclosed courtyards/quadrangles may be created by patient ward/treatment buildings and connecting corridors at sub-type 1 veterans hospitals. The majority of these buildings, which are also found as later additions to Period I hospital campuses, have restrained characteristics of the Classical Revival architectural style. Examples of characteristic ornamentation found on Period II patient ward/treatment buildings include symmetrical fenestration, projecting central pavilions with the pediment filled with a lunette or circular vent, hip or gable roofs, decorative surround for the facade and possibly central rear entry, wood or terra cotta cornice, water table, brick quoins, brick banding along the basement level, and Flemish or common bond masonry exteriors. Those employing the Spanish Colonial Revival/Mission Revival architectural style usually have stucco exteriors and few decorative elements. Many of the H-buildings from Period II were originally constructed with open porches at the end or along the side elevations of the return wings. The smaller Period I patient ward/treatment buildings have similar porches, although with little decorative treatment. In the majority of the examined H-buildings, the porches have been enclosed with windows and masonry exterior walls. A limited number have been surveyed that remain open with metal screens.

Neuropsychiatric veterans hospitals (sub-type 1) were constructed with patient ward/treatment buildings serving specific purposes, including acute buildings for the treatment of those who require intensive treatment, an infirmary building for those patients that are bedridden or in need of constant care, a continued treatment building, and parole buildings for patients requiring little supervision. The sub-type 1 hospital could have varying numbers of H-buildings dating from Period II but of a type found at both Period I and II hospitals housing specific types of patients. Three categories of buildings relating to patient ward/treatment buildings would have been specific to the veterans tuberculosis hospitals (sub-type 2) during both Periods I and II: infirmary, semi-infirmary, and ambulant. Each of these buildings housed patients with varying degrees of physical debilitations caused by the disease.

The buildings associated with the general medical and surgical hospitals (sub-type 3) are similar to those found at sub-type 1 and 2 hospitals, except for the fact that other than the main/administration building, only a single patient ward building, or no building at all, was constructed on the campus during the period of significance. Patient turnover at sub-type 3 hospitals was high in comparison to sub-type 1 and 2 hospitals and therefore large campuses with the capacity for long term patients were not necessary. In certain examples, such as Indianapolis, Indiana, a patient ward building was constructed after the initial buildings.

The buildings associated with the homes/general medical hospitals (sub-type 4) constructed during Period II are very similar to those located at the other three sub-types of veterans hospitals. The sub-type 4 facilities originally provided general medical facilities, and domiciliary buildings not associated with the other sub-types of hospitals were located on the sub-type 4 campuses. Similar buildings found at all four hospital sub-types include the recreation building, manager's residence, duplexes, nurses' quarters, and maintenance/utility buildings, such as a garage, laundry, boiler plant and associated stack, and warehouse.

Chapels are found at the majority of Second Generation Veterans Hospitals but usually are located in an existing building, such as the main/administration or one of the patient ward/treatment buildings. Religious services may also have taken place in recreation buildings, if a specific space was not

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designated for a chapel. It is unclear whether or not chapels were located in existing campus buildings by World War II, but it's possible, since references are made to Quonset huts housing chapels after the Second World War because of limited space in the permanent hospital buildings. The dates for the initial movement toward providing chapels on the campuses of Second Generation Veterans Hospitals is unknown, although chapels were located on the campuses of the NHDVS.

Connecting corridors are common at the majority of Second Generation Veterans Hospitals. Built during the initial construction period or as later additions, the connecting corridors are one- or two-story structures that serve as connectors between the buildings that serve patients in the central core group. The connecting corridors provide patients and employees protection from the elements. Some of the connectors have been increased in height to accommodate a second floor. Other connectors are partially below grade and are often referred to as tunnels. The connectors commonly have brick exteriors that may be undecorated or have brick pilasters or arches creating divided wall planes. Some facilities have covered entries along the corridors that enclose courtyards, allowing motorized vehicles access to the area. As early as 1914, connectors consisting of tunnels with or without walkways overhead appear to have been common among government hospitals.³⁴⁶

Constructed as a detached single dwelling, the director's or manager's residence is a common building located at the majority of Second Generation Veterans Hospitals. Although the actual design differs at the various hospitals, many of the residences exhibit Colonial Revival decorative elements. Most do not have symmetrical facade fenestrations. The residences are similar to those constructed during the same period in many suburban developments.

Duplex quarters are a common building located within the residential quarters group at the majority of Second Generation Veterans Hospitals (Figures 14 and 15 depict examples of duplex quarters found at Montgomery, Alabama, and Newington, Connecticut).³⁴⁷ The duplexes normally have symmetrical fenestration and commonly exhibit Colonial Revival design elements with brick exteriors, although examples with stucco and wood siding have also been identified. Certain examples of duplexes examined from Period I were built in the Dutch Colonial Revival architectural style.

Nurses/attendants' quarters are common buildings found at many of the Second Generation Veterans Hospitals. The nurses/attendants' quarters are normally located within the residential quarters group of buildings and are composed of a two- or three-story rectangular block, although the actual design differs at the various facilities (Figure 16 is an example of a nurses' quarters located at Des Moines, Iowa).³⁴⁸

Another building commonly found at Second Generation Veterans Hospitals within the residential quarters group is the multi-bay garage. The garages were for the employees residing on the campus. Usually constructed of structural tile or concrete block, the garages commonly have shed roofs and a window or vent along the rear elevation for each facade bay.

Warehouses or storehouses are normally located in the maintenance/utility group of buildings, but they are also found in a number of instances to the rear of the kitchen/dining hall building. Warehouses

³⁴⁶ John Allan Hornsby and Richard E. Schmidt, *The Modern Hospital; Its Inspiration: Its Architecture: Its Equipment: Its Operation* (Philadelphia, PA: W.B. Saunders Company, 1914), 36.

³⁴⁷ United States Department of Veterans Affairs, Engineering Department, Central Alabama Veterans Health Care System-West Campus, Montgomery, Alabama; United States Department of Veterans Affairs, Engineering Department, Veterans Affairs Connecticut Healthcare System-Newington Campus, Newington, Connecticut.

³⁴⁸ United States Department of Veterans Affairs, Engineering Department, Veterans Affairs Central Iowa Health Care System, Des Moines, Iowa.

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are typically single-story, rectangular, gable-roof buildings with loading docks and brick or stucco exteriors.

The boiler house (or plant) is commonly located in the maintenance/utility group of buildings. The actual design may vary at each hospital, although the general form is normally composed of a multi-story, rectangular block with large window openings and vents projecting from the flat roof. A tall stack composed of structural tile or brick was originally associated with the boiler house, but in many instances the stack has been removed.

Water towers and tanks are located at many of the Second Generation Veterans Hospitals, although a number of campuses no longer retain the original structure but have a replacement water tower. Water towers are usually located in or near the maintenance/utility group of buildings, although examples are also found in the central core group of buildings.

a. Period I Veterans Hospitals (1919–to mid-1920s)

The Period I veterans hospitals appear to have been influenced by the designs of the branches of the NHDVS, as they incorporated a number of elements from the First Generation Veterans Homes. The major influence appears to have been the campus setting, with detached buildings serving specialized functions. The buildings were constructed for specific purposes, which included the segregation of members/patients according to the level of their disability/illness. The branches of the NHDVS and the Period I veterans hospitals also shared common functional building types, including main/administration, mess hall/kitchen, hospital, theater/recreation, staff quarters, laundry, boiler house, and various shop buildings. Chapels were located at the branches of the NHDVS, but stand alone chapels do not seem to have appeared on campuses of veterans hospitals until the Second World War. It is unclear if space for chapels was provided in existing buildings prior to World War II.

Where Period I hospital facilities were constructed at former military posts, existing buildings were remodeled by the Treasury Department, and a few new buildings might be erected. This was the case at North Little Rock, Arkansas, as only a handful of buildings were constructed by the Treasury Department. Those main/administration buildings constructed during Period I are normally H-shaped and are closely associated with the kitchen/dining hall and patient ward/treatment buildings. The patient ward/treatment buildings found at veterans hospitals dating to Period I are smaller than those constructed in later years, and they do not incorporate return wings on both the facade and rear elevations. In addition, the massing of early patient ward/treatment buildings is smaller than that of those erected during Period II.

The buildings of the NHDVS branches were constructed in various popular architectural styles incorporating elaborate decorative details nationally prevalent during the late nineteenth and early twentieth centuries. The NHDVS branches also appear to have been designed by numerous architects in private practice. In contrast, the Second Generation Veterans Hospitals built during Period I exhibit the Colonial Revival architectural style but with nominal decorative elements. Speed of construction and minimization of cost were two of the hallmarks of these early veterans hospitals. To meet the time constraints and lower expense costs, standardized plans were developed and utilized, resulting in similar buildings found at the Period I hospitals. Colonial Revival architectural characteristics associated with Period I hospitals may include hip or gable roofs; brick or stucco exteriors; dormers; pediments with lunettes; simple molded or dentil cornices; symmetrical facade fenestration; projecting central pavilions; central facade door surrounds of stone or terra cotta; fanlights over secondary entries; tripartite windows; and windows filled with double-hung, multi-light sashes. The buildings of Period I

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were designed by government architects with input from various medical professionals. While the branches of the NHDVS were developed to meet the long-term residential needs of their members with minimal medical care and a military style environment, the Period I veterans hospitals were constructed to rehabilitate and heal disabled soldiers in an expeditious manner, as patient turnover was expected to be, if not rapid, continuous.

The majority of veterans hospitals built during both Periods I and II utilized the Colonial Revival architectural style that was nationally popular during the first half of the twentieth century for residential, institutional, and government buildings. The Colonial Revival style includes decorative references from the early history and various regions of the United States and can also be further categorized into the Classical Revival, Spanish Mission Revival, Spanish Colonial Revival, Tudor Revival, and Dutch Colonial Revival, among others. The buildings utilizing the Colonial Revival style are not exact reproductions of colonial structures, as massing can be enlarged and decorative elements from different time periods can be merged into a single building.

b. Period II Veterans Hospitals (late 1920s–1950)

Veterans hospitals of Period II exhibit greater use of Colonial Revival ornamentation than those of Period I, especially the main, recreation, and residential quarters buildings utilizing Classical Revival decorative elements. Additional decorative elements commonly found on Period II main and recreation buildings include terra cotta pilasters, large columns supporting entry porticos, pediments filled with lunettes or medallions, wide cornices with modillions and dentils, decorative brickwork above window openings and along the raised basements, quoins, and fanlights over main entrances. The main buildings of Period II became monumental in size and the focal point of the campus. Additional nationally popular architectural revival styles were employed for veterans hospitals during Period II. Although no two hospital campuses are exactly the same, the standardized architectural styles employed for the four sub-types of hospitals allowed similar if not exact copies of buildings to be constructed at different campuses.

The main/administration buildings continued to evolve in the late 1920s, becoming monumental in size in comparison to those of Period I and utilizing additional Colonial Revival decorative elements along the facade and side elevations. This is clearly evident in the main buildings of both the Bedford, Massachusetts, and Northport, New York, neuropsychiatric veterans hospitals. The main buildings of both hospitals, dating to 1928, exhibit three-story central mass projections with elaborate door surrounds, brick banding along the raised basements, water tables, quoins, and dormers. The central masses of both buildings have flat roofs and they extend a full story above the main block. The decorative elements are more abundant than those of Period I but are not at the level of the fully realized buildings that began to be constructed in the 1930s. Classical Revival architectural elements were utilized to some degree for the main buildings of the late 1920s, but additional characteristics are found on main/administration and recreational buildings dating to the remainder of Period II. The main buildings of veterans hospitals constructed in the late 1920s through 1950 exhibit Colonial Revival elements, such as symmetrical fenestration; projecting pavilions; decorative entry stairs and entrances; entry porticos with columns; pediments filled with lunettes or terra cotta medallions; modillion and dentil cornices; slate or tile roofs; brick chimneys (or faux chimneys); cupolas; dormers; stringcourses; water tables; brick banding along raised basements; jack arches over window openings; two-story porches with arched openings along the side elevations of the main block or rear elevations of the return wings; and windows filled with double-hung, multi-light sashes. The cupolas crowning the main buildings

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provide further emphasis that these structures served as the focal point of the campus during Period II. The same decorative features were utilized for all four sub-types of veterans hospitals constructed during Period II if the facilities were constructed in the Colonial Revival style. The use of the Colonial Revival architectural style promoted the influence of the Veterans Administration and its precursors by serving as a physical reminder of the early struggles in the formation of this country and the leaders that persevered in the creation of the United States. This veneration for the origins of the nation is the understood basis for the popularity of Colonial Revival architectural styles.

While the Colonial Revival architectural style utilizing Classical Revival decorative elements was the most widely employed for veterans hospitals during Period II, other architectural styles were utilized on a limited basis. Sub-type 1 veterans hospitals utilizing other architectural styles include those in Waco, Texas (Italian Renaissance Revival); Canandaigua, New York (Jacobethan Revival); and Murfreesboro, Tennessee, where the buildings exhibit a mixture of Colonial and Greek Revival influences. Other eclectic architectural styles employed for select sub-type 3 veterans hospitals from Period II include the French Colonial architectural style associated with New Orleans (Alexandria, Louisiana); Egyptian Revival (Marion, Illinois); and Mayan Deco, a variant on the Art Deco architectural style (San Francisco, California). The Spanish Colonial Revival/Mission Revival architectural styles were employed at sub-type 3 and 4 hospitals of Period II in the South and Southwest.

In the reviewed literature it is often stated that local building traditions were referenced in the design of the Second Generation Veterans Hospitals. While this may be proved in a limited number of examples, such as the Period II Spanish Colonial Revival/Mission Revival architectural styles employed for veterans hospitals in the south and southwest portions of the nation, the majority of veterans hospitals were constructed with Colonial Revival stylistic exteriors, whether or not they were employed historically in local or regional building traditions.

The main buildings of the 1940s continued to evolve, as certain examples became larger and exhibited less ornamentation than those constructed in the 1930s, resulting in the overall facade wall plane appearing flat in comparison to main buildings of the 1930s. The expansion of the size of main buildings in the late 1930s through 1950 may reflect the continuing evolution of hospital design within the Veterans Administration. Examples of these larger but more lightly adorned main buildings include Fayetteville, North Carolina (opened 1940), and Lebanon, Pennsylvania (opened 1947).

The use of revivalist architectural styles offers one of many links between the various Second Generation Veterans Hospitals through the use of building ornamentation that was nationally popular during the first half of the twentieth century. The buildings' decorative styles speak to the period of original construction. Many of the later buildings added to the hospital campuses in the 1940s utilized the same architectural styles and massing as the original structures of the facility, offering compatible compositions of buildings within the campus landscape. These additions and later structures exhibiting similar exterior attributes and scale as the original buildings may be found on the majority of campuses.

A consistent architectural style was utilized throughout the veterans hospital campuses during both Periods I and II, creating a harmonious architectural environment at each facility. Only after the period of significance, beginning in the 1950s, did the exteriors of buildings added to the hospitals no longer exhibit the original architectural scheme within the campus. The buildings constructed after the period of significance normally emphasized functionality over style and were rectangular, flat-roof structures with little if any exterior ornamentation. This is true for all Second Generation Veterans Hospital campuses, whether dating from Period I or II, in any of the four sub-types.

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iii. Grouping of Buildings by Function

The buildings of the Second Generation Veterans Hospitals are arranged in groups by function, including the central core group (administration/main building, kitchen/dining hall, recreation building, and patient ward/treatment buildings), residential quarters buildings (manager/director's residence, duplexes, nurses' and attendants' quarters, and garages), and maintenance/utility buildings (boiler plant, stack, garage, warehouse, laundry, shops, and water tower/tank). The flag pole is nearly always found in the central core group. While the buildings of the early Second Generation Veterans Hospitals are grouped together by function, there may be an overlapping of certain buildings, depending on the organization of the campus. In addition, the proximity of the groups/buildings to one another is in some instances more concentrated in Period I hospitals than in the hospitals constructed during Period II, although this may partially be the result of a consideration to reduce construction expenses and/or demands of the topography. Overall, the grouping of buildings by function is consistent throughout the hospitals of both Periods I and II, although variances do occur.

The central core group is normally comprised of the main/administration, recreation, kitchen/dining hall, and patient ward/treatment buildings. The main/administration building is usually the largest and exhibits the most decorative elements of the campus buildings. The original kitchen/dining building is commonly located to the rear of the main/administration building. Because the functions of the kitchen/dining building related to nearly all patients and staff members, this building is one that may have numerous additions because of increasing patient capacity or changes in food preparation/service. The central core group of buildings is commonly connected by exterior corridors. These corridors along with the buildings of the central core group may create one or two enclosed courtyards at larger sub-type 1 hospitals, depending on the number of patient ward/treatment buildings and the campus design.

The quarters group, consisting of the manager's/director's residence, duplexes, attendants' and nurses' quarters, and garages, is normally constructed some distance from the central core group in order to provide privacy to the employees of the hospital. The quarters group is often obscured from the central core group of buildings by mature vegetation. The number of buildings within the quarters group varied depending upon the number of staff members expected to live at the hospital campus. In certain instances the nurses' and attendants' quarters, two or three-story rectangular dormitory buildings, may be located closer to the central core group because of the overall lack of space within the center of campus, or possibly the large quarters buildings were constructed after the original campus buildings. In many examples the quarters group is situated around an oval or rectangular open lawn that serves as public space for the employees living on campus.

The maintenance/utility group of buildings is usually located to the rear of the central core group of buildings or in an area of campus not easily viewed from the main/administration building, although this is dependent on the size and topography of the site. The maintenance/utility group of buildings normally consists of the laundry, boiler plant and the associated stack, garage, fire station, warehouse, engineering shops, water tower/tank, and farm buildings. Most Second Generation Veterans Hospitals originally provided their own steam heat with a boiler plant and adjacent radial chimney or stack. The boiler plants were usually powered by coal or oil. Often the laundry, garage, boiler plant, and one of the shop buildings are arranged along a lane oriented to one another or in a U-shape. The remnants of railroad spur beds are sometimes visible in the maintenance/utility group of buildings of early hospitals, since general supplies and coal for the boiler plant were delivered by rail. Buildings related to former

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farm operations, usually associated with sub-type 1 hospitals, are not always located to the rear of the central core group. The few extant buildings related to the past agricultural operations are usually some distance from the central core group and the maintenance/utility group, such as at Northampton, Massachusetts, and Roanoke/Salem, Virginia. Any remaining farm buildings are commonly utilized now for storage by the facility. In some instances Quonset huts, brought to the campuses after World War II, are also found at many facilities that currently use them for storage. When originally placed on the hospital campuses, the Quonset huts served as temporary chapels, canteens, bowling alleys, libraries, and residential quarters to meet the demands placed on the facilities by the increased number of veterans from the Second World War.

There are a few notable differences with the grouping of buildings by function between the four sub-types of hospitals. The major difference is in the proximity of the maintenance/utility group of buildings to the central core group in certain examples of sub-type 3 hospitals dating to Period II. The sub-type 1, 2, and 4 hospitals commonly have larger campuses and more buildings than sub-type 3 hospitals. The smaller tracts of land utilized by sub-type 3 hospitals often constricted the overall design of the facility, forcing maintenance/utility buildings in closer proximity to the central core group of buildings. The smaller number of buildings may also have made it more economical to condense the footprint of the buildings within the campus. Because it was constructed on a hilltop, the Period I hospital at Muskogee, Oklahoma, also a sub-type 3 facility, shares a similarly condensed grouping of buildings by function within its campus. The Muskogee hospital was originally constructed by the state of Oklahoma and leased to the Veterans Bureau. The Muskogee facility was purchased in 1925 by the Veterans Bureau.³⁴⁹

iv. Landscape Characteristics

The site for each Second Generation Veterans Hospital was thoroughly studied by a selection committee to ensure the property met the necessary requirements. The sites selected for some of the Period I Second Generation Veterans Hospitals were chosen by the Consultants on Hospitalization. Many of these hospitals, construction on which began between 1921 and 1923, were located on surplus government land at former Army cantonments and involved the remodeling and expansion of existing PHS facilities or were constructed on tracts donated to the federal government for the specific purpose of a veterans hospital. The Palo Alto/Menlo Park hospital is such an example, as it was originally opened in 1919 by the PHS on the site of the former Camp Fremont. Through the supervision and design of the Consultants on Hospitalization and the Treasury Department, additional buildings were completed in 1923.³⁵⁰ As with those sites chosen by the Consultants on Hospitalization, later hospital sites procured by the Veterans Bureau and Veterans Administration involved the inspection of numerous possible locations offered by local officials and municipal governments that hoped to acquire a lucrative government facility in their area.

The Veterans Bureau and Veterans Administration identified specific criteria a site should adhere to before choosing the location of a Second Generation Veterans Hospital. The requirements of the site would also have been similar among the four sub-types of veterans hospitals, such as an elevated site on a rise, if possible; access to adequate utilities, including water, sewer, and municipal fire protection;

³⁴⁹ "VA Hospital: 50 Years Service to Vet, City, State," *Muskogee Daily Phoenix* (Muskogee, Oklahoma), April 30, 1973.

³⁵⁰ *Report of the Consultants on Hospitalization*, 53.

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a location away from factories or other nuisance producing entities; improved roadways and/or railroads nearby to provide access to patients, visitors, and employees as well as supplies and fuel for the boiler plant; a sufficient pool of local employees; and adequate housing for employees living off campus.

First the hospitals were to be located near veteran population centers in order to better serve the health care needs of a large number of former soldiers. Sites for sub-type 1 and 2 hospitals were to be located on the edge of towns with a pastoral setting. According to a 1944 article describing the prerequisites for Veterans Administration hospitals, sub-type 1 hospitals with a capacity of 1,000 to 2,000 patients were to be located on tracts between 400 and 500 acres in size. It was suggested that sub-type 2 hospitals with a capacity of 300 to 500 patients be located on a site containing approximately 100 acres. Sub-type 3 hospitals, usually located on smaller tracts, could be located in urban areas or along the edge of towns with sufficient land for future expansion.³⁵¹

The tract for the Second Generation Veterans Hospital was to include a portion that was elevated above the height of the surrounding terrain. According to the 1944 article discussing the hospital site requirements, "An effort is always made to locate the hospital buildings at an elevation higher than the remainder of the site so that they will be in a commanding position....The elevation of the site should be such as to afford a good outlook over the surrounding country and provide adequate surface drainage. A site with gentle slopes is preferable to one whose topography is sharply rolling or to a perfectly level site."³⁵² The majority of veterans hospitals from Periods I and II have the main/administration building located on a rise that allows this building to serve as the focal point of the campus, not only for the staff and patients of the facility but also when viewed by the public at large. This prominence within the landscape is a direct projection of the federal government's stature in the vicinity and, from a public perspective, the vital work conducted by the facility in serving the health care needs of veterans. The buildings associated with the Second Generation Veterans Hospitals are normally the most notable and impressive structures in the vicinity. Later additions to the campus, such as multi-story, late-twentieth-century medical buildings, may have shifted the focal point away from the original main/administration building. Even with later facilities built to fulfill the main building's original purpose, the main/administration building of Period II can still be identified by its monumental size and architectural characteristics as the initial focal point of the campus. The original main/administration building at early Second Generation Veterans Hospitals may not be as obvious as later buildings serving a similar purpose. The buildings of these early hospitals have minimal decorative elements to identify one as more prominent than the others, although the main/administrative building is usually centrally located within the original campus setting. Another exception can be seen with Second Generation Veterans Hospitals that began as former Army forts where the hospital buildings were added to the original campus.

For all Second Generation Veterans Hospitals, the availability of transportation to the site was of vital consideration. Rail service in the vicinity was another component vital to the location of a veterans hospital. A spur of the railroad could be found on numerous hospital campuses dating to Period I as a means of delivering supplies and fuel to the facility. But the actual railroad and station were not located on the hospital grounds, because the noise and fumes from the train were seen as detrimental to the health and recovery of patients. Few remnants of the railroad spurs once located at many of the Period I hospitals are extant. A passenger station in close proximity provided hospital patients and staff members a modern, efficient, and affordable transportation option. Adjacent roads and highways

³⁵¹ Morris, editor, "General Requirements for Hospital Sites," 28.

³⁵² Ibid, 28, 30.

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provided bus service for patients and employees and later accessibility for the majority of hospital patrons and staff by automobile.

Locations for the Second Generation Veterans Hospitals were also dependent on access to sufficient potable water and sewer facilities. In several cases the hospitals constructed water purification plants and provided their own water sources, either through wells or by impounding streams, creating reservoirs. The reservoirs also provided recreation opportunities for the patients through fishing and offered a natural design element to the campus landscape. Sewage treatment plants were also built at some of the hospitals, although many sites later began utilizing municipal water and sewer lines.

Unlike the branches of the NHDVS, which had developed naturalistic landscapes including lawns, gardens, and water features, the campuses of the Period I hospitals constructed for the Veterans Bureau appear to have had few outdoor public areas for patients other than the parade grounds or courtyards in the immediate proximity of the central core group of buildings. Early histories of some hospitals indicate that the emphasis was on completing construction of the hospitals to meet the patient demands of disabled World War I veterans, and the grounds were a secondary consideration. Instances of patients improving the grounds through filling ditches (such as those located at former military training facilities), planting trees and grass for lawns, and preparing athletic fields are described in hospital histories. The placement of the hospitals on elevated terrain appears to have been an early prerequisite in the site selection of Veterans Bureau hospitals, as many of them are located on rises or hilltops. The overall design of a number of these hospitals have military characteristics, such as oval open lawns similar to parade grounds surrounded by the hospital buildings, crescent-shaped parallel drives lined by buildings, or grid patterns of drives and buildings. This military landscape design, although not found at all Period I Veterans Bureau hospitals, would be expected in some instances, since a number of the campuses were planned by the construction arms of the Army and Navy. In a number of examples, such as Northampton, Massachusetts, and Chillicothe, Ohio, a ceremonial entrance drive is an integral element of the original design plan, although it may be attributable more to the placement of the hospital within the site and the topography than to a conscious decision to create a truly formal entrance drive. While a ceremonial entry drive may have been created, in a number of the Period I hospitals this drive does not extend to the facade of the main building. Therefore, a planned ceremonial entrance drive does not appear to have been integral in the overall design of the Period I hospital campuses.

The campus setting is a common thread among the four sub-types of veterans hospitals constructed during both Periods I and II. The sub-type 1 hospitals were located on large parcels of land to accommodate future expansion and provide privacy and seclusion to patients as they worked toward overcoming their disabilities. The large tracts also supported farming operations, including vegetable gardens, orchards, dairy operations, livestock, and/or crop production. The agricultural endeavors were encouraged as therapeutic occupational training and provided the facilities with fresh produce and meat, thus subsidizing the hospital's operating expenses. These farming activities, serving both an economical purpose and as occupational therapy, appear to have been adopted from the branches of the NHDVS. As the patient population of many sub-type 1 veterans hospitals declined, especially after the advent of psychotropic drug therapies in the 1950s and early 1960s, farming operations were discontinued. As farming operations came to an end, large tracts of land were deemed surplus. In conjunction with the transfer of land formerly utilized for farming operations was the loss of the associated agricultural buildings. Excess land at sub-types 2, 3, and 4 veterans hospitals was also determined as surplus and was removed from hospital ownership. These surplus tracts were disposed

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of by transferring them to local governments or by selling land to the public. Most campuses have been reduced in size, and encroaching development has occurred over the years.

Sub-type 2 hospitals were also located on large tracts of land but required a smaller area than sub-type 1 hospitals, and they were commonly located in rural areas on the outskirts of towns or cities. Farm operations do not appear to have been utilized for occupational therapy at sub-type 2 hospitals as they were at sub-type 1 hospitals. Sub-type 3 hospitals could be located on sites containing 50–100 acres. Sub-type 3 hospitals that were constructed in downtown or urban locations could be placed on smaller tracts. Sub-type 4 homes/general medical hospitals were also located on large tracts of land at the edge of communities. At least one of the sub-type 4 facilities, at Roseburg, Oregon, appears to have utilized limited farming operations including raising hogs and vegetables. A 1936 site plan map revised to 1972 indicates the facility had three hog houses, a farrowing house, feed granary, two corn cribs, and two barns sometime in the past. None of the agricultural buildings were extant in 1972.³⁵³

The campus setting and the accompanying natural landscaping with mature trees and large lawns provided the patients picturesque surroundings and also served as additional therapeutic strategies. A 1944 article indicates the “roads, walks, drainage, grading and landscaping” are “designed by thoroughly experienced landscape architects. The site immediately around the buildings and adjacent to the entrance road is developed into lawns with trees and shrubbery arranged to provide suitable approach to the buildings and pleasant surroundings for patients during their convalescence.”³⁵⁴ The regional characteristics, terrain, and site location factor into the design of the veterans hospital campus. An effort was made to place the hospital facilities on higher elevations than the surrounding vicinity, because it was determined that the fresh breezes and changing vistas while traversing the campus grounds would provide patients with a healthy and stimulating environment. The campuses of the sub-types 1 and 4 facilities of Period II often included curving drives and sidewalks as common design elements, allowing various and changing views as patients and visitors traveled by the plantings, lawns, and buildings of each campus. The curving sidewalks of the landscaped campuses also offered patients opportunities to walk as a form of exercise in a bucolic but controlled environment. In many instances the vegetation utilized in landscaping the campuses, such as trees and shrubs, was of native species. Typical street grid patterns were avoided if possible, allowing for scenic paths utilizing the available or modified natural contours. Ceremonial entry drives leading from the main road to the facade of the main/administration building became common landscape elements during Period II, as many sub-type 1 and 4 main and patient buildings were placed some distance from the main road. The elevated terrain leading to the main/administration building added to the formality of the entrance drive. The position of the main building within a large campus with nurtured lawns and trees, and separated from the general public by restricted fencing and entrances, some with gatehouses, added to the authority projected by the hospital. Water features, such as streams, ditches, ponds, and lakes, were added to the landscapes of some sub-type 1 campuses. These features provided additional recreation possibilities to the patients through fishing and picnicking, but they also, in certain instances, provided water for the facility. A number of sub-type 1 hospitals also contain a baseball field for therapeutic activities and to allow interaction between patients and the public at special events. Large tracts, especially those in front of the central core group of sub-type 1 hospitals, have been modified to accommodate golf courses. The athletic fields and golf courses continue to provide the open spaces

³⁵³ United States Department of Veterans Affairs, files of the Facilities Management Department, Roseburg Veterans Affairs Medical Center, Roseburg, Oregon.

³⁵⁴ Edwin B. Morris, editor, “Landscaping,” *The Federal Architect* 13, no. 1 (October 1944): 30.

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originally associated with the hospitals' landscapes. The larger tracts of land associated with Period II sub-type 1 and 4 veterans hospitals allowed the campuses to be less compact than earlier veterans hospitals, although this continued to be dependent on the topography of the site and the sub-type of hospital. The overall campus, with its natural and built elements, served as a purposely designed form of physical therapy for the patients of all four sub-types of hospitals.

The naturalistic landscape design for the sub-type 3 hospitals could not be as fully executed as that of sub-types 1, 2, and 4 hospitals because of the smaller overall size of the campus. While curving drives and sidewalks, a ceremonial entrance drive, mature vegetation, and open lawns may be found at sub-type 3 veterans hospitals, they are necessarily on a smaller scale that coincides with the reduced amount of acreage within the campus boundaries.

III. Significance:

Over 4.5 million men and women served in the various military services of the United States during the First World War and over three times that number served during World War II. Designed and constructed between 1919 and 1950, Second Generation Veterans Hospitals are significant as the physical manifestation of the federal government's commitment to providing medical care primarily to veterans of World War I, but later, medical care was extended to military personnel from other conflicts. This commitment resulted in the largest hospital network in the nation. These hospitals offered, for the first time, continuing medical care to veterans whose eligibility for this benefit expanded over time from those suffering only service related disabilities and illnesses to include all non-service related medical conditions. The medical care provided to veterans of this period was a momentous advancement from the domiciliary and hospital care provided by the branches of the federal government's NHDVS (First Generation Veterans Homes), which originally focused primarily on serving Union Civil War veterans who volunteered for military service. Whereas branches of the NHDVS operated as long term domiciliary and hospital facilities, the Second Generation Veterans Hospital's mission was the rapid rehabilitation and healing of veterans through modern medical facilities, therapies, medicines, and surgical techniques. While only eleven NHDVS branches were operated by the federal government, the number of Second Generation Veterans Hospitals had expanded to 136 hospitals with 106,000 beds by mid-1950, including those at the former NHDVS branches. This large number of hospitals provided extensive access to veterans residing throughout the nation.³⁵⁵ This level of care, provided at little or no charge, often exceeded that available to the general public. In an era devoid of widespread insurance-based medical care, veterans received the best available care at institutions located in every geographic region of the nation.

Physical characteristics provide the basis of identification for these hospitals, including the use of a campus setting, nationally popular architectural styles associated with patriotism and regional building traditions, standardized building designs, and buildings grouped within the campus by associated functions. Buildings utilizing standardized plans developed during the period of significance were often added to preexisting campuses of PHS and NHDVS facilities before entirely new facilities incorporating the design principles were constructed. Although the hospitals dating to this transition period and those that followed have characteristics that unite them, they can be divided between two periods of construction: 1919 to mid-1920s and late 1920s to 1950. In addition, advances in modern warfare and medical care during the Great War resulted in the establishment of four specific sub-types of hospitals

³⁵⁵ *Administrator of Veterans Affairs Annual Report for Fiscal Year Ending June 30, 1950*, 9–10.

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constructed by the Veterans Administration and its predecessor the Veterans Bureau: neuropsychiatric, tuberculosis, general medical and surgical hospitals, and homes/general medical hospitals.

Second Generation Veterans Hospitals, found throughout the contiguous United States, may be listed in the National Register of Historic Places under Criteria A and/or C. Pertinent to Criterion A, Health/Medicine, the facilities provided critical health care for thousands of disabled veterans throughout a large geographical area. Pertinent to Politics and Government, local Congressional delegations often worked tirelessly to ensure that their communities were selected as the location for these hospitals. Constructing the hospital complexes provided needed jobs to the communities, especially during the Great Depression, and in many communities the Second Generation Veterans Hospitals were major employers throughout the period of significance. Pertinent to Criterion C, Architecture, the hospitals provide important evidence of the use of standardized designs and the evolution of these designs during the period of significance. Architecture serves as one of the principal identifiers of the Second Generation Veterans Hospitals. The architectural treatments of the hospitals incorporated nationally popular architectural styles, and in certain examples historical regional building traditions were utilized. The prolific use of Colonial Revival and Classical Revival styles was a conscious decision to promote the patriotic nature of the facilities. The same architectural style was utilized throughout the campus with varying degrees of ornamentation dependent on the building function, creating a cohesive decorative style within an institutional setting. Standardized designs for typical buildings were developed early during the period of significance. These standardized building models continued to evolve throughout the 1920s into the fully realized Colonial Revival and Classical Revival exterior designs expressed in the facilities of the 1930s. The evolution in building design continued to 1950. Besides the typical buildings and architecture, the hospitals are also identified by their campus setting and detached buildings serving specific functions. Along with the standardized building plans, the landscape designs of the campuses also evolved through the period of significance. The campus settings, dependent upon the hospital sub-type and site topography, changed from formal designs in 1919 to a more naturalistic campus setting throughout the 1930s to 1950.

Because of their benefits to veterans as well as their economic benefits, Second Generation Veterans Hospitals were highly sought after by local communities and then became important monuments within their state. As a result, the majority of these hospitals are significant at the local and state level. A small number of hospitals may rise to the national level of significance, however. Examples of hospitals that may be nationally significant would include those with minimal alterations and few additional buildings constructed after the period of significance, thereby retaining an exceptionally high degree of integrity; rare surviving important examples of the four hospital sub-types; or those exhibiting national significance under additional areas of significance, including Criterion B or D. The level of significance for each hospital should be individually evaluated, since the level of significance will have to be justified within each nomination.

The period of significance covered under this multiple property documentation form extends from 1919 to 1950. On March 3, 1919, Congress enacted Public Law, No. 326 of the 65th Congress (40 Stat. L., 1302), providing slightly over \$9 million for the United States Treasury Department to acquire hospital facilities for veterans, both male and female, of World War I that were under the care of the Bureau of War Risk Insurance and the PHS. The legislation also transferred certain Army and Navy hospitals to the PHS.³⁵⁶ The termination date for the period of significance is 1950, the date the last hospital physically embodying the design principles characteristic of Second Generation Veterans

³⁵⁶ Weber and Schmeckebier, 156–157

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Hospitals appears to have been constructed. With the selection of General Omar Bradley to head the Veterans Administration after World War II, changes in the organization began to take place, including the site selection and design of veterans hospitals. Most post-World War II hospitals of the Veterans Administration were contained in large towers and designs were moving away from the campus plan that served veterans of World War I. The first hospital designed for returning World War II veterans was Tomah, Wisconsin. Design of this facility began in 1944, and it opened in 1947. The Tomah neuropsychiatric hospital shares similar characteristics with the previous sub-type 1 Second Generation Veterans Hospitals, such as a monumental main building exhibiting Classical Revival architectural style; a decentralized campus plan with H-buildings connected by enclosed corridors; and buildings with similar functions arranged into three groups. Even though the Tomah facility was constructed to serve World War II veterans, the facility continued to utilize design elements developed for Second Generation Veterans Hospitals. Other Veterans Administration hospitals constructed after the Second World War, built to serve American veterans of the largest global conflict in world history, also continued to incorporate characteristics developed for Second Generation Veterans Hospitals rather than the multi-story tower commonly associated with Third Generation hospitals. Because of this transition period, periods of significance encompassing the Second and Third Generation Veterans Hospitals overlap, with the Second Generation Veterans Hospitals' period of significance ending in 1950. The Montrose, New York, neuropsychiatric veterans hospital, which opened in 1950, appears to be the last veterans hospital constructed that continued the design philosophies of the Second Generation Veterans Hospitals and is therefore included in this context.

Third Generation hospitals, or site-specific construction that took place during the post-1950s, may also possess significance under themes not fully developed as part of this Multiple Property Documentation form. Individual buildings located within Second Generation facilities may achieve eligibility for associations defined by National Register Criteria A–D, and more recent structures may satisfy the test for exceptional importance for buildings less than 50 years of age established by Criteria Consideration G. Second Generation hospitals with substantial construction/modification after the period of significance (1950) may no longer merit consideration for the National Register as a result of lost integrity, as outlined by this context; however, these facilities should be considered as representative examples of more recent episodes of VA hospital construction or expansion. Additional research would be required to define completely the elements of theme, place, and time needed for the historic context.

IV. Registration Requirements:

A United States Second Generation Veterans Hospital, or its individual components, eligible under this multiple property documentation form must meet the following requirements: it must have been designed, built, or utilized by the United States government between 1919 and 1950 for the primary purpose of providing general medical, surgical, respiratory, neurological, or extended care to veterans of America's armed forces; it must consist of resources related to one another through common purpose, design, materials, function, development, and campus setting; it must represent the distinctive characteristics of a type, period, or method of construction or be associated with individuals significant in local or state history; and it must retain integrity. "Integrity" is defined as "the ability of a property to

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convey its significance.³⁵⁷ The National Register recognizes seven aspects or qualities that in various combinations define integrity: location, design, setting, materials, workmanship, feeling, and association.³⁵⁸ Although the United States Second Generation Veterans Hospital multiple property documentation form is mainly used to determine the eligibility of districts, it may also be utilized to determine the eligibility of individual resources if they retain sufficient integrity to convey their significance.

Several factors must be considered in evaluating Second Generation Veterans Hospitals for National Register Eligibility; these are described fully in the *National Register Bulletin: How to Apply the National Register Criteria for Evaluation*.³⁵⁹ First, when evaluating a potential historic district, the individual resources must possess linkages to the historic theme and be identifiable as a distinct entity. Additionally, the individual resources may lack distinction, but the majority of the components composing a district must contribute to the overall significance through scale, massing, setting, plan, or architectural attributes. An additional factor is when the assemblage of resources does not meet the necessary threshold for eligibility as a historic district. This may occur when the design and/or function of the VA hospital is masked by new construction after the period of significance, when modifications to the majority of buildings results in an indistinguishable entity, or when demolition of historic-era buildings significantly affects the overall integrity of the hospital complex. In some cases, discrete portions of the complex may merit eligibility as a historic district even though the composite sense of theme, place, or time is lost. The possibility of individual eligibility must also be examined. Resources may exhibit the distinctive characteristics of a time, place, or method of construction under Criterion C. Additionally, individual resources may have significant associations with individuals or groups important in local, state, or national history. In these circumstances, the resource should be evaluated using guidance provided by the National Park Service in the *National Register Bulletin: How to Apply the National Register Criteria for Evaluation*. A third factor is the issue of uniqueness or scarcity of a specific property type. Diminished levels of integrity are acceptable if comparable property types exist and exhibit a greater degree of alteration. Many Second Generation Veterans Hospitals do possess unusual architectural detailing or spatial configurations within the designated theme and period of significance. These resources must be evaluated in comparison to other examples of the property type and within the overall context established through the multiple property nomination and other pertinent documentation.

Resources determined not eligible under the Second Generation Veterans Hospital historic context, whether individually, contributing, or as a historic district, should be evaluated further for National Register eligibility. Resources may be eligible under Criteria Consideration G. Under Criteria Consideration G, properties may prove eligible if they have achieved significance within the past fifty years and are of "exceptional importance."³⁶⁰ Any of the four basic criteria for evaluation may have application under Criteria Consideration G. A second factor in reviewing eligibility determinations for veterans hospitals that do not appear to merit National Register inclusion under the Second Generation historic context is applicability within different historic themes. The massive buildup of veterans health-

³⁵⁷ United States Department of the Interior, National Park Service, *National Register Bulletin: How to Apply the National Register Criteria for Evaluation* (Washington, DC: United States Department of the Interior, National Park Service, 1997): 44.

³⁵⁸ Ibid.

³⁵⁹ Ibid.: 6, 46-47.

³⁶⁰ Ibid., 42.

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care facilities during the Third Generation period of the post-World War II decades impacted earlier hospitals and brought about the construction of new facilities. Although specific registration requirements, along with an associated definition of historic contexts, is not incorporated into the multiple property documentation nomination form for United States Second Generation Veterans Hospitals, evaluations addressing this era of veterans hospital construction must take into consideration alternative areas of significance that would be associated with Third Generation building complexes.

Each campus and resource must be evaluated on its own merits because the initial number and type of buildings constructed on the campus of a Second Generation Veterans Hospital were dependent on a number of factors, including topography, acreage, bed capacity, and the original designation of the hospital, whether neuropsychiatric, tuberculosis, general medical and surgical hospital, or homes/general medical hospitals (sub-types 1, 2, 3, and 4). Although fewer buildings may have been constructed on a sub-type 3 or 4 campus, the functions of the buildings, grouping of buildings by function, and campus setting are qualities shared between all of the facilities without regard to sub-type. All surviving resources that existed on these campuses in 1950 are considered contributing resources, unless they have lost integrity. This includes preexisting buildings found at former military posts, PHS facilities, and NHDVS branch campuses, or within private facilities adapted for veterans hospital use. These resources represent the transition between government-sponsored veterans health care policies before and after World War I.

Buildings associated with Second Generation Veterans Hospitals, including those of standardized designs, may be located on the campuses of former NHDVS branches. Erected to primarily serve World War I veterans, these buildings, if constructed during the period of significance and retaining integrity, may be evaluated for listing in the National Register of Historic Places under this multiple property documentation form as either a district or individual buildings as a representative example of its particular property type.

The Second Generation Veterans Hospitals continue to provide medical care to veterans, and as a result their facilities are continually modified to offer the most up-to-date medical care options. Common alterations found within many hospital campuses include:

- Reduction in the amount of land associated with the campus during the period of significance;
- Alterations to the interior finishes and reconfiguration of interior spaces within the hospital buildings;
- Re-designation of the original function of a building to a different purpose;
- Replacement windows, doors, and roofing materials;
- Filling in of openings for windows and doorways or increasing/decreasing their original size;
- Addition of ramps and automatic doors at entries of buildings to accommodate patients/visitors with disabilities;
- Replacement cladding of soffits and cornice moldings;
- Filling of dormers and lunettes in gables with vents relating to the HVAC system;
- Enclosure of porches on patient ward/treatment, main/administration buildings, and quarters with brick and/or windows or other materials;
- Removal of the cupola from monumental Period II main buildings;
- Loss of the radial chimney stack associated with the boiler plant;
- Replacement or loss of water tanks/towers;

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- Removal or lack of extant farming outbuildings associated with former agricultural operations at sub-type 1 hospitals;
- The construction of additions to existing buildings; for example, those containing stairwells or elevators to accommodate additional egress to the building;
- Construction of enclosed connecting corridors after the period of significance;
- Construction of an additional story to connecting corridors dating to the period of significance;
- Construction of small buildings after the period of significance;
- Construction of buildings that are large and may dominate adjacent buildings dating to the period of significance;
- Demolition of buildings utilized or constructed during the period of significance;
- An increased number of parking lots to accommodate staff, visitors, and patients;
- The introduction of drives and entries or the reconfiguration of a drive within the campus because of improvements/changes to surrounding streets or roads;
- The introduction of recreation facilities, such as golf courses, baseball fields, picnic areas, and shelters;
- The introduction of smoking shelters, bus shelters, electrical switch stations, and emergency electric generator buildings.

Additions constructed to buildings after the period of significance are found at nearly all Second Generation Veterans Hospitals. These additions cumulatively impact the integrity of the district or individual resource. As stated in Linda McClelland's *National Register Working Draft White Paper*, Evaluating the Significance of Additions and Accretions: "An assessment of the effect of the addition on the property's historic integrity is an important step in evaluation and may also become a deciding factor in eligibility, especially in cases where a question of incompatibility arises between the old and the new."³⁶¹ McClelland offers suggestions for appraising the impact an addition may have on a resource, such as its compatibility to the building, whether it obscures original detailing or principal elevations, its connection to the resource, and the visibility of the addition when viewing the resource.³⁶² Such questions will facilitate the determination of impacts an addition may have on a resource.

All changes to a historic property after the period of significance can diminish the integrity of a property to some degree, and their impact on a specific hospital has to be carefully evaluated on an individual basis. Although a hospital may continue to have the integrity needed to convey its significance even though some of these alterations have taken place, it is important to note that the cumulative effect of changes, even minor ones, can eventually impair the ability of a property to convey its significance. Thus, all character defining features should be recognized and protected in the future.

Because of the unique characteristics of their built environments, sub-types should be considered when evaluating integrity. None of the hospitals originally constructed as sub-type 2 (tuberculosis hospitals) continue to function in their original capacity. Of those that remain, the majority appear to have been converted to sub-type 3 (general medical and surgical) hospitals. Many of the re-

³⁶¹ Linda McClelland, *National Register Working Draft White Paper*, Evaluating the Significance of Additions and Accretions, (2008); located on the World Wide Web at the National Park Service website, http://www.nps.gov/nr/publications/guidance/NR_workshop_3-11-09/White_paper_on_additions_4-09.doc. Accessed November 2010.

³⁶² Ibid.

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designations from sub-type 2 to sub-type 3 appear to have taken place in the late 1950s and early 1960s. Also, few of the patient buildings typically associated with only sub-type 2 hospitals, such as infirmary, semi-infirmary, and ambulant patient buildings, appear to remain extant. Those that do remain speak to the original purpose of the sub-type 2 hospitals and the treatment of veterans suffering from tuberculosis. Because of the seeming interconnection between the sub-type 2 and 3 hospitals created by the re-designation of tuberculosis facilities to general medical and surgical hospitals and the loss of patient buildings associated with veterans tuberculosis hospitals, they will be discussed together, while sub-types 1 and 4 will be examined separately.

The majority of all four sub-types of Second Generation Veterans hospitals have numerous characteristics in common; however, differences in the spatial arrangement and patient care buildings are apparent dependent on the original purpose of the facility. In determining whether a specific sub-type of facility maintains qualities of integrity sufficient for listing in the NRHP, the criteria of integrity established for eligibility must be examined.

Location – All four sub-types of veterans hospitals must be sited in their original locations.

Design and Setting - Evaluating integrity of design and setting is based on identifying changes to individual buildings as well as examining changes to the overall landscape occurring after the end of the period of significance. Generally, individual buildings constructed at all four sub-types of hospital created an architecturally cohesive campus. Most buildings constructed at Period I hospitals exhibited red brick or stucco exteriors with minimal exterior ornamentation. During Period I details typically used for the central core group of buildings followed the Colonial Revival styles, whereas the residential quarters may exhibit elements of the Dutch Colonial Revival or Spanish Revival, for example. This is illustrated in the case of Tuskegee, Alabama, an example of a sub-type 2/3 hospital, where residences were constructed in a locally popular style. Hospitals built during Period II exhibit more exterior decorative elements and the construction of monumental main/administrative buildings.

The integrity of the hospital campus setting relies substantially on its retention of the spatial design dating to the period of significance. The open lawns, courtyards/quadrangles, fields, open vistas to the main entrance road, formal entry drives, mature trees and vegetation, and the spatial design of the buildings constructed throughout Periods I and II are all important elements. Since some Period I veterans hospitals were incorporated into existing military posts or NHDVS branches, their spatial design will vary from those designed and initially constructed to serve as a hospital for World War I veterans. The former Army reservation may retain much of its original design, which often includes buildings encircling the parade grounds and rows of officers' quarters. Second Generation period buildings were often constructed in undeveloped areas of the former facilities, such as to the rear of existing buildings or in open lots around the parade ground. Some of the preexisting buildings may have been razed for the construction of a building during the period of significance. Those that survive are significant because they convey the transition period.

Landscape elements associated with sub-type 1 veterans hospitals include water features, such as ditches, ponds, and lakes. Often the ponds and lakes were used and may continue to serve as recreational facilities for patients. Rock fences and retaining walls may also be found on these hospital campuses. Landscape designs for Period II, sub-type 1 hospitals often incorporated the natural topography of the site, making use of curving drives and sidewalks that continue to contribute to the integrity of the campus setting, as does the formal entrance drive that extends to the original main/administration building. The increased use of these facilities brought on by the addition of

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services, buildings, and outpatient care is reflected in the landscape of the sub-type 1 hospitals. Parking lots for employees, visitors, and patients have been increased in size at the majority of these facilities when compared to the period of significance. Although parking lots diminish the qualities of design and setting of a sub-type 1 hospital, they continue to offer the open vistas and spatial configuration found during the period of significance. Also contributing to the open landscape of many sub-type 1 veterans hospitals are athletic fields and golf courses. Because of their large original landholdings and their patient population, sub-type 1 veterans hospitals are more likely to have such outdoor sport facilities. While the majority of baseball fields and golf courses were added after the period of significance, they continue to provide the open spatial relationships originally associated with the campus.

Landscaping elements are also important design characteristics of sub-type 2 and 3 hospitals. Formal landscape planting designs appear to have been developed for a number of Period II hospitals that include curving drives and sidewalks, although the smaller campuses of the sub-type 2 hospitals exhibit fewer of these landscape elements as more linear drives and sidewalks are incorporated into the campus design. The evolution from Period I to II in the use of more naturalistic, or picturesque, landscape plans reflects the evolution of landscape designs through the period of significance. These landscape elements also speak to the individuality of each campus and are important design elements that the campus should retain. The increased use of these facilities through the addition of services and outpatient care is reflected in the increased size of parking lots at the majority of these facilities when compared to those in existence during the period of significance. This growth in paved surfaces is in direct correlation with the continued reliance on individual vehicular transportation. While parking lots diminish the qualities of design and setting for a sub-type 2 or 3 hospital, they continue to offer the open vistas and spatial configuration found during the period of significance.

Slight differences are seen at general medical/domiciliary (sub-type 4) VA campuses. Only three were constructed: Bay Pines, Florida; Biloxi, Mississippi; and Roseburg, Oregon. Even though a different architectural style was utilized at each of the three facilities, each of the sub-type 4 facilities was designed by the Veterans Administration and opened during Period II. While the architectural style and embellishment of these hospitals created an architecturally cohesive campus, the topography and natural setting of the facilities contributed substantially to the setting. Following the general practice established for VA hospital campuses, the monumental main building serves as the focal point with other patient buildings at sub-type 4 facilities were constructed along the perimeter of a large ellipse. The main buildings are different than those of the other three sub-types in that they do not have return wings and the upper stories were originally open porches. Patient buildings dating to the period of significance can be oriented either toward or away from the ellipse; for example, some of the buildings face the adjoining bay, such as at Bay Pines and Biloxi. Landscape elements associated with some of the sub-type 4 hospitals may incorporate water features as an integral component of the design. The Bay Pines and Biloxi facilities made use of the adjacent bays and their close proximity to the Gulf of Mexico. The central core buildings could be oriented to the bays to take advantage of the gulf breezes and views over the bays. Typical of hospital complexes throughout the nation, parking lots have increased in size when compared to the period of significance. Although parking lots diminish the qualities of design and setting of a sub-type 4 facility, they continue to offer the open vistas found during the period of significance. Because of their large original landholdings and their patient population, sub-type 4 campuses may have outdoor sport facilities added to their landscapes. While the majority of sport facilities were added after the period of significance, they continue to provide the open spatial relationships originally associated with the campus.

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One of the most significant modifications to the design and setting most often associated with sub-type 1 veterans hospitals is a reduction in the overall size of the facility's landholdings. The majority of sub-type 1 hospitals had large tracts of land that were usually associated with the former agricultural operations of the hospital, originally utilized for occupational therapy. Once the agricultural operations ceased, the excess land was often sold or transferred. Along with this loss of farmland was the removal or transfer of agricultural outbuildings. Few sub-type 1 hospitals retain any physical vestige of the former farming operations. This trend also occurred at many sub-type 4 veterans homes/general medical hospitals. The majority of sub-type 4 hospitals had large tracts of land, because the number of buildings and bed capacity were expected to expand after initial construction. Limited agricultural pursuits took place at Roseburg, Oregon, including the raising of hogs and vegetables, but large agricultural operations do not appear to have been conducted at the three sub-type 4 facilities constructed during Period II. By the 1950s excess land was determined to be surplus and ownership was transferred to other parties. The loss of land holdings dating to the period of significance impacts the integrity of design and setting of sub-type 4 homes/general medical hospitals. The impact of this loss of property will have to be assessed for individual facilities and will depend on the cumulative effects of other changes.

The overall design of the four sub-types of Second Generation Veterans Hospital campuses include the grouping of buildings according to associated functions into three specific groups: central core group (with the main/administration building, kitchen/dining hall, recreation building, and patient ward/treatment buildings), residential quarters (including manager's/director's residence, duplexes, and nurses'/attendants' quarters), and the maintenance/utility group (consisting of the boiler plant and associated stack, water tower, garages, warehouse, laundry, maintenance shops, greenhouse, and buildings with other support functions). The location of the groups varies within each campus, depending on the size of the campus, location of main access roads, and especially topography. Not every group is totally distinct from the others at each hospital, as some groups are in closer proximity to one another than at other facilities. This occurred at those hospitals where the kitchen/dining hall building is integrated with the boiler plant and garage, such as Indianapolis, Indiana, and Tuscaloosa, Alabama—both sub-type 2/3. A few examples of hospitals constructed during Period I have residential quarters in close proximity to the central core group of buildings. An evolution of building design is identifiable at Period I hospitals with Period II buildings incorporated into the campus. Later additions, although constructed within the period of significance, may force an overlapping of the distinct groups. Examples include a nurses' quarters that may be constructed in close proximity to the central core group as the physical plant of the hospital continued to expand. So while the three groups should be visibly identifiable, they may not always be spatially distinct. Additionally, not all campuses retain all three groups of buildings associated by function. In certain examples, the hospital campus may no longer retain the residential quarters. Although this group of buildings is a vital ingredient in understanding the overall development and characteristics of the Second Generation Veterans Hospitals, it may be that certain hospitals have lost this distinct grouping of buildings. In other instances, a single example of a building may retain sufficient integrity to convey significance, and only this individual building may be eligible for listing in the NRHP.

Buildings constructed after the period of significance are usually small utility buildings, such as emergency generators, electrical switch stations, or picnic and smoking shelters. The introduction of these small buildings and structures within the campus of all four sub-types of hospital will impact the integrity of design of the overall hospital campus. In most instances the introduction of these small utility buildings will only cause a minor impact to integrity, but cumulative effects should also be considered.

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Quonset huts were placed at numerous Second Generation Veterans Hospitals after World War II to provide needed additional space, as the hospitals attempted to provide medical care to veterans of this latest conflict. Quonset huts that were placed on the campus during the period of significance will be eligible as long as they retain integrity of design, materials, and workmanship. Quonset huts placed in service after the period of significance will be considered noncontributing resources.

A number of veterans hospital campuses have large-footprint or multi-story medical buildings or additions constructed after the period of significance. These buildings and additions may be detached or may adjoin buildings dating to the period of significance, and common characteristics include towers set back from the leading edge of the buildings and flat roofs. They usually convey a construction date after the period of significance through massing, scale, fenestration, and materials. The construction of such buildings/additions is often necessitated by the expansion of services and the increasing number of veterans eligible for medical care. The footprint of these additions can be considerable in comparison to those dating to the period of significance; however, they may be partially screened by trees, thereby reducing the visual impact of the lower floors throughout the campus. Portions of the lower floors may be compatible with the campus buildings dating to the period of significance in terms of materials and massing. Setbacks reduce the scale of the addition or building and thus its visual impact. Many of the buildings introduced to Period I and II campuses are single story, such as nursing home care units, and impact the spatial pattern of the campus but do not physically overwhelm buildings dating to the period of significance. If buildings, such as H-shape patient ward/treatment buildings of sub-type 1, were removed for the construction of a large non-contributing resource within a courtyard/quadrangle, then the introduction of this non-contributing resource and the loss of the Period I or II building diminishes the historic quality of setting for the campus. In other instances the medical building or addition is located in the ellipse or parade ground in front of the original main/administration building. Such a large addition to a Second Generation Veterans Hospital facility will impact the historic characteristics of design and setting within the campus. The degree of its impact is determined by the compatibility of its location, scale, massing, exterior architectural design, and materials with the buildings dating to the period of significance. The existence of such an addition or building to the campus does not in itself eliminate the specific hospital's eligibility for listing in the NRHP as a district under the United States Second Generation Veterans Hospitals Multiple Property Documentation form. In other cases, the construction of a noncontributing resource adjacent to or very near the original focal point of the campus, such as the main/administration building, may totally diminish integrity of design and setting of adjacent buildings eliminating the integrity of a historic district. In other instances, a single building, if it rises to the level of individual eligibility, may be listed in the NRHP under the United States Second Generation Veterans Hospitals Multiple Property Documentation form despite modern intrusions.

A number of sub-type 2/3 hospitals are located on hilltops with little available space for additional growth of facilities. These sub-type 2/3 hospitals often have buildings and/or additions that were constructed after the period of significance, and with little open space available for new construction these newer facilities are often constructed adjacent to or surrounding original campus buildings. Because of the impacts to the setting and design of these hilltop hospitals, they are more likely to not be eligible for listing in the NRHP as a district than other Second Generation Veterans Hospitals due to the overall impact on their integrity. But portions of the campus or an individual building may retain sufficient integrity to convey significance and therefore its eligibility for listing in the NRHP.

The cumulative effect of all changes after the period of significance has to be evaluated before a final determination of integrity for a hospital can be made. The National Register boundaries should be developed for each individual hospital. In certain examples the NRHP boundary may be developed so

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as to exclude portions of the campus that no longer retain integrity of design and setting sufficient to convey the hospital's significance. Only portions of the campus may retain integrity as a district, such as a grouping of intact patient care buildings or a single resource if it rises to the level of individual eligibility, and as such may be listed in the NRHP under the United States Second Generation Veterans Hospitals Multiple Property Documentation form. If a veterans hospital or individual resource does not meet the eligibility requirements established under the Second Generation context, consideration must be given to alternative areas of significance that would be associated with Third Generation building complexes.

Materials and Workmanship – Evaluating integrity of materials and workmanship is common to all four sub-types of hospital; it is based on identifying changes to the hospital's buildings occurring after the end of the period of significance. It is important to determine whether or not character defining elements of an individual hospital survive. The majority of resources constructed within the hospital's period of significance should exhibit original materials and workmanship. Replacement windows, doors, and roofing material impact all types of hospitals' eligibility under the United States Second Generation Veterans Hospitals Multiple Property Documentation form, and these are some of the most common alterations to the buildings. Replacement material should be similar to and compatible with the original material. Other common alterations include the enclosure of window openings on secondary elevations and of porches utilized by patients, especially those found on patient ward/treatment buildings.

Other common modifications to patient and administrative buildings on hospital campuses that impact integrity are: ramps to facilitate entry to the buildings for disabled patients; awning or other shelter added to the main entry and obscuring the original door surround; and egress/ingress additions containing stairwells and/or elevator shafts. Egress/ingress additions on patient ward/treatment buildings usually incorporate materials sympathetic to the original structure, and therefore these additions, although diminishing materials and workmanship, may not automatically render a resource as noncontributing.

The main building is the focal point of the vast majority of Second Generation Veterans Hospitals designed/constructed during the period of significance. In certain instances a main building may not have been constructed at Period I hospitals because existing buildings were converted by the Veterans Bureau. For Period II hospitals these monumental structures, if constructed with Classical Revival architectural style decorative elements, may be capped by a cupola. In certain examples the cupola has been removed, usually because of water or lightning damage. The removal of the cupola diminishes the materials and workmanship of the building. Even with the removal of its cupola, the building's monumental size and normal placement on an elevated site allows it to continue to serve as the focal point of the campus. Therefore, although the building's integrity is diminished, it may continue to be a contributing resource to the overall campus.

Additions to buildings of a hospital can render the resource as no longer contributing to the district through the loss of integrity of materials and workmanship. This is especially true of additions to the principal elevation of the main/administration building. As the focal point of the hospital, its facade is the primary "face" of the campus. Thus, changes to the facade or additions that supplant the original design may render the building as noncontributing. Large additions with setbacks from the facade and featuring sympathetic design elements do not automatically render the building as noncontributing if it continues to serve as the focal point of the campus. Multi-story additions with a comparable or larger footprint than that of the original building that obscure major portions of the side and rear elevations

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may also render a building from the period of significance as a noncontributing resource because of the loss of integrity of workmanship and materials.

Modifications to buildings within all types of hospitals impact the integrity of each resource. Each resource should be evaluated individually to determine whether or not it retains integrity of materials and workmanship and whether it continues to be a contributing resource to the historic district or if a single building rises to the level of individual eligibility.

Feeling and Association – Feeling and association are two characteristics of integrity that relate to hospital campuses as a whole, taking into consideration the various modifications occurring after the end of the period of significance. The hospital buildings should continue to communicate their sense of time and place as a hospital constructed/utilized during the period of significance and its connection to other hospitals of this typology. Modifications impacting the qualities of feeling and association include additional parking lots, reduction in the size of the original land holdings, introduction of athletic fields and golf courses, and construction of buildings/additions after the period of significance. Analysis of integrity of feeling and association should take under consideration certain commonalities found at other hospitals of the same sub-type, including buildings of similar scale, materials, decorative features, and architectural styles creating an architecturally cohesive campus; buildings recognizable by function at each campus; similar buildings by function but also exhibiting evolving designs as the standardized plans changed from Period I to Period II; grouping buildings by function into three, if not distinct, then identifiable groups; siting of the main/administration building to serve as the focal point of the campus; the flag pole, located to the front of the main/administration building; and the campus setting, exhibiting its mature landscaping, open spaces (such as courtyards/quadrangles, parade grounds, lawns, and golf courses), and water features, including lakes and ponds. All of these characteristics should be examined to determine whether or not the campus retains integrity of feeling and association.

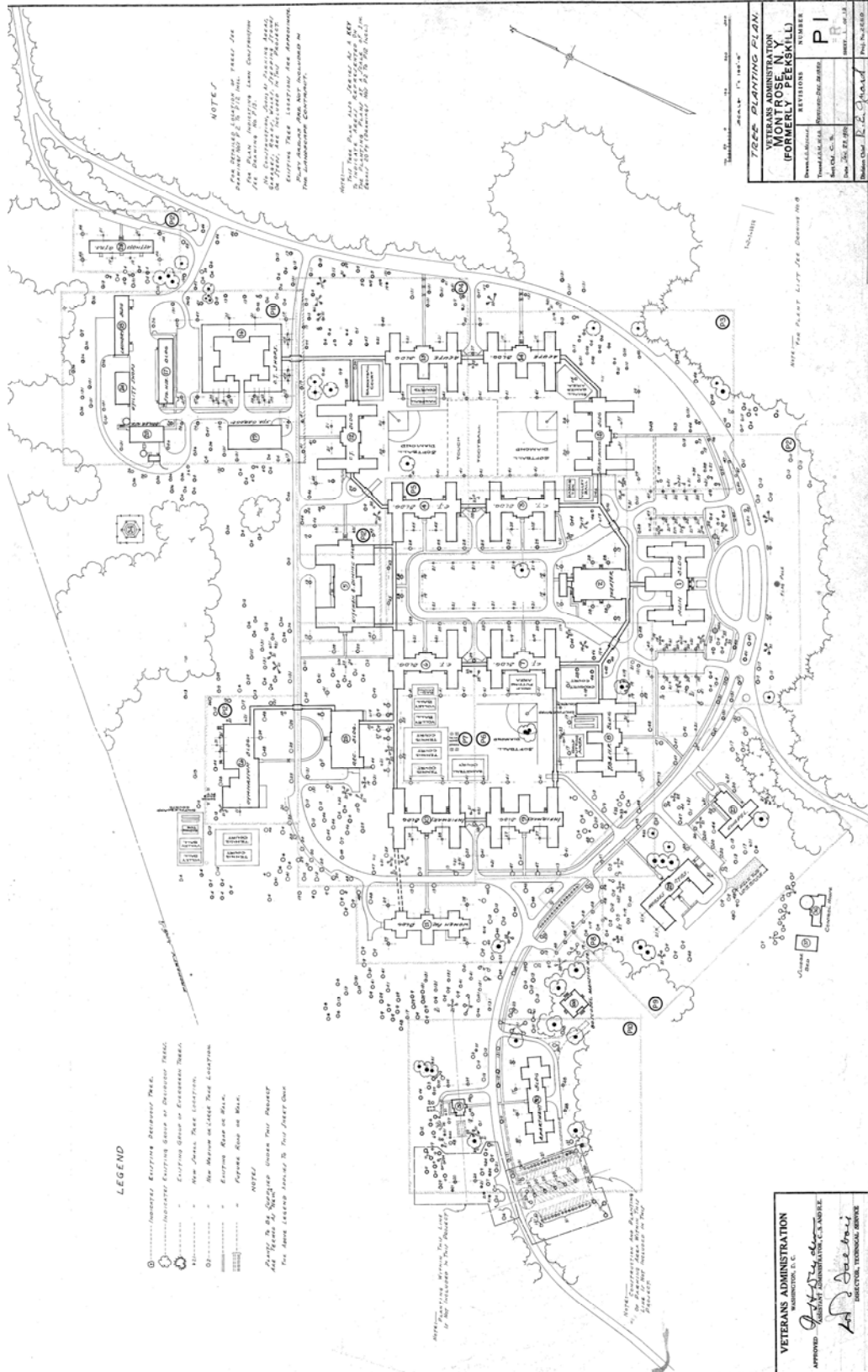


Figure 3. Tree Planting Plan, Veterans Administration, Montrose, New York, reissued 1950.

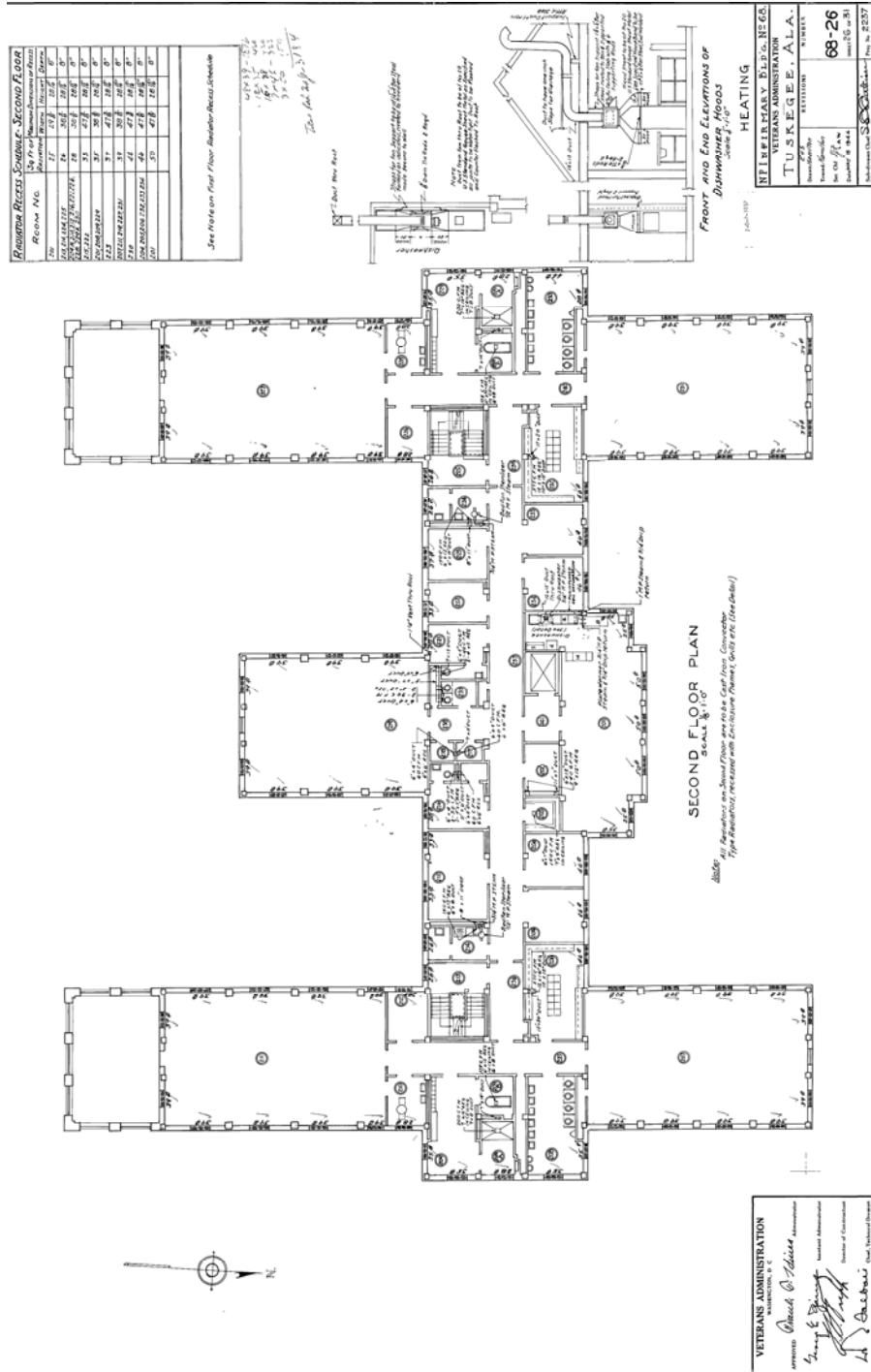


Figure 4. Second Floor Plan, NP Infirmary Building No. 68, Veterans Administration, Tuskegee, Alabama, 1944.

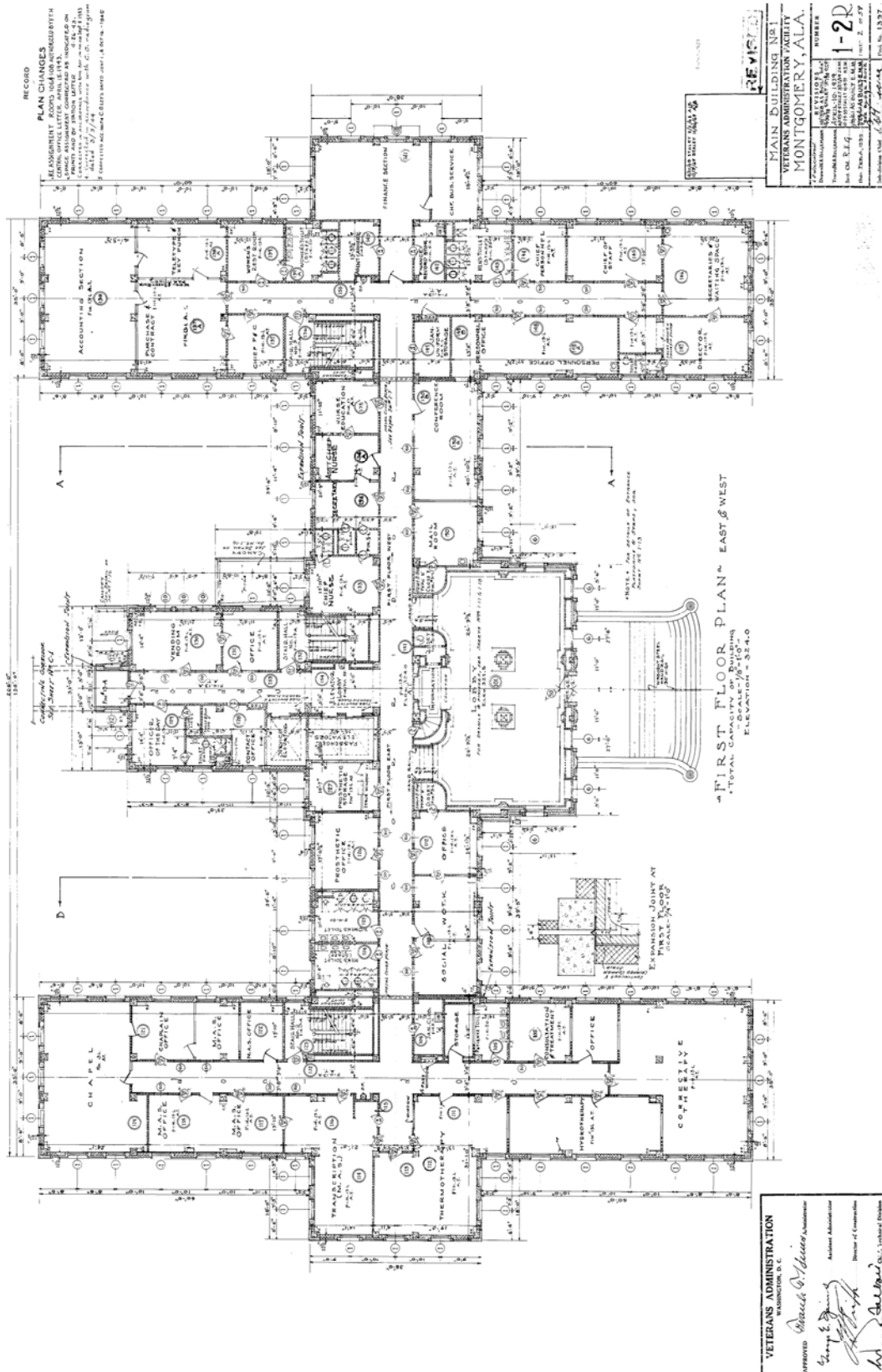


Figure 5. First Floor Plan, Main Building No. 1, Veterans Administration, Montgomery, Alabama, 1932 revised through 1969.

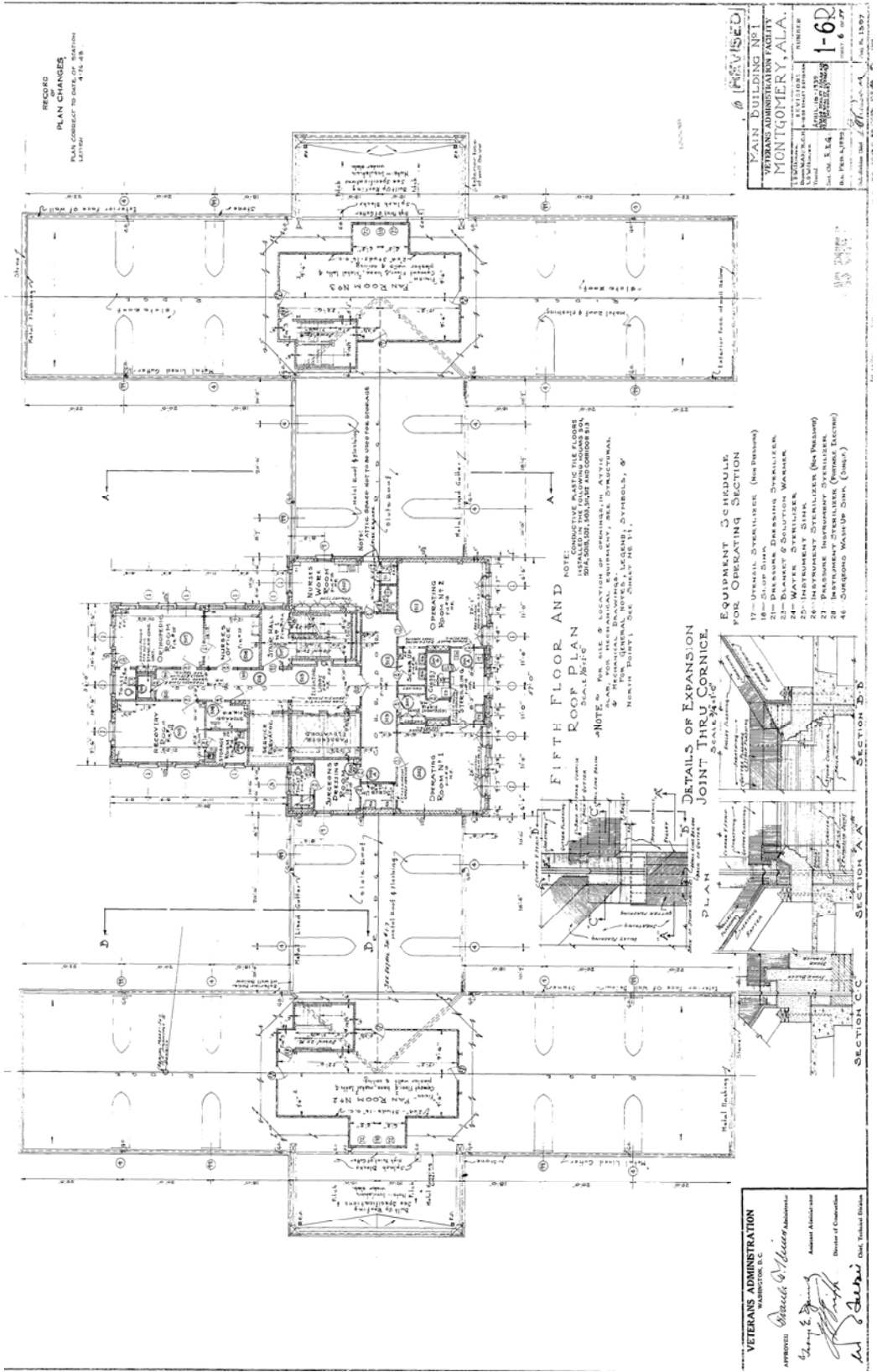


Figure 6. Fifth Floor and Roof Plan, Main Building No. 1, Veterans Administration, Montgomery, Alabama, 1939 revised through 1969.

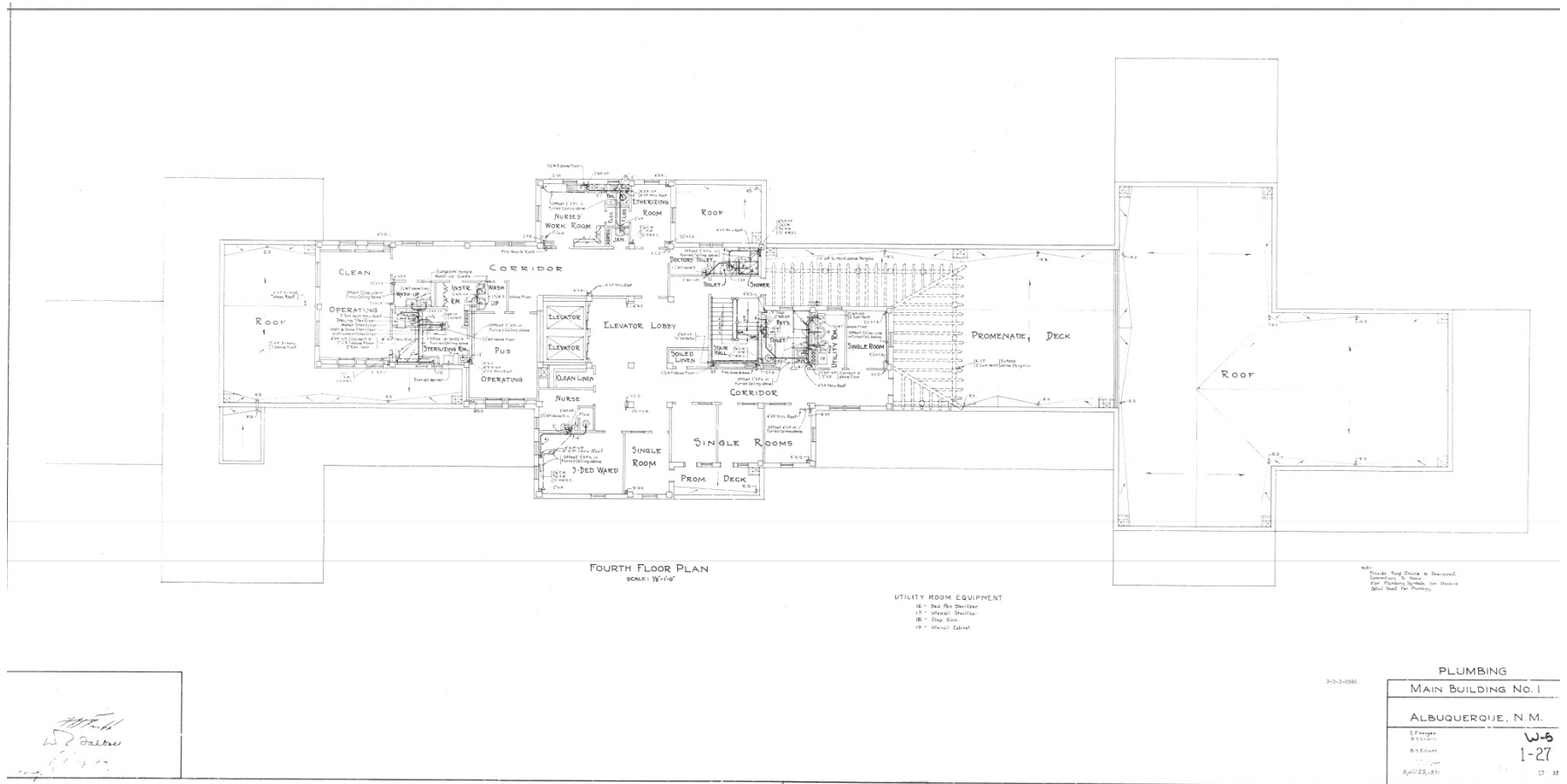


Figure 7. Fourth Floor Plan, Main Building No. 1, Albuquerque, New Mexico, 1931.

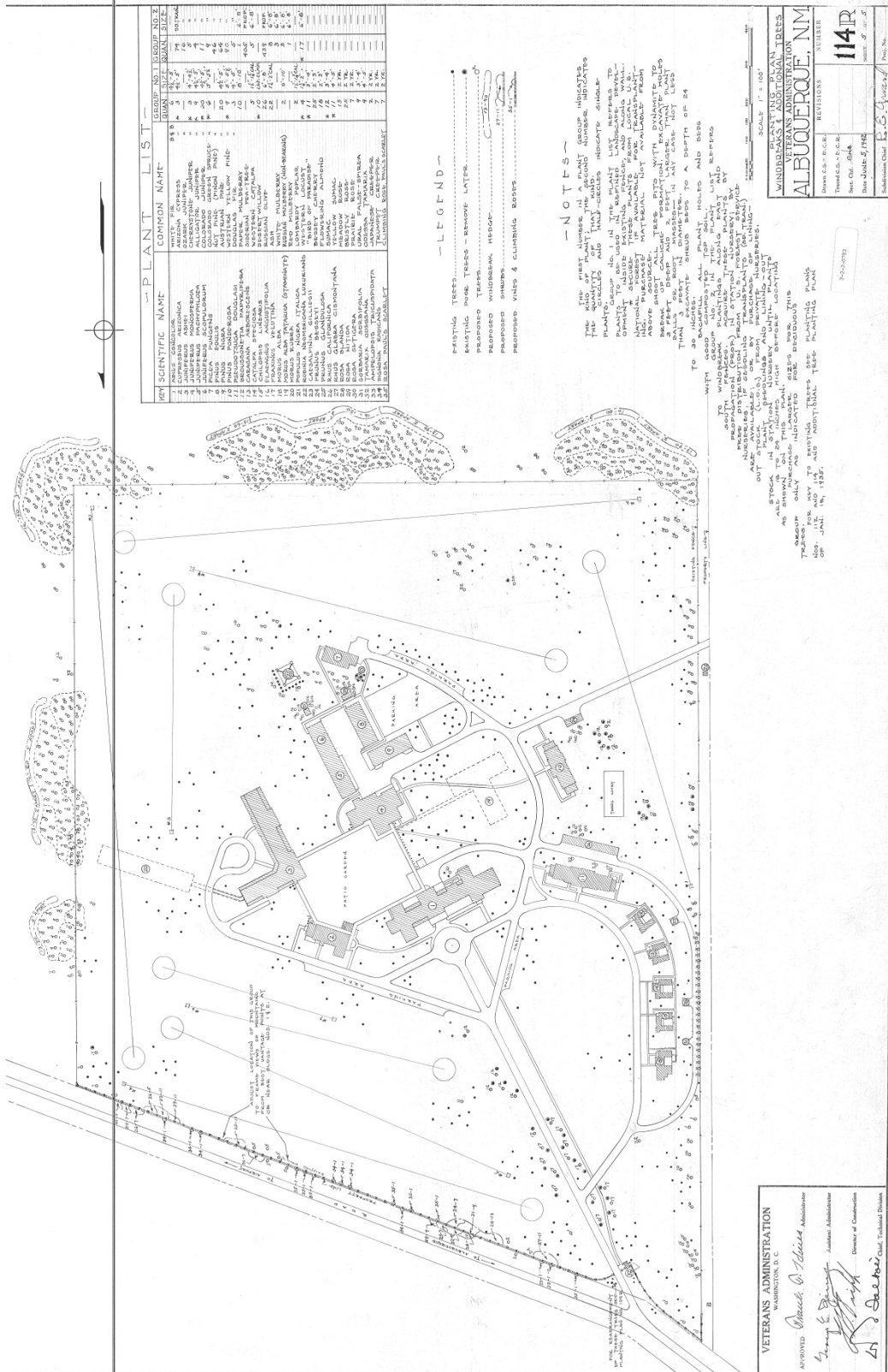


Figure 8. Planting Plan, Windbreaks and Additional Trees, Veterans Administration, Albuquerque, New Mexico, 1942.

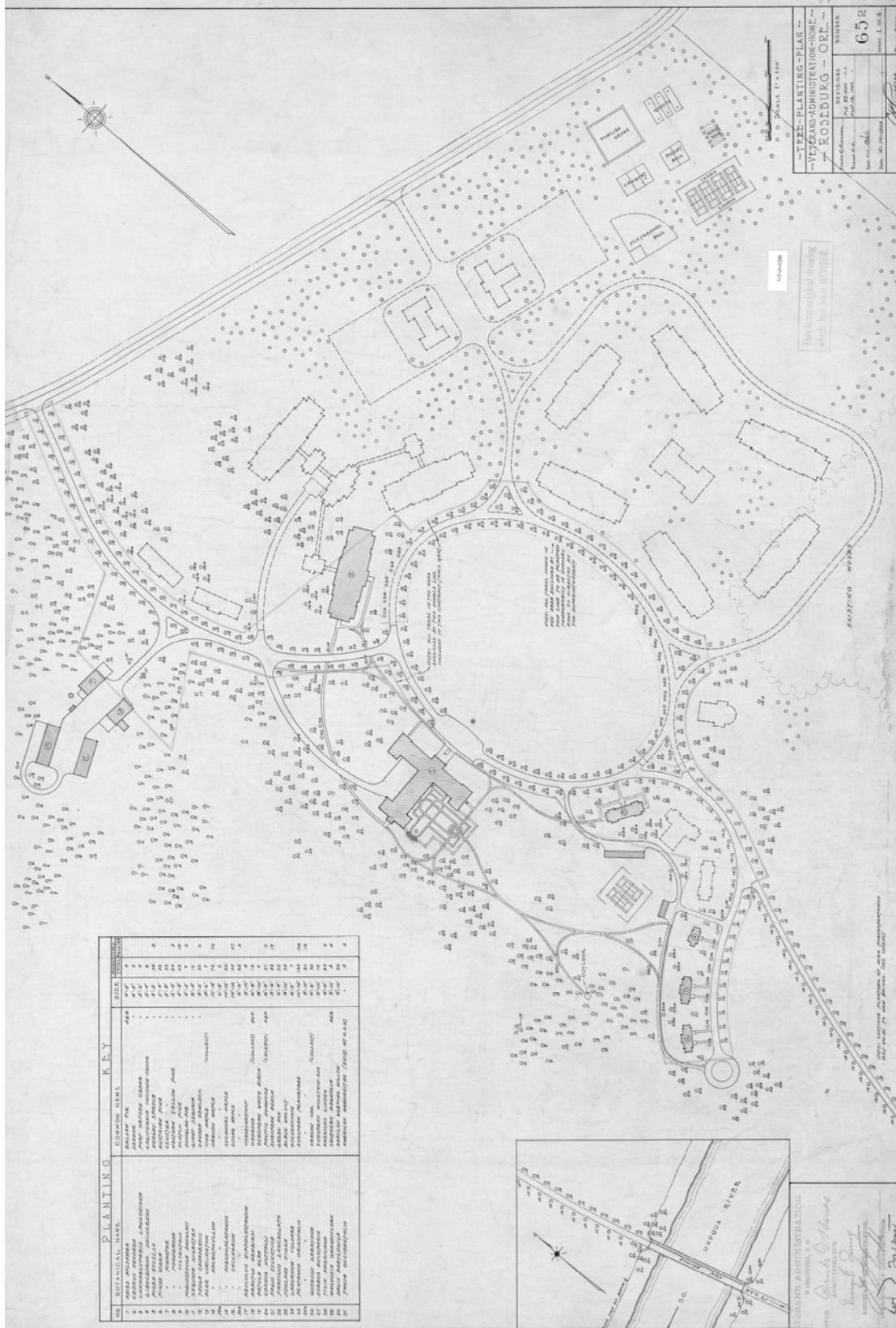


Figure 9. Tree Planting Plan, Veterans Administration, Roseburg, Oregon, 1933 revised 1934.

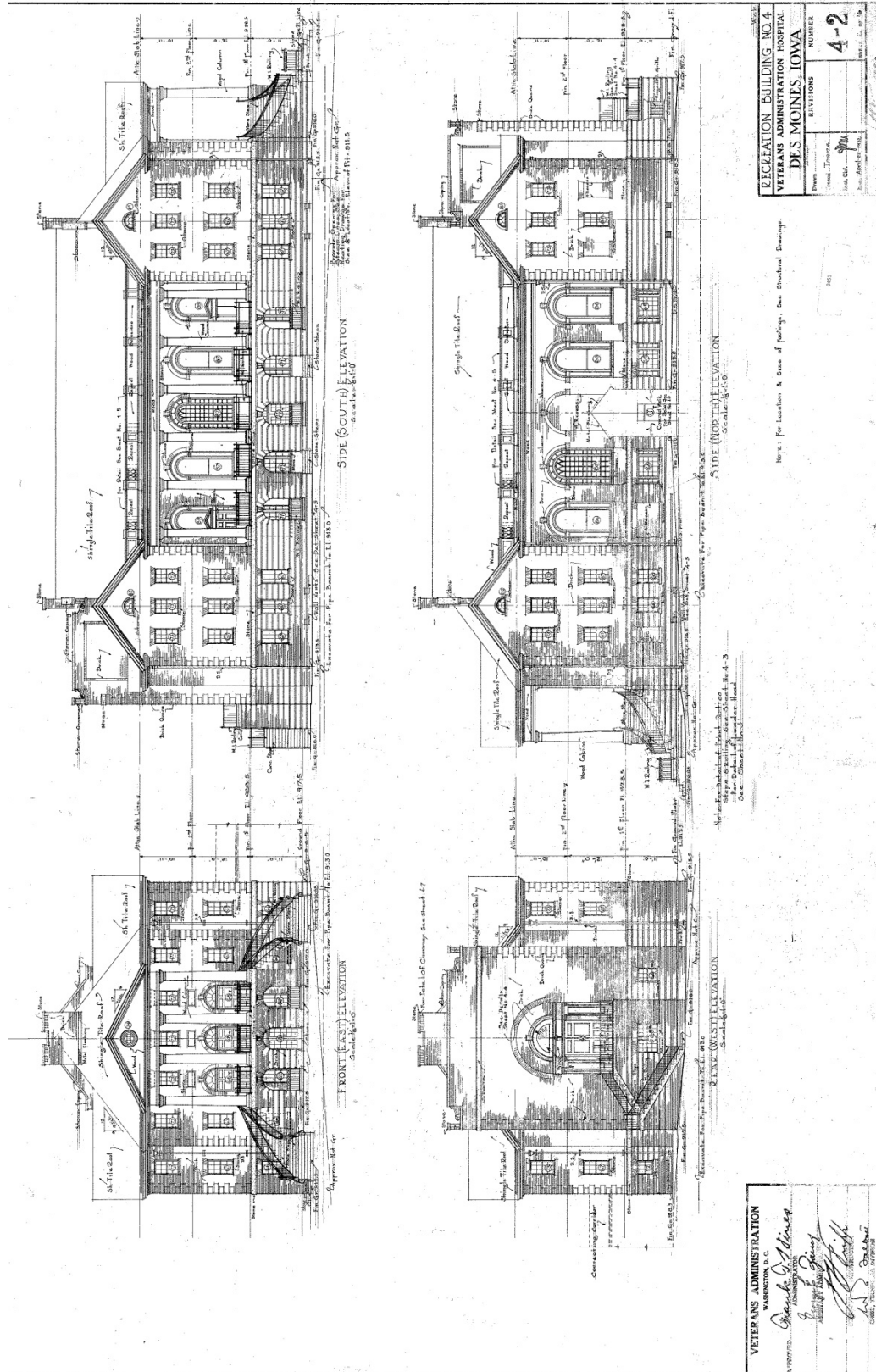


Figure 10. Elevations, Recreation Building No. 4, Veterans Administration, Des Moines, Iowa, 1932.

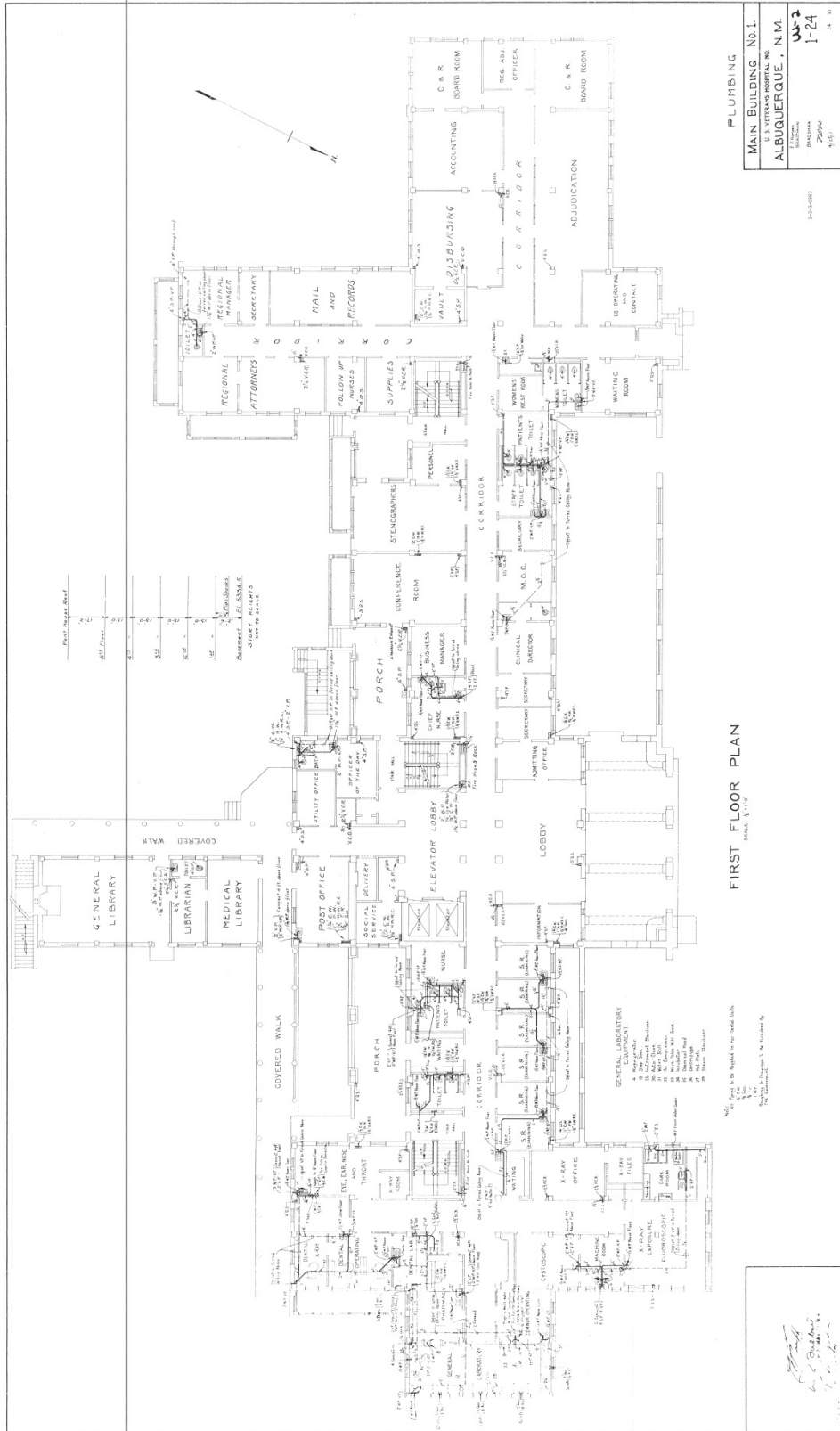


Figure 12. First Floor Plan, Main Building No. 1, U.S. Veterans Hospital, Albuquerque, New Mexico, 1931.

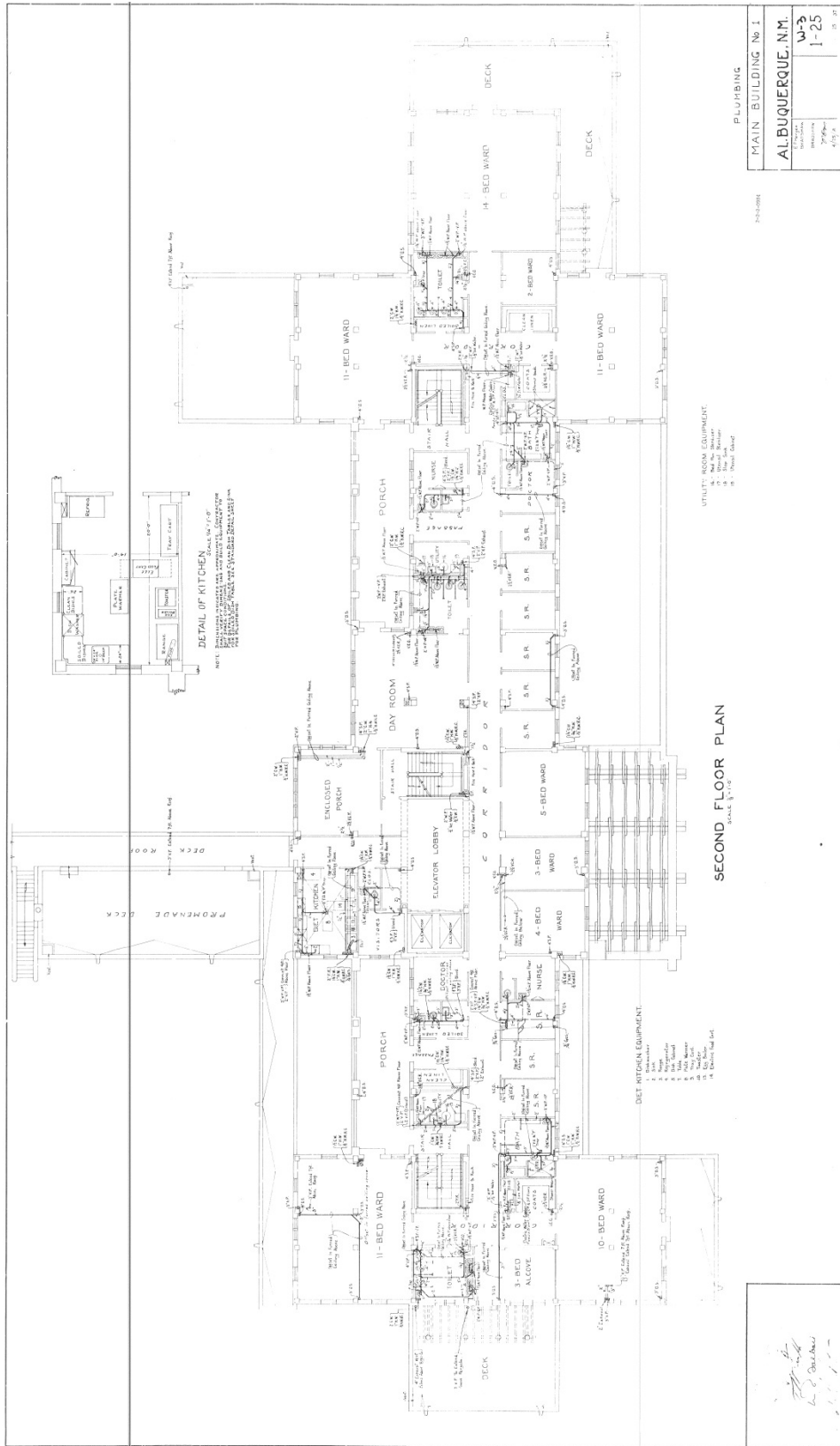


Figure 13. Second Floor Plan, Main Building No. 1, Albuquerque, New Mexico.

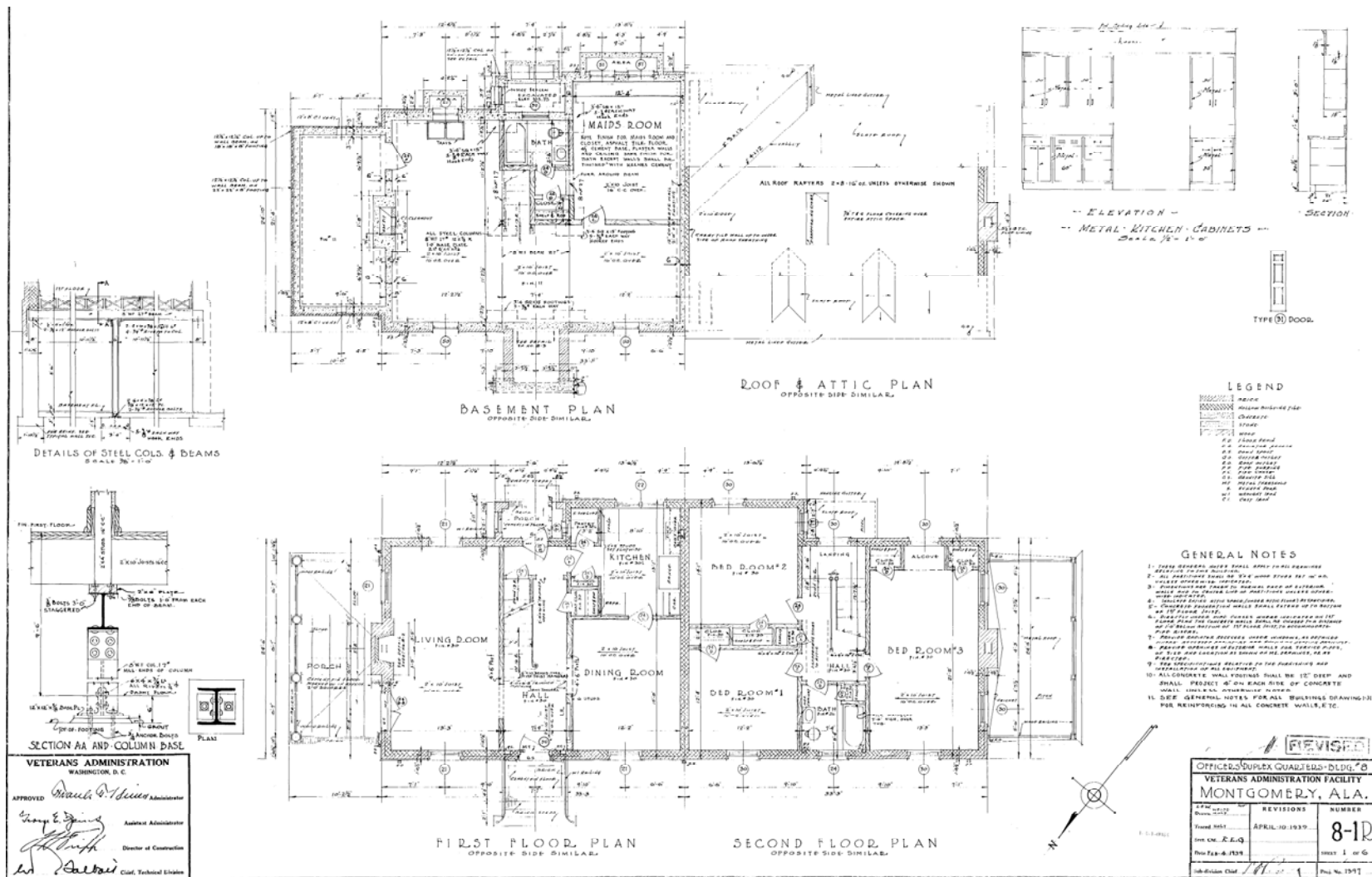


Figure 14. Floor Plans, Officers Duplex Quarters, Building 8, Veterans Administration, Montgomery, Alabama, 1939.

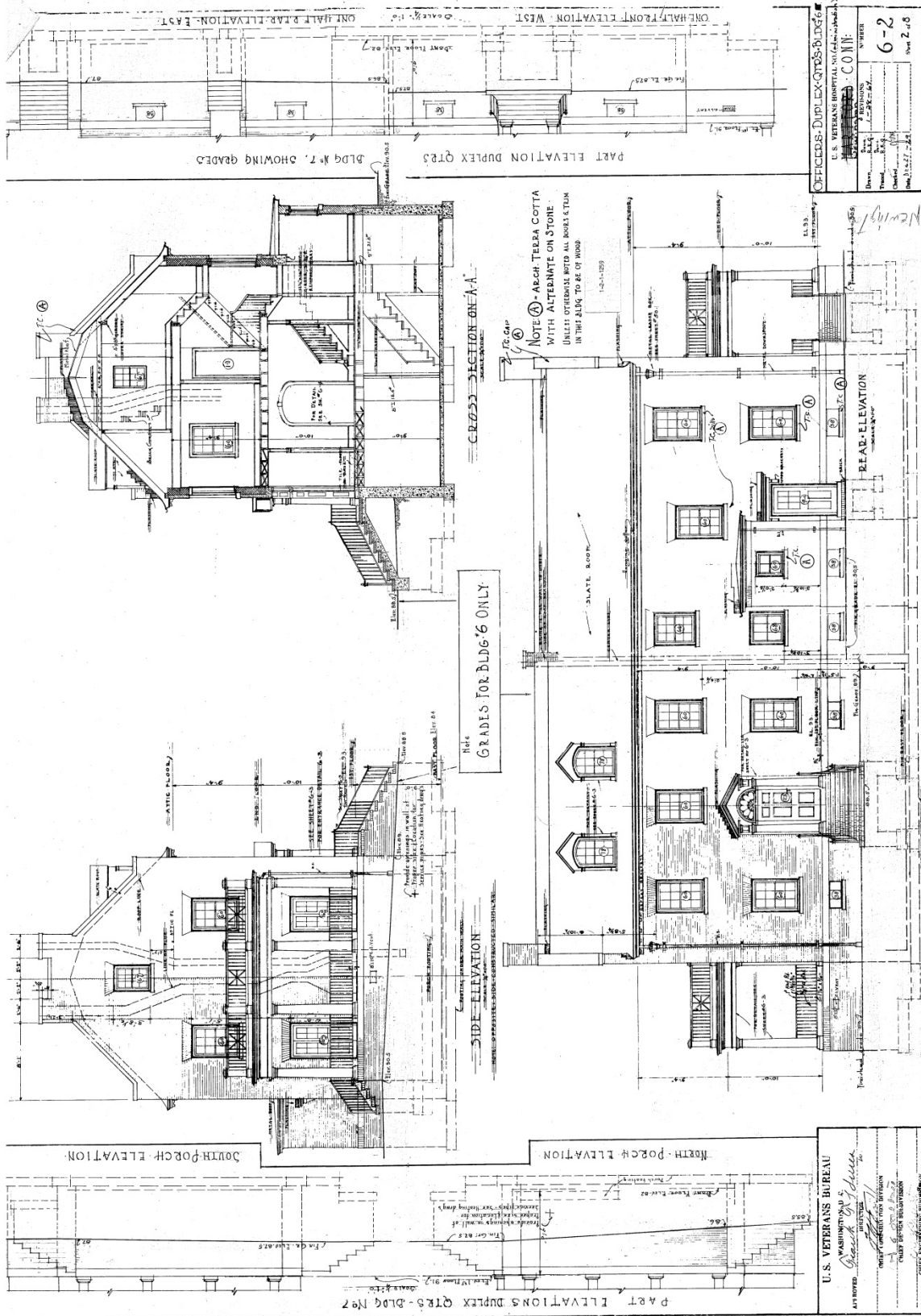


Figure 15. Elevations and Cross Sections, Officers Duplex Quarters, Building 6, U.S. Veterans Bureau, Newington, Connecticut, 1929 revised 1964.

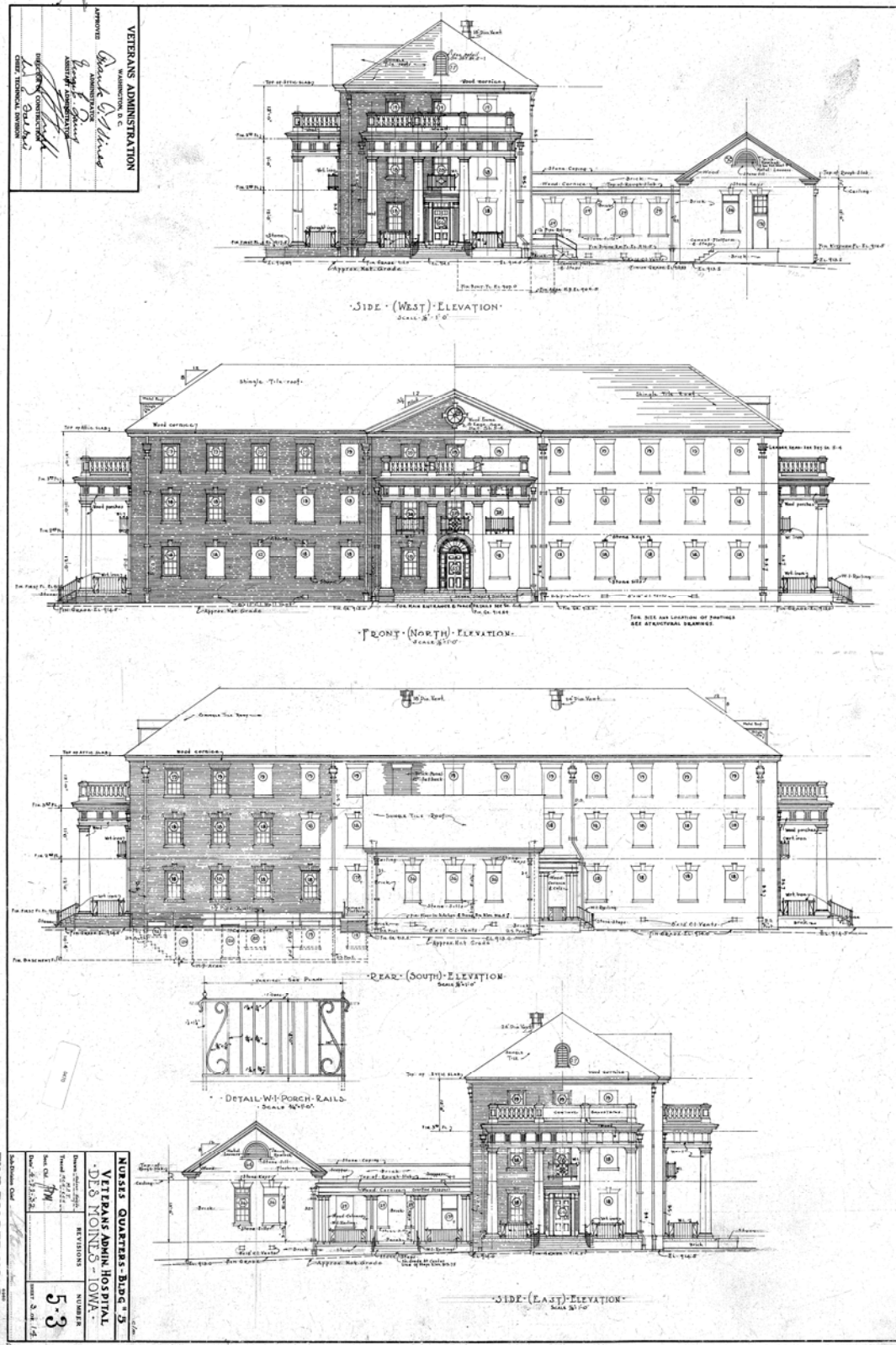


Figure 16. Elevations, Nurses Quarters, Building 5, Veterans Administration, Des Moines, Iowa, 1932.

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G. GEOGRAPHICAL DATA

The Second Generation Veterans Hospitals are located within the continental United States. A listing of Second Generation Veterans Hospitals is included in an Appendix of this nomination.

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H. SUMMARY OF IDENTIFICATION AND EVALUATION METHODS

The development of the multiple property documentation form for the United States Second Generation Veterans Hospitals was sponsored by the Historic Preservation Office, Office of Construction and Facilities Management, Department of Veterans Affairs in Washington, D.C. Forty-three medical centers located throughout the contiguous United States were chosen by the Historic Preservation Office to be surveyed over a three-year period from 2008 through 2011. This multiple property documentation form was developed to serve as a guide in determining eligibility for individual hospital campuses. A preliminary draft of the multiple property documentation form was completed based on archival research. The archival research began with a review of sources obtained from the library of the central office of the Veterans Affairs offices in Washington, D.C.; the National Archives; and the Library of Congress. Determinations of eligibility had been completed for the majority of the Second Generation Veterans Hospitals in the early 1980s. Limited revisions with supplemental information have been added over time to the existing determinations of eligibility. This data was used along with that obtained in primary and secondary sources to complete a preliminary draft of the multiple property documentation form. During the site visits, each facility was mapped, photographed, and a written description was prepared. Archival sources at the facilities as well as local libraries were reviewed. This information was then used to finalize the multiple property documentation form.

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Appendix Second Generation Veterans Hospitals Dating to the Period of Significance

On March 3, 1919, Congress enacted the first appropriation to purchase or lease medical facilities for veterans of World War I. This legislation, Public Law, No. 326 of the 65th Congress (40 Stat. L., 1302), placed responsibility for medical care of World War I veterans with the United States Public Health Service.³⁶³ Public Act No. 47 of the 67th Congress [H.R. 6611], passed on August 9, 1921, addressed the formation of the Veterans Bureau, improvements toward the facilities utilized by the bureau, and amended the War Risk Insurance Act. An Executive Order, issued by President Warren G. Harding on April 29, 1922, referred to Section 9 of the above Act and called for the Public Health Service to transfer to the Veterans Bureau any facilities under its authority that were utilized in the care and treatment of veterans. The Executive Order also stated that any hospitals under construction by the Treasury Department were to be transferred upon completion to the Veterans Bureau.³⁶⁴

The following hospitals are divided by Period I and II. The designation number was originally assigned by the Public Health Service, and the Veterans Bureau continued to number its facilities chronologically until the late 1920s. Also included are the known opening and closing dates of the facilities and the original sub-type designation (if known). Available information indicates the dates of various actions regarding the National Register status of listed VA Hospitals. Some previous National Register activities relate to individual buildings or are focused on periods and themes prior to those established for Second Generation VA Hospitals. Many of the referenced actions were completed several years ago. The limited scope, passage of time, and new perceptions of historic significance should be considered for any undertaking with possible effects on these resources.

Designation Number	State	City	Dates of Operation (VA)	Sub-type (defined by 2 nd Generation VA Hospital context)	National Register Action
Period I					
13	Alabama	Mobile	8/1/21 to 6/30/23	3	None
14	Louisiana	Algiers (Annex to New Orleans Marine Hospital)	9/24/21 to 12/6/29	3	None
24	California	Palo Alto/Menlo Park (Camp Fremont)	4/1/19 to Present	2	None
25	Texas	Houston	4/2/19 to 6/25/19; 2/6/20 to 6/30/23	N/A	None
26	South Carolina	Greenville	4/5/19 to 5/12/24	2	None

³⁶³ *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1931*, 20; Adkins, 104; Weber and Schmeckebier, 156–157; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 4–5.

³⁶⁴ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, (Washington, DC: U.S. Government Printing Office, 1922), 601, 608–610.

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27	Louisiana	Alexandria	4/7/19 to 5/1/28	2	None
28	New York	Dansville	5/1/19 to 9/13/20	1	None
29	Virginia	Norfolk (Sewell's Point)	6/2/19 to 5/24/22	3	None
30	Illinois	Chicago	6/13/19 to 6/30/23	3	None
31	Texas	Corpus Christi	6/15/19 to 9/14/19	3	None
32	Washington, DC	District of Columbia	6/24/19 to 5/3/65	N/A	None
33	Florida	Jacksonville	6/27/19 to 10/1/19	3	None
34	Massachusetts	East Norfolk	6/30/19 to 5/18/22	1	None
35	Missouri	St. Louis	7/1/19 to 6/1/23	3	None
36	Massachusetts	Boston	7/1/19 to 12/1/22	3	None
37	Wisconsin	Waukesha	7/10/19 to 9/30/58	1	None
38	New York	New York	8/15/19 to 3/9/22	N/A	None
39	Pennsylvania	Hoboken	9/1/19 to 9/11/20	3	None
40	New Jersey	Cape May	9/3/19 to 9/28/21	1	None
41	Connecticut	New Haven	9/12/19 to 4/30/27	2	None
42	Maryland	Perry Point (Perryville)	9/20/20 to Present	1	Determination of Eligibility, 2008
	Maryland	Perryville Purveying Depot ³⁶⁵		Appears to be associated with #42	
44	Massachusetts	West Roxbury	12/1/19 to 7/20/28	1	None
45	North Carolina	Biltmore	12/6/19 to 12/1/22	3	None
46	New Mexico	Deming	12/15/19 to 6/15/20	3	None
47	Pennsylvania	Markleton	1/7/20 to 2/22/21	3	None
48	Georgia	Atlanta	2/1/20 to 6/21/66	3	None
49	Pennsylvania	Philadelphia	2/18/20 to 11/18/32	1	None
50	Arizona	Whipple Barracks (Prescott)	2/16/20 to Present	2	Listed, 1999
51	Arizona	Tucson	3/15/20 to 10/18/28	2	None
52	Idaho	Boise	4/19/20 to Present	3	Listed, 1972*
53	Illinois	Dwight	6/4/20 to 1/31/23; 9/20/23 to 5/24/33; 4/15/35 to 8/12/65	3	None
54	California	Arrowhead Springs	6/15/20 to 6/15/24	3	None

³⁶⁵ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, (Washington, DC: U.S. Government Printing Office, 1922), 609; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924*, (Washington, DC: U.S. Government Printing Office, 1924), Chart No. 6; Evaluation Division, Coordination Service, comp., *Origin, Development, and Utilization of U.S. Veterans Hospitals* (1928 with revisions through 1933), non-paginated, located in the files of the Department of Veterans Affairs, Historic Preservation Office, Office of Construction and Facilities Management, Washington, D.C.; Robinson E. Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967): 395–409; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1929*, (Washington, DC: U.S. Government Printing Office, 1929), 108–109.

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55	New Mexico	Fort Bayard (Silver City)	6/15/20 to 8/9/65	2	None
56	Maryland	Baltimore (Ft. McHenry)	7/1/20 to 11/1/23	3	None
57	Iowa	Knoxville	8/15/20 to Present	1	Determination of Eligibility, 1981
58	Louisiana	New Orleans	9/16/20 to 12/31/21	1	None
59	Washington	Tacoma	9/13/20 to 1/11/29	2	None
60	North Carolina	Oteen (Asheville)	10/15/20 to Present	2	Listed, 1985
61	New York	Fox Hills	10/15/20 to 4/15/22	N/A	None
62	Georgia	Augusta	11/20/20 to Present	1	Determination of Eligibility, 1981
63	Florida	Lake City	12/6/20 to Present	2	None
64	California	Camp Kearney	1/2/21 to 3/15/26	2	None
65	Minnesota	St. Paul	1/4/21 to 4/20/27	3	None
67	Missouri	Kansas City	1/5/21 to 7/2/28	3	None
68	Minnesota	Minneapolis	2/8/21 to 7/2/28	3	None
69	Kentucky	Ft. Thomas	2/15/21 to 4/1/26	N/A	None
71	Massachusetts	Sterling Junction	3/12/21 to 6/30/22	3	None
72	Montana	Helena (Ft. William Henry Harrison)	6/6/19 to Present	3	Determination of Eligibility, 1981
73	Illinois	Chicago (AKA #30a), Annex to #30	7/15/21 to 2/29/24	1	None
74	Mississippi	Gulf Port	7/16/21 to 2008	1	Determination of Eligibility, 1980
75	Iowa	Colfax	7/5/21 to 2/7/23	3	None
76	Illinois	Maywood (Edward Hines, Jr. Hospital)	8/8/21 to Present	3	Determination of Eligibility, 1982
77	Oregon	Portland	11/1/21 to Present	3	None
78	Arkansas	North Little Rock (Ft. Logan H. Roots)	12/1/21 to Present	1	Listed, 1974*
79	Kentucky	Dawson Springs (Outwood)	2/22/22 to 7/10/62	2	None
80	Colorado	Las Animas (Ft. Lyon)	3/1/22 to 2001	2	Listed, 2004
81	New York	Bronx	4/17/22 to Present	1	None
83	Alabama	Mobile (Same as #13)	8/1/21 to 6/30/23	N/A	None
84	Louisiana	New Orleans (Algiers, Same as #14)	9/24/21 to 12/6/29	N/A	None
85	Washington	Walla Walla	5/10/22 to Present	2	Listed, 1974*

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86	Wyoming	Ft. Mackenzie (Sheridan)	5/12/22 to Present	1	Listed, 1991
87	Ohio	Chillicothe	11/15/21 to 6/16/24	3	None
88	Tennessee	Memphis	8/14/22 to 4/8/58	3	None
89	Massachusetts	Rutland (Rutland Heights)	5/15/23 to 8/23/65	2	None
90	Oklahoma	Muskogee	6/14/23 to Present	3	Determination of Eligibility, 1981
91	Alabama	Tuskegee	6/15/23 to Present	1 & 2	None
92	Missouri	St. Louis (Jefferson Barracks Reservation)	3/16/23 to Present	3	Determination of Eligibility, 1980
93	Texas	Legion (Kerrville)	7/1/23 to Present	2	None
94	Washington	Tacoma (American Lake)	2/16/24 to Present	1	Listed, 2009
95	Massachusetts	Northampton	4/21/24 to Present	1	Determination of Eligibility, 1980
96	New York	Sunmount (Tupper Lake)	8/15/24 to 8/12/65	2	None
97	Ohio	Chillicothe	6/1/24 to Present	1	Determination of Eligibility, 1981
98	New York	Castle Point	9/24 to Present	2	None
99	Missouri	Excelsior Springs	10/15/24 to 7/31/63	3	None
100	Michigan	Camp Custer (Battle Creek)	10/15/24 to Present	1	Determination of Eligibility, 1981
101	Minnesota	St. Cloud	9/20/24 to Present	1	Determination of Eligibility, 1980
102	California	Livermore	4/11/25 to Present	2	None
103	Pennsylvania	Aspinwall (Pittsburgh)	10/10/25 to Present	2	None
104	California	San Fernando	4/1/26 to Present	2	None
105	Illinois	Chicago ³⁶⁶	3/1/26 to Present	1	Determination of Eligibility, 1982
Period II					
106	Minnesota	Minneapolis	4/9/27 to Present	3	None
107	Massachusetts	Bedford	7/17/28 to Present	1	Determination of Eligibility, 1980

³⁶⁶ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1922*, 609-610; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924*, Chart No. 6; Evaluation Division, Coordination Service, comp., *Origin, Development, and Utilization of U.S. Veterans Hospitals* (1928 with revisions through 1933), non-paginated, located in the files of the Department of Veterans Affairs, Historic Preservation Office, Office of Construction and Facilities Management, Washington, D.C.; Robinson E. Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967): 395-409.

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108	New York	Northport	4/16/28 to Present	1	Determination of Eligibility, 1980
51 (New hospital kept previous facility's #)	Arizona	Tucson	10/18/28 to Present	2	Determination of Eligibility, 1981
109	North Dakota	Fargo	6/3/29 to Present	3	None
27 (New hospital kept previous facility's #)	Louisiana	Alexandria (located on same site as Hospital #27)	12/2/29 to Present	3	Listed, 1986
110	New Jersey	Lyons	10/4/30 to Present	1	Determination of Eligibility, 1980
111	Pennsylvania	Coatesville	11/11/30 to Present	1	Determination of Eligibility, 1981
112	Nebraska	Lincoln	4/30/31 to Present	3	Determination of Eligibility, 1980
113	Connecticut	Newington	5/15/31 to Present	3	Determination of Eligibility, 1980
114	Kentucky	Lexington	4/1/31 to Present	3	Determination of Eligibility, 1980
115	Indiana	Indianapolis	1/4/32 to Present	3	Determination of Eligibility, 1981
	Texas	Waco	3/6/32 to Present	1	Listed, 1994
	Utah	Salt Lake City	7/15/32 to 2/15/62	3	Listed, 1996
	Alabama	Tuscaloosa	7/15/32 to Present	3	Determination of Eligibility, 1980
	New Mexico	Albuquerque	8/22/32 to Present	3	Listed, 1983
	South Carolina	Columbia	10/15/32 to Present	3	Listed, 2009
	West Virginia	Huntington	11/1/32 to Present	3	Determination of Eligibility, 1982
	New York	Canandaigua	2/9/33 to Present	1	Determination of Eligibility, 1981
	Florida	Bay Pines	3/16/33 to Present	4	Determination of Eligibility, 1980
	Oregon	Roseburg	5/8/33 to Present	4	Determination of Eligibility, 1980
	Mississippi	Biloxi	8/10/33 to Present	4	Listed, 2002
	Kansas	Wichita	11/16/33 to Present	3	Determination of Eligibility, 1980
	Arkansas	Fayetteville	4/2/34 to Present	3	Determination of Eligibility, 1980
	Iowa	Des Moines	4/2/34 to Present	3	Determination of Eligibility, 1980
	New York	Batavia	5/3/34 to Present	3	Determination of Eligibility, 1980

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	New York	Batavia	5/3/34 to Present	3	Determination of Eligibility, 1980
	Wyoming	Cheyenne	5/4/34 to Present	3	Determination of Eligibility, 1980
	California	San Francisco	4/22/35 to Present	3	Listed, 2009
	Virginia	Roanoke/Salem	4/22/35 to Present	1	Determination of Eligibility, 1981
	Vermont	White River Junction	10/17/38 to Present	3	Determination of Eligibility, 1980
	Michigan	Dearborn (Allen Park)	4/15/39 to 6/2/96	3	None
	Nevada	Reno	5/22/39 to Present	3	None
	Tennessee	Murfreesboro	2/4/1940 to Present	1	Determination of Eligibility, 1980
	Texas	Amarillo	4/8/1940 to Present	3	Determination of Eligibility, 1980
	Texas	Dallas	8/22/1940 to Present	3	Determination of Eligibility, 1981
	North Carolina	Fayetteville	10/17/40 to Present	3	Determination of Eligibility, 1980
	Alabama	Montgomery	11/1/40 to Present	3	Determination of Eligibility, 1981
	Ohio	Cleveland (Brecksville)	11/1/40 to Present	3	None
	Maryland	Ft. Howard (transferred from War Dept., new hospital completed 1/4/44)	3/17/41 to Present	3	Determination of Eligibility, 1979
	Illinois	Marion	6/8/42 to Present	3	Determination of Eligibility, 1980
	Massachusetts	West Roxbury	1/20/44 to 7/10/52; 10/15/53 to Present	3	Determination of Eligibility, 1981
	Wisconsin	Tomah	3/4/47 to Present	1	Determination of Eligibility, 1981
	Pennsylvania	Lebanon	9/15/47 to Present	1	Determination of Eligibility, 1981
	New York	Montrose ³⁶⁷	5/15/50 to Present	1	Determination of Eligibility, 1982

³⁶⁷ *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1924*, Chart No. 5; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1925*, (Washington, DC: U.S. Government Printing Office, 1925), 94, 345, 355; *Annual Report of the Director United States Veterans Bureau for the Fiscal Year Ended June 30, 1926*, (Washington, DC: U.S. Government Printing Office, 1926), 77; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1931* (Washington, D.C.: U.S. Government Printing Office, 1931): 152–153; Evaluation Division, Coordination Service,

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Former NHDVS Branches That Came Under the Authority of the VA in 1930					
	Maine	Togus	1866 to Present (originally operated as the NHDVS Eastern Branch; transferred to VA in 1930; 2 nd Generation hospital building completed in 1933)	Converted to 1, 1944	Determination of Eligibility, 1980*
	Ohio	Dayton	1867 to Present (originally operated as the NHDVS Central Branch; transferred to VA in 1930; 2 nd Generation hospital building completed in 1930 or 1931)	Converted to 3 with Domiciliary, 1946	Listed, 2004*
	Wisconsin	Milwaukee	1867 to Present (originally operated as the NHDVS Northwestern Branch; transferred to VA in 1930; 2 nd Generation hospital complex completed in 1933)	Converted to 2 with Domiciliary, 1944	Listed, 2005*
	Kansas	Leavenworth	1885 to Present (originally operated as the NHDVS Western Branch; transferred to VA in 1930; 2 nd Generation hospital complex completed in 1933 and hospital in 1939)	Converted to 1 with Domiciliary, 1945	Listed, 1999*

comp., *Origin, Development, and Utilization of U.S. Veterans Hospitals* (1928 with revisions through 1933), non-paginated, located in the files of the Department of Veterans Affairs, Historic Preservation Office, Office of Construction and Facilities Management, Washington, D.C.; Adkins, 395–409; “Dedication of the New Facility at Fayetteville, N.C.,” *The Medical Bulletin of the Veterans Administration* 17, no. 3 (January 1941): 322; information provided through emails by Darlene Richardson, Veterans Affairs Historian and Kelly Merrifield, Veterans Affairs Intern on January 19, 2010.

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	Virginia	Hampton	1870 to Present (originally operated as the NHDVS Southern Branch; transferred to VA in 1930; 2 nd Generation domiciliary building completed in 1939)	Converted to 3 with Domiciliary, 1946	None
	New York	Bath	1878 to Present (originally operated as New York State Soldiers' and Sailors Home; transferred to NHDVS in 1929; transferred to VA in 1930; substantial 2 nd Generation hospital opened in 1937 and domiciliary in 1939)	Converted to 3 with Domiciliary, 1937	Determination of Eligibility, 1980
	California	Los Angeles (Wadsworth)–	1888 to Present (originally operated as the NHDVS Pacific Branch; transferred to VA in 1930; 2 nd Generation building campaign began in 1934)	Converted to 3 and Domiciliary	Determination of Eligibility, 1981
	California	Brentwood (Los Angeles)– Located on portion of former NHDVS Pacific Branch	1888 to Present (originally operated as the NHDVS Pacific Branch; transferred to VA in 1930; 2 nd Generation building campaign began in 1937)	1, 1937	Determination of Eligibility, 1981
	Indiana	Marion	1888 to Present (originally operated as a NHDVS branch; transferred to VA in 1930; 2 nd Generation neuropsychiatric hospital completed in 1942)	Converted to 1, 1932	Listed, 1999*

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	Illinois	Danville	1898 to Present (originally operated as a NHDVS branch; transferred to VA in 1930; 2 nd Generation medical and surgical building completed in 1934)	Converted to 1, 1936	Listed, 1992*
	Tennessee	Johnson City	1903 to Present (originally operated as the NHDVS Mountain Home Branch; transferred to VA in 1930; 2 nd Generation building in 1935)	Converted to 3 with Domiciliary, 1946	Determination of Eligibility, 1979*
	South Dakota	Hot Springs	1907 to Present (originally operated as the NHDVS Battle Mountain Sanitarium; transferred to VA in 1930; ³⁶⁸)	Converted to 3 with Domiciliary, 1946	Listed, 1974*

*Determined eligible or listed in the NRHP under a different context than the Second Generation Veterans Hospitals Multiple Property Documentation Form.

³⁶⁸ Robinson E. Adkins, *Medical Care of Veterans* (Washington, DC: U.S. Government Printing Office, 1967), 395–409; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1931* (Washington, D.C.: U.S. Government Printing Office, 1931), 28; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1932* (Washington, D.C.: U.S. Government Printing Office, 1932), 20–21; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1936* (Washington, D.C.: U.S. Government Printing Office, 1936), 9; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1944* (Washington, D.C.: U.S. Government Printing Office, 1944), 10; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1945* (Washington, D.C.: U.S. Government Printing Office, 1946), 6; *Administrator of Veterans Affairs Annual Report for Fiscal Year Ended June 30, 1946* (Washington, D.C.: U.S. Government Printing Office, 1947), 8, 95–98; *Administrator of Veterans Affairs Annual Report for Fiscal Year Ending June 30, 1947* (Washington, D.C.: U.S. Government Printing Office, 1948), 134; National Park Service, “History of the National Home for Disabled Volunteer Soldiers,” Veterans Affairs National Home for Disabled Volunteer Soldiers, “Discover Our Shared Heritage Travel Itinerary,” http://www.nps.gov/nr/travel/veterans_affairs/History.html, accessed January and August 2010; *Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ended June 30, 1939* (Washington, D.C.: U.S. Government Printing Office, 1939), 112; Suzanne Julin, “Draft: National Home for Disabled Volunteer Soldiers; Assessment of Significance and National Historic Landmark Recommendations” (2007), 44, 50, 54–55, completed as a Cooperative Agreement between the National Council on Public History and the National Park Service, Midwest Regional Office, located on the World Wide Web on the National Park Service website at: <http://www.nps.gov/history/nhl/Downloads/NHDVS/NHDVS%20Draft%20Two.pdf>, accessed September 2011.

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